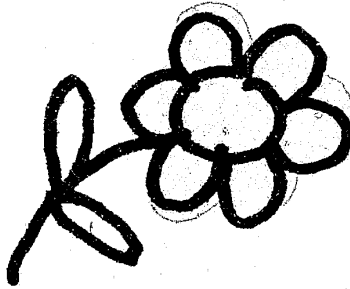


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Volume II



**a research sampler on
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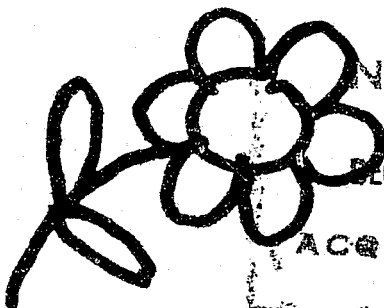
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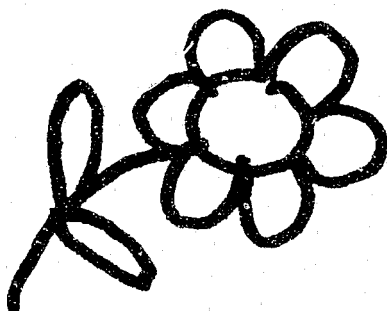
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Part V. Families in
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ANTISOCIAL CHILDREN AS ADULTS

Principal Investigator: Lee N. Robins, Ph.D.

*Author: Herbert Yahraes**

For no apparent reason, a youth grabs an 85-year-old woman in front of her doorstep and chokes her to death. A 15-year-old boy steals a neighbor's car and is picked up 3 weeks later, hundreds of miles away, because he had parked on the wrong side of the street. A middle-aged woman is jumped by a gang of teenage girls—avid for money, of which she has none—and winds up in the hospital.

Such items dot the Nation's newspapers daily, and hundreds of thousands of similar cases are believed to go unreported every year. In 1975, close to 2 million young people under 18—about 20 percent of them girls—were arrested for offenses ranging from murder to vagrancy, and including burglary, larceny, vandalism, arson, and assault. Of all people arrested, 45 percent are under 18. During 1965-1974, according to the National Center for Juvenile Justice, the delinquency rate rose by almost 59 percent.

What has science to tell us about why kids go wrong?

Two of the most comprehensive studies of the roots of violent and other antisocial behavior in children and of antisocial personality in adults—that is, an ingrained attitude of disdain for both law and people—have been conducted by Lee N. Robins, research professor of sociology in psychiatry, Washington University School of Medicine, St. Louis.

*See note at end of chapter.

In the first study, more than 500 patients who were seen at a St. Louis child-guidance clinic in the 1920s were followed into their forties. A group of 100 matched controls was used. In the other study, more than 200 normal, young black males were followed into their thirties. Then, some years later, Robins and her associates also examined the school and juvenile police records of many of the original subjects' children who were over 18.

The findings of this research, confirmed by other investigators, have posed and answered a number of major questions:

HOW EARLY DOES ANTISOCIAL PERSONALITY IN ADULTHOOD GET ITS START?

Robins answers that, in childhood, "The people we have studied have been mostly lower class . . . and have had a lifetime of exposure to hardship If they did not respond with psychopathic symptoms when exposed to such an environment in childhood, they did not begin to do so as adults." Antisocial personality "apparently *cannot* begin in adulthood." In fact, unless there had been marked antisocial behavior before 18, "a diagnosis of adult antisocial personality was never made."

Robins emphasizes that onset was usually early in childhood—particularly among boys. "Most boys began having obvious difficulties as soon as they began attending school. The first signs were truancy, failure to perform well academically despite adequate IQs, stealing, and disciplinary problems in the classrooms." Another indicator was to be found in poor relationships with classmates. For a few boys and most of the few girls who became antisocial as adults, such behavior did not emerge clearly until early adolescence, usually at ages 12 to 14.

A typical antisocial child first drew attention because of difficulties during the early school years. How many had already shown serious problems in the home and neighborhood is not known, but "there are many anecdotal accounts of problems dating from infancy." Robins continues: "The fact that we do not know whether onset is really at birth is a serious lack in trying to understand the etiology. If it is truly a disorder with which one is born, the social environment would have to be seen as at most a modifying, rather than an instigating, factor."

The role of heredity in criminal and delinquent behavior has been studied to some extent by others, with no clear outcome. In animals, a strong genetic element making for *aggressive* behavior has been proved.

HOW DO ANTISOCIAL CHILDREN TURN OUT?

Among children referred to the child-guidance clinic because of antisocial behavior, one-fourth turned out to be antisocial adults, one-twelfth were alcoholics or drug addicts, and one-ninth were psychotic. Only 16 percent recovered by the age of 18 and had no further psychiatric problems by the age of 40. Reports Robins: "This was in marked contrast both to children referred to the clinic for reasons other than antisocial behavior, who were more often well and rarely sociopathic as adults, and to a comparison group of normal school children, 60 percent of whom were well and only 2 percent sociopathic."

The antisocial child who develops into an antisocial adult is not carefree, as popularly believed, but "liable to suffer internal misery." More significant from society's view, "he also contributes importantly to most of our major social problems." It is from antisocial children that "a very high proportion of the prisoner population comes, as do many of our vagrants, our skid row inhabitants, those drug addicts who resort to crime to support their habits, and even substantial proportions of those psychotic adults who require restraint because of their aggressive and combative behavior Also from this group come many of the parents whose children end on welfare rolls, as wards of the State, or as adopted children, because the parents simply do not provide sufficient financial or affectional care for them. These neglected, impoverished, or adopted offspring themselves have a very high risk of childhood antisocial behavior disorders Thus the high frequency of antisocial disorders in the child population is preserved from one generation to another."

As Robins emphasizes, these findings have impressive implications for public policy. "They suggest that if one could interrupt the antisocial patterns so readily discernible by children's parents, teachers, and peers, one might greatly reduce the scope of the world's social problems."

WHAT CHILDHOOD SYMPTOMS PREDICT ADULT DELINQUENCY?

No one symptom marked every person who became delinquent as an adult, but some symptoms were very common. In more than half of the cases, these included "theft, incorrigibility, running away from home, truancy, associating with other delinquent children, staying out past the hour allowed, discipline problems in school, and school retardation." Among symptoms that were less common but occurred significantly more often than in controls were fighting, recklessness, slovenliness, enuresis, lying for no apparent gain, failure to show love, and an inability or unwillingness to show guilt over disturbing behavior.

None of these behaviors was an infallible predictor of antisocial personality, known also as "sociopathy" or "psychopathy." In other words, the behaviors were found also in some of the children who did not become antisocial adults. "Indeed," Robins reports, "less than half of even the most highly antisocial children" were diagnosed sociopathic when followed up years later; virtually none of these adults, however, was psychiatrically healthy. The *number* of symptoms was a considerably better predictor than any particular symptom or combination of symptoms. The more antisocial symptoms—such as lying, stealing, truancy—a child showed, the more likely he was to become an antisocial adult.

WHAT LIGHT DOES THIS RESEARCH SHED ON THE BASIC CAUSES OF ANTISOCIAL BEHAVIOR?

In the case of an antisocial *adult*, Robins answers, it is extremely difficult to separate those aspects of the environment that may affect behavior from those aspects that are affected by the adult himself:

The sociopath lives in a depressed neighborhood because his early behavior has kept him from completing school and his current behavior patterns make it very hard for him to hold a job or to pay his rent even when he has the money. He is divorced or separated because he has been nonsupporting, abusive to his spouse, and unfaithful. He is isolated from family members because he has long since shown them a lack

of interest and has failed to provide them with his current address.

Robins finds no reason to indict the broken home as a major factor in the development of antisocial personality.

Possible causes for antisocial behavior are also difficult to tease apart. However, drawing on the work of other investigators as well as on her own, Robins in 1975 examined the three factors of sex, race, and parental behavior and found that each had an influence.

Among antisocial children, she reports, boys outnumber girls four to one or better. "Furthermore, girls who do have behavior problems tend to come from families that are worse than the boys', suggesting that girls may have a higher threshold of vulnerability to genetic and/or environmental factors . . . or that girls experience more parental control than boys even in relatively disrupted families." Whether the proportion of antisocial girls has increased in recent years, as a kind of corollary of the movement toward sexual equality, is not yet clear.

As for the racial factor, Robins notes that black children, compared with white, have higher rates of school dropout and of juvenile delinquency and, when referred to child-guidance clinics, are more often seen for conduct disorders and less often for neuroses. "However," she points out, "racial discrimination as reflected in poorer quality of education, police prejudice, or psychiatrists' stereotypes might explain some or all of these differences."

A 1968 study of black children and white children in the South, cited by Robins, did find that black school boys reported more antisocial behavior than whites "suggesting that biased reporting is not the whole story." And a 1974 study of English school children found that both parents and teachers of blacks and whites reported a higher rate of antisocial behavior among the former. It seems likely that these differences, too, are rooted in the different social climates usually encountered by members of the two races.

As might be expected, parents had an influential role. Whether their role was genetic in nature, or environmental, or both, antisocial parents produced a significantly greater proportion of delinquent youngsters. Among white males who were 17 by 1959, the delinquency rate for those having an antisocial parent was 28 percent; for the others, 13 percent. Similarly among black males who were 17 by 1973 the delinquency rate was 43 percent if either parent was antisocial; otherwise, zero. Among black females, 24 percent of those whose fathers had been arrested at least once were delinquent, but none of those whose fathers had not been arrested were delinquent.

However, the relationship between parental behavior and the diagnosis of antisocial personality in these same children as adults was not always as direct. The effect of deviant parents in increasing the risk of their children becoming antisocial adults was strongest among children in the middle range of antisocial behavior. Conversely, conforming (not antisocial) parents tended to have children who became conforming adults even when these children were moderately antisocial. In contrast, among both white adults and black adults who as children were either "highly" antisocial or "highly" conforming, parental behavior did not have such a significant effect. This differential effect suggests that, in the extremes of childhood behavior, parental influence is outweighed by other factors.

Perhaps surprisingly, Robins finds no reason to indict the broken home as a major factor in the development of antisocial personality.

Our data suggest that the broken home is in fact an unimportant variable that is correlated with outcome only because antisocial parents usually separate. The child's experiencing the break itself does not seem to be the critical factor. Death of parents without problems led to no increased risk of antisocial personality, nor did we find that children's being early separated from an antisocial parent reduced the risk. Since amount of exposure to the parent seemed to have little effect, either negatively or positively, perhaps we should look to genetic factors, perinatal factors, and very early influences rather than to the experience of growing up in the parents' household as the crucial factors.

Nor, to the investigator's surprise, did low social class add much to the ability to predict antisocial personality, once the parents' and child's own behaviors were taken into account.

Similarly, Robins found no support for another popular theory, one engrained in folk wisdom, that a child's undoing can often be traced to bad companions. This explanation "must be treated with great caution," she reports, because the bad companions, instead of having led the child astray, may have been selected by him—after his problem behavior began—precisely because of a similarity of interests. "Whether children engaged in antisocial acts independently or in gangs," she notes, "they had approximately the same risk of antisocial behavior later on. Similarly, we found no effect of the neighborhood delinquency rate on the chances that the black school boys we studied would develop delinquency."

Research by Robins and her associates suggests that "at best, peer group pressure or imitation may be a necessary but not a sufficient condition to explain delinquency." They add that nondelinquent parents "*apparently were able to inoculate their children against enticement into delinquent activities even in the high delinquency areas to which housing segregation confined most blacks*" (italics supplied).

HOW DOES THE TYPE OF PARENTAL DISCIPLINE AFFECT OUTCOME?

When parents used discipline that Robins calls *adequate* and that also has been described as *love-oriented*, only 9 percent of the boys referred to child-guidance clinics turned out as adults with a sociopathic, or antisocial, personality. Precisely the same outcome occurred when parental discipline was too strict or, in the words of some other investigators, *punitive*.

Of the children whose parents were *too lenient*, or who exerted no discipline because they were uninterested in the child, the rate of antisocial personality as adults was about 30 percent.

Those results, Robins points out, confirm the earlier finding by William and Joan McCord that *both* love-oriented and punitive discipline "militate against convictions and incarceration, while excessive leniency, inconsistent discipline, and disinterest are associated with records of convictions." Moreover, "when

supervision during the teenage period was described as adequate, only 9 percent were later diagnosed sociopathic personality. . . ." This rate almost doubled among children who were sometimes supervised and sometimes not. And it more than tripled when they were supervised little, if at all.

CAN DELINQUENCY BE PREVENTED?

The findings reported above are strong evidence that some types of discipline and parental attitudes are far more effective than others in forestalling antisocial behavior.

Some additional light on the question is provided in a recent analysis by Robins and an associate, Eric Wish, of the development of deviance in Robins' black male subjects. Among other things, the investigators hoped to learn—by studying the sequences of deviant behaviors in these children—if certain behaviors manifested quite early could be used to predict other antisocial behaviors later on. The findings included: Absence from school in the earliest years was linked both to dropping out of school in later years and to leaving home; drinking alcohol before the age of 15 was also linked to leaving home.

"If there is a practical message in our efforts," these investigators report, "it is that centering efforts on preventing truancy in the first and second grade and drinking before 15 is likely to have the greatest payoff at least cost."

WHAT IS THE EFFECT OF SEPARATION FROM THE FAMILY?

A number of other investigators have added to our understanding of the roots of antisocial behavior. For instance, a noted English child psychiatrist, Michael Rutter, concludes that the separation of a child from his family does have "some association" with the later development of antisocial behavior. However, this effect is caused not by the separation itself but by "the family discord which precedes and accompanies it." The discord need not be active; it may simply be marked by lack of affection. The effects are the same. However, "a good relationship with one parent can go some way toward mitigating the harmful effect of a quarrelsome unhappy home."

In the case of transient separations, lasting at least 4 consecutive weeks, Rutter found that, when the separation was from one parent only, there was no rise in antisocial behavior.

The contrary was true when the child was separated from *both* parents. However, this finding held "*only* in homes where there was a very poor marriage relationship. . . ." Where the marriage had been rated "fair" or "good," the child's separation from the parents did not affect the rate of antisocial activity.

On the basis of his own as well as of a number of other studies on permanent separations, Rutter concludes that overall, "children from a broken home have an increased risk of delinquency." But the cause of the breakup is important. The psychiatrist cites findings from three studies that "the delinquency rates are nearly *double* for boys whose parents had divorced or separated . . . but for boys who had lost a parent by death the delinquency rate was only slightly (and nonsignificantly) raised." In permanent as well as in transient separations, the link between the separation and antisocial behavior seems to be not the separation itself but the discord and disharmony leading to it.

Rutter carried his investigation further by studying children who had been separated from their parents because of family discord or deviance and found themselves in new family situations. The new situation was still very poor for a number of these children; for others it was fair or, for a few, even good. For children whose new family situations were very poor, the rate of antisocial disorder was doubled.

Rutter poses a major question: "*Why* and *how* does family discord interact with a child's temperamental characteristics to produce antisocial behavior?" He suggests several possible mechanisms. First, parents of delinquents may differ in the way they supervise and discipline their children. Parental discord may be important only to the extent that it is "associated with erratic and deviant methods of bringing up children." Second, laboratory studies have shown that children, after watching someone behaving aggressively or deviantly, tend to go and do likewise. Perhaps, then, parental discord is linked to an antisocial outcome in the child simply because it gives him a model of hostility and antisocial behavior to copy. Finally, says Rutter, perhaps "the child learns social behavior through having a warm, stable relationship with his parents," and this relationship "provides a means of learning how to get on with other people. . . ." In this case, the basis of antisocial behavior might be "difficulties in interpersonal relationships."

IS THERE EVIDENCE OF BIOLOGICAL FACTORS?

In addition to social and cultural determinants of violence and other antisocial behavior, a number of investigators suggest that young people prone to violent behavior may differ from normal young people in the activity of their hormones and neurotransmitters.

One of the proponents of this view, psychiatrist Derek Miller of the University of Michigan Medical School, theorizes that inappropriate hormonal responses to stress are produced in some violent youths. He supports this hypothesis with observations that these individuals tend to think of people as things instead of as human beings and, in consequence, do not appear to get excited when acting violently. Although this attitude does not always lead to violence, Miller believes that it does if the person is genetically vulnerable to it and has had relevant nurturing experience, i.e., parents who frequently use physical force without explanation.

Consistent with Miller's theory are data compiled by University of Virginia School of Medicine psychiatrist Ake Mattsson. In an attempt to locate biological abnormalities in youngsters prone to violence, he finds that the tendency of delinquent boys to have lower cortisol excretion than other boys helps to explain their low level of excitement. Mattsson is quick to point out, however, that almost all of the delinquent boys had very disruptive early family lives.

Strong evidence that delinquent boys show other physiological differences has been obtained by psychiatrist Peter H. Wolff (of the Children's Hospital Medical Center, Boston) and his associates. In one project, for example, Wolff was studying a condition called the "choreiform twitch," a slight motor instability that is difficult to detect except by neurological examination. Wolff calls it "a kind of noise in the central nervous system." It can occur almost anywhere. When a youngster is reading, for example, his eyes will be focusing on one part of the page when the extraocular muscles may give a sudden twitch and shift the focus elsewhere for an instant. Boys whose delinquency has brought them into trouble with the law, Wolff finds, have a much higher incidence of choreiform twitch at an age when most other boys have outgrown it.

Wolff and his fellow investigators, beginning then to look more closely at antisocial youngsters, administered the Lincoln-Oseretski test of motor maturation to 15 delinquent boys between 14 1/2 and 15 1/2 years old. (This test measures a wide range of neuromuscular skills, such as jumping, crouching, balancing, sorting matchsticks, and picking up coins.) All 15 delinquents turned out to be in the *lowest 5 percent* of all boys their age. "A rather startling finding," Wolff comments. In contrast, all but one of the controls, who were normal youngsters of the same age as the delinquents, ranked in the *highest 30 percent*. The IQs of all the boys in both groups were normal or higher.

The investigators also administered the test to 15 boys being treated for learning disorders. These boys, too, had IQs that were normal or above. This time the finding was also a surprise: All but one of the boys with learning disability placed just the same as the delinquents—in the lowest 5 percent of the population.

Another study, using different tests with groups of 11-year-old delinquents and normals, also found differences in neuropsychological functioning.

On the basis of these and other studies, the investigators suggest that "children with delayed or disturbed neuromuscular development are more likely to be identified as delinquents when they grow up in a lower-class context and to be identified as children with learning disabilities when they come from a middle-class environment."

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* Contract Writer -278-78-0014(SP)

Principal Investigator: Lee N. Robins, Ph.D.
Professor of Sociology
Department of Psychiatry
Barnes and Renard Hospitals
4940 Audubon Avenue
St. Louis, Missouri 63110

PRESCHOOL INTERVENTION FOR CHILDREN AT RISK

Principal Investigator: Jon E. Rolf, Ph.D.

*Authors: Vivian R. Isenstein, NIMH, and William Krasner**

"We professionals," said Dr. Jon E. Rolf, "must face the fact that we really know very little about preschool children, what is helpful and what is harmful to them. We know very little about the causes of behavior problems in very young children. We should admit it and then launch on a mutual voyage of discovery with parents, with other workers, and with the children themselves."

Dr. Rolf, Associate Professor of Psychology at the University of Vermont, is Director of the Vermont Child Development Project (VCDP). Together with Dr. Joseph E. Hasazi, his co-investigator, and the rest of his staff, his "voyage of discovery" started in 1973. They have been gathering and organizing millions of pieces of information about the etiology of behavior disorders in early childhood in order to understand the multiple and interrelated causes of these disorders. They have also been designing and testing early therapeutic intervention strategies and procedures that might someday prove useful for primary prevention.

THE CONCEPT OF VULNERABILITY TO MENTAL DISORDER

Dr. Rolf noted that school teachers and counselors rarely identify disturbed children early in their school careers unless they are very withdrawn, overly aggressive, or overtly antisocial.

*See note at end of chapter.

cial. Many other children with psychological problems remain undetected. They move along in school or perhaps begin staying behind for reasons that have little to do with intelligence. However, with academic failure, more children with psychological problems will be noticed by their teachers, but typically they will still be children with overt, easily recognized behavior problems. Some will be called hyperactive, but most will be judged as disturbing to the class. They become discipline problems. They are sent to the principal's office; their parents are called in; some are punished; some are referred to counselors or psychologists.

At this point, 20/20 hindsight comes into play. Investigating social workers and examining psychotherapists find patterns that seem to go back to early childhood. These children had shown signs, in early school and even before, of being at risk, but the symptoms had gone unnoticed by parents who may have had their own problems or did not want the bother or the stigma of having a "disturbed" child. Unfortunately for these children at risk, there are few other adults around to notice these early signs or to know how to help these children prior to their becoming "problem children" in the elementary schools.

It would be easy to blame ignorant or careless parents for not noticing early deviations, but the truth is that, even from the scientific viewpoint, too much about the origins of behavior disorders is unknown and unexplored. Hindsight analysis is not the same as the ability to predict which children will develop problems. In the past, theories that hoped to identify and to explain the etiology of behavior disorders in children usually focused either on how crucially important early experiences and environmental stresses were (e.g., broken home, poor family, violent neighborhood) or on the child's constitutional vulnerability (that is, inheriting genes for schizophrenia from an already schizophrenic parent). The theoretical position used to focus etiological research on the discovery of incontestable proof as to which—environment or genes—was the causative factor of deviant behavior. Fortunately, within the last decade a notable shift has occurred in the attitudes and dogma of developmental psychopathologists. Most now acknowledge the legitimacy of the interaction of a multitude of environmental and constitutional causes. This is particularly true for research-

ers studying new methods for the early identification of and intervention for vulnerable young children.

Would it be possible, in any case, to predict which children will have behavior disorders? Dr. Rolf and his colleagues think so. Healthy competition among researchers has improved the quality of potentially useful predictors based on data coming from life-history research and from samples of high-risk children studied prospectively. Furthermore, there appears to be a growing consensus that the most vulnerable children have been identified as being:

- Those with deviant parents, especially those parents with psychotic and criminal histories.
- Those with chronic aggressive behavior disorders.
- Those who have suffered very severe social, cultural, economic, and nutritional deprivations.
- Those who have physical, temperamental, or intellectual handicaps.

THE CONCEPT OF PREVENTION

Having identified these risks—these warning signals in other words—the next question is: How do we use this information? The Vermont Child Development Project is an example of applied research at its best. The answer is to try to prevent pathologic behavior from developing in children at risk by “innoculating” them with competence-promoting early experiences much like the concept of giving the vaccine to infants to prevent smallpox. However, one must remember that smallpox has a single cause, and still it took much research before the cause was discovered and much testing before the effectiveness of the preventive vaccine was proven.

Could the multiple causes of psychopathology in young children be proven and prevented? Could early symptoms in disturbed children be reduced, duration shortened? Could preschool child-care facilities be used as treatment centers? Dr. Rolf and his cohorts are attempting to answer these questions. Keeping in mind that there is no one specific target behavior, no one universally proven treatment strategy, no one target treatment time, and constantly changing environmental variables, Dr. Rolf decided to test the efficacy of a therapeutic day-care intervention program at the same time he was gathering

baseline data on children with already detected behavior disorders and on children at varying degrees of risk in the population at large. Specifically, he was interested in studying the development of competent behavior in both vulnerable and nonvulnerable children, the symptoms and duration of pathology in preschool children, the relationship of preschool measures of competence to school measures of social adjustment and academic prowess, and the relationship of the observed patterns of incompetence in preschool and early-school children to recognized signs of incipient adult psychopathology.

SCOPE OF THE PROJECT

The Vermont Child Development Project was designed with four major components—epidemiological surveys, high-risk family studies, intervention studies, and a follow-along survey—running simultaneously.

The *epidemiological survey* has already sampled a broad cross section of over 1,000 preschool-age children in day-care centers and at home in an effort to obtain basic data on the developmental patterns of skills and behavior disorders in large non-clinic populations of preschoolers. The Vermont Behavior Checklist, developed specifically for this project to determine developmental differences in children, and the Family Background Information Form have been used by child caretakers at 30 day-care centers, at approximately 6-month intervals, on 650 of the children. In addition, 400 families whose children are in home care were also administered the instruments. Of the 650 children, 210 were rated at the same time by their parents. An additional 1,100 first-grade children (half the first graders in the county) have also been screened annually through teacher ratings using the Lambert Pupil Behavior Rating Form and peer ratings by their classmates. At the same time, additional ratings have been made by VCDP behavioral observers, and ratings assigned to cumulative school records on each participant.

The *high-risk family studies* look at the social, intellectual, and physical competencies of several groups of vulnerable preschoolers—those having parents who have received treatment for psychotic, neurotic, character, or marital problems. Two major psychiatric treatment institutions have cooperated with

the VCDP to identify 450 high-risk families who met the criteria. A subsample of 50 of these target families and an equal number of control families have been contacted for intensive evaluation of the family members and their preschool children's development.

The *intervention studies* are being conducted at the Ethan Allen Child Care Center, formerly the University of Vermont's Home Care Enrichment Center, to determine how effective typical and/or specially designed day-care experiences are for helping already disturbed or vulnerable children. For each intervention child there are four control children, two of whom are randomly selected from other day-care facilities and from home-care environments and two who are matched on behavior and family background variables. The vulnerable children experience the usual day-care program and, at the same time, individualized therapeutic procedures to promote greater competencies (social, intellectual, and physical) and to diminish maladaptive behaviors. Daily treatments and assessments are made on both the children under treatment and their matched controls. The intervention studies also include voluntary counseling programs that have been designed for the parents of the vulnerable children in the program.

At the beginning of the study, each of the vulnerable children received a thorough medical examination. Also, a special balanced-diet program was designed and initiated by a University of Vermont nutritionist for all children at the day-care center; and, when necessary, some parents were given nutritional information to improve home meals.

A *follow-along survey* is studying the developing competencies of preschool children in general in order to set social and intellectual norms. With permission of their parents and teachers, specific preschool children are then followed into their school careers to elicit data with which to make outcome comparisons.

Several studies have used children from pathogenic families as subjects, but the VCDP is unique in its depth, target population, overall goals, and potential for usefulness. It is unique in its site—Chittenden County, Vermont—a relatively isolated New England valley with a mix of urban and rural areas and a well-balanced population that provides a stable community of subjects and controlled variables. The project works with pre-

school children from 2 to 6 years of age, particularly those under age 4, a tough-to-research but extremely important group. Also, no other high-risk child research project actively puts the emphasis on testing therapeutic interventions.

One great advantage of the combination of epidemiological surveys and of intervention programs is, interestingly, the light shed on the behavior of normal children. First, data collected from the general population of children can serve as a base against which to plot and measure the deviations and the patterns of recognized problems; second, they give greater insight into what the norms really are for this age group. So little has actually been known about preschoolers that much that had been accepted as fact turns out to be theoretical folklore and often professionally espoused mythology.

HOW NORMAL IS NORMAL?

One of the most significant findings from prior studies is that there are two major behaviors that reliably demonstrate the types of disorder among school-aged children: externalizing or "acting-out" behaviors (usually unsocialized aggressiveness) and its opposite, internalizing (withdrawing) behavior. None of these studies, however, has indicated how strong or how widespread these behaviors are among very young boys and girls in day care or at home.

Data from a random sampling of 1,100 VCDP youngsters, not cases referred for treatment or defined as at high risk but taken from the general population, show that examples of both aggressive and withdrawal behaviors can usually be found in the majority of children. For instance, over 41 percent of the boys struggled or picked fights with other children at least once a week. But what is most important is the frequency or severity of the fighting: Less than 10 percent made a constant habit of it, struggling or fighting several times a day or continuously all day long. These latter frequencies of fighting define abnormal rates of fighting for preschool boys and not just the occurrence of fighting per se.

There were other interesting sidelights about sex and age stereotypes. Very young girls may be spicer, but in certain situations and at ages less than 3, they are no more sugar and everything nice than the boys. At age 2 they show as much or

more aggressiveness, including temper tantrums and constant demands for adult attention. They pick fights as frequently as boys. But, in the later preschool years, whether from constitutional factors or from watching their elders and television, the boys catch up to and surpass the girls in all categories of aggressiveness.

“. . . an overabundance of energy and trouble being in one place for a period of time, the cardinal symptom of hyperactivity, must be expected in normal preschoolers”

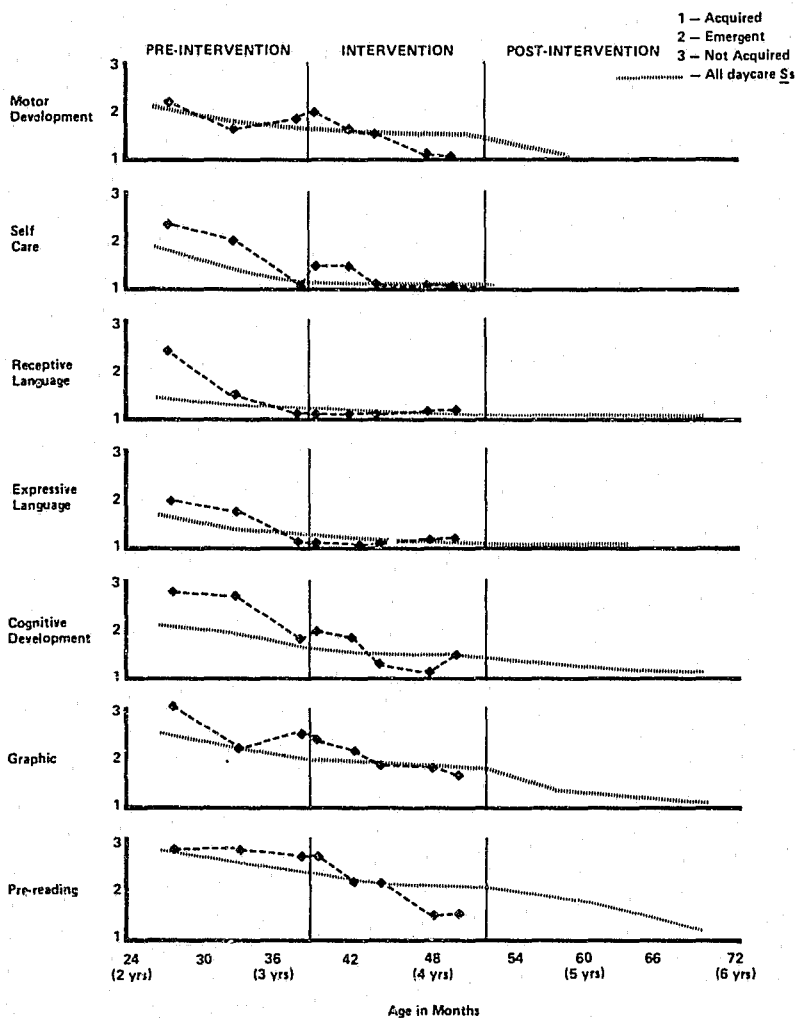
Most important, perhaps, is the impact these findings must have on our treatment modalities and our pet ideas that are based on concepts of normality which may be only partly true or false. For instance, “hyperactivity” is usually defined as an abnormal condition, synonymous with “minimal brain dysfunction,” which in turn is considered to be an organic syndrome and is frequently treated with stimulant drugs. But the VCDP data show that “an overabundance of energy and trouble being in one place for a period of time,” the cardinal symptom of hyperactivity, must be expected in normal preschoolers. If not, one-fourth of all children from 18 months to 5 1/2 years, rated as being active almost all of the time, have “damaged brains.” Asks Dr. Rolf, “Which alternative explanation would you choose?”

Classifications of the behavior disorders of the very young have been handicapped by lack of reliable data—specifically by a lack of sufficient representative samples of children available for examination. There are several reasons for this. First, as previously mentioned, parents are often hesitant to bring their infants and preschoolers with troublesome behavior to a clinic or doctor for diagnosis or treatment because they often correctly believe the children will “outgrow it.” In some instances psychologically disturbed parents would be, for their own reasons, even less likely to bring their children for study. Indeed, they might not want the signs of child abuse to show or they

FAMILIES IN DISTRESS

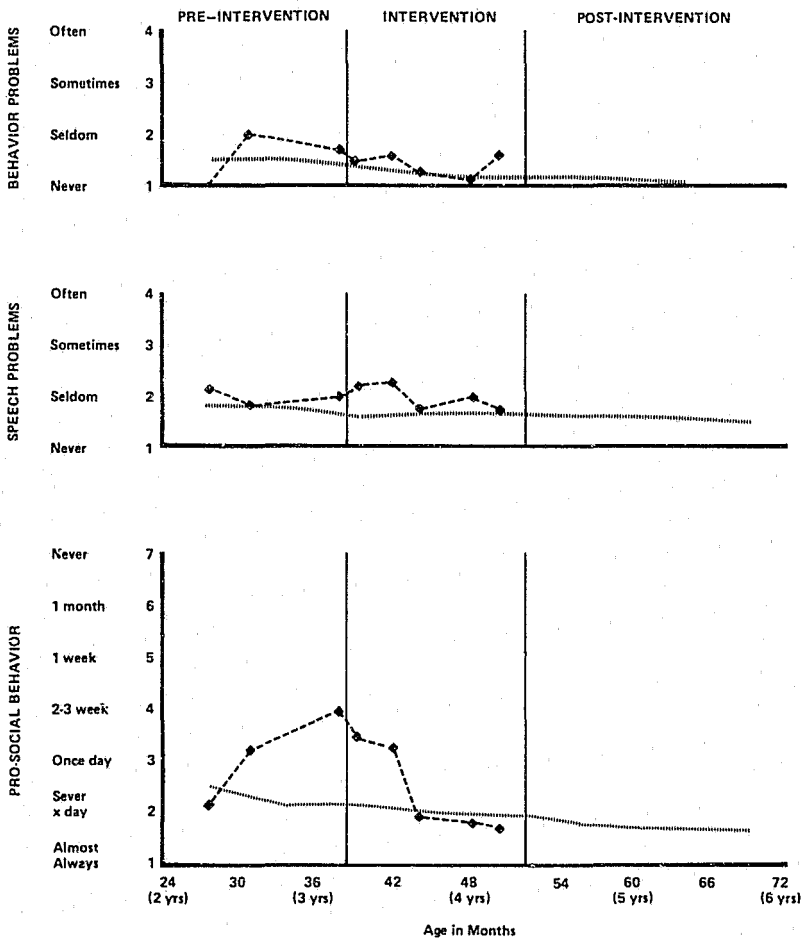
DEVELOPMENTAL PROGRESS

Intervention Subject 13472



Intervention Subject 13472

ALL DAYCARE Ss



may need a disturbed scapegoat child to hold their own lives together. But in most instances, parents simply might not consider antisocial or prepsychotic symptoms important or as anything abnormal. Indeed, when members of the staff of the VCDP pointed out to some parents that their children were violently aggressive, attacking and hurting other kids for little or no apparent reason, a few parents answered with some surprise, "What's wrong with that? I was just like that myself when I was a kid."

Secondly, unlike older children, many seriously and chronically disturbed preschoolers will probably not be noticed, screened, or evaluated by professionally trained teachers, guidance officers, or nurses; they will not be referred by concerned and trained nonrelatives for psychological evaluation. As a result, prior to studies such as the VCDP, the incidence and prevalence of behavior disorders among the very young must be inferred from searches of a limited number of clinic cases. How can conclusions about the types and prevalence of abnormal behavior drawn from such records be scientifically sound?

In contrast to previous studies, the VCDP has created a developmental risk profile program, identifying and quantifying normative behaviors among preschoolers and measuring their interactions with family background and environmental variables. The data amassed for these profiles are not only useful for epidemiological purposes, but they also provide a baseline against which to measure the effectiveness of early therapeutic interventions for children with different early experiences. Curves that show both how quickly normal developmental skills are acquired and problems are abandoned can be compared between the high-risk children in intervention and the large number of controls who receive no treatment but who have had similar or dissimilar childhood rearing environments. An example of a comparative developmental risk profile appears on pp. 506-7.

EARLY INTERVENTION IN THEORY AND PRACTICE

The theory—or theories—of early intervention stress the relationship of early environment to behavioral development. They date at least to the 1940s and provided the early impetus for the broad scale preschool intervention programs of the 1960s, including Head Start.

Historically, the first intervention programs concentrated on cognitive development because it was concluded, or felt, that social and emotional immaturity would be expressed, and could be measured, by poor school performance. These programs were predicated on the belief that children who had behavior problems would lose "learning time" because they could not adapt to the school routines, e.g., emotional upset and social disorientation disrupt intellectual concentration and the learning process, creating a substantial gap between potential and performance among children with trouble. A related school of thought holds that emotional disorders are really defects in social interaction and that the origins for these defects occur in the first few years of life, in interactions with others, young and old, who must contend with the stresses of bad neighborhoods and homes. The obvious solution, therefore, would be to give the children "enriched environments" and better adults and children to use as models. Most federally funded day-care and Head Start programs have tried to do this.

Most day-care centers are designed to help parents, not children.

Today, a well-run nursery school or day-care center, particularly one that puts its major emphasis on therapeutic or competence-promoting strategies rather than baby sitting, meets most of the criteria of good models and enriched environment. Says Dr. Rolf, "Coming to day care gives children a chance to get out of a possibly pathogenic home, to meet other kinds of socially capable kids and adults they might not have dreamed about, and whose behavior can serve as examples. At the center they can get good food, attention, a chance to play in a good social atmosphere." The concept of the therapeutic day-care center is not new, but few have existed because of lack of money for specially trained staff and perhaps because our society is unprepared for day care in those terms. Most day-care centers are designed to help parents, not children. For example, the WIN (Work Incentive) program was devised to get mothers off welfare and into the labor market.

Those centers that have used treatment have usually used traditional day-care programs with minor therapeutic modifications. The teacher's or therapist's major job was to turn the child from socially unacceptable forms of behavior toward what would be acceptable. Each center essentially would go its own way in developing a treatment package for each child. Further, there was usually no consensus—and no evaluation or proper definition—about what worked best and why. In retrospect it seems obvious that, regardless of the theoretical bias of a particular center or therapist, what worked best was a combination of various methods adapted to the individual child—the eclectic and pragmatic approach.

ECLECTIC APPLICATION AND EVALUATION OF EARLY INTERVENTION

Although both are classified as "at risk," there is a substantial, if not fundamental, difference between those children who come from backgrounds or with handicaps that statistically indicate a greater chance of disorder and those children who already have serious problems when they come to the day-care centers. And there are even greater differences between "at risk" children and the controls of the VCDP intervention research who remain in their homes.

Different children, different types of children, call for different intervention strategies. This has been a basic precept on which the project has built its program and a basic conclusion

"Label a child handicapped, set him aside in special groups for his kind of handicap, and he will probably stay handicapped and labeled."

drawn from implementing the program. It is also an inevitable and essential part of the "voyage of discovery" approach. The project is trying, simultaneously, to assess the therapeutic effectiveness of two related types of intervention. On one hand, they are trying to judge the impact of day-care and nursery school experiences in general on various samples of children

judged to be at risk, as compared to the controls at home. On the other, they are trying to define, develop, and judge the effectiveness of specific and specialized competence-promoting strategies of already disordered children.

The VCDP does not believe in segregation of children with special problems. In the current intervention site, the Ethan Allen Child Care Center in Winooski, Vermont, no segregation—be it by sex, social class, behavioral problem, etc.—is practiced. Very few children, no matter how severe their disorders, are turned away. (Some are referred when they can get better treatment elsewhere for certain problems.) They are exposed to, and they play with and relate to, a broad range of other kids. Drs. Rolf and Hasazi feel strongly on this point and have written eloquently on it. "If an intervention program is to be implemented within a day-care setting . . . the maladjusted and well-adjusted children must be mixed together in order to facilitate the learning of appropriate social behaviors under controlled conditions." They follow a large number of authorities in public education who find that segregation of handicapped children has seriously damaging effects on self-image and helps initiate a self-fulfilling prophecy. Says Dr. Rolf: "Label a child handicapped, set him aside in special groups for his kind of handicap, and he will probably stay handicapped and labeled."

If the maladjusted can learn appropriate social behaviors from normals, what about the reverse? Dr. Rolf smiles. "This negative modeling can and does happen. For example, one mother came to us, horrified, to tell us that her small son, while being complimented for being a nice boy by an elderly lady they met on the street, told her that she was an old (obscenity)." However, that boy's behavior was quickly corrected by his mother. Most of the modeling and influencing ultimately do go in positive prosocial directions.

Perhaps the most compelling argument for early therapeutic interventions with high-risk children is that it might not only treat and ameliorate, but be prophylactic as well—build up resistances, better methods of coping, greater flexibility of response. For these purposes, too, the intervention program at VCDP serves as a laboratory. The overall goal remains straightforward: to help the children while finding out how. To accomplish this, one can wear the two hats of humanist and

experimentalist: The children must be regarded warmly, and the data and evaluations must be regarded with cold objectivity.

THE INTERVENTION PROCESS

Six modes of intervention are used—day-care curricula, consultation, referral, direct child contact, parent and family contact, and advocacy/follow through. Any one intervention mode can be applied to a singular behavior problem, but, more commonly, intervention of necessity involves the simultaneous application of several modes to deal with complex problems. Flexibility is emphasized.

The usual day-care activities are maintained at the Center. However, the intervention aspects are tailored to the special needs of individual children. It would be unwieldy to cite the many variations of a technique adapted to one situation. The general goals are to improve social, intellectual, and physical competencies to give the children self-confidence and a feeling of well-being.

Social competencies are usually developed through a graded series of cooperative play and work activities, group theatrical skits with peer and teacher roles assigned, and practice in socially acceptable behaviors. Visits to various institutions such as churches, stores, and fire stations not only make the children aware of the existence and function of these units but also teach them society can work for the good of all. At the same time, these pursuits enable the children to interact with a variety of people whom they wouldn't usually see, and they learn to appreciate and accept a range of individuals and their differences.

It is difficult to speak of age-appropriate intellectual competence when much of what children learn depends upon their readiness to do so. However, generally, the program objectives are to stimulate creativity, concept development, verbal comprehension and expressions, critical thinking, and sensory discriminations (visual, auditory, and tactual). Perhaps developing inquisitive behavior is the most important part of this effort. Although much environmental-sensory stimulation is done informally through manipulated play activities, more formal instruction in number, alphabet, and language training is done

through tapes and records and repetitive exposure, practice, and reinforcement.

Before attempting to work on physical competence, each child's vision, hearing, motor coordination, and tactual sensitivity are carefully evaluated. Through games, sports, dancing, and rhythm exercises, the children are taught about their bodies and how to control their movements. They also learn the relationship of their bodies to physical structures and objects. Most importantly, they learn to cooperate with other people.

Although the three types of intervention appear to be autonomous, in practice there is much interrelatedness. Many of the activities promote all three competencies at the same time. Should we be overwhelmed with the busyness of the intervention program, Dr. Rolf is quick to point out that free unstructured play opportunities are available in large quantities and that the children derive much pleasure from their experiences.

Paul is an example of one who profited from intervention and whose progress was dramatically portrayed on the developmental profiles. He was one of the early cases and is still in the project. He was referred to the VCDP by a social agency investigating possible abuse and neglect. Both his parents had histories of psychiatric hospitalizations and still showed signs of severe psychological problems. At age 3 1/2 he had almost no language skills, wasn't toilet trained, couldn't take care of his own simple needs, and his social skills were typical of children half his age. Since he was in such bad shape, intervention had to start with the most elementary problems—including getting him to the day-care center on time and in reasonably good condition. His mother, lonely while her husband was away would keep the children up late for company and go to bed so heavily sedated that she could hardly get up and make breakfast for Paul in time to take him to the Center. He missed sessions often, and when he did come was apt to be sleepy, hungry, and irritable.

Finally, arrangements had to be made by the project staff and funding obtained to hire a driver to pick him up and to bring him to the Center. The intervention programs for Paul had to be addressed to many problems—socialization with other children, cognitive skills, self-help, use of the toilet, and so on, including speech therapy and training in the verbal expression

of feelings. He differed from the others not only in degree but in variability. On the developmental profiles his curves rise and fall like those of an erratic steeplechaser, compared to the more smooth curves of all the control subjects. Paul's shifting pattern seemed to reflect the periodic crises the family went through, as well as his uneven attendance at the Center.

With time, most of the developmental curves of the intervention subjects approach the norm as skills are acquired via the therapeutic programs. In Paul's case, by the time he reached age 5 (18 months after his start in day care) his curve was, in most measures, nearly parallel to that of the rest of the subjects. The biggest problems and greatest deviances were still in social and general behavior—as noted before, the areas most closely affected by the continuing distressing situations at home.

Each child is different. So are the interventions. Dr. Rolf says, "Some kids will respond to more freedom—the open classroom kind of thing—and open up like flowers. But others will just fly apart; they need structure—perhaps a new structure—that they don't get at home. You gently try one approach, then another to find the one that works best.

"In working with children, with parents, and with teachers, we must develop mutual trust on the basis of recognition of our mutual ignorance concerning the causes of behavior problems and the desires to discover new methods to help the children help themselves."

ROCKS AND SHOALS

Intervention with high-risk children must run into problems, and their nature, and possible approaches to solutions may be as instructive as the successes.

The Parents

The greatest source of problems in the VCDP intervention program has not been the children. Parental involvement or lack of it, both in relation to the children and the intervention strategies, came around to haunt the staff again and again. Although the programs were meant primarily to revolve around children and their needs, parent participation and cooperation are built in and are vital. When a child enters the

program, the parents must agree to meet with project staff at least once a month to discuss progress and behavior at home. Some parents have been seen as often as once a week for counseling and support in childrearing. Nevertheless, when a 10-week program of parent education was designed and developed, though all parents of target children showed interest, only one actually showed up at the first meeting. This poor attendance was both frustrating for the staff and illustrative of the resistance or reluctance of parents to be actively involved. Indeed, such reluctance is very commonly encountered in cases where young children are experiencing developmental delays or behavior problems. Reports from other intervention projects describe recurrent difficulties with engaging the active participation of the parents in the child's treatment programs.

Unlike many other early intervention programs, such as Head Start, that deal primarily with cognitive development, the VCDP has chosen to work with all parents, even those who are themselves seriously disturbed.

Often, some of these parents contribute to their children's problems (and the staff's): They do not get children up in time for day care; they do not give them basic health and nutritional care—clean clothes, baths, or adequate food; they deliberately confuse the children about the treatment program, encouraging them to actively oppose the staff. Sometimes a parent or both parents may need to keep the child disturbed—he may be all that holds them, or the family, together. As noted, Paul's mother, with her husband gone at night, kept the children up to comfort her. At 4 years of age, highly disturbed, Paul would still reassure her, "Don't worry, Mommy, I'll be the man of the house." He would take care of her. Says Chris Gault, a primary planner and implementer of the therapy programs, "Children tend to blame themselves for whatever went wrong at home, even for the abuse that was visited on, or befell, them." Paul's statement may have comforted his mother but did little for him.

Working with parents and children at the same time involved walking a tight rope—trying to find that difficult balance between loyalty to the family, so that they would continue to trust the worker, and loyalty to the child's welfare and interest, when that might involve confrontation with the parents; this was especially true when neglect or abuse was in-

volved. With some families it was hard to impress the parents with the seriousness of the child's condition. They had problems of their own, and in their world everyone has troubles. With withdrawn children, of course, the difficulties are not always obvious to the untrained; and to many overburdened mothers a good child is one that makes no trouble.

Because lack of parental cooperation does present a serious obstacle in any program for high-risk children, the VCDP suggests that future research plans include the investigation of new ways to motivate parents to join the therapeutic team.

Multiplicity of Problems

To a lesser extent, the scope and profusion of a child's own difficulties make trouble in planning. Most of the children in intervention not only have physical and learning problems, but social ones as well.

The broad spectrum approach to intervention—particularly for multiproblem children—has many advantages, mostly that progress is more likely to be made in a limited period of time. Its major disadvantage, apart from the demands on the personnel, is that precisely isolating what led to the positive changes is more difficult when there is more than one uncontrolled variable. This does not mean that the intervention programs are haphazard—they are all aimed at specific targets—but being initiated at once, or close upon one another, it is hard to determine which one made the difference. A brief case history might illustrate the problem in intervention planning.

Unlike Paul, Fred had been attending the day-care center for some time before intervention. He seemed fine in most areas, but he seldom spoke to or played with other children, though he did interact with adults. This behavior did not improve the longer Fred stayed in day care (without intervention), so the presumably salubrious effects of day care alone were not working sufficiently, at least not for him. In fact, the troublesome ways he increasingly went about attracting attention of adults led to his referral. The routine day-care center activity was actually increasing the severity of his problems, and he needed special programs to change this trend toward more prosocial behaviors.

At the time intervention began, positive social interactions with other kids in his group were rare, far less frequent than is typical for his age level. The case, having worsened in the months before intervention, was stubborn; it was 6 months before a definite change was noticeable. But after that the gates opened, and his progress was rapid. By the end of another 6 months, his social behaviors were normal and very positive. Intervention was no longer necessary. Fred was not as serious a case, from all appearances, as Paul; even so he received speech and language therapy twice a week, individual work with project staff that concentrated on cognitive development delays, and small group play that was supervised. In the small group he was, first, exposed to children with strong positive social skills who tried to involve him and led into activities and games that encouraged cooperative play; he was literally taught to play with other children and socially rewarded if he did. In addition to all this, project staff worked with day-care center teachers, and their responsiveness to Fred was altered to pay more attention to positive behavior and to ignore attention-getting ones. This fit in with and complemented the peer-play intervention. In short, we might say that Fred was given the "full treatment," or a good deal of it, and the positive results justified the effort.

Since children differ so much it may not be as important to find out what interventions worked with one child as to find that a broad spectrum approach will work with many. Fred is a success story despite his initially serious problems. So is Paul; and there are others.

Prior Agency Affiliations

Related to all this is the fact that most of the families of the high-risk children are not only multiproblem, but multiagency affiliates. They are affiliated with the project, with the day-care center, and with a number of social agencies, some of which might wish they would go elsewhere. All these affiliations, programs, and philosophies must be coordinated or contended with. Some families have had a long and unpleasant history with other agencies and vice versa. They may carry over resentments and stereotypes; or, on the other hand, they may look upon affiliation with the VCDP and the Ethan Allen Center as a chance for breaking off with the others.

When children are accepted into day care, therefore, several interesting phenomena are likely to occur. Often the referring agencies and parents act as if they had finally succeeded in their dreams of getting the child into a mythical sanctuary in which all needs would be met; and the time had now come to relax and get out from under. So welfare agency case workers, therapists from mental health centers, and visiting nurses all tend to terminate their active participation—in effect, to cut out. “When the agency people leave,” says Dr. Rolf, “the parents often ‘go to ground.’ They withdraw to their homes, close the door, and try to avoid working with day-care and intervention staff. So our staff works hard with the kids during the day and then gets frustrated because the next morning much of the previous day’s progress has been undone at night. These parents have developed an avoidance reaction to agency people, so the necessary parent-education work can’t be started.” The result is that the highest-risk children—with severe disorders, from multiproblem families, who need help the most—are also the poorest risks for steady progress in gains in social and intellectual competence. The same parents who created much of the risk prevent it from being treated realistically. Paul may be considered such an example: Lower-risk children, who may have similar problems but have more reachable parents, are generally the more appropriate short-term intervention cases. Fred is that kind of example, for his parents followed his progress closely and were very pleased with the appearance of each new social skill.

Worker Resistance

Disturbed parents are not the only ones who may resist researchers intervening with their children. Day-care center staff members who develop proprietary or surrogate parental interests often have attitudes which make cooperative research difficult. Sometimes it seems to Dr. Rolf and his group that some of their more vocal critics among the workers must have been influenced by mad scientist movies, because they could hardly have had any experience (much less bad experience) with real researchers. To those who apparently prefer to rely on practical experience, love, and intuition alone, researchers must by definition be cold manipulators; and tender children (perhaps all society) must be protected from them. Fortunately,

negative stereotypic attitudes are exhibited by relatively few, and most parents and day-care providers are understanding and cooperative. "Maybe," says Dr. Rolf, "this minority is necessary to cool down unethical researchers. But it is very tiring and depressing to have to keep defending ourselves and reassuring everybody that we are not evil and unloving Fagins in search of an *Oliver Twist*, or agents of a corrupt and authoritarian government. It wastes a lot of time and energy."

Associated with the "all research is evil" attitude is the fact that work with children attracts a wide range of people with differing philosophies and motivations. Some have superb skills and sympathy, with good relations with children, staff, and parents. But some choose to work in day care apparently because they feel they will be free to do as they please—that child care and therapy are varieties of free-form art in which excellence is achieved by untrammelled freedom of expression. Supervision and evaluation of performance by others are not only undesirable but philosophically abhorrent to them. The intuitions of the worker are better for the children than any rules or the past experiences of others. What this means in practice, of course, is that it is often impossible to have consistent approaches to intervention either within or between centers and difficult or impossible to reconcile programs for cooperative effort or transfer. For example, one room in a center may allow "fair fights" (and thus reward physical aggression), while the next room does not permit fights and will separate, even isolate, combatants until the conflict can be resolved some other way. Therefore, says Dr. Rolf, "Anyone who starts intervention studies in an already existing day-care center with such free spirits at work can't expect programs to be either totally accepted or equally implemented by all staff. But, only those programs which will work in such a real world setting can generalize to other real settings."

Having described the frustrations and difficulties, however, Drs. Rolf and Hasazi would like to make one thing clear. While there have been complications (including blizzards, epidemics of flu, and chicken pox) in trying to follow their research design, the complications are really very trivial in light of the enormous support provided to the project by Center staff.

FORGING AHEAD

Impediments to progress are encountered only by persons going somewhere and are important only if speed and movement toward goals have been generated. The Vermont Child Development Project has accomplished much since its inception in September 1973.

The epidemiological surveys of preschool children in Chittenden County, Vermont, have been initiated and are continuing. Both matched and randomly selected control children have been obtained for comparison with the high-risk children in the intervention program. Much basic data have been collected that will identify specific age-appropriate behaviors in preschool children and will also provide insight into behavior disorders in the early years. The Vermont Behavior Checklist, one of the more important measures created for this project, has been proven a reliable instrument. Another technique designed specifically for the project—the developmental risk profile—has proven useful for outlining the progress of a single child in areas of motor development, self-care, cognitive achievements, and prosocial behaviors and enables a graphic comparison between children, or within each child over time.

Weekly visits to psychiatric treatment facilities to recruit patients have provided 50 high-risk families with preschool children who have participated in the study. These families, as well as an equal number of control families, have had each family member and their preschool children's development evaluated through structured interviews, tests, self-report measures, and behavioral observations.

To date, 28 children have participated in the intervention program; some having completed their second year or more. Therapy goals—a written set of specific behavioral objectives—were established for each child individually based on their social, cognitive, and preacademic skill levels. Intervention approaches have drawn heavily on behavior modification and Adlerian concepts, and considerable attention has been given to developing interpersonal relationships. Between group comparisons on all dependent variables and a variety of within-subject experiments have been designed to evaluate particular therapy or teaching techniques. Definitive counseling programs were developed for the parents of the intervention children.

The epidemiological surveys of competence and disorder have now followed the children into the public schools, starting in the spring of 1975, with the active cooperation of four district superintendents, the principals of 12 schools, teachers in 46 classrooms, and the parents of about 1,100 children. Competencies in school and related activities have been rated by teachers, classmates, behavioral observations, and cumulative record data. As more of these follow-along data come in, it will be interesting to see what patterns develop.

The voyage of discovery at the University of Vermont has been under way now for more than 3 years. No final destination has been reached, but much has been learned about research navigation in the community, about research impediments and cross currents, about how to stick on course, about the dimensions and conformations of what is to be explored, even if it cannot now all be seen. Millions of facts have been collected; and tables, charts, and profiles of progress have been made. Certain stereotypes, believed to exist by many, have been proven to be myths; but phenomena that are even more important and remarkable are taking shape, just ahead. Says Dr. Rolf, "We're working toward primary prevention with very young, high-risk children. Sometimes we know where we're going, sometimes we feel our way. It's a long trip, but we're moving with all deliberate speed and respect for all our children."

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Principal Investigator: Jon E. Rolf, Ph.D.
Director, Vermont Child Development
Project
Department of Psychology
University of Vermont
Burlington, Vermont 15401

RUNAWAYS REVISITED

Principal Investigators: Lucy Olson, Ph.D., Elliot Liebow, Ph.D., Milton Shore, Ph.D., and F. Vincent Mannino, Ph.D.

Author: Mary C. Blehar, Ph.D., NIMH

In 1961, a group of social scientists at the Mental Health Study Center in Adelphi, Maryland, a suburb of Washington, D.C., began working with Prince George's County juvenile authorities on what was then becoming a problem of epidemic proportions, namely that of young people running away from home. Even in that pre-Vietnam, pre-flower child era, children were leaving their homes at such an alarming rate that Judge Ernest Loveless of the Seventh Judicial Circuit became convinced that professional collaboration was needed to comprehend the situation. Responding to this need, a Study Center team, composed of Robert Shellow, Julian Schamp, Elliot Unger, and Elliot Liebow, began a research project designed to provide some answers.

With the assistance of the Police Department, they obtained names of all missing persons between the ages of 10 and 17 during a period from 1963 to 1964. As it turned out, most of the cases were runaways, although a few were children mistakenly reported by parents as missing when in fact they were actually staying with friends or other relatives. Seven hundred fifty cases of missing youths, consisting of nearly equal numbers of boys and girls, from local primary, middle, and secondary schools, were officially reported.

In 1967 the research team published their findings in a monograph published by the Society for Research in Child De-

velopment. It provided information about the children's family backgrounds, school performance, and peer relations. However, in so short-term a study, the issue of the lasting consequences of running away could not be addressed.

More recently, Liebow, presently head of NIMH's Center for Studies of Metropolitan Problems, joined with Mental Health Study Center staffers, Drs. Milton Shore, F. Vincent Mannino, and Lucy Olson in an attempt to track down some of the former runaways, now young adults, to determine how they had fared over the years. The following is, in large part, the story of 14 of them as they are seen trying to cope with the complexities of modern living. But let us turn back the clock to 1961 when the original research was undertaken.

THE ORIGINAL STUDY

As a preliminary step in their research, Liebow and his coworkers reviewed the existing literature on running away. What they found was more theory than hard data. Most of the theories were dated, insofar as the act was usually embedded in the context of social and economic conditions prevailing at the time the theorist was writing.

An early interpretation of running away saw it as an expression of youthful exuberance. The prototypical runaway was Huckleberry Finn, whose exploits up and down the Mississippi River were chronicled by Mark Twain. In this view, youths might leave their small towns or farms to seek adventures or flee home misadventures, but there was little that was pathological about their behavior. Indeed, it was a positive indicator of normal growth.

A later theory conceived of running away in economic terms. During the Great Depression of the late 1920s and early 1930s, economic stresses pushed large numbers of young men into a mobile zig-zag across the Nation as they sought work. A study of 3,352 such youths registered between 1934 and 1935 in a regional camp of the newly created Federal Transient Service cited family financial strain as the usual reason for running away.

A third more recent theory was closely aligned with traditional clinical psychiatry. Its proponents had worked with youths in homes for delinquent and disturbed adolescents. Per-

haps because of their experiences, these workers tended to see running away as indicative of severe pathology. Youths who engaged in it were thought to be impulsive, disorganized, and otherwise prone to sociopathic behavior.

The early Study Center team was not fully satisfied with any one of these theories as an exclusive explanation of the contemporary patterns they were observing. The romantic theory seemed too fanciful. The economic-stress theory was not particularly plausible among the relatively advantaged population of Prince George's County. The clinical theory seemed too harsh an indictment of so large a number of children. It was better, they concluded, to make few assumptions and to let the data guide them empirically to an understanding of motivations.

After obtaining the names of missing children, the researchers contacted parents by telephone, explained the purpose of their work, and, if permission was granted, conducted a telephone interview. In this aspect of their endeavor, they were exceedingly successful; they interviewed almost 98 percent of parents. In a smaller number of cases, 96 to be exact, they conducted a face-to-face interview with the runaway child.

Another facet of the early study involved a comparison between the runaways and a random sample of County youths. A questionnaire asking about home and school life was sent out to a group of nonrunaways enrolled in secondary schools. The same information was obtained from the runaways interviewed.

The sample of 750 was special in one very important way. It was the first one to include almost all families of children reported as missing. Previous studies, conducted in mental health clinics or homes for delinquents, were open to criticism for failure to obtain a representative group of runaways. Their conclusions that runaways were deeply troubled or even sociopathic were based on an already select pathological sample, but they had not shed much light on the status of the many runaway youths not requiring special treatment. Because the Study Center team had surveyed a much more representative population, they were in a far better position to make statements about runaways. As a cautionary note, however, they suggested that perhaps they were dealing with only "the tip of the iceberg" since episodes of running away may have gone unreported by parents in the most highly disorganized families

or in those where hope for reconstructing the missing child had been abandoned.

CHARACTERISTICS OF THE EARLY RUNAWAYS

Who were the early runaways and what types of families did they come from? The Study Center team reported them to be, on the average, between the ages of 16 and 17 and from homes very typical of County families in terms of income and parental education. Relatively few came from low-income households and relatively few from those of high income. Most were squarely in the middle.

The runaways did diverge from the norm in two ways, however. They were more likely to be living with only one of their natural parents and more likely to have changed addresses in the past year. Hence, in terms of broad indices at least, their home lives were less stable than those of other children. On the other hand, they were no more or less likely to report disagreements with their parents than were the randomly sampled secondary school youths who answered the questionnaire. Both groups reported a high incidence of conflicts.

Parents of nonrunaways were not sampled, so no comparison could be made between them and parents of runaways. However, in the small subsample of families where the child had been mistakenly reported to police as missing, parents were much less likely to note problems with their children than were parents of runaway youths. The researchers concluded that adolescence was a generally tumultuous period for most children, who tended to perceive disagreements with parents as significant, but that parents themselves were much less likely to disclose difficulties to professionals unless they were of major proportions.

In the area of school performance, which will be reported on in detail when the clinical-followup study is discussed later, the runaway children had many more problems than the general population of youths. It was not that the runaways were less capable or intelligent—on a standard IQ test, the two groups were equivalent—but they were less motivated to achieve academically.

Surprisingly, one-third of both runaway and nonrunaway children polled reported some encounters with local police in

the preceding year, but formal charges were more often filed against the runaways, although five-sixths had no police records.

Even over the brief span of the early study, certain names kept reappearing on the missing-persons rosters. These children, labeled "repeaters," were singled out for special attention. The research team found that the repeaters were most nearly similar to the stereotype of runaways as delinquent, impulsive, and disorganized. They had experienced far more school and home difficulties than nonrepeaters and their problems were more severe in nature. They were the ones whom the team believed to be in special jeopardy for normal development.

In discussing their findings in 1967, the researchers were careful to qualify them. They had examined only suburban children. While they had sampled a far larger and more representative group than ever before, they had not dealt with the universe of runaways. Perhaps the most in need had different characteristics. They had looked at runaway children over a brief period of time. In order to understand the full consequences of the behavior, it would be necessary to follow them over the years into young adulthood. Their research had provided a short-term analysis of runaway youths and had laid the foundation for a longitudinal study.

THE EARLY 1970s' STUDY OF FOURTEEN FORMER RUNAWAYS

In the early 70s, public interest in runaway youths was rekindled by several events. Children were leaving home in large numbers in protest over the Vietnam War, the compulsory draft system, and in generalized disapproval of parental materialism. Gravitating to counter-cultural meccas, such as New York City's East Village and San Francisco's Haight-Ashbury, they practiced, refined, and sometimes abandoned a myriad of alternative lifestyles.

In Texas, several missing boys were found victims of brutal and bizarre homosexual murders. Their parents had not heard from them for months and in some cases even for years, and many parents had given up hope of ever finding their children. The shock and horror created by disclosure of circumstances

surrounding the murders further increased public awareness of the problem. While the motivations of the early 1960s' runaways were, superficially at least, somewhat different from those of youths in the late 60s and 70s, the act itself still held painful consequences for parents.

In response to public pressure, during the presidency of Gerald Ford, Congress enacted the Runaway Youth Bill, which mandated the establishment of runaway houses for children who might be drifting in strange cities without money or friends. These houses were meant to be places where wanderers could come to get a meal, rest, and perhaps some advice about difficulties that had led them to leave home. Telephone hot-lines were established so that runaways and those contemplating running away could call a friendly and understanding person.

It was in this social milieu that the investigators became convinced of the importance of following up a small group of the early 1960s' runaways. They envisioned their work as providing some preliminary answers to questions about the long-term consequences of running away and as yielding some hunches that could in turn be tested in a full-scale followup study if the results of the smaller one proved promising.

The research team tracked down 14 former runaways; half of them men and half women, and Olson interviewed them in depth about their past and present lives. She also interviewed a sibling close in age to each former runaway in order to make intrafamilial comparisons, and where possible she spoke with parents, grandparents, and other family members. All in all, she spoke to 89 persons. What was found will be reported with emphasis on two spheres of functioning, school and present work. While schooling is in the past, it seems to provide a link to problems the former runaways encountered in employment.

In general, outcomes seem to depend in large part on two dimensions, the social class of the youths and their repeater-versus-nonrepeater status. Of the 14 seen, 7 each came from middle- and working-class backgrounds. Seven were repeaters, the others nonrepeaters. Social class seemed to provide a context in which the original act of running away was interpreted by the subject and by his or her family; and those who had run away repeatedly seemed more impaired in their functioning than those for whom the behavior was an isolated incident.

Perhaps central to an understanding of the problems encountered by the former runaways was their previous school history. As Olson explained, in our society important events of passage, such as high school or college graduation, typically follow fairly fixed timetables, largely dictated by the exigencies of ongoing social institutions. These timetables identify crucial transitions in a person's life and give it much of its shape and meaning. Whether or not a person is "on schedule" determines to a great extent how successfully he or she is integrated into the larger social structure.

School, particularly high school, is an arena in which important kinds of socialization take place. People learn vocational skills and methods of relating to others which can stand them in good or bad stead for later life. Ideally, graduation should signify competence in these areas. Unfortunately, while school played a central role in the runaways' lives, it failed to have the desired consequences. Of the fourteen, only six completed school, and this they managed with difficulty. None went beyond the 12th grade. Their shortened school careers contrast with those of their nonrunaway sibs, who, with one notable exception, received diplomas by the standard age of 18. Six siblings went on to college, all of these graduated, and two continued in professional or graduate schools. The differences in length of schooling are most striking when repeaters are compared with their siblings and with nonrepeaters. With one exception, all of the repeaters dropped out of secondary school, and only two of the nonrepeaters did so. The former group accounts for most of the difference between the runaways and their sibs in schooling length. Table 1 summarizes these findings.

Table 1—Length of Schooling

<i>Groups</i>	<i>Dropped Out</i>	<i>Diploma Only</i>	<i>College</i>
Nonrunaway Siblings	1	8	5
Runaways	8	6	0
Repeaters	6	1	0
Nonrepeaters	2	5	0

Middle-class runaways were expected by their parents not only to finish high school but to continue on to college. Howev-

er, only three of seven met the modest expectation and none the more ambitious one. Understandably, the educational gap between middle-class runaways and their sibs was greater than among the working-class groups. Differences among the former ranged from 3.5 to 9 years and among the latter from 1 to 3 years.

A table, while it can demonstrate the scope of some school problems, cannot capture the subjective element of others. Among middle-class parents, standards of academic excellence held for children were higher than among working-class parents. Even when middle-class runaways were putting in an average performance in school, their parents often considered them to be doing poorly. For instance, one girl with a C average aroused such disappointment in her mother that the woman took her to a psychologist for an IQ test. Upon learning that her daughter had a very high IQ indeed, the mother placed her in a boarding school from which she promptly ran away, only to return home and do much worse than before in the local school. By contrast, the parents of working-class runaways rarely engaged in severe and ego-deflating battles with their children over school.

The relative academic successes of their siblings was also a source of discomfort to the middle-class runaways. Parents would characterize them as "awkward" and "stupid" and the sibling as "bright" and "talented." The runaways themselves made such comparisons and found themselves wanting. One middle-class young woman, identified as possessing an IQ in the genius range, never did well in school and dropped out in the tenth grade after receiving a number of Ds and Fs. Her sister, whose intellectual abilities were not as great as hers, graduated at the top of her class. Clearly, many of the runaways possessed the ability to perform in school but they were hindered by personal problems that interfered with learning.

Academic failures and failure to complete high school had obvious implications. Lacking self-discipline, constructive work habits, and actual skills, the runaways were at a serious disadvantage vis-a-vis other youths. Additionally, when they fell behind academically, they also tended to suffer socially with teachers and peers. This is suggested by the frequency with which they got into trouble at school for such acts as classroom disruption and confrontations with teachers or were suspended

or expelled. Table 2 illustrates the distribution of school problems among the runaways and their sibs. Ten of the 14 runaways encountered school-discipline problems while only one of the sibs did so. Again, these difficulties were more pronounced among the repeater group, all of whom had chronic and severe problems to contend with.

Table 2—Behavior Problems* in School

<i>Groups</i>	<i>Behavior Problems</i>	<i>No Behavior Problems</i>
Nonrunaway Siblings	1	13
Runaways	10	4
Repeaters	7	0
Nonrepeaters	3	4

*Refers to reports of two or more disciplinary actions taken by teachers, principals, and other school authorities.

Class differences in the occurrence of disruptive behavior were noted, with disruptions being more common among working-class youths. The working-class runaways tended to express their hostility to school authorities openly, directly, and forcefully. As one man said, "When the teacher hassled me . . . I'd tell her to go to hell." Others recounted how they used disruptive strategies to wreak havoc in the classroom. When middle-class youths got into trouble, it was usually not for classroom antics but for stealing, drug or alcohol abuse, or truancy. Their response to these problems and consequent exposure was one of humiliation. Their classmates tended to compound their problems by ostracizing them or by being cruel. As one middle-class runaway put it, "All I knew was, these kids were piling up on me It was really a nightmare."

Many of the runaways expressed to Olson during interviews how they had felt bored, frustrated, and defeated while in school. They had demonstrated these emotions by various acts of school disruption and by withdrawing from most school and cultural activities. They viewed their teachers as hostile and restrictive. Some spent time in parking lots or woods near the school "just fooling around, not doing much of anything." Others simply vanished from the premises entirely. While middle-class runaways recognized implicitly the value of education and reacted to this recognition with anxiety, working-class

runaways saw little relationship between school and the "real world."

Interestingly enough, despite their poor school performance, when they were interviewed years ago, many of the youths had expressed hopes for the future. They spoke of going on to college and entering professional careers. Today, they are woefully unprepared to fulfill such ambitions or even much more modest ones. In retrospect, many see their flight from school as an abandonment of their visions and as a "fatal" step that removed them from the mainstream of adult life. Defensive about their lack of education, they now look back and view school as having failed to prepare them technically, socially, and psychologically for the next step in life—the world of work.

WORK

For most young people, after schooling, the next step toward assimilation into adult life is to enter the world of work. But for those who had run away from home, this entry was problematical. Table 3 summarizes the current job status of the 13 who work or who have worked in the past and their siblings. The kinds of jobs they hold or have held are shown in table 4. Eight of the runaways, not including a housewife, are unemployed, and five of these have never held any kind of regular job lasting more than a few months.

By contrast, all but one of the nonrunaway siblings are now employed and have worked regularly. Most have white-collar jobs, and even those who do blue-collar work have more specialized, technically demanding positions than the runaways. The siblings, with the exception of one high school dropout, take

Table 3—Employment Status* of Runaways and Nonrunaway Siblings

<i>Groups</i>	<i>Employed</i>	<i>Unemployed</i>
Nonrunaway Siblings	12	1
Runaways	5	8
Repeaters	1	6
Nonrepeaters	4	2

* Table excludes a housewife and her sibling.

Table 4—Job at Last Employment (by Class)

		Family of Origin	
		Middle-Class	Working-Class
Non-runaway Siblings	Social worker		Printer (master)
	Psychiatric nurse		Elevator repairman
	Editor		(Fed. gov't employee)
	Self-employed businessman		Computer programmer
	Lawyer (exp: still in school)		Administrative assistant
	College teacher		Legal secretary
	Computer programmer		Keypunch operator (Construction worker)
Run-aways	Salesman		Electrician
	Electrician		Bartender
	Munitions worker (Air Force)		(Autobody repairman)
	(Bus Boy)		(Housepainter's helper)
	(Laborer)		(Construction worker)
	(Receptionist)		(Stock worker)
	(Beekeeper)		

* Shows latest job regardless of present employment status. Unemployed status indicated by parentheses.

their jobs seriously, regarding them as careers. Their work courses show the typical pattern of increased responsibility and upward mobility as they acquire expertise and experience. For the runaways, their many odd jobs have not added up to a career but at best have served to provide an occasional source of income. Many of the runaways have quit jobs or have been dismissed from them. The changes have been precipitated by such factors as misconduct at work, poor performance, trouble with the boss, or their own general discontent.

Personal income gives further confirmation of the runaways' dire circumstances. As might be expected, the runaways, when they work at all, earn less than their siblings (\$8,500 versus \$13,000). Five runaways have no income and are supported either by parents or by social-welfare agencies. Several of the men admit to having supported themselves intermittently by pushing drugs or committing robberies. Even among the very

few who make a relatively substantial amount of money, debts are common. Some are supporting families, others have income drained by alimony or child support. In general, financial liabilities limit already strained economic resources.

Necessity rather than affection has thrown many of the runaways back on their families adding to what amounts to an already great strain in their relations.

The former runaways' living arrangements are yet another reflection of problems in making a living wage. Fully half of them do not live in separate residences but have remained either in their parents' homes, in institutions, or in makeshift households. Most do not have their own means of transportation but must rely on others, usually their families, to get them around. Necessity rather than affection has thrown many back on their families, adding to what amounts to an already great strain in their relations.

As was the case in schooling patterns, the work patterns of the repeat runaways demonstrate their greater difficulty in coping. Only one repeater has a regular job today, and the others have sketchy and intermittent work histories. They are more likely than the one-time runaways to depend on their families or social-service agencies for assistance.

Class differences in work tend to be much less marked in actual performance than in personal sentiments. Working-class runaways are somewhat ambivalent about their lack of success in the job market. They alternate between enjoyment of their freedom from "the rat race" and frustration at being without a job or working at one they dislike. Unemployment compensation offers an attractive alternative to boring employment for many.

For middle-class runaways, problems in the work world seem to follow naturally from earlier problems in school. They tend to feel a greater sense of failure and devastation than the working-class runaways. Taking little pleasure in unemploy-

ment, the middle-class young people compare their own unsuccessful circumstances with that of their more prosperous parents and siblings.

OTHER ASPECTS OF THE ADULT LIVES OF THE RUNAWAYS

While their work patterns demonstrate most clearly the unfocused nature of the runaways' adult lives, love, friendship, and family relations also reflect their difficulties in being assimilated into the culture at large.

Many of the former runaways have experienced severe problems in forming and maintaining meaningful love relationships. When they have married, they have tended to live in situations fraught with tension. Several marriages and unformalized relationships have been dissolved.

Friendships seem likewise ephemeral and transitory, although class differences emerge in specific patterns. Working-class runaways describe themselves as spending a great deal of time in social activities of a diffuse nature. An acquaintance, not seen for a long time, may drop by and spend the day drinking with the runaway, only to disappear again for months. Social activities tend to be spur-of-the-moment, and "friendships" often end on a violent or aggressive note when the friend does something that is perceived as inamicable. More often than not, relationships that give the superficial appearance of starting out well end abruptly.

The siblings of the working-class runaways spend less time in general social activities, but they have smaller and more stable circles of friends, many of whom they have known since their high school days. Other friends, of more recent vintage, work with them. Such an avenue of lasting acquaintance is closed to their nonworking siblings.

Fragile though they may be, the social relationships of the working-class runaways at least provide them with a source of ready companionship. By contrast, middle-class runaways seem isolated and forlorn. Perhaps because the middle class is much more formal and structured, there exist fewer opportunities for making casual acquaintances at a neighborhood restaurant or pub. Having severed school ties years ago and failing to achieve lasting work relationships, many of the middle-class sample have very little occasion to get to know others. Their siblings,

on the other hand, describe themselves as having a surfeit of good friends with whom they share common interests.

Perhaps the most paradoxical finding of all concerns the former runaways' relationships with their own parents. Several years after their abortive attempts to separate themselves prematurely from family authority, they are still dependent, supported by frustrated parents who see themselves burdened long after their responsibilities for childrearing should have ended. Many of the runaways live at home but treat it merely as a place to stop off, to shower and eat, much as they would use a motel.

Parents have to accommodate to outbursts of violence, particularly marked among the working-class segment of the sample. However, they seem to view more philosophically their child and their relationship than do middle-class parents who are still less accepting both of failures and overt hostilities.

By contrast, the siblings, who did not break early ties, have virtually all managed to establish themselves in their own homes with their own new families. Their relationships with their parents remain strong but are qualitatively positive rather than negative, hostile, or resentful, as opposed to those of their less fortunate sibs, who persist in relating to parents in a juvenile and conflicted manner.

The violence which erupts at home also filters down into the former runaways' behavior in their general social milieu, as can be witnessed by their police records. Whether their offenses are characterized only by implicit violence against society—burglary, drug pushing—or actual violence against persons, nine of the former runaways have police records. Of these, all but two are repeaters, who into adulthood continue to show the most persistent signs of sociopathy.

SUMMARY

If youthful running away is viewed as an *isolated act*, relatively little negative can be stated about its long-term significance for the individual's development. When the act is *repeated*, and especially when it co-occurs with other youthful acts of truancy, vandalism, or disruptive behavior, running away can be a signal of long-term problems. Of itself, it disrupts a youth's schooling and social relations, at least temporarily, but it is not

clear that running away *causes* later problems. Rather, it is probably one element in a broader causal network characterized by disruption of normal developmental patterns.

While at this point no statement can be made about the consequences of running away per se (as contrasted to statements about the signal value of repeated acts in indicating the possibility of serious disturbance), it is nonetheless clear that the adult outcomes of the 14 runaways seen seem to be filtered through social class. Even though they are by no means successful adults, the working-class runaways appear to be more firmly anchored in their social milieu than the middle-class group. The former appear not to have jeopardized their class position so drastically by leaving school as did the latter, who are more isolated from the very formal structures that allow the middle-class individual to fit in adequately. The disruption of schooling and inability to find meaningful work have severed the middle-class runaways more drastically from social positions they might otherwise have been expected to achieve.

On the other hand, sociological variables cannot account entirely for the distressing outcomes of the runaways. Even familial factors cannot do this, since the runaways' siblings, subjected to the same environmental conditions and at least roughly equivalent home conditions, have apparently thrived. Even after such factors are taken into account, there remains a residual element of causation, rooted in the individual's psychology or in peculiarities of the parent-child relationship, that is not readily amenable to broader-level interpretations.

The Study Center followup research is highly suggestive of the consequences of running away, but because of its relatively modest scale cannot be taken as definitive. As the researchers readily point out, even the early 1960s' sample did not include all runaways, only those reported to police by parents. In the followup study, Olson may have spoken to a somewhat special group, perhaps those with more problems, or at least more willingness to air problems, than others, who may have gone on to make better life adjustments. The researchers also stress that running away, while an individual act stemming at least in part from personal troubles, is still deeply rooted in the broader social environment. The cohorts of the early 1960s' runaways generally viewed their potentialities with an optimism not held by youths today. Running away during that

time may have been a greater act of deviance and a more significant sign of discontent than running away was during the flower-child era of the later 60s and early 70s, when leaving home almost came to occupy the position of a fad. In the late 1970s, running away from home may again signal great disturbance, since it is a radical departure from a more general course followed by youths, which involves intensive and serious preparation in school for entry in what they perceive to be an increasingly competitive job market. Social factors provide a background for the enactment of personal crises.

An adolescent's running away disrupts families throughout the generations. Aside from immediate negative impact on parents and siblings, it has long-term undesirable effects on parents who must deal with the prolonged childhood of their offspring at a time when they had anticipated a bit more peace, and on the runaways themselves, who are generally unable to establish and maintain satisfactory new family units.

Because of the provocative nature of the findings of the small-scale study, the research team would like to undertake a larger followup study of the Prince George's County runaways so as to answer with more certainty questions such as under what conditions, to what extent, and in what ways, running away is associated with problems in adulthood. Other questions they would like to address are whether differences in age at the time of running away, length of stay away from home, and sex of the child, make for differences in the long-term outcome. Most crucial from a policy perspective, they want to find out what kinds of support and assistance the former runaways received during or following their experience and, in retrospect, what kinds of services would have been useful to them.

A large-scale study, such as the one they envision, would provide important information to those who must decide on strategies for intervention and prevention. In making distinctions, not only between runaways and nonrunaways, but also among runaways themselves, the research team has begun to provide a more refined picture than previously available of a special at-risk population of youths.

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Mental Health Study Center: NIMH

Principal Investigators: Lucy Olson, Ph.D.

Assistant Professor of Psychology
Department of Psychology
Rhode Island College
Providence, Rhode Island 02908

Elliot Liebow, Ph.D.

Chief, Center for Studies of Metropolitan Problems

Division of Special Mental Health Programs

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

Milton Shore, Ph.D.

F. Vincent Mannino, Ph.D.

Mental Health Study Center
National Institute of Mental Health
2340 University Blvd., East
Adelphi, Maryland 20783

PSYCHOSOMATIC ASPECTS OF DIABETES IN CHILDREN

Principal Investigator: Salvador Minuchin, M.D.

Author: Julius Segal, Ph.D., NIMH

It has long been assumed that conflict between parents imposes an emotional burden on their children. Because the young child is so heavily dependent for a sense of well-being on the quality of interactions with parents, signals of stress between mother and father are logically thought to have a palpable impact on the young.

At the Family Therapy Training Center of the Philadelphia Child Guidance Clinic, Dr. Salvador Minuchin and his associates, Dr. Lester Baker—director of the Clinical Research Center of Children's Hospital—and Dr. Ronald Liebman—medical director of the Child Guidance Clinic—have been investigating the role of family conflict in the psychosomatic ills of children. They do not suggest that stress in the family—or any other stress—can, of itself, produce such physical ailments as diabetes. As psychologist Dr. Bernice Rosman—research director at the Clinic—and her colleagues on Minuchin's team put it: "The sick child admittedly has a predisposing physiological vulnerability. A diabetic child has diabetes and will inevitably manifest its symptoms. What happens, however, is that some children, already diabetic, cannot be managed medically. They are resistant to treatment. And for them, we suspected that stress in the family is a factor."

The cues for the researchers' hypothesis were hardly subtle. Minuchin and his associates had repeatedly observed cases of

children whose psychosomatic problems were especially severe and who were typically unresponsive to treatment. They began working in 1966 with a small group of such severe, or "brittle," juvenile diabetic children incapacitated by their disease. These children had been hospitalized on the average of every 3 to 4 weeks, suffering bouts of ketoacidosis—a serious disturbance in the blood's acid-base metabolism. Exhaustive study had failed to uncover any organic cause for such recurrent crises. Moreover, when the children were removed to a hospital or children's residential facility, away from home and family, their bouts with ketoacidosis ceased. When they were returned home, however, the pattern inevitably resumed. Individual psychiatric therapy had failed to change the pattern of hospitalization, and the hunch was, therefore, that emotional factors embedded in the family were triggering the episodes.

In one typical case, a diabetic 8-year-old girl, whose daily insulin dosage was of the order of 30 units, was given over 500 units of supplemental insulin over a 24-hour period and *still* required hospital admission for diabetic acidosis. The supplemental insulin, provided to the child by her mother, was rechecked and found to have normal biological potency. On admission, the child's blood glucose was extremely elevated, and the degree of her acidosis was acute. A single standard dose of insulin was administered. It was readily effective, thus ruling out unusual forms of insulin resistance.

Such episodes led to the hypothesis that it was the emotional family milieu that triggered bouts of ketoacidosis and the subsequent resistance of the child to standard treatment.

Were these diabetic children, so resistant to treatment (Minuchin and Baker call them the "psychosomatic" group), reacting in a special way to family conflicts? If so, how were they different from other children who, while also diabetic, were free of disabling attacks of ketoacidosis?

A STUDY OF "PSYCHOSOMATIC" DIABETIC CHILDREN

To answer the question, Minuchin and his research team contrasted the stress reactions of the "psychosomatic diabetics" with those of two other groups of diabetic children serving as controls—one of them made up of children showing symptoms

of behavior disorders, the other made up of children who had no psychological difficulties, i.e., "normal" diabetics.

The biochemical mechanism responsible for the onset of diabetic acidosis is widely acknowledged to be the release of free fatty acids (FFA) in the blood. The same substance can be regarded as an index of emotional arousal or stress—even in normal children—typically rising within 5 to 15 minutes of exposures to stress. Minuchin's study involved, therefore, an ingenious arrangement designed to unobtrusively test changes in the FFA levels of the vulnerable children at the very time that stressful events in the family were unfolding.

Using what Minuchin calls the "standardized family diagnostic interview," the research team studied the children in the three diabetic groups, along with their parents, in a setting designed to evoke and intensify conflict and tension within the family. To establish a baseline, a half hour was spent settling the parents in an interview room, while the child took a place in an observation room behind a one-way mirror. From that vantage point, the child could see and hear the parents but could not participate. The psychiatrist next told the parents to choose and discuss a family problem and then left for a half hour. Having sown the seeds of discord, the psychiatrist returned and heated up the conflict by clearly allying himself with one spouse against the other. Finally, the child, who had all the while been observing the parents' arguments from the safety of the observation room, was brought into the interview room, and now the psychiatrist asked the parents *and* child to help each other decide how to resolve the problem. After a half hour, in which parents and child interacted, the entire family adjourned to another room, with no medical personnel present, for what the investigators called a "recovery period." The entire experience—up to the recovery period—was video taped.

To assess the physiological stress reactions of the family members to each stage of this experience, Minuchin and his team had equipped all of the participants of the study—parents as well as children—with "heparin locks," needles specially designed to allow continuous blood samples to be drawn without disturbing the subject and without the risk of clotting. These were inserted in the arms of the participating family members before the experiment began so that blood could be

drawn every 15 minutes by laboratory personnel who were hidden behind a screen.

The free fatty acid levels in the blood samples were later measured and the results matched with clinical assessments of the video-taped family transactions. By correlating the FFA levels with clinical appraisals of family interaction, the investigators were able to define the relationship between patterns of family behavior on the one hand and the emotional arousal patterns of the three groups of diabetic children on the other.

The results clearly marked the seriously ill diabetic children as different from children in the other two groups. At each point in the experiment—while watching the parents become involved in conflict, seeing it exacerbated by the psychiatrist, and especially when immersed in the conflict themselves—the “psychosomatic” children experienced a significantly greater “turn on” of stress as measured by the free fatty acid levels in their blood. Moreover, these levels remained elevated—and, in some cases, continued to rise—even after the conflict had subsided, while the children and their parents were “unwinding” in a natural setting.

THE FAMILY TASK INTERVIEW

The investigators might simply have assumed that the brains and bodies of these acutely ill children were more vulnerable to stress, but they wondered whether there might be something about their lives within the family that put them at risk for serious bouts with diabetes.

To assess the quality of the interactions among family members and especially the involvement of the child in parental conflict, the investigators engaged each of the families in a “family task interview.” The technique allowed the investigator to observe family members interacting with one another as they attempted to answer a series of questions and perform a task in concert. Included in the family setting for this part of the experiment were not only the diabetic children, but also one or two siblings whose presence provided an even richer insight into family interaction.

The group tasks did not focus on family pathology or serious problems: While some items did invite the discussion of ordinary family disagreements and unpleasant feelings, the re-

mainder were either neutral or positive in tone. The task directions were recorded and played back on a tape deck situated just outside the circle of family members. Once the initial instructions were given—for example, that there were no “right” or “wrong” answers or that anyone could operate the recorder—the family was left to its own devices; no one outside the family reentered the room until the tasks were completed. Here are a few examples of what the family heard when the tape recorder was set in motion:

Suppose all of you had to work out a menu for dinner tonight and would all like to have your favorite foods for dinner, but you can only have one meat, two vegetables, one drink, and one dessert. Talk together about it, but you must decide on one meal you would all enjoy that has one meat, two vegetables, one drink, and one dessert. Remember, you must end up agreeing on just one meal that everyone would enjoy. Okay, turn off the machine and go ahead.

Now in every family things happen that cause a fuss now and then. Discuss and talk together about an argument you had, a fight or argument at home that you can remember. Talk together about it, like what started it, who was in on it, and what went on, and also how it turned out in the end. See if you can remember what it was all about. Take your time. Turn off the machine and go ahead.

We have something we want you to build together. We have one made up for you to copy from. There are enough pieces for you to put it together. The model you will copy from is on the table. Use the pieces in the box next to it to build your copy from. The pieces in the box are divided up into bunches, one bunch of pieces for each one of you to start with. You can work on the table. Remember, it's for the whole family to work on together. Okay, turn off the machine and go ahead.

CHARACTERISTICS OF FAMILY INTERACTIONS

Did the families containing “psychosomatic” children operate differently from the others in response to the tasks? Minuchin and his coworkers found that there were, indeed, some unique elements in the interactions among family members containing a psychosomatic child.

To begin with, the sickly diabetics appeared to be inextricably and pathologically *enmeshed* in their families' currents of conflict. In such a family, changes in one member or in the relationship between two of them reverberate throughout the family system; even two-way conversations are rapidly diffused by the entrance of other family members, and one family member may even finish another's sentences. A conflict between any two members sets off a chain of shifting alliances within the whole family as other members get involved. The boundaries that define an individual's private life space are fair game for others, so that privacy is chronically punctured in the name of "togetherness" and sharing. ("Why do you change the furniture around in my room all the time when I'm not there," a 15-year-old, for example, complains to his mother.) Family members also intrude on each other's thoughts, feelings, and communications. One member may relay messages from another member to a third, thus blocking direct communication. In enmeshed families, executive hierarchies are confused. Children may join one parent in criticizing the other, and often the children take inappropriately parental roles toward each other. In the absence of a clearly defined and effective parental collaboration, parents work at cross-purposes in relating to children. Often one parent enlists a child's support in struggles with the other parent.

For the sick child, the capacity to protect the family from conflict through the use of symptoms may act as a major reinforcement for the illness.

In families with a psychosomatically ill child, members also exhibited an undue degree of *overprotectiveness and concern* for each other's welfare; nurturance and protective responses are constantly sought and supplied. A sneeze, for example, sets off a flurry of handkerchief offers, and queries and complaints about fatigue may punctuate the flow of conversation. Critical remarks or demands are often quickly followed by pacifying behaviors. Moreover, signs of distress frequently cue family

members to take steps to avoid the approach of "dangerous" tension or conflicts. For example, the sick child's emotional outburst may elicit comforting and help designed to avert exposure or exploration of family conflicts. Family members' perceptions of one another are structured around protective concerns, particularly where there is a sick child. In such families, the parents' overprotectiveness retards the child's development of autonomy and competence. (A father tells his two adolescent diabetic daughters, "If Mommy and I could only take the needles for you, everything would be all right.") In turn the children, particularly the psychosomatic children, feel great responsibility for protecting the family. For the sick child, the capacity to protect the family from conflict through the use of symptoms may act as a major reinforcement for the illness.

Minuchin and his colleagues also found that the psychosomatically ill diabetic child was typically a member of a family marked by *extreme rigidity*, committed to maintaining the familial status quo. Such families experience great difficulty in periods when change and growth are necessary. For example, when a child in an effectively functioning family reaches adolescence, the family will be able to change its rules and patterns or relationship in ways that allow for increased autonomy while still preserving the family continuity. But the family of a psychosomatically ill child operates like a closed system. When events that require change occur, family members insist on retaining accustomed methods of interaction. Consequently, conflict avoidance circuits must be developed, and the sick child serves as a particularly useful detouring route. When the family's low threshold for conflict is approached, the sick child simply becomes ill, allowing family members to detour conflict via their concern for him or her. Because issues that threaten change are not allowed to surface, these families live in a chronic state of submerged stress. Typically, the family represents itself as normal and untroubled except for the sick child's medical problem.

Also characteristic of these families was an *inability or unwillingness to resolve conflicts*, a pattern often buttressed by a strong religious or ethical code. As a result, there can be no explicit negotiation of differences. Problems are left unresolved, to threaten again and again and continually activate the family system's "avoidance circuits." Often one spouse is the

"avoider." The other may bring up problems, but the avoider always manages to deflect the kind of confrontation that would lead to the acknowledgment of conflict and its negotiation. A man, for example, may simply leave the house when his wife tries to discuss a problem. While other, normal families may bicker continuously, the constant interruptions and changes of subject typical of enmeshed families obfuscate any conflicts before they are brought to the fore.

PATTERNS OF FAMILY CONFLICT

Minuchin found dramatic evidence that the parents of psychosomatically ill children are literally using their children to absorb the stresses induced by their adult conflicts.

Minuchin and his team were especially interested in learning whether the psychosomatically ill child was drawn into the conflicts of the parents in a unique way. They went back, therefore, to the data of the experimental family conflict situation and found characteristic patterns of behavior that clearly affect the child's ability to "turn off" psychologically—and physiologically—after the stress has passed.

Three patterns of involvement seem to severely handicap the child's ability to "turn off" and, Minuchin concludes, are therefore related to psychosomatic illness.

The first, which Minuchin calls "triangulation," involves a splitting of the spouses. The children are pressed to ally with one parent against the other. They are put in such a position that they cannot express themselves without siding with one parent against the other. Statements such as, "Wouldn't you rather do it my way?" are used in the attempt to force the child to take sides. One demonstrative father was finally able to express his covert criticism of his wife, accusing her of coldness to the children. Both parents then pressed their daughter to say whether she preferred her father's ways and

wanted her mother to change. Stuck between the two adults, she was unable to speak.

In the second pattern, which Minuchin calls "parent-child coalition," a split also occurs between the parents, but in this instance the child tends to enter into a stable coalition with one parent against the other. One wife, for example, was unable to express her rage over her husband's refusal to protect her from his mother's attacks. The sick son became deeply involved as his mother's protector and spokesman for her complaints, urging his father to protect her from her mother-in-law. Although the father tried to persuade his son to reject the mother's *childish* demands, the boy doggedly maintained his enmeshed *adult* stance.

In the third type of pattern, called "detouring," the father and mother are united and submerge their conflicts by "protecting" or blaming their sick child, who is now defined as the only family problem. In several such family studies by Minuchin, the parents required that the children reassure them that they were good parents or join them in worrying about the family. Such parents occasionally vacillate between their concerns for the children and exasperation over the burdens the children impose by "not trying to help themselves." In most cases, parental concerns absorb the couple, so that all signs of marital strife—even minor differences—are suppressed or ignored.

Such maneuvers may often occur, of course, in the transactions of effectively functioning families. In Minuchin's view, however, normal families can shift to other modes of conflict confrontation and negotiation. The rigid families with psychosomatically ill children are more likely to engage in self-defeating maneuvers exclusively—virtually as a way of life.

Minuchin found dramatic evidence that the parents of psychosomatically ill children are literally using their children to absorb the stresses induced by their adult conflicts. Analyses of the blood samples of parents and children show conclusively that when, in the experiment, the children were brought from behind the one-way mirror into the presence of their squabbling parents, the youngsters' FFA levels *rose* dramatically as they became involved in their parents' tensions. At the same time, the parents' FFA levels were dramatically *reduced*. In today's vernacular, the adults had "laid it on" their children.

As Dr. Rosman (1975) describes the sequence: "When the interviewer comes in and makes this problem, the parents' FFA levels go up, and so does the child's. When the child comes into the room, the child's level goes up further, but the parents' levels come down. There is an absolute crossover."

How, then, do seriously psychosomatically ill children get that way? The answer, Minuchin says, is not a simple one, but three factors are involved. First, the child is physiologically vulnerable; that is, a specific organic dysfunction is present. Second, the child's family is characterized by enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. Third, the sick child plays an important role in the family's pattern of avoiding conflict—a role that serves to reinforce the symptoms.

Dr. Minuchin and his colleagues have studied other disorders—asthma, for example, and anorexia nervosa—and have found that, regardless of the specific physiological problem, the children who suffer severe psychosomatic attacks are the children from constricted family situations—the children who are receiving the brunt of their parents' conflicts. There is little wonder, then, that all of these acutely ill children fare better when they are removed from the family scene. But whisking sick children away from their parents, Dr. Minuchin is quick to emphasize, is at best a stopgap measure. His ultimate goal is to treat not the child, but the family—essentially to reorganize family patterns.

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Research Grant: MH 21336

Principal Investigator: Salvador Minuchin, M.D.
Philadelphia Child Guidance Clinic
1700 Bainbridge Street
Philadelphia, Pennsylvania 19146

PHYSICAL VIOLENCE IN FAMILIES

*Principal Investigators: Murray A. Straus, Ph.D., and
Richard J. Gelles, Ph.D.*

*Author: Herbert Yahraes**

The first survey of family violence in this country—violence between spouses, between parent and child, and between one child and another—based on a representative cross-section of American families is being completed under the leadership of Murray A. Straus, professor of sociology at the University of New Hampshire. Coinvestigators are Richard J. Gelles, associate professor of sociology at the University of Rhode Island, and Suzanne K. Steinmetz, associate professor of sociology at the University of Delaware.

Even though leaping divorce rates have served notice that the family is troubled, the evidence of actual violence uncovered by the Straus team is likely to astound almost everyone except those who have engaged in similar but less comprehensive studies.

For instance, on the basis of their nationwide sample, Straus and his coworkers estimate that during the year of the survey, 1975, approximately 1.7 million American children (out of nearly 46 million from age 3 to 17 who were living with both parents) were kicked, bitten, punched; or beaten up ("beaten up" being whatever the parents chose to consider it); or threatened with a gun or a knife; or actually had a gun or a knife used on them. In some cases, these punishments were used only

*See note at end of chapter.

once during the year, but in most cases, except for guns or knives, many times.

Also on the basis of the survey, 6,000 parents out of every 100,000—husbands or wives or both—used the more serious types of violence on each other during 1 year. And when there was fighting between the parents, there was much more likely to be fighting among the children and aggression by the children against the parents.

The extent of child abuse and other violence in American families, along with their causes and means of prevention, is the topic of this chapter.

Straus and Gelles point out that "even the less violent acts that parents carry out on their children . . . could, if they were done to strangers or adults," be considered illegal and subject to police action.

The investigators spent 7 years developing and testing questionnaires and checklists, conducting preliminary studies, and in other ways preparing for the national survey. For example, Straus developed the Conflict Tactics Scale (CTS), a set of questionnaires on how family members attempt to deal with conflicts among one another. The physical violence section of the CTS contains the following categories: pushing, slapping, shoving, or grabbing; throwing things at someone; kicking, biting, or punching; hitting with an object; beating up; threatening with a knife or a gun; and actually using a knife or a gun.

The investigators then isolated *severe* violence indexes that used only the following acts: punching, kicking, biting, hitting with an object, beating up, and using or threatening to use a knife or a gun. Finally, from the severe violence index used to estimate the extent of parental violence against children, the researchers omitted the item "hitting with an object." This was done to meet the objection that the parents in many cases may not have been making an out-of-control assault but "merely" punishing with the traditional strap, cane, or paddle.

But Straus and Gelles emphasize that in their view even the mild forms of physical punishment should not be condoned and should count as violence. They assert that *none* of the items on the CTS is acceptable "for relations between *any* human beings" [emphasis added]. They point out that even the less violent acts "that parents carry out on their children . . . could, if they were done to strangers or adults," be considered illegal and subject to police action.

As employed in the national survey, the CTS contains three groups of items on how conflict is resolved. One group covers the use of rational discussion and argument; another, the use of verbal expressions of hostility; the third, the use of physical violence. Parents were asked how often each tactic had been used during the preceding year with the particular child chosen to be interviewed.

Earlier research had indicated that the CTS is a valid measure. But the questionnaire does have some drawbacks. For instance, the consequences of each parental act are not brought out—even in cases where a parent admitted to having used a knife or a gun.

The survey itself was conducted by trained investigators of the Response Analysis Corporation, Princeton. Straus and his colleagues then spent 2 years analyzing the answers and developing reports on various aspects of the study. Some parts of the project, in fact, were still being analyzed in 1978.

The study produced 2,143 completed interviews with adults, roughly half with husbands and half with wives. These interviews were conducted in families living in 103 areas—counties or groups of counties—that, taken together, represent the Nation's major demographic characteristics, such as geographical location, size of family, and socioeconomic status. More than half of these families had at least one child between the ages of 3 and 17 living at home, and each such parent was questioned about one of his or her children. If the family contained more than one child, the child to be discussed by the parents was selected at random. The investigators describe the full sample of 2,143 families as "extremely representative" of American families.

OCCURRENCE OF VIOLENCE AGAINST CHILDREN

If the survey's findings are generalized to all the country's 46 million children aged 3 to 17 and living with both parents, an estimated 6.5 million children are physically attacked by a parent during the course of the year. This figure includes those children who are subjected only to the milder forms of violence, such as pushing and slapping.

The total drops sharply when the violence is limited to severe acts—kicking biting, punching, beating up, and using or threatening to use a knife or a gun. Under this limitation, "only" an estimated 1.7 million children are abused per year, and "only" three or four out of every 100 parents are abusers.

Straus adds:

The data just presented might overstate the amount of child abuse because a family is included if even one isolated incident of abusive violence occurred during the year. On the other hand, these rates may understate the extent to which children are severely assaulted by their parents because the figures do not take into account how often such assaults occurred. The answer to this question is that if one assault occurred, several were likely. In fact, a single incident occurred in only 6 percent of the child abuse cases. The mean number of assaults per year was 10.5 and the median 4.5.

The incidence of severe abuse is much larger than that estimated by the U.S. National Center on Child Abuse and Neglect (NCCAN). By NCCAN figures, about 1 million children a year are abused. But the number *physically* abused, according to these figures, is about 250,000. Why the difference between NCCAN's 250,000 figure and that of the estimated 1.7 million obtained by the Straus-Gelles-Steinmetz study?

Straus reports two main reasons:

1. The NCCAN figures are based on incidents which come to official attention. This leaves out the vast number of cases in which physical abuse is suspected and not reported, as well as the equally vast number of cases in which a child is injured but in which there is no suspicion of abuse.

2. Probably the most important reason why our rates are so much higher is that our data are based on violent acts carried out, rather than on injuries produced. Fortunately, children are resilient. Many are the children who have been thrown against a wall and who simply bounce off with, at most, a bruise

Straus believes that "even our very high rates of child abuse" are *underestimates*. For one thing, the survey omitted children "in the high-abuse-risk age running [from] birth to age 3." For another, the data come from reports by parents to a survey-making stranger, to whom the parents might not have been entirely truthful. Again, parents were not questioned about every type of abusive act—burning, for example, and wiping out a child's mouth with lye or other noxious substances. Moreover, the information pertains only to one parent's abuse—the one interviewed, either the father or the mother. Finally, "the omission of children living in one-parent households may lead to underestimating because there are reasons to think that child abuse is greater under the strain of trying to raise children without the aid of a partner."

Among the other findings:

- 63 percent of the respondents (either the mother or the father) mentioned at least one violent episode during the previous year with the particular offspring randomly selected to be interviewed.
- 58 percent of the respondents reported slaps or spankings: 41 percent reported pushing or shoving; 13 percent said they had used some object with which to hit the child. About 5 percent had thrown something at the child.
- As for the most dangerous types of violence, about 3 percent of the parents reported having kicked, bitten, or hit the child with a fist. More than 1 percent said they had beaten up the child. One-tenth of 1 percent—or 1 in 1,000 parents—reported they had threatened the child with a gun or a knife, and the same proportion said they had actually used a gun or a knife on the child. Almost 3 percent said they had *ever* threatened the child with one of these weapons, and the same proportion said they had ever actually used a gun or a knife on the child.

The investigators estimate that as many as 46,000 American children had knives or guns used on them by their parents during the survey year, while between 1 and 1.4 million children had ever undergone such punishment.

“Children who have been hit grow up to ‘hit’ their spouses and their children.”

Do children ever hit parents? Indeed so, particularly in families where parents act violently both toward each other and toward their children. When that situation occurred, 70 percent of the children hit their mothers, fathers, or siblings in the course of the survey year. When there was no violence between parents, that proportion dropped to 5 percent.

From studies by himself and many other investigators, Straus is convinced that physical punishment in the great majority of cases neither damages children's personalities nor makes them mentally ill. Exceptions exist: children who have been beaten to a pulp or maimed by their parents. “But where noncrippling physical punishment is used,” he goes on, “there is a difference in willingness to use violence on others. The research is very clear on this: Children who have been hit grow up to ‘hit’ their spouses and their children. And children who have been hit often enough—there is yet no definition of ‘often enough’—are likely to become violent youngsters and violent adults and to use force even in situations that other hitters would find inappropriate.”

SOME FACTORS AFFECTING LEVELS OF PARENTAL VIOLENCE

The most serious forms of punishment, including the use of guns and knives, are as likely—or more likely—to be employed by mothers as by fathers. And mothers are more likely than fathers to slap or spank the child, to throw something at him or her, or to hit the child with something. Part of the reason is that women have the main responsibility for child care.

Boys are treated violently only very slightly more often than girls. During the survey year, 66 percent of the sons were

struck at least once, as compared with 61 percent of the daughters. Straus thinks this virtually equal experience with physical punishment is part of the reason women are about as violent as men within the family, though much less violent outside it. According to one hypothesis, our society believes that violence serves to toughen boys, and that toughness is desirable. Perhaps in confirmation, the National Commission on the Causes and Prevention of Violence Survey found in 1968 that 7 out of 10 people interviewed considered it good for boys to have a few fist fights.

The child's age makes a difference, too. During the survey year, some type of force was used on 86 percent of the children 3 or 4 years old; 82 percent of those from 5 to 9; 54 percent of the children from 10 to 15; and 33 percent of those from 15 to 17. The investigators offer two possible explanations for these differences. Perhaps parents find it hard to use reason in punishing younger children. Or perhaps younger children interfere more often with their parents' activities.

Social class plays a role, too. Parents among the lowest-income groups and with low-status occupations were much more inclined than the others to use the most violent forms of punishment. Also, Straus found in earlier research that among working-class families, there was no significant correlation between husband-wife violence and children's delinquency, while among middle-class families, the correlation was highly significant. His explanation: In the middle class, husband-wife violence is more of a violation of the norms—even though violence between parents is only slightly less common than in the working class. So middle-class children are more likely to be adversely affected.

Straus and Gelles were somewhat puzzled because parents actually admitted using severe and dangerous forms of punishment. Their tentative explanation is that many of the parents did not consider such forms deviant but, rather, acceptable or tolerable childrearing techniques.

VIOLENCE BY HUSBANDS AGAINST WIVES

Straus recalls an incident on a BBC television show in the spring of 1974. One woman asked another, "What makes you

think he doesn't love you anymore?" The reply was simply: "He hasn't bashed me in a fortnight."

The investigator also calls attention to a news item in the Portsmouth, N.H., *Herald* of September 13, 1977:

The New Hampshire Commission on the Status of Women has rejected a plan to help battered wives, saying that wifebeating is caused by the rise of feminism. "Those women 'libbers' irritate the hell out of their husbands," said Commissioner Gloria Belzil Commission members, appointed by Governor Meldrim Thomson, said any program to help battered wives would be "an invasion of privacy."

"This statement," Straus comments, "suggests that a certain amount of violence in the family is 'normal violence' in the sense that it is deserved (for example, by 'irritating the hell' out of one's spouse) and that unlike violence outside the family, the State should not interfere."

Then there was the student who asked Straus how she could narrow a term paper on violence in the family to something manageable. He suggested that she limit her paper to one of three aspects of the subject: Violence between husband and wife, or between parent and child, or between the family's children. The student was astounded by that last topic. "Well," she said, "I never thought of my brother hitting me as violence."

There seems to be a cultural norm, Straus remarks, making it legitimate for family members to hit one another. "In respect to husbands and wives, in effect, this means that the marriage license is also a 'hitting license.'"

The marriage license as a "hitting license" is not just a matter of the folk culture . . . it also remains embodied in the legal system despite many legal reforms favoring women. In most jurisdictions, for example, a woman still cannot sue her husband for damages resulting from his assaults, because, in the words of a California Supreme Court judgment [1962], "this would destroy the peace and harmony of the home"

Of course, criminal actions can be brought against an assaulting husband, but here, too, there is an almost equally effective bar inherent in the way the criminal justice system actually operates If a wife wants to press criminal charges, she is discouraged at [every] step, beginning with police officers . . . who will not

make arrests, and going on to . . . judges who block convictions in the miniscule fraction of cases which do not reach court. (Straus 1977)

Again, a survey conducted by the National Commission on the Causes and Prevention of Violence found that about one out of four of those interviewed agreed that it is sometimes permissible for a husband to hit his wife. And an experiment in which Straus participated found that when people read about an assault by a man on a woman, those who were told that the couple was married recommended much less severe punishment.

Straus points to several reasons why even one beating may be highly significant. It is a debasement of life, and there is physical danger involved. Finally, many of the beatings are part of a power struggle, and "it only takes one such event to fix the balance of power in a family for many years—or perhaps for a lifetime."

Of the adults interviewed, 28 percent reported that the husband had acted violently toward his wife during the course of 1975. Moreover, 3.8 percent of the wives had been *severely* attacked—by being kicked, bitten, hit with a fist, beaten up, or attacked with a weapon.

There was great variation in the number of attacks. About one-third of the wives who were attacked got beaten only once. At the other extreme, one-third were beaten five or more times.

If the survey's findings are generalized to all U.S. couples—about 47 million—they indicate that approximately 1.8 million wives are severely attacked by their husbands at least once a year. On the other hand, if the proportion of wives attacked by their husbands is limited to the respondents who actually used the term "beaten up" or something similar, the percentage becomes 1.1. This would bring the nationwide figure to more than half a million wives beaten up in the course of a year.

Comparing the survey findings with national crime statistics, the researchers demonstrated the truth of their hypothesis that violence *in* the home is more common than outside of it. FBI statistics show 190 assaults for every 100,000 persons. The survey's rate for husband-wife assaults alone is 6,100 per 100,000 persons. Straus emphasizes that the latter figure includes only the more serious types of violence.

The overall rates of husband-wife violence do not support the widely held view that violence between spouses occurs mainly among couples of the lower-income class. The rate of *severe* husband-wife violence, though, was found to be at least twice as high among blue-collar as among middle-class families.

The research team reminds us that people are more likely to be murdered by a relative, particularly a husband or a wife, than by anyone else. On the basis of studies by other investigators in other countries and cultures, family violence is what anthropologists refer to as a "near universal."

Straus believes there was considerable underreporting of most types of violence, even the more severe ones, by husbands against wives. "There is a large group for whom violence is so much a normal part of the family system," he explains, "that [it] is simply not a noteworthy or dramatic event to be remembered." Then, too, there is reluctance to admit severely violent acts "because of the shame involved if one is the victim, or the guilt if one is the attacker." Finally, because the sample was limited to couples living together, the data probably omit much violence of the type that often leads to divorce.

"These considerations," the investigator says, "plus the higher rates in our pilot studies . . . suggest that *the true incidence rate is probably closer to 50 or 60 percent of all couples than it is to the 28 percent who were willing to describe violent acts in a mass-interview survey.*"

PREVENTION OF WIFEBEATING AND OTHER FAMILY VIOLENCE

Straus has a number of suggestions for preventing the use of violence against wives. These include:

- Tell the public the facts. He believes that awareness "can contribute to the demise of the 'hitting-license' norm because such a norm is contrary to other norms and values about the family."
- Define marriage as a relationship in which use of physical force is simply unacceptable—"as unacceptable as it is be-

tween those one works with or with whom one goes bowling or plays tennis." For the wife, Straus continues, this means making clear that physical force will not be tolerated. "In an unknown but perhaps not insignificant proportion of cases, this alone could serve to alter the situation, because the hitting-license aspect of marriage is so much an unperceived, taken-for-granted norm, and is so contrary to other widely acknowledged and valued norms concerning marriage."

- Reduce to the fullest extent possible the use of physical force by the Government. American families are part of a violent society. "Violence is truly built into the very fabric of American society," says Straus, "and into the personality, beliefs, values, and behavioral scripts of most of our population. Elimination of wife-beating depends not only on eliminating sexual inequality but also on altering the system of violence on which so much of American society depends." Straus reminds us that the U.S. Supreme Court recently upheld both physical punishment in the schools and the death penalty and that the Government maintains a worldwide military establishment. "The necessity for and efficacy of much governmental violence is highly questionable, as illustrated by the controversy over the efficacy of the death penalty, of police toughness (to say nothing of police brutality), and of the still widespread practice of physical punishment in the schools These examples of governmental violence provide powerful models for the behavior of individual citizens."
- Limit depiction of violence in the mass media to the maximum extent possible consistent with preserving freedom of expression and artistic integrity. Almost all scientific reviewers of research during the last 10 years, Straus reports, have concluded that "violence in the media is part of a societal pattern which keeps America a high-violence society."
- "Gradually eliminate physical punishment as a mode of childrearing."

- Encourage parents to reduce violent acts among their children. Above all, parents should not define, either explicitly or implicitly, such acts as permissible. [In one sample of youngsters studied by this investigator, almost two-thirds while high school seniors had hit or been hit by a brother or sister, yet only one-third had hit or been hit by someone outside the family.] Of course, if parents are to reduce violence among their children, both parents and children must be given other techniques "for coping with and resolving the inevitable conflicts of family life . . ." Straus points out that promising methods for reducing parent-child and sibling-sibling conflict have been developed in recent years. Chief among these are behavior-modification techniques, which, in essence, provide rewards for desired behavior.
- Sponsor research to determine the social and psychological conditions which lead some parents to be cold and distant rather than warm and loving, and translate the results into programs to assist such parents.
- Recognize the inevitability and legitimacy of conflict within the family—for reasons noted later in this chapter—"rather than consider it an atypical deviation. Once the inevitability and legitimacy of conflict within families is recognized, the way is open to learn efficient and constructive ways of resolving it."
- Eliminate the system under which "women's occupations" tend to be poorly paid, "and the equally pervasive difference between the pay of men and women in the same occupation." In spite of recent laws intended to put the sexes on an equal economic basis, Straus says, women with full-time jobs earn only 57 percent of the amount paid men.
- "Reduce or eliminate the sex-typed pattern of family-role responsibilities." Straus holds that many women will find greater fulfillment as members of the paid labor force and that many men "will find greater fulfillment than they now experience" if they share equally in household tasks. "Full sexual equality," this sociologist believes, "is essential for prevention of wifebeating."

- "Establish or subsidize a comprehensive and high-quality system of day-care centers for preschool children." Straus makes this recommendation both because beaten wives are expected to take care of the children if the marriage breaks up and because such facilities "are needed by millions of women who enjoy fully satisfactory marriages."

However, he continues:

Sexual equality, by itself, is almost certainly *not* going to end conflict and violence between husbands and wives. It will reduce or eliminate *certain types* of conflict, but at the same time create new types of conflict. Issues which are *not* now the subject of disagreement in millions of families—such as who will work for wages and who will be in the household labor force, or more specific issues such as who will do the laundry—will no longer be determined by subscribing to the patterns of family roles which have been worked out over the centuries. Rather, they become open questions over which severe conflict can arise. It is by no means inconceivable that *neither* partner will want to be in the paid labor force, and that *neither* will want to do the laundry. Consequently, a reduction in the level of violence also depends on couples having the interpersonal and conflict-management skills necessary to cope with and realize the benefits of a less rigid type of family system. Millions of people lack these skills and almost all of us can improve them.

- Stop making differences between boys and girls in the way parents interact with them and in parental expectations for them.
- Cease "the implicit toleration of wifebeating which comes about through statutory and common law; through the attitudes of the police, prosecutors, judges; and through cumbersome and ineffective procedures which make even the available legal remedies and protection ineffective."

ADVICE FOR WOMEN WHO ARE BEATEN UP

A preliminary version of a chapter section by Straus on "What Can a Battered Wife Do?" was submitted to Katherine G. Lynch, Director of the Victims Advocate Program, Dade County, Florida. She commented in part as follows:

I am sure you are well aware of the obstacles facing the woman who tries to follow your suggestion At present, in Dade County, her frustration and conviction that she has no viable alternatives would be strongly reinforced 95 percent of the time. Friends, neighbors, and nearby relatives will often only help one or two times, if then; they frequently blame the woman for not "making" the marriage work and are afraid the husband/boyfriend will turn on them if they "interfere." (It's a realistic fear: They occasionally get pretty threatening with our staff.) Legal Services here cannot even do intake on domestic cases for 2 months, because of funding problems. Legal Aid—as you stated—declares all women with working husbands ineligible because of their husband's income. A restraining order is very difficult to get, and usually does not permit incarceration for violation, but rather necessitates another court hearing several weeks away. So far in our experience very few cases have gotten past the preliminary level: In those few, the defendant was acquitted or placed on "misdemeanor probation," for which in Florida there is no staff assigned. The woman who tries to get a job is often beaten by her mate for so doing, either at home or on the job, or he otherwise harrasses her at work until she loses the job. The whole situation is so frustrating and volatile that it's no wonder most of the "professional helpers" try to turn their backs on it.

I appreciate your efforts to help the battered woman find her way through the maze, but am concerned she will blame herself when [she] fails—and reinforce her own poor self-image both in her own eyes and in those of the public—instead of working with others to try and change the larger patterns

Nevertheless, Straus offers a number of specific suggestions. First, he advises, *get help*. Best sources are persons or groups, notably feminist organizations, "committed to changing the sexist structure of the family and society." Refuges, shelters, or "safe houses" for battered wives, if the community is fortunate enough to have such, are obvious sources of information and support, even if the wife does not intend to live temporarily in such facilities. Moreover, women's groups in a growing number of communities are setting up "hot lines" dealing with, among other problems, wifebeating. One of them, Abused Women's

Aid in Crisis, in New York City, serves as a national clearing-house for information and referrals.

A number of legal steps are available, too, "but all are difficult and uncertain because the judicial system is focused on 'preserving the family' rather than protecting wives from physical injury."

Straus points to a number of other possible sources of help, including the Family Service Association of America, psychologists and other professional workers trained in marriage counseling, and clergymen. He cautions, though, that these traditional sources of help "also tend to be traditional in the sense of . . . commitment to a patriarchal family system." He stresses the importance, too, of seeking help from friends, neighbors, and relatives: "Even if the advice is worthless and the moral support not forthcoming, just the act of getting the issue into the open can help to create the psychological readiness to take the initiative for whatever steps are necessary."

It is also essential to *cancel the "hitting-license."* Even if such usual complaints that the wife is a nagger or a lousy housekeeper are accurate in a given case, "that no more justifies a beating than being a 'griper' or a 'slacker' at work." Straus adds: "It is important to realize that friends, neighbors, relatives, and therapists often start by trying to find out who or what is wrong. A beaten wife must reject that approach, even though these issues must ultimately be faced. Whatever else is wrong, all parties must acknowledge that hitting is wrong."

The wife must make clear that if the "hitting-is-wrong" agreement is violated, she can and will leave. She must plan ahead for this possibility and have a specific place to go and specific plans for a job. In fact, Straus thinks that getting a job or job training while the marriage is still intact is a highly important means of averting further beatings, since it reinforces the threat that the wife, if brutally treated, will leave.

Some presumed authorities have urged women to get rid of their inner hostilities by ventilating their anger or "letting it all hang out"—an approach related to the encounter-group movement. Straus notes that such advice is based on the "ventilation" theory of aggression control. "That theory starts with the assumption that all of us have built into our nature a greater or lesser tendency toward aggression which somehow must find expression. If we attempt to repress this deep, bio-

logically based motivation, it will only result in a more destructive explosion of the innate aggression drive at some later time."

But, the investigator continues, almost no research "with any pretense of scientific rigor supports the theory, and much of it shows the reverse In general, aggression . . . (either verbally or physically) tends to (a) produce counter-aggression, (b) impedes getting to the real problem, and (c) if it does succeed in squelching the other person, reinforces the use of aggression as a mode of interaction." A study of 385 couples by Straus found that the greater the amount of verbal aggression, the greater the amount of physical aggression as well. It is essential to be *assertive*. "But one can be assertive without being aggressive."

Why do most abused wives stay with their husbands? Gelles conducted interviews with members of 41 families in which wives had been beaten and with a similar number of neighboring families. Nine of the abused women had left their husbands, 13 had called in the police, 8 had sought counseling from a social-service agency.

This investigator found three main factors influencing an abused woman's behavior. A beaten wife was most likely to stay when the violence was least frequent and severe. The more a beaten wife had been struck as a child by her parents, the more likely she was to remain with her abusive husband, presumably because she had become used to violence in the home. Moreover, the fewer the resources she had for getting along without her husband, the more likely she was to stay.

Gelles found also that women who had observed physical fights between their parents were more likely to be beaten by their husbands: Presumably the parents had served as models of what to expect in marriage. Or possibly these women, having witnessed violence in their childhood homes, Gelles suggests, were more likely to marry violence-prone men.

Of the beaten wives, only 25 percent of those who did not leave their husbands or seek help in other ways held jobs. The proportion of wives who left or sought help was twice as great among those who did have paid employment. A job made a difference, the investigator suggests, not only because it gave the woman money of her own but also because it enlarged her view of the world.

He quotes one beaten woman as saying:

Until I started being out in the public, to realize what was going on around me, I was so darned stupid and ignorant. I didn't know how the other half of the world lived. And when I started being a waitress I used to love to sit there—when I wasn't busy—and watch the people—the mother and the father with their children—and see how they acted. And I started to feel like I was cheated . . . and it started to trouble me and I started to envy those people. So I said, "You know . . . am I supposed to live the way I'm living?"

However, the length of formal education did not distinguish between those abused wives who left or who sought help and those who did not; nor did the number of children.

Gelles reports that "one fact remained quite clear at the end of the 80 interviews: Most agencies and most legal organizations are quite unprepared and unable to provide meaningful assistance to women who have been beaten by their husbands." Moreover, many of the beaten wives never sought help nor left home because such actions would have ruptured "the carefully nurtured myth of their fine family life."

Advice on the prevention of violence between parent and child and among brothers and sisters is among the subjects still being considered by Straus, Gelles, and Steinmetz.

VIOLENCE BY WIVES AGAINST HUSBANDS

As Straus puts it, violence between husband and wife is far from being a one-way street. Among the husbands, in the national survey, 12.1 percent had acted violently against their wives during the preceding year. Among the wives, 11.6 percent had acted violently against their husbands. Moreover, the wives tended to act violently somewhat more frequently than their husbands. These findings are based on the occurrence of *all* acts the investigators consider violence. Violence classed as *severe* was somewhat more likely to be used by the wives than by the husbands.

Straus holds, nonetheless, that social policy should give primary attention to the abused *wives*. One reason is that a study carried out in preparation for this research showed that husbands were more likely than wives to underreport violence—probably, Straus thinks, because the use of physical violence is

so much a part of the male way of life that many instances are forgotten.

Among other reasons:

- Men have greater physical strength than women, so it is more likely that they will seriously injure their wives rather than the other way around.
- A disproportionately large number of attacks by husbands occur when the wife is pregnant.
- For economic and social reasons, women often see no alternative to putting up with male brutality.

A ROOT CAUSE OF VIOLENCE: HOW CHILDREN ARE RAISED

Among the basic causes of wifebeating and husbandbeating, according to Straus, are the childrearing patterns of American parents. Typically, these include the use of physical punishment and thus instill in the child the idea that violence is acceptable and even necessary.

When physical punishment is used, as it is in nearly all American households, Straus says, several outcomes can be expected. "First and most obviously, is learning to do or not do whatever the punishment" is expected to correct. Less obvious but equally or more important are three other lessons which are so deeply learned that they become an integral part of one's personality and world view. The first is the association of love with violence. The child learns that those who love him or her the most are also those who hit. The second is that practice of physical punishment gradually establishes "the moral rightness of hitting other family members." Finally, the child also learns that "when something is really important, it justifies the use of physical force." The investigator adds: "These indirect lessons are not confined to providing a model for later treatment of one's own children. Rather, they become such a fundamental part of the individual's personality and world view that they are generalized to other social relationships, and especially to the relationship which is closest to that of parent and child: that of husband and wife."

Citing studies by other investigators, Straus points out that parents who abuse their children are often people who were severely punished physically themselves as children.

Both the national survey and research by a Straus colleague, Steinmetz, add another link to the chain of circumstances making for family violence. Husbands and wives who treat each other violently, Steinmetz found, punish their children physically more often than other couples. Moreover, their children act violently against brothers and sisters more often than do the children of other couples.

Another basic cause of family conflict, Gelles and Straus explain, is that family members spend so much time interacting with one another. And these interactions cover a broad range of subjects. For example, shall the stereo be used for Bach or for rock?; shall we go bowling or attend a movie?; who gets to use the bathroom first? Moreover, the degree of injury felt under certain circumstances is likely to be greater by far than if the same problem were to arise with an outsider. "The failure of a work colleague to spell or to eat properly may be mildly annoying But if the bad spelling or table manners are those of one's child or spouse, the pain experienced is often excruciating."

Among other reasons for the high level of family violence, the investigator cites these:

- Dissatisfaction over undesirable behavior is exacerbated by parental attempts to change it.
- Generational and sex differences in culture and outlook make the family "an arena of culture conflict."
- Family statuses and roles are usually assigned on the basis of age and sex rather than on the basis of interest and competence. Further, "not all husbands have the competence needed to fulfill the culturally prescribed leadership role," so they assert themselves violently.
- The family continuously undergoes major changes in structure because of such potentially stressful events as "the birth of children, maturation of children, aging, and retirement."
- To protect, train, and control a child, "parents are permitted . . . to use a level of physical force . . . that is denied even prison authorities in relation to training and controlling inmates."

OTHER FACTORS MAKING FOR VIOLENCE

The national survey finds a correlation between the use of alcohol and the occurrence of violence in the home. Straus and his fellow-workers believe this is partly because some people get drunk as an unconscious excuse to beat up someone.

The educational level of the parents apparently does not affect family violence one way or the other. But income and occupation definitely do: the higher the income level and the higher the occupational status, the lower the amount of violence.

Families isolated from relatives and friends show higher rates of violence than do other families, probably because people with relatives and friends can turn to them for help, Straus believes, and also because relatives and friends can intervene if the situation deteriorates too far.

Also more likely to use violence are persons judged to have what Straus describes as *mean* personalities and persons with little social competence. The latter group turns to the use of force to compensate for a lack of ability to get along with people.

On the basis of earlier research by Steinmetz and others, Straus points out that violence in the family seems to lead to violence outside the family. "For example," he says, "almost all the political assassins came from homes where they had been much beaten." The national survey also corroborates earlier findings that the beaten child is the one most likely to become a childbeating adult.

Among other causes of family violence, Straus lists the characteristics of the species, the neurobiological makeup of specific persons, and personality development. In most cases, he and his colleagues believe, there is probably a complex interaction among all these factors.

THREE THEORIES OF VIOLENCE

The researchers also investigated three theories often used to explain interfamily violence.

The first is *conflict theory*, which holds that when individuals, groups, and organizations are faced with a problem, they do not seek consensus or compromise. Instead, each person or group seeks to further its own interests and views conflict as

natural. "Violence is likely to occur in the family as an outcome of these conflicts," Straus says, "because violence is a powerful mode of advancing one's interest when other modes fail"; indeed, in some families, violence is the mode of first choice. At issue is not the presence of conflict, which is almost universal in this society, but the ways of resolving it.

Another proffered explanation is *resource theory*, which states that violence and threats of violence are fundamental to the organization of any social system, including the family. However, violence is used as a resource in the family only when other resources are lacking. For instance, a man who wants to be dominant in his family but has been poorly educated, holds a low-prestige job, and lacks skill in getting along with people may resort to violence to maintain his position in the family. Moreover, underdog family members may turn to violence to redress grievances when other resources are inadequate.

A third explanation is *structural theory*, in which violence is seen as an outcome or expression of social expectations, or the pattern of life, or the situation in which a person lives, all structural determinants of behavior.

Straus prefers this last theory and reports that the national survey confirms that it is the most important. However, the other two theories also contribute to the explanation of family violence.

HOW TO HAVE A FAMILY THAT DOES NOT USE FORCE

Suppose a person is about to get married, or has just recently married, and would like some specific ideas on how to avoid violence in the new family. What would Straus say?

Perhaps the first thing, he replies, is to recognize that conflict is a part of life, including family life. Having recognized that, one should realize that conflicts within the family can and should be settled nonviolently, just as they usually are outside the family. The chief means are negotiation and compromise, give and take. "One of the main principles to keep in mind is that you want things from other people but that they also want things from you, and it's possible to do a trade. There's a sort of reciprocity: If I do things that please you, you tend to do things that please me."

Another basic need, Straus continues, is to recognize that most people at the back of their minds have a rule which says that it's OK to hit someone if he or she is being unreasonable. Then the married couple must say, "The rule in this family is *no violence*." "If they don't say that and mean it," Straus adds, "the other rule comes into play."

Of course, there has to be some means of getting justice; everybody has gripes. "You have to say what's bugging you, and the other person has to say what's bugging him. Then the two of you have to work it out. You can call the process *intellectualization*, or *reasoning*, or even *confrontation*—but confrontation in the sense of getting the issues out and discussing them, and trying to arrive at some settlement, without being abusive."

When a man comes home at night grouchy and complaining, and his wife tells him, "You're just bringing your conflicts home from the outside world and taking them out on me"—is the wife behaving acceptably?

"Yes, that's perfectly legitimate," answers Straus. "She's giving you her complaint, getting it out on the table, telling you what she thinks is wrong. That's OK. But if she said: 'You damn mean bastard, why do you deliberately do these things to torture me? What was wrong with your father and mother?' And other stuff like that. That's verbal violence, and it is wrong. It is *not* getting the issue out and discussing it."

Straus' research and observations convince him that a sizeable amount of physical violence *is* brought in from outside. "You beat up your wife because you couldn't beat up your boss. You're *not allowed* to beat up your boss but you *are* allowed to beat up your wife. Those are the rules of the game as it's been played thus far. Here again we have social structure theory at work."

Another fundamental step to forestall or eliminate family violence, Straus maintains, is to eliminate physical punishment, "because physical punishment provides the most fundamental training in the use of violence."

Physical punishment starts with infants. An infant crawling on the floor picks up something dirty and puts it in his or her mouth, so you tell the child not to do that. The child, of course, doesn't really understand, puts the thing in his mouth, and mommy or daddy

slaps his hand. Now that's something done for the child's own good, but it's also something that teaches the child that love and violence go together, that those who love you are also those who hit you. And that's so indelibly fixed in the growing child's mind that most people think that it's a biological link rather than something that's just learned from earliest infancy on. In addition, the child learns it is morally right that the parents punish him physically, because, after all, it's for the child's own good. And that's the basic origin, I think, of the rule that it's okay to hit other family members if they're being unreasonable.

We've had lots of people say, "Yes, I was running around with that other man, so I deserved it when he threw the pot of hot coffee at me." That's going back to the little child. I don't mean that she's right running around with other men, but I mean that no matter what you do, no one has the right to throw a pot of hot coffee at you, or even to slap you, or push you. Even in prisons, we don't permit physical punishment any more.

Finally, there is one other way to prevent or eliminate family violence, Straus adds. That is to "eliminate the husband as 'head of the family' from its continuing presence in the law, in religion, in administrative procedure, and as a taken-for-granted aspect of family life." Straus makes this suggestion because he believes that probably the most basic factors leading to wifebeating are "those connected with the sexist structure of the family and society."

But however deeply rooted, violence is not a necessary or biologically inevitable fact of life. It is learned. It is an expedient or resort employed at the individual level and reflected at other levels. At the level of nations, violence is often sanctioned as a patriotic duty. At the level of a government's relations with individual citizens, it is sometimes forbidden and usually controlled. At the level of individuals' social relations with each other, it is almost always proscribed except for specified mitigating circumstances.

From level to level, from culture to culture, from age to age, the rules of conduct governing the use and expectation of physical violence have varied and also been related. But it is at the level of the family where most of us learn our initial lessons in

violence, first in how we are treated and eventually in how we treat others.

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Principal Investigators: Murray H. Straus, Ph.D.

Professor of Sociology
University of New Hampshire
Durham, New Hampshire 03824

Richard J. Gelles, Ph.D.
Associate Professor of Sociology
Department of Sociology
University of Rhode Island
Kingston, Rhode Island 02881

CHILD ABUSE: A REVIEW OF RESEARCH⁽¹⁾

Author: Julius Segal, Ph.D., NIMH

INTRODUCTION: HISTORY OF AN ENDANGERED SPECIES

The 2-year-old child lies frail and immobile in her crib. Only her eyes move, as if fearfully searching the world for the next violent blow, her body—shoulders, back, legs, arms, chin, cheekbones—a mosaic of angry bruises and scars, her shrunken buttocks laced with cigarette burns. The child cannot or will not speak, and her response to a gesture of open-armed tenderness is panic—and an empty, tearless, and agonizing scream.

Another child, only 7 but appearing ancient, has become a grotesque satire of youth—the product of chronic abuse and mutilation by his elders. His feet are crushed, his shoulders bent out of shape, his head held at a tilt, the result of repeated insult to the brain. As he walks alone in the busy market, he excites the curious gaze and revulsion of passers-by

The two cases are indistinguishable, both in their stark brutality and in the scorn they portray for the destiny of an innocent child. They differ only in their origins. The first child is a patient at Children's Hospital, Washington, D.C., August 1976 The second has been dead over 2,000 years, a forgotten dust speck of the Roman era. Taken together, they symbolize a fact that shouts at us from the pages of history: Since the beginning of time, the world's children have constituted an endangered species—a yielding target for the frustrations, conflicts, projections, unresolved hates, and smouldering anger of the adults who so often tyrannically bestride their lives.

Although child abuse and neglect have only recently commanded a wave of national attention, the bleak outlook for so many contemporary children is no new phenomenon. As chronicled by child historian Lloyd deMause, the history of childhood is a panorama of incredible cruelty and exploitation (1974).

DeMause examined 200 statements of advice on childrearing offered by writers before the 18th century, and he found that most approved of child beatings. "Virtually every childrearing tract from antiquity to the 18th century recommended the beating of children," he concludes. The advice fell on willing ears. Over the centuries, children have been beaten and battered regularly, beginning even at birth. DeMause believes that a very large percentage of the children born before the 18th century would be regarded as truly "battered" by today's standards.

The tradition of physical punishment administered freely to children gained acceptance over the centuries as a virtual way of adult life—and not only among the poor and uneducated. Venerable figures in history are embedded in the pattern—the poet Milton mercilessly beat his nephews; Beethoven abused his pupils with a knitting needle, or even bit them; the father of Louis XIII, a whip at his side, taught the 2-year-old not to whimper when confronted by a flogging. John Calvin preached that a parent's duty to God and the child required breaking the will of the infant at the earliest possible age. And, consider one mother's testimony on childrearing, given in 18th century England: "When turned a year old (and some before), they were taught to fear the rod, and to cry softly." The words are of Susannah Wesley, wife of John, the founder of Methodism. While the act of abusing children clearly has a long history, current clinical and scientific interest in the subject is, surprisingly, still in its infancy.

The Act and Its Victims

In July of 1962, the *Journal of the American Medical Association* published an article by pediatrician C. Henry Kempe and four fellow physicians that quickly became a benchmark in pediatric medicine. Titled *The Battered-Child Syndrome*, the article exposed for the first time as a medical phenomenon the brutal fact of children's lives over the ages (1962). Here, in medically impersonal yet chilling detail, are the essential con-

clusions reached by Kempe and his team, and the suggestions they gave to their fellow doctors for spotting a battered child among other suffering children in their care:

The battered-child syndrome may occur at any age, but, in general, the affected children are younger than 3 years. In some instances the clinical manifestations are limited to those resulting from a single episode of trauma, but more often the child's general health is below par, and he shows evidence of neglect including poor skin hygiene, multiple soft tissue injuries, and malnutrition. One often obtains a history of previous episodes suggestive of parental neglect or trauma. A marked discrepancy between clinical findings and historical data as supplied by the parents is a major diagnostic feature of the battered-child syndrome. The fact that no new lesions, either of the soft tissue or of the bone, occur while the child is in the hospital or in a protected environment lends added weight to the diagnosis Subdural hematoma (bleeding between the brain and skull), with or without fracture of the skull, is, in our experience, an extremely frequent finding even in the absence of fractures of the long bones. The characteristic distribution of these multiple fractures and the observation that the lesions are in different stages of healing are of additional value in making the diagnosis.

The publication of Kempe's article sparked a wave of interest in the phenomenon of child abuse; it was as if medical charts had suddenly verified the existence of an ancient crime. In the press, each day brought new essays of outrage. "The reports of injuries read like the case book of the concentration camp doctor," wrote one astonished reporter. As in the case of any behavioral phenomenon, statisticians quickly began their attempts to define the scope of the problem. How extensive is child abuse?

The answer is still unclear, primarily because a universally plausible, uniform definition of child abuse is difficult to establish. The range of physical punishments endured by children—and the reasons for them given by adults—make the task of defining the act difficult. Moreover, the channels through which child-abuse cases are reported are often blocked with defensiveness, denial, and rationalization, both by physician and parent alike.

Still, for the researcher, a standard accepted definition of abuse is necessary to assess its prevalence and study the impact of prevention programs. After reviewing the various criteria used by researchers to define child abuse, psychologist Ross D. Parke (1975), working in collaboration with Candace Whitmer Collmer, suggested that abuse be considered to exist when the child suffers non-accidental physical injury as a result of acts—or omissions—on the part of his parents or guardians “that violate the community standards concerning the treatment of children.”

Estimates of the number of American children abused in roughly such terms each year range from a half million to 1.5 million. Moreover, two in every 1,000 abused children are estimated to die as a result of the trauma suffered at the hands of their tormentors.

Most researchers in the field have long believed that surveys of child-abuse cases seriously underestimate the problem. Many parents never bring their battered children to medical attention, and others who are repeated abusers manage to shift from one doctor or hospital to another in the hope that the child's injuries will be regarded as accidents. Often, the types of injuries inflicted are not readily detected. Even if they are, the physician may fail to report many cases to a central registry, thus leaving behind no trace of the brutal reality.

As a result of a recently completed national survey, the assumption that child abuse is more prevalent than shown by earlier statistics has been reinforced. A team of sociologists studying a nationally representative sample of 2,143 families has found that child abuse is a dramatic and visible aspect of a much broader pattern of violence that characterizes the American family today (Gelles 1977).

The findings are based on a survey of over 1,100 couples who had at least one child between 3 and 17 living at home. Among parents of children age 3 to 9, over 80 percent were found to use physical punishment, including acts which often go well beyond “routine” slaps. Moreover, the pattern applies to older as well as young children. The survey shows that over a third of all American children between 15 and 17 had been hit by their parents during the survey year.

The study reveals, moreover, a surprising range and severity of violence toward children by their parents. For example, 20

percent had hit the child with some object, and over 4 percent indicated they had "beaten up" the child. Even more astounding, according to Gelles, is the fact that nearly 3 percent of the parents used a knife or gun on their young targets. Applying this rate to the population of children aged 3 to 17, Gelles estimates a total of about 1,200,000 children whose parents had at some time in their lives attacked them with a lethal weapon.

Gelles identified the types of violent acts which are most likely to produce serious physical injury for the child. These include kicking, biting, hitting with a fist or object, beating up the child, threatening the child with a knife or gun, and actually using a knife or gun. Using this index he found that 3.6 percent of the parents interviewed admitted at least one of these violent acts toward the child in the previous twelve months. This suggests that each year well over one and a half million American children from the ages 3 to 17 experience an attack by their parents which could cause severe bodily harm or death.

Telling as these statistics are, they still do not capture the range of abuses to which children are subjected by their adult guardians. Psychologist David Bakan has summarized them:

Children have been brought into hospitals with skulls fractured and bodies covered with lacerations Children have been whipped, beaten, starved, drowned, smashed against walls and floors, held in ice water baths, exposed to extremes of outdoor temperatures, burned with hot irons and steam pipes. Children have been tied and kept in upright positions for long periods. They have been systematically exposed to electric shock; forced to swallow pepper, soil, feces, urine, vinegar, alcohol, and other odious materials; buried alive; had scalding water poured over their genitals; had their limbs held in open fire; placed in roadways where automobiles would run over them; placed on roofs and fire escapes in such a manner as to fall off; bitten, knifed, and shot; had their eyes gouged out (1973).

The conclusion is inescapable: Tens of thousands of children now receive not love and support but rage and rejection and savage batterings. Survey data translate into the sight and sound of a child brutalized by a parent.

What are the effects of abuse on young victims? What are the survivors like?

The Fate of Abused Children

To date, only meager scientific effort has been directed toward learning about the consequences later in life for abused children. Michael S. Wald, professor of law at Stanford University, and author of an exhaustive analysis of the legal ramifications of child abuse, has found that until about 1970, no one studied abused children at all—only the abusive parents (1975). Moreover, as University of Pittsburgh social worker Elizabeth Elmer points out, most of the studies which do exist are weakened by the absence of control groups, making it impossible to define exactly how abused children compare with comparable samples of unabused children (1977a).

Despite this paucity of solid scientific data, sufficient evidence already exists to outline the impact of abuse on its victims: If they survive at all, abused children appear to emerge with their intellectual functions impaired; they suffer physical, psychological, and social problems that scar not only them but, should they have children, the next generation as well.

Clinical observations, for example, have long suggested that abuse can seriously alter a child's physical resources—not only the ability but even the willingness to survive. In his paper on "The Unwelcome Child and his Death-Instinct," psychoanalyst Sandor Ferenczi concluded decades ago that "children who are received in a harsh and disagreeable way die easily and willingly. Either they use one of the many proffered organic possibilities for a quick exit, or if they escape this fate, they keep a streak of pessimism and of aversion to life" (1971). Pioneer child researcher Rene Spitz dramatically demonstrated the condition in studies of children placed in foundling homes (1971). Those children endured the rejection and neglect of their "caretakers," suffered physical deterioration and a dramatically higher death rate than otherwise would be expected. In extreme cases, total withdrawal to an apathetic, vegetable-like existence promptly led the child to its "quick exit."

Psychologist John Money, of The Johns Hopkins University School of Medicine, for example, has described a condition termed "psychosocial dwarfism"—a direct outcome, he contends, of severe and malignant child abuse (1977). The endocrine system of the victimized child may simply cease its usual

production of growth hormones, Money reports, and in the environment of abuse and neglect the young body stops growing normally. The result is a dwarfed child, stunted in both physical and mental growth—a grotesque anomaly of normal child development. Such children, Money points out, can be readily misdiagnosed as psychotic or mentally retarded. When finally seen by a physician, children suffering psychosocial dwarfism show evidence of the physical and psychic trauma they have endured. Their bodies are often laced with infected lesions, burns, and scars; an investigation of their families reveals that many of the children have been isolated, severely punished even while asleep, and chronically starved.

When children with psychosocial dwarfism are removed from the family to a hospital or foster home, Money reports, their precipitous physical decline is reversed. Their body chemistry changes. They begin to produce growth hormones and resume normal development. One child grew eight inches during the first year away from his family. In Money's study of 16 such patients, an improved living environment led also to a catch-up in mental growth—a rise in intelligence quotient and increased learning achievement.

For many abused children, lingering physical disabilities merge with intellectual and emotional ones in a pattern that invites lifelong problems. In 1974, for example, pioneer child abuse researcher Harold P. Martin reported the results of a 5-year followup of 58 abused children. Although the injuries suffered by these children had not been especially severe, approximately a third showed poor physical growth, and over half suffered neurological abnormalities. More than 60 percent evidenced personality difficulties, including low self-esteem, inability to enjoy interpersonal relationships, learning disorders, and behavior problems. The children's average IQ was in the normal range, but nearly three times the expected number fell below 85.

The studies by Money and Martin, and others like them, portray the dramatic impact of child abuse but lack comparison with matched groups of children *not* suffering abuse. A rare study using such control subjects—in this case, children suffering comparable body injuries through accidents rather than abuse—has now been reported by Elmer (1977a). She has described the results of an 8-year followup designed to compare a

small group of abused children with a matched group of accidentally injured children, utilizing measures of health, development, behavior, and school progress as gauges.

Infants, all of them from poor families, were selected for study from referrals to the X-ray department of Children's Hospital of Pittsburgh. All of the tiny patients were suffering from what the investigator calls an "impact event"—for example, a fall, or a blow. Each injury was judged by a pediatrician, a family interviewer, and Elmer herself to be the result either of abuse or accident. To place a child in the abuse category, the three judges had to agree unanimously, using one or more of three specific criteria: an actual report of abuse; a conflicting history, or one suspiciously inadequate to explain the patient's condition; or evidence of injuries incurred at more than one time. All children not judged to have been abused were placed in the accident category.

At the outset of the study, a number of differences between the two groups were apparent. The abused babies weighed significantly less, their heads, often beaten and bruised, were smaller, and they showed signs of neurological problems. They tended also to be slower in motor development and were significantly more variable and negative in their moods.

By the time the babies returned for a final outpatient evaluation one year later, five of the abused children had been placed in substitute care. As a group, however, they continued to weigh less, were shorter in stature, and had a smaller head circumference, although no longer significantly so. Health problems continued to be more severe among the abused children. Even some whose weight had been satisfactory at the beginning of the study, for example, were now significantly below the average for their ages. Mental, motor and language development, however, had slackened in both groups, more than half of each scoring below normal. Differences in temperament had disappeared also, largely because the accident children had become more negative and thus had begun to resemble the abused children more closely.

Now, 8 years later, Elmer matched 17 of the abused children with 17 from the accident group in age, race, and sex, and compared them not only with each other but with control groups of hospitalized children who had experienced neither abuse nor accidental injuries in infancy. After the intervening

years, she found that the earlier differences had disappeared. There were now no substantial differences among the children in their physical health, language development, intellectual status in school, self-concept, or behavior. What most surprised Elmer, however, was the extent of various problems across the entire sample, including controls. Seventy percent of all the children, for example, had speech problems, including poor articulation, chronic hoarseness, intermittent loss of speech, and stuttering, all often associated with tension and anxiety. Over half showed some degree of behavior disturbance, and nearly 40 percent were doing poorly in school. None of these disabilities, however, was significantly greater in one group than in either of the others.

Elmer's results suggest that the effects on children of poverty—and the family disorganization that accompanies it—may be as powerful as abuse. All of her subjects, abused or not, grew up in impoverished homes that were chaotic, disorganized, and marked by an abiding threat of violence. Such an environment may be a powerful, overriding factor that masks even the special impact of abuse.

Elmer's results do not mean, however, that child abuse itself has no appreciable effect. It would take a great deal more controlled research with children across a broad range of age and economic levels to measure specific outcomes rigorously. Meanwhile, however, studies of many samples of children continue to remind us that the penalties paid by the victims may be enormous.

Brandt F. Steele, professor of psychiatry at the University of Colorado Medical Center, and a staff member of Denver's National Center for the Prevention and Treatment of Child Abuse and Neglect, has recently detailed some of the effects of abuse on the psychological development of the child (1977). Unlike Elmer's subjects, most of Steele's families were above the poverty level. Moreover, his concern is not alone with children who have suffered physical trauma—fractures, burns, bruises, and internal injuries—but with those experiencing emotional deprivation and degradation, nutritional neglect, sexual abuse, and life in an environment shorn of all stimulation as well. He is particularly concerned with children who suffer such conditions in the early months and years of life.

Steele's results are unequivocal. "Maltreatment during this period," he reports, "not only results in immediate damage, but can also lead to deficits which affect the entire course of the child's life and distort all of his later psychological, emotional and cognitive development."

Problems in an abused child's development can often be explained in brute physiological terms. Repeated blows to the head, and the resulting bleeding inside the skull, ultimately mean the destruction of brain tissue. Parents may succeed in producing the same outcome, however, without obvious head trauma. Steele finds that subtle hemorrhages, diffusely scattered through the brain substance, can take place when an infant is simply shaken, leaving no external signs of injury. The net result of the brain damage endured in either case may range from a lowered IQ to profound mental retardation, defects in vision, and impairment of motor skills. Commonly, the baby suffers a delay in language development considerably greater than one might expect from the IQ score itself.

Steele is not surprised to find such disturbances resulting from injuries to the brain, but he is surprised and disturbed that many of the same impairments are suffered by children *without* head injuries and the accompanying neurological damage. They are the victims instead of a harsh, neglectful, and emotionally abusive environment. In approximately a third of the children without head injuries, for example, Steele reported borderline IQs or lower and, again, a large number suffering significant language deficits.

It is this inability to handle language that emerges as one of the most common characteristics among abused and neglected children. "Many of them," Steele has found, "show significant learning problems when they enter the educational system in pre-school, kindergarten or first grade." Steele contends further that a significant number of those living their young lives in our institutions for the mentally retarded are there as a result of abuse and neglect. "Many of the children who utilize the services of our overloaded special education programs in the public schools," Steele adds, "are there for the same unhappy reasons."

Steele reports also among abused and neglected children a "tragically low sense of self-esteem" which endures into adulthood. "It is a residue," he says, "of the many times the child

was criticized, belittled and punished or injured when he failed to meet the excessively high parental expectations. Success, if it ever occurred, was not praised, and there was no way to develop a sense of worth." Steele is impressed also by the apathy and depressive mood, the lack of any spontaneity and joy among abuse victims.

Among the most poignant characteristics found by researchers is the abused child's "hypervigilance," a tendency to be wary and watchful of the world, as if he expected the next unreasonable blow to fall at any moment. It is the same fearful attitude found among concentration-camp survivors who, for years after they emerged from their long ordeal, were readily startled and panicked by even normal sounds, of footsteps or shouting, that reawakened old horrors. Steele finds that when abused children observe violent physical and verbal actions of others, even though not directed at them, the result is often terror that cannot be assuaged.

What happens ultimately to abused children? "Some with the help of fortunate circumstances, can lead fairly normal lives," Steele contends. "Other children who are more severely damaged are never able to develop adequate skills of learning and living. They maintain precarious borderline adjustments, and are often in trouble. A small proportion become quite aggressive [and are], repeatedly in trouble at home, in the neighborhood, and at school. A larger number appear very well-adjusted, are extremely compliant, obedient, thoughtful and helpful. But this is a superficial adaptation to avoid disaster; underneath they are lonely, empty and emotionally disturbed."

Not surprisingly, such disturbance sometimes finds expression in the later sexual lives of abused children.

The Sexual Problems of Abuse Victims

A special problem found in dramatic evidence among abused children is embedded in their sexual attitudes and behavior. One of the most striking results of Elmer's study, for example, was the finding that so many of her sample of abused children grew later to develop significant difficulties in their sexual identification. Elmer herself was surprised. She did not set out to assess sexual problems, but comments from several of the examiners converged to suggest that this was a significant area for investigation. Seven of the abused children were spontane-

ously described by their examiners as confused in their sexual identification, or unable to separate their sexual from their aggressive impulses. Only two of the children suffering accidental injuries were thought to have such problems, and even these were less severe.

Under an early barrage of abuse from the outside world, young victims seem to lose a sense of identity and to enter a prolonged and unresolved sexual crisis.

Can it be that, while traumatic injuries suffered either through accident or abuse leave some psychological scars in common, it is the relentless and purposeful attack on a child by a significant adult "protector" that can especially damage developing sexual self-identity in the young personality?

The findings of Elmer and her team agree with observations made centuries ago. Aristotle concluded that deviant sexual behavior becomes a way of life among "those who are abused from childhood." Moreover, the connection between abuse and sexual problems did not escape the sharp clinical observations of early psychoanalytic theorists. Ferenczi concluded that unwelcome, rejected children grow to be frigid and impotent (1971), and from his vast clinical files sex pathologist Richard von Krafft-Ebing deduced decades ago that traumatic experiences in childhood often produce adult sexual deviations (1969).

Such theoretical speculation might be dismissed as derived from isolated clinical incidents were it not for supportive data now available from research such as Elmer's and, even more dramatically, from animal studies. During their ground-breaking research on infant development, Harry F. Harlow and his team of investigators at the University of Wisconsin amassed convincing data linking early abuse with later sexual pathology among primates (1974).

Harlow's original purpose was to establish experimental neuroses in infant monkeys by arranging for them to be traumatized and abused by their mothers. Later, as the animals grew older, he and his fellow researchers were struck by some of the long-term and difficult-to-reverse effects of their early manipulation. Prominent among these were sexual difficulties and aberrations.

One experimental approach was to inflict on the young monkeys a "rejecting mother" who, on schedule or demand, violently separated her baby from further contact. A wire frame,

embedded in the mother's spun-nylon covering, was displaced abruptly upward and backward, causing the infant to be relentlessly disconnected from its source of protection and love. Next, Harlow developed an "air blast mother" with a series of nozzles down the entire center of her body which released compressed air under high pressure—an extremely noxious stimulus to monkeys. Then he introduced a "shaking mother," which could be made to jerk her infant violently until its teeth chattered. Finally, he devised a "porcupine mother," extruding brass spikes over the front of its body and offering an abusive and painful response to the infant's attempts at nuzzling.

As the months and years passed, Harlow and his coworkers found the traumatized monkeys to deviate increasingly from the normal. The animals sat in their cages, strangely mute, staring into space, relatively indifferent to people and their monkey peers. Many clutched their heads in both hands, rocking back and forth in the manner of the typical autistic child; others engaged in violent frenzies of rage, grasping and tearing at their legs with such fury that they sometimes required medical care. Eventually, Harlow realized that he had, indeed, raised a laboratory filled with severely damaged monkeys.

Because of housing pressures, some of the animals lived in pairs for several years while growing to sexual maturity. In the earliest reports of his classic studies, Harlow began to note the absence of normal sexual behavior among his abused breed. "When the older, wire-cage-raised males were paired with the females at the peak of estrus, the introduction led only to fighting, so violent and vicious that separation was essential to survival. In no case was there any indication of normal sex behavior"

At this point Harlow (1975) took the 17 oldest of his experimental female animals showing consistent estrus cycles and a similar number of obviously mature males and engaged them in an intensive re-education program to see whether the damage could be repaired. He paired the females with "the most experienced, patient, and gentle males," and the males with his "most eager, amiable, and successful breeding females." The results were startling. "When the laboratory-abused females were smaller than the patient, gentle males, the girls would back away and sit down facing the males, looking appealingly at these would-be consorts. Their hearts

were in the right place, but nothing else. When the females were larger than the males . . . they would attack and maul the ill-fated male."

Harlow (1975) reported the training program for the males to be equally unsatisfactory: "They approached the females with a blind enthusiasm, but it was misdirected enthusiasm. Frequently, the males would grasp the females by the side of the body and thrust laterally, leaving them working at cross purposes with reality. Even the most persistent attempts by these females to set the boys straight came to naught. Finally, these females either stared at the males with complete contempt or attacked them in utter frustration."

Harlow's whimsical prose does not soften his harsh results. Monkeys abused in their infancy tended to grow into sexually incompetent and perverse adults, and their attempts to engage in normal sexual activity ended in frustration and failure. From different sources—the initial clinical insights of Ferenczi and Von Krafft-Ebing, Elmer's controlled studies of abused and accidental-injury children, and Harlow's abuse experiments on monkeys—the evidence is accumulating that sexual debility, perhaps irreversible, may be a long-term effect of child abuse.

Planting the Seeds of Violence

Perhaps the most malignant outcome of child abuse, however, is the seed of violence so often sown in the heart and mind of the young victim. The Biblical warning that foresaw the "sins of the fathers" visited on their children is nowhere more fully realized than in the ugly intergenerational chain of violence spawned in the home where child abuse occurs.

Centuries ago, the sage Ben Sirach observed: "The branch sprung from violence has no tender twig." His observation has now been confirmed repeatedly by investigators who find an unusually high rate of violent behavior, including juvenile delinquency and crime, among children abused earlier by their adult parents and guardians.

The number of such untender twigs in American society is proliferating at an alarming rate. While violence in general has been steadily increasing in our society, recent years have witnessed an especially remarkable spurt in the incidence of violent behavior among the young. Violent crimes committed by children of all ages have been increasing between three and

four times faster than they have in the general population (Wolfgang 1976).

But no array of statistics can accurately portray the challenge posed by a violent child to those who share his world. For parents, siblings, peers, teachers, and, ultimately, law-enforcement authorities, such children test the limits of adult compassion and caring, raise tides of guilt and self-doubt, and challenge the most sympathetic responses in our repertoire.

“If we want to understand violence in general, we must pay attention to how we treat our infants and small children.”

Contrary to the views of some, television is not the prime model for our children's violent behavior. What appears on the small screen is actually a pale, two-dimensional representation of the violence that many children experience in depth each day in kitchens, living rooms, and bedrooms across the country. Based on their national survey, sociologists Murray A. Straus, Suzanne K. Steinmetz, and Richard J. Gelles conclude that violence between members of the same family occurs more often than it does between any other individuals or in any other setting except wars and riots (Gelles 1977).

Steele reports studies in the Denver area showing that fully 80 percent of youngsters picked up as juvenile offenders have been abused and neglected early in life (1977). He cites one investigation of 100 youngsters picked up for the first time; 84 were found to have been physically abused before school age and 92 had been bruised, lacerated, or had a bone broken by a parent within a year and a half previous to confronting the law (1977). Followup studies cited by Steele tell the same story. In California and New York, for example, children reported to be abused and neglected were followed for a dozen years or more. Nearly two-thirds of them emerged as delinquents.

No one will deny that other factors may be involved in the origins of violent behavior in the young. The importance of abuse as a springboard for the later abuse of society, however,

cannot be swept away. "If we want to understand violence in general," concludes Steele, "we must pay attention to how we treat our infants and small children."

Contrary to popular assumption, diagnosable mental illness is rarely a characteristic of abusive parents. Abusive parents do not fall neatly into traditional psychiatric diagnostic categories such as schizophrenia or manic-depressive psychosis. Although some psychotic individuals are responsible for child abuse, Kempe estimates that less than 10 percent of abusive parents actually can be classified as mentally ill (1962).

Are there instead certain personality characteristics that abusive parents share in common?

Various investigators have suggested a bewildering array of traits, describing such parents, for example, as immature, impulsive, rigid, domineering, self-centered, hypersensitive, and more. They have not succeeded, however, in constructing a coherent portrait. In 1972, after an extensive analysis of the existing research literature on the subject, John J. Spinetta and David Rigler found general agreement only that the abusive parent allows aggressive impulses to be expressed too freely; there was little consensus, however, on the source of these impulses. In another review one year later, Gelles found that, among the 19 traits identified by various investigators as typical of abusive parents, there was agreement by two or more authors on only four; the remaining 15 traits were each unique only to one researcher's findings (1973).

The most systematic study of personality attributes of child-abusing mothers was reported in 1969 by Barry Melnick and John R. Hurley. They compared two groups of ten mothers, largely poor and black, one made up of abusive mothers, the other serving as controls. The groups were matched in age, social class, and education. The abusing mothers revealed lower self-esteem, less family satisfaction, less need to give nurturance, higher frustration of their dependent needs, and a less openly rejecting stance toward children. Even these findings, however, are not necessarily generalizable—for example, to fathers, or to parents of either sex at higher socioeconomic levels. It is noteworthy, too, that on two-thirds of the other personality dimensions studied the two groups of mothers differed not at all.

But there do appear to be some qualitative differences between the two types of parents. Three characteristics of abusive parents stand out: an acceptance of abuse as a way of parental life; a tendency to harbor grossly unrealistic expectations of children and to view them as evil; and a background of abuse in their own childhood.

To begin with, parents given to child abuse appear to regard physical punishment as quite natural and appropriate in rearing their young. Elmer reports the experiences of a colleague during visits to the homes of families being studied. "Even though the parents knew they were under observation by outside professionals," says Elmer (1977b), "several reacted to their children's objectionable behavior by hitting them." The parents had been judged abusive by the court and *knew*, therefore, that they were in trouble; yet evidently it did not occur to them to curb their attacks.

Elmer found the same attitude toward punishment among parents in her own study. One mother, angry at her child for not bathing, looked about for a strap with which to beat the child. It was only by chance that the strap could not be found; otherwise the beating almost surely would have taken place, despite the presence of an interviewer. Such parents, in Elmer's view, simply do not see corporal punishment as related to abuse; instead they are "doing what comes naturally."

For the parent given to abuse, it is never too early to begin showing the child who is boss. Slaps, spankings, beatings, all these begin virtually at birth. Moreover, the attitude does not appear to depend on social class. Barbara M. Korsch and her colleagues interviewed 100 mothers of infants under 18 months of age, all of whom ranged from low to middle class (1965). One-quarter of the mothers had started to mete out physical punishment before their babies were 6 months of age. Almost half the women were spanking before the infants were 12 months of age, even though they believed it was preferable to defer such punishment until the age of 1 year. Elmer's study focused on families ranging from very low to very high socioeconomic classes, but the tendencies of the mothers were much the same as among those studied by Korsch. "Over 80 percent were using physical punishment by the time the children were 12 months old," reports Elmer. Few mothers distinguished between teaching and punishment.

With such a readiness to apply physical force, it is not surprising that the line between child discipline and child violation often becomes blurred.

In the view of Kempe and his staff, there appears to be an unbroken spectrum of parental acts towards children ranging from "reminder pats" on the bottom through severe spanking and bruising to the breaking of bones and the fracturing of skulls. The readiness of parents to yell, scold, punch, hit, and yank very small children is common, and the investigators feel, therefore, that in dealing with the abused child, they are not observing an isolated, unique phenomenon, but only the extreme form of an attitude toward childrearing common among parents in our culture.

The abusive parent, already comfortable with physical force, appears also to harbor surprisingly unrealistic expectations of the child. From their direct observation of abusive parents and their children, Steele and Carl B. Pollock concluded not only that parental demands for performance are heavy but that they are premature by far, "clearly beyond the ability of the infant to comprehend what is wanted and to respond appropriately" (1968). Such parents persistently deal with their children as if they were much older than they really are.

Abusive parents tend also to view their victims as evil, harboring malevolent intentions that must be exorcised. Elmer has heard parents describe a baby weighing 15 pounds as "out to get me," or as "a little Communist." The abused child is seen somehow as purposely malicious and antagonistic. For historian deMause, the roots of such attitudes lie deeply buried in the psyches of offending parents. Throughout history, he contends, adults have used their children as objects onto which they could project their own unconscious conflicts and struggles. In psychoanalytic terms, such parents "void" their feelings onto their young.

It is a background of abuse in their own childhoods, however, that emerges as the most overriding characteristic of adults who violate their children. "It is out of the pool of abused, neglected children that the next generation of abusive parents will come," says Steele. "These unfortunate people have carried into adult life their main psychological patterns of lack of trust, fear of social contacts, inability to have pleasure, low self-esteem, mild depression, great neediness and inability to em-

pathically love When they have children they repeat the behavior of their own parents; they expect their children to behave in ways to satisfy the excessive parental needs. Especially in times of crisis the parents turn to their babies for comfort; the children are bound to fail and are punished or neglected. The cycle repeats itself." Throughout history, according to deMause, adults have unleashed similar long-smoldering hate and anger against the defenseless child.

The chain of abusive and neglectful behavior thus created has emerged consistently in attempts by researchers to tap the psychological roots of abusive parents. Most dramatic, perhaps, is the evidence that surfaced from the work of Harlow, part of it described earlier. It will be recalled that Harlow and his coworkers at the University of Wisconsin succeeded in producing child batterers among monkey mothers simply by depriving them, as children, of all signs of maternal or peer love. Although raised in a faultlessly, physically hygienic environment with bodily needs satisfied, they were not allowed to know affection of any kind.

Harlow admits his own surprise. "Frankly we never thought we could produce the battered-child syndrome in the rhesus monkey," he says. Yet he did—by raising motherless monkey mothers, animals who had "never known mother love themselves and had never had the chance to express love to a mother nor to exchange affection in play with agemate monkeys." He has since concluded that mother love can be prevented almost perpetually by withholding such love from the mother-to-be, even if she isn't to be a mother for many years.

Two different behaviors characterized the unloved, motherless monkeys grown to be mothers themselves. One was to totally ignore the babies, to neglect them, a response that is totally foreign to the behavior of both human and monkey mothers, who, typically, "at the dimmest detection of distress, rush to the babies and clasp them to their breasts with tender love and care."

The second basic behavior was, in Harlow's words, "grim and ghastly." When the infant made contact with the mother's body, he reports, "the mother would disattach the infant. She would literally scrape it from her body and abuse the infant by various sadistic devices. The mother would put the baby's face against the floor and rub it back and forth In most cases

our experimenters were able to stop sadism at this point, but some mothers were so violent and vicious that the baby was barely saved or even lost. Not infrequently the mother would encircle the infant's head with her paws and, in one case the skull of the neonate was crushed before mother and child could be separated, so little had we anticipated the severity of the events in the reproduction of the battered-child syndrome."

How comparable are the human vestigial responses to early trauma?

"There are practically no exceptions," says Selma Fraiberg (personal interview, 1978), whose evidence emerges from a long career as a clinician and researcher studying children born bereft of normal human bonds. "I do not think I have ever seen an abuser of a child or for that matter an abuser of his wife who had not experienced abuse in his own childhood."

Children Who "Ask for It"

Elmer (1977b) has described an unfolding situation common to many young married couples:

They eagerly awaited the birth of their little bundle of joy and prepared the pink dress, the pink crib, the pink-and-white room. As it turns out, pink is not suitable, for the baby is a boy. Moreover, the dress is slobbered on, and the crib is where the baby cries, not where he sleeps. In fact he rarely sleeps, eats sporadically, spits up much of his food, and is often smelly and dirty. He never listens; whatever his mother says, he does just the opposite. No matter what methods the parents try, the baby doesn't learn to become dry and clean, to eat neatly, to live on schedule Instead of living happily ever after, the couple becomes more and more fatigued, more irritable, less tolerant of normal baby behavior

The new arrival introduces a stress which often tests the limits of a parent's capacity to protect and care for a child

Such circumstances, Elmer believes, are often a prelude to physical punishment of the newborn and, ultimately, abuse. The case highlights a fact of family life experienced by countless parents. The new arrival introduces a stress which often tests the limits of a parent's capacity to protect and care for a child, especially when no strong commitment to the newcomer exists from the start.

Certain characteristics of the newcomer, high among them excessive irritability and crying, can help push parents beyond their threshold of violence. Newborns who fret a great deal appear to run a greater risk of harm than those who are placid and easily soothed. Such a "difficult" temperament may be determined by constitutional factors. Or, as Martin and Patricia Beezley have pointed out, it may arise from subtle early malfunctions of the infant's central nervous system, rarely identified by medical or nursing staff (1974). The result in any case is a child who is typically described by parents as irritable, colicky, fretful, and difficult to feed, satisfy, or diaper. Parents of such children, they report, develop feelings of inadequacy, guilt, and anger; nothing about the baby's behavior makes them feel good about being parents. For adults with a "high potential to abuse," such an infant can soon precipitate vicious attacks.

To compound the problem, the difficult baby who suffers abuse may quickly develop behavior patterns which, in turn, invite still more harm. Bakan concludes that abused children, unlovable to begin with, tend to take on characteristics which make them even more unlovable (1973). "The child who is abused and neglected," he finds, "becomes ugly in appearance and behavior and invites further abuse and neglect. Abused children develop such traits as fear of being alone, continued whimpering, shyness, fear of novel situations of any kind, hypersensitiveness to pain, overreactiveness, fear of engaging in any action at all even to help themselves . . ." The victim, it would seem, begins early to contribute to his own disastrous fate.

Of all the infant's characteristics, the one that appears most likely to invite abuse is low birth weight. Supporting data have emerged from a host of studies. From hospital records between 1960 and 1969, for example, Michael Klein and Leo Stern retrieved the charts of children diagnosed as victims of "battered-

child syndrome," 51 in all. Nearly one-fourth of them had weighed below 6 pounds at birth—over three times as many as one would expect to find in the population at large. Since mothers of low socioeconomic status are more likely to give birth to underweight children, the researchers re-examined their data, controlling for social class. Among poor families, the incidence of abuse was still over twice as high among low-birth-weight infants.

Low-birth-weight infants are disproportionately premature, frail, and underdeveloped. What is it about the frail infant, born prematurely, that invites violence? To begin with, Parke and Collmer point out, the underdeveloped newborn often violates the common parental expectations that the baby will be attractive and lovable (1975). It is neither. Moreover, such infants impose greater demands on their parents than do normal children. Feeding disturbances are common, and the babies are more irritable and cry more. Progress in muscular development, speech, and socialization is often naggingly slow during the first two years. "Although research is badly needed to specify the exact characteristics of the low-birth-weight infant that elicit parental abuse," Parke and Collmer conclude, "it is clear that the burden, stress, and disappointment associated with the birth and care of a low-birth-weight infant could increase the probability of abuse."

Child development researchers Sarah Friedman and Blanche Jacobs, at the National Institute of Mental Health, have observed how nurses help propagate or intensify negative attitudes towards premature infants. "We see how they talk about the children," says Friedman. "They often hate them. If they develop a hate for the child everyone begins to disown the child. You come in and ask 'how is this baby doing?' The answer is *I don't know. I'm not taking care of this child.*" Jacobs adds that the dynamics of a nursery for premature infants is very different from the norm. The staff can often gang up on babies that they don't like. A baby that doesn't thrive is a symbol of failure, and they don't like it. If he is ugly to begin with and troublesome, the spiral of neglect can begin. The researchers point out that the mother who comes to visit her premature child after leaving the hospital gets a lot of "vibes" from the attitudes of hospital staff. The spiral of neglect and isolation builds up (personal interviews, 1978).

The problem may be compounded by the impact on mother of her separation from the premature infant at the very start of their relationship. A child born prematurely is typically not available to mother for long periods precisely at the time when critical attachments are beginning to take hold. A host of studies of both animal and human mothers and infants, some of them reported earlier, have demonstrated that such early separation can have a significant effect on the mother's behavior and attitudes—her skills as a mother, her self-confidence, even her physical interactions with the child.

From their studies, John H. Kennell and his associates have reported subtle evidence with potentially explosive ramifications (1977). Mothers who were permitted physical contact with their premature infants beginning in the first days of life, they found, spent significantly more time engaged in cuddling and other intimate behaviors during later feedings than did mothers who first handled their babies only after 20 days. Mothers enjoying early contact more often held their infants cradled close to their body or on their chest or shoulder; furthermore, they were more likely to look at and talk to the infant during feeding rather than to pay attention to others. Separated mothers, in contrast, often held their infants at some distance from their bodies and showed less evidence of attachment. The potential for abusive behavior is less by mothers who have enjoyed the opportunity to form strong emotional bonds with their infants. The premature newborn, removed from contact with the mother, is a likelier victim later, therefore, when encounters begin in earnest with a mother who has not made the critical early connections of love.

Studies such as those by Kennel, Klaus, and others demonstrate the importance of early experiences in the later development of the child. Yet it should be kept in mind that the data provided by these studies portray trends and tendencies, not immutable facts of human development. Indeed, some child-development authorities have recently challenged the notion that one can always anticipate from the experiences and behaviors of infancy what a child will be like later on in life. Among them is Harvard professor of human development Jerome Kagan, who reminds us that recent evidence from longitudinal studies provide a portrait of child development that is more

plastic, more malleable by later experience than has hitherto been believed to be the case (Kagan 1978).

Help for Abusers and Their Victims

The foregoing data expose the need for programs that will effectively reduce the suffering of children and break the chain of abuse that links the generations. Can preventive measures be introduced to end the relentless attack on abused children and offer them and their families a chance for normal existence? Not all cases of child abuse are comparable, of course, and no one preventive measure, therefore, can work in all cases. In the view of a number of experts in the field, however, a range of existing programs appears to offer hope for dealing with child abuse. Parke and Collmer have described six categories of such programs (1975):

- *Parent Groups*, which provide abusive parents with an opportunity for group discussion and emotional support. Group members, often isolated in their own individual lives, report that they profit from knowing that other people have problems and feelings similar to their own.
- *Home Support Programs*, which involve lay therapists functioning as family friends for abusive parents. In contrast to typical social workers, who carry a load of 15-30 cases, an aide is assigned to only one or two families, with the aim of providing advice and support over an extended period on a regular basis, usually in the parents' home; the aide is available by phone day and night, and the parent is encouraged to make contact during a crisis.
- *Hotline Telephone Services*, organized along the lines of those successfully offered to suicidal persons. The public, made aware of the 24-hour emergency services through the media, is encouraged to call for support in a crisis situation, or to seek referral to an agency offering direct advice and therapy.
- *Crisis Nurseries and Drop-off Centers*, providing the stressed parent with 24-hour emergency short-term care for infants. Such facilities emerged from the frequent observation that, when harrassed parents are faced with the task of caring for their children without a break, abuse is more likely to occur.

- *Child-Care Instruction*, based on the demonstrable fact that many abusive parents share common misunderstandings about childrearing. In some instances, the essentials of child care are taught in parent group meetings, while in others individual instruction is offered in the home. Emphasis is on the practical aspects of child care, including the troublesome area of child discipline.
- *Public Education*, aimed at increasing general awareness of the origins and nature of child abuse. Because many adolescents share only vague and unrealistic ideas about parental feelings and behavior, such educational efforts are especially useful to them.

Parke and Collmer offer an important reminder. Many claims have been made on behalf of various intervention efforts, but none has been sufficiently evaluated. Still, until systematic assessments are carried out, such programs must be regarded as vehicles of hope for both victim and abuser.

When Should Therapy End and the Law Take Over?

For those engaged in the helping process, a sharp and rending dilemma often presents itself: How to balance the therapeutic impulse with the feelings of revulsion, outrage, and censure evoked by the abusive parent.

Rosenfeld and Newberger propose a number of criteria that clinicians might use to help decide whether an abusive parent should best be approached with compassion or control (1977). Examples are: if the child's injuries appear to be the result of an isolated experience triggered by stress; if the parent shows some concern or guilt; if the parent's behavior is not deviant in other ways—for example, alcoholic or criminal; if the child is seen by the parent as basically good and worthy of love; if the parent is able to view the child as a separate entity ultimately worthy of compassion and empathy; and if the parent appears to have sufficient strength of personality to be able to learn to control violent and aggressive impulses. If a few of these are the case, then a compassionate stance appears appropriate. If, on the other hand, the child is the victim of severe and recurring injuries, the parent seems unconcerned or displays other deviant behavior, sees the child as intrinsically "bad," cannot distinguish the child's needs from his or her own, and lacks the

psychological health and adaptive strength to deflect harmful impulses, then an intervention approach weighted toward "control" may well be invoked.

Ultimately, the best hope for all lies in the development of techniques for anticipating child abuse, for preventing it before the pattern begins to take hold at all. The work of one seasoned research team is directed toward this end.

An Early Warning System

At the National Center for the Treatment and Prevention of Child Abuse and Neglect, in Denver, C. Henry Kempe and his coworkers have acted on the conviction that it may be possible to pick up signs of trouble between the newborn infant and its mother at birth (Grey, Cutler, and Kempe 1977). Children who are most likely to be battered later can often be identified from their mothers' reactions during labor and during and after delivery, Kempe believes.

One of the important clues to future difficulties for the child, for example, is lack of direct eye contact between parents and newborn, says Kempe. Other parental reactions that might suggest future problems of child abuse and neglect include lack of an active interest in the baby, unreasonable levels of expectation toward newborns, disappointment over the child's sex, hostile reactions, and inappropriate comments.

Kempe believes that, as a result of his early identification techniques, prevention of major injuries is possible. "We can do nothing about how people are raised. We can do nothing about how they see their children. But we can from the very first do something about lifelines and rescues and about crises management." Kempe believes that his approach can identify families who need extra help—that is, "outreach services" that all children should have.

In the Colorado study (in which Kempe's collaborators were Jane D. Gray, Christy A. Cutler, and Janet G. Green), 100 mothers believed capable of "abnormal parenting practices" were evenly divided among a High Risk Intervene (HRI) group

and a High Risk Nonintervene (HRN) group. Fifty mothers at low risk for abnormal parenting were selected as controls.

- A prenatal interview was given each mother, with information gathered on the parent's upbringing, feelings about this pregnancy, expectations for the unborn child, attitudes toward discipline, availability of support systems, and the present living situation.
- A questionnaire was administered to the mother during the prenatal or early postnatal period, covering the same ground as the prenatal interview.
- Mother-infant interaction was assessed on forms completed by the labor and delivery-room nurses or from videotapes.
- Observation and/or interviews were given during the postpartum period.

As it turned out, "information gained from observers in the delivery room was most accurate in predicting potential for abnormal parenting practices." The investigators add: "If delivery room observation is not feasible and only one opportunity for evaluation exists, the early postpartum period affords the best opportunity . . ."

Intervention was provided by a pediatrician, who examined the baby in the newborn nursery, talked with the parents, and scheduled the first pediatric visit when the infant was two weeks old. After that, the doctor saw the child bimonthly and at other times when the mother or the doctor felt necessary. The pediatrician also telephoned the family two or three days after the child left the hospital and during the weeks when a clinic visit was not scheduled, and he provided support whenever a medical or other crisis was present. The families were not told that this service was exceptional. Also included in intervention were weekly visits by public health nurses. Lay health visitors—persons who assess the child's general health status, offer emotional support to the family, and provide liaison with the health system—were used whenever indicated.

When the children were at least 17 months old, home visits were made to 25 randomly selected families in each of the groups under study. Some of the findings:

- No child in the HRI group (high risk, intervention) and none in the low-risk group suffered an injury thought to be secondary to "abnormal parenting practices" that was serious enough to require hospitalization. However, five children in the HRN group (high risk, no intervention) required inpatient treatment for serious injuries, which included a fractured femur, a fractured skull, barbiturate ingestion, a subdural hematoma, and third-degree burns. One of the five serious injuries (the burns) was preceded by relatively minor inflicted trauma, including cigarette burns, scratch marks, and strap marks. These all received medical attention but were never reported, nor was an attempt made to involve other helping agencies in an effort to prevent further injuries. There is a possibility that the third-degree burns and the resulting contractures could have been prevented if intervention had been initiated promptly. In another case, a subdural hematoma and its resulting intellectual deficit and neurological handicap might have been prevented if intervention had been instituted during a "social admission" to a hospital just prior to the injury. If appropriate interventions to alleviate social pressure had been undertaken at this point, there is a possibility that the injury would not have occurred (Gray, Cutler, Dean, and Kempe 1977).
- Possible indicators of high risk had been considered to be the mother's race, age, and marital status, and the family's socioeconomic level. As it turned out, the mother's race was *not* a significant variable. However, single and young mothers were considered at higher risk for abnormal parenting practices; also "there was a trend toward 'financial difficulty' in mothers in the high-risk groups."

The Denver investigators arrived at a conclusion that is reported most gently in their own words:

Families identified as being in need of extra services must have access to intensive, continuous intervention which is both positive and supportive. It makes little sense to provide excellent prenatal, obstetrical, and neonatal pediatric care in our hospitals, only to abandon the most needy young families at the hospital door and leave to chance, or to parent motivation, the needed access to helping professionals (Gray, Cutler, Dean, and Kempe 1977).

Such prediction efforts, Parke and Collmer believe, are among the most important recent innovations in the area of child abuse research. If they are successful in identifying potentially abusive caretakers, education programs for parents can begin immediately after the child is born, thus short-circuiting the developing patterns of interaction that portend later abuse. It is far easier to prevent the evolution of such patterns than modify them after they have taken hold.

In thus providing parents with the capacity to deal well with their children, we may yet reverse the inexorable chain of violence that now binds the generations.

Note

(1) This report is adapted from a chapter appearing in *A Child's Journey: Forces that Shape the Lives of our Young*, by Julius Segal, Ph.D., and Herbert Yahraes (New York: McGraw-Hill, 1978).

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HELPING ABUSED CHILDREN AND THEIR PARENTS

Principal Investigator: James T. Kent, Ph.D.

Author: Mary C. Blehar, Ph.D., NIMH

A 12-month-old infant with a painful and swollen hand is brought into Los Angeles Children's Hospital. His nervous young mother's account of the injury is vague and inconsistent. Skeletal X-rays confirm the pediatrician's initial diagnostic suspicion that the baby has other hairline fractures, some of them partly healed, most of them unlikely to have come about by accident. He concludes that the child is probably a victim of Non-Accidental Injury (NAI). The case is reported to the police, as required by California law. Pending investigation of the case by the Los Angeles Police Department Child Abuse Unit and the Department of Public Social Services, and final determination by the juvenile court, the infant is removed from the family home.

A 7-month-old girl is brought into the hospital by a grandmother who complains that the mother, her own daughter, is not taking proper care of the infant. Examiners observe that the baby is unresponsive to social stimulation and far below normal in height and weight. After a few days' stay in the hospital, during which time she is well fed, the baby gains weight dramatically. The case is again referred by the attending pediatrician to the Department of Public Social Services as an instance of Failure to Thrive (FTT), its probable cause being environmental deprivation.

These are but two examples of the kind of abusive treatment to which young children in America are subjected today. In Los Angeles alone, the reported rate of non-accidental injury and child neglect was around 300 per million of population in 1976, and comparable rates were reported for other urban centers. Some experts suspect that the true incidence may be even higher. The number of abuse cases coming to the attention of authorities has grown rapidly in recent times, as more and more publicity is given to the problem. Whether abuse is actually increasing, or whether it is just being reported more, is debatable. But the fact remains that substantial numbers of young children suffer a variety of neglectful or injurious experiences at the hands of the very adults who are responsible for the children's safety and well-being.

A Children's Hospital team in Los Angeles, California, has been involved in an intensive, long-term study of abused children and their families. The Family Development Project, as it is named, is headed by Dr. James Kent, a clinical psychologist and recipient of an NIMH grant. He and his coworkers combine research interests with daily practical concerns for the care and treatment of children and their parents. Team members have diverse professional backgrounds. Among them are pediatricians, psychiatrists, clinical psychologists, social workers, nurses, specialists in development, parent aides, and office staffers. Together they comprise a dynamic group which takes a multidisciplinary approach to what is a multidimensional problem.

Speaking briefly in his hospital office about the many causes of abuse, Kent points out that there is a wide range of psychological characteristics associated with abusing parents, the most commonly cited profile involving a childhood history of physical or emotional neglect, low self-esteem, high dependency needs, and unrealistic expectations for the performance of very young children. Children are viewed as sources of reassurance about personal adequacy, and when they fail to provide this reassurance (as they often do by crying or by disobeying), the parent sees herself (or himself) as rejected. The impulsive response to rejection is excessive anger and punishment. The child suffers accordingly. That sociological factors are also implicated in abuse is shown by national surveys indicating that the overwhelming majority of abuse and neglect cases come

from socially and economically disadvantaged groups. Although Kent finds this circumstance to prevail in Los Angeles, he points out that, until recently, there has been an apparent reluctance on the part of private physicians to report to police patients suspected of abuse. At present, only 1 percent of abuse referrals come from the private sector, though this situation is changing as a result of physician education efforts now being undertaken by the American Academy of Pediatrics.

Kent does not think that low socioeconomic status is a condition necessary for abuse to occur. He points out that parent self-help groups, called Parents Anonymous, have sprung up in Los Angeles and other urban centers throughout the United States, and that these groups are made up almost exclusively of middle-class parents. Thus abuse is not limited to any one social stratum; yet it is obvious that the stresses of low socioeconomic existence may help to push susceptible parents into abusive patterns.

What about the abused children? How do they fare? What long-term outcomes are associated with early abuse? The clinical picture of an environmentally deprived (FTT) infant is well known: malnutrition, retarded bone age, vulnerability to infection, stereotyped motor behaviors, and emotional apathy. When Failure-to-Thrive children are placed in more stimulating and responsive environments, they tend to improve dramatically. Still, many professionals question whether the effects of early deprivation can ever be undone completely. If the issue is physical development, then the outlook is optimistic, except in isolated cases of severe and prolonged malnutrition in the first months of life. But if the issue is social/emotional development, the prospects for complete recovery are much dimmer. Many deprived children are never able to form close personal ties, many suffer from character disorders, and many also tend to lag behind their more fortunate peers in language development and concept-learning capabilities.

Physically battered (NAI) children present a somewhat different clinical picture. The incident that led to injury may be isolated, or it may be one of a series. Deliberately inflicted injury is by its very nature not usually as chronic as neglect or environmental deprivation, but it can be extremely dangerous. At Los Angeles Children's Hospital, where casefinding is pursued aggressively, the mortality rate for battered children is

around 5 percent. Elsewhere it is undoubtedly higher, estimates of 10 percent being common. Even when a child survives abuse, some 20 to 40 percent sustain permanent damage, usually to the central nervous system.

The children suffer from numerous emotional difficulties. They tend to be aggressive and to have difficulties with peer relations. Overall, their emotional adjustment is poor. On measures of intellectual development, they do not appear to be affected as severely as in the emotional domain, but very few score in the superior ranges.

RESEARCH GOALS

Although Kent and his colleagues are interested in differences between abuse-prone parents and other parents, they are trying to answer an even more significant and complex question concerning differences among abusers themselves. Parents of Failure-to-Thrive infants are distinct in many ways from parents of victims of Non-Accidental Injury, and even within these two categories of abuse parents vary widely. If a system for categorizing parents according to reasons for abuse can be developed, Kent claims, then professionals can estimate the degree of risk each child has for reabuse, and treatment of both parents and children can be tailored to fit individual cases. To this end, the Children's Hospital team workers have been gathering psychological, physical, and sociological information about the families they see. This information has been used to sort abuse-prone families into four clusters. The clusters will be refined continually as more information about abuse becomes available, but Kent has already written a preliminary paper describing four kinds of parents of children suffering from Non-Accidental Injury. Dr. Robert Jacobs, a Children's Hospital pediatrician, has also identified three types of parents of Failure-to-Thrive infants. These clusters will be described in detail later.

Another research aspect of the program consists of a comparison between two groups of abused children and parents. A "control" group, that is, a group matched to a test group in every respect except the one being tested, contains children who were previously identified at the Hospital as victims of NAI or FTT. They received the social-service assistance availa-

ble, usually consisting of visits from an employee of the Department of Public Social Services. The second group contains children who are also victims of abuse but who *in addition* to regular social services participate with their parents in a program developed by the Family Development Project team. Participation in this program is the only difference between this group and the control group. The children in the two groups receive evaluations both at the time of the abuse and periodically afterward so that their physical and social development can be monitored.

Treatment Considerations

Kent and his coworkers are worried about the long-term development of the children in their program. Usually when a child is reported to authorities because of suspected parental abuse, he or she is removed from the home and placed in foster care. Studies of children in such care indicate that they improve initially in physical growth and intellectual development but that the longer they stay the more likely they are to develop difficulties in relating to their peers and to adults. It appears that the effects of the abusing incident are compounded by foster care or by separation from parents. Kent sees this circumstance as representing a central problem in the effective treatment of abuse.

This portrait of parents in pain over the loss of their offspring is unlike the popular picture of abusers as homicidal sadists who have little capacity to feel positive emotions.

While it would be foolish to return children home indiscriminately and to hope that their parents would not reabuse them, indefinite separation from parents may put many children at risk for developmental deviations that are less dramatic than physical injury but perhaps equally detrimental to long-term growth and development. Consequently, the team has evolved the philosophy that children should not be placed in foster care

unless it is absolutely necessary (i.e., unless there is clear-cut reason to think that reabuse will occur). The parent-child bond is so fundamental a tie that we tend to take it for granted. But in the first months and years of life, it is either not yet well consolidated or else easily disrupted. Long separation may cause significant damage to the child's development. Most of the children's parents are likewise having difficulty in bonding. Removal of the child further impedes this fragile process. While foster care takes the child away from immediate danger, it involves a severance of what some consider to be infants' and toddlers' earliest and most important love relationships and may subject them to a succession of caregivers. Kent points out that children can have deep emotional ties, even to parents who are indifferent or abusive. Separation is almost always a painful experience, no matter how objectively "bad" the parent is. Parents too experience profound grief when their children are taken from them. They can become so preoccupied with regaining them that they are distracted from indepth therapy that could alleviate conditions leading to abuse.

This portrait of parents in pain over the loss of their offspring is unlike the popular picture of abusers as homicidal sadists who have little capacity to feel positive emotions. On the contrary, most of the parents Kent and his coworkers have seen love their children but are ambivalent. Circumstances in their environments have tended to tip the balance of love and hate (present, say most psychiatrists, in all close relationships) toward hate and aggression. It is the work of the skilled therapist to re-establish a more suitable equilibrium.

When a child is referred to Children's Hospital, Kent and his colleagues must decide about placement. The decision depends on the sorts of factors that are emerging from the "risk" profiles. A few parents are frankly psychotic and impulse-ridden. They cannot be trusted not to reabuse a child placed in the home again. Other parents require more superficial re-education about child behavior and emotional development. Each case is unique and therefore requires careful individual deliberation. Kent believes that the shockingly high rates of reabuse can be lowered and the abuse of other children, some of them as yet unborn, be prevented by prompt and effective intervention.

While a major activity of the Family Development Project is research, on a practical level the entire staff is involved in day-to-day casefinding and treatment. Many cases of abuse in Los Angeles County end up being referred to the Hospital for diagnosis and treatment. Although technically the Department of Public Social Services has jurisdiction over a case, in practice the caseworker usually listens carefully to the team's deliberations and, in most instances, follows their advice.

Diagnostic Techniques

Usually the first staff contact parents have is with Dr. James Apthorp or Dr. Robert Jacobs, both pediatricians. Apthorp, one of California's leading experts in the diagnosis of Non-Accidental Injury, sees cases where abuse is suspected. Jacobs sees Failure-to-Thrive children.

As for the pediatrician's tasks, Dr. Apthorp says that first he must assess whether an injury is accidental or deliberate. (In many instances, parents deny knowledge of any incident of inflicted injury.) Second, he must inform parents of his diagnosis, a duty that can be very painful. Third, if the child comes under the auspices of the protective services, he must assess developmental status and eventually developmental progress.

Most of the injured children Apthorp sees are infants and toddlers under 3 years of age. They come in with a variety of injuries, ranging from relatively minor bruises and cuts to severe and life-threatening conditions that require prolonged hospitalization and that can lead to permanent damage. He explains that it is usually not difficult to distinguish between accidental and non-accidental injury. The location of injuries, their type, and the explanation parents offer often provide invaluable clues. For instance, bruises on a preambulatory infant are more suspicious than on an active toddler. Bruises on the child's backside and those that leave the imprint of an instrument are highly questionable.

Parent behavior also can help establish a diagnosis. Mona Finnilla, the staff's pediatric nurse practitioner, reports that mothers of accidentally injured children are more likely to behave in an extremely distraught manner than are mothers who have inflicted the injury themselves. Dr. Stan Katz, one of the team's two clinical psychologists, suspects that parents who admit to the act of abuse initially may have a less favorable

therapeutic prognosis than parents who start out denying wrongdoing. In the latter case, the experience of shame and guilt (implicit in denial) may indicate more effective coping strategies and greater willingness to work in therapy to prove commitment and efficacy as a parent. Furthermore, parents who admit abuse may feel that their confession is sufficient in order to have their child returned and then believe that they have no further psychotherapeutic responsibilities. Research is being conducted presently to verify these impressions.

The diagnosis of Failure to Thrive (FTT) secondary to a diagnosis of environmental deprivation is usually no more difficult to make than one of NAI. Defined technically as weight and height measurements below the third percentile for age, FTT is most commonly found in children under 1 year of age. When an FTT infant is first seen, the pediatrician must entertain the possibility that there is an organic basis for the condition; but this diagnosis is easily dismissed if and when the baby gains weight rapidly after a few days in the hospital. A baby who has been chronically underfed is likely to have a small head circumference as well as low weight, while a baby suffering from acute malnutrition will have relatively normal height and head circumference. Other indications of psychological failure to thrive are parental reports that the baby has not had immunizations, poor infant skin care or untreated infections, inappropriate infant clothing, or atypical or unresponsive behavior.

For suspicion of injury (NAI) or neglect (FTT) to lead to action, it is not necessary to establish which parent is "guilty," or even that the parents (rather than a babysitter or sibling) were themselves responsible for the injury. It is sufficient that the child's condition be severe enough that parental action should have prevented it from developing or that it called for immediate attention. (This is not to say that a parent whose child is injured by a babysitter and who takes him or her to a doctor immediately will have the child removed. In this case, action is considered prompt and appropriate.)

On the other hand, if X-rays give evidence of repeated injuries that parents would have had to notice but took no action, it does not matter that they deny wrongdoing. The child's safety and well-being are of paramount importance.

Enlisting Parent Participation

Once the probability of abuse has been established by the pediatricians, the parents are put in touch with the Project's social workers, Heather Halperin and Jill Pospisil. Halperin sees the parents of children diagnosed as NAI, Pospisil parents of children diagnosed as FTT. They have the difficult job of informing parents that their children are going to be taken from them, at least temporarily, and that they are under suspicion by authorities. In some cases, proof of injury can lead a parent of an NAI child down a long and costly road of court hearings, possibly ending in incarceration. (In the past, parents of an FTT child were rarely charged with any offense if they cooperated actively in the treatment, but as the program progresses, more FTT cases are being referred to the courts.) At the same time, the social workers must try to establish rapport with the parents. While participation in the Family Development Project is voluntary, most parents perceive the staff as having real power over them, since staffers can determine what happens to the child. This circumstance creates conflict in parents' minds. The staff must present themselves as people who want to help the parents, while at the same time they also have to tell parents that the police might be in touch with them, that their child is to be removed, and that they should participate in a program of therapy.

Halperin stresses how sensitive this first contact is. She describes her role as one of a stranger entering the parents' lives at a most difficult time. The parents almost inevitably see themselves accused of harming the child, and frequently they will ask whether they seem like people who would "do that sort of thing." At the same time the social worker wants to help the parents get through what will probably be an embarrassing and emotionally painful experience. It is her task to impart to them the message that she can be trusted and wants to be their friend.

If the parents agree to participate in the Project, their personal lives will be subject to unprecedented scrutiny. They will be asked to fill out several questionnaires about themselves, undergo three to five interviews with staff members, fill out a long social history with the social worker, submit to psychological and psychiatric evaluations, and then meet with the social

worker and a Department of Public Social Services representative to discuss the future. Even if they agree to cooperate fully in all these undertakings, the social worker can make no promises to them about the return of their child. The initial reaction of many people to the first meeting is anger, bewilderment, and defensiveness. Halperin herself confesses to occasional doubts about what she is doing and saying. It is far easier on the social worker, she says, if the parents admit to the injury. It is very hard to tell people that they need therapeutic intervention if they claim that they did not do anything wrong.

EVALUATION OF FAMILIES

Psychological evaluations of the parents play a large part in determining what happens to the child in the future as well as what course of treatment to follow. Often, the social workers make initial reports to the staff about the parents. Then psychologists Kent and Katz see the parents in a series of sessions. If the case calls for it, staff psychiatrists will also work up an assessment.

In a first interview, parents are asked about their relationships with their own parents in childhood (a common finding in cases of NAI is that parents themselves were abused as children), their educational and employment histories, their social relationships and outside activities, histories of pregnancies and childcare experiences, and marital satisfactions.

Except in a few areas, abusive parents generally have lower-than-average expectations for their child's development.

For the Project's research purposes, it is highly desirable that parents provide a detailed account of the circumstances of the abuse, but frequently the particulars are not easily brought forward. Before the very people they see as authorities, parents understandably are afraid to admit to an act of injury. In other cases, they are less than candid because they are ashamed and anxious. Gradually, as the parents' confidence is gained, information does become available, and when it does it is used to

enrich the risk profiles the team hopes to refine with further study.

In addition to general social history items, information about a parent's attitudes toward parenting is especially useful in planning a course of therapy. Kent and his coworkers have been gathering data on parental expectations for children's behavior. It is commonly thought that abusing parents expect unrealistically high performances from children and that when these expectations are frustrated abuse occurs. In fact, preliminary findings from a *parental expectations survey* indicate the opposite. Except in a few areas, abusive parents generally have lower-than-average expectations for their child's development. One of these areas is control of crying, where they anticipate very early mastery, despite the fact that crying in early infancy is much more apt to be an expression of physiological needs than a device for annoying a parent. Since young children cry often (and, claim some, more often when not responded to), abuse-prone parents are caught in a vicious circle. The child's crying is misinterpreted as rejection to which those parents may be especially vulnerable and so overreact, which increases the child's crying. More generally, abuse is triggered when parents fail to make realistic assessments of a child's abilities at a given stage of development.

Kent and his coworkers are obtaining a variety of personality assessments of parents. Some techniques involve administration of standard evaluation tests; others require parent interviews with the staff social workers, psychiatrists, and psychologists. The measures are designed to reflect a parent's ability to control aggressive impulses (an important factor in assessing risk of reabuse), capacity for nurturant behavior, and positive response to available treatments.

In addition to parental assessments, detailed assessments are made of the children's physical, intellectual, and social-emotional functioning. For instance, at the time of admission to the Hospital, anthropometric measurements (the child's size, weight, proportions) and bone-age studies (skeletal development relative to age) are made for all FTT cases and for any NAI case below the tenth percentile in height. Laboratory studies include routine blood and urine work. Neurological normality as well as physical strength and coordination is assessed. Motor and intellectual development are measured through the use of

standard tests. Emotional adjustment is more difficult to pinpoint, but staff members rate children on ability to form interpersonal bonds, aggressive behavior, attention span, and general affect. These measures are repeated at 6-month intervals both for the control and the study children. After all results are in, the two groups will be compared in order to see what effect participation in the Family Development Project has had on developmental progress.

A favorable outcome of treatment for parents will be assessed primarily in two ways. First, anecdotal accounts from the various team members who have had contact with the parents will be used to form a general impression. Ratings of parents are made every 3 months in order to assess parent responsiveness to contact, initiative in bringing about change, and capacity for nurturing and protecting children.

Second, when the child is placed back in the home (which happens in nearly all FTT cases and in an as-yet-undetermined percentage of NAI cases), the parent-child interaction is assessed through observation, as are the quality and amount of stimulation provided the child by the home environment.

TEAMWORK IN ACTION

One recent afternoon in Los Angeles the therapeutic team, headed by Kent, met to make a decision about the placement of a child. The particular case that day was a difficult one for the staffers to deal with. The parents were atypical for the sample—they were solidly middle class and semiprofessional. The suspected abuse had been detected by a private physician who had referred the family to Children's Hospital. Both parents denied any wrongdoing. On the other hand, each accused the other of the abuse. The infant, a 7-month-old boy, had been a planned baby, and his mother professed to be a staunch practitioner of breastfeeding in order to enhance bonding. There was considerable disagreement among the team members as to what should be done with the child because the family situation was complicated and the circumstances surrounding the abuse ambiguous. Some favored keeping the infant with the husband's mother who lived close to the couple so that his own mother could have the ready access to him she required for breastfeeding. Others feared that this proximity

could create problems. First of all, relationship between mother-in-law and the child's mother had already been strained before the abuse, and it was felt that the mother-in-law would most likely join her son in blaming his wife for the child's condition. If so, relations between husband and wife would further degenerate. Secondly, making the child so readily accessible to the parents might allow for reabuse. The group's discussion was freewheeling and, at times, heated. Some believed the mother's denials, others (the staff psychiatrist, among them) the father's. Only by a narrow majority was it decided to place the child in the mother-in-law's home. The deciding factors were two: First, while the injuries sustained were multiple, they had not been so serious as to endanger the infant's life. And now that the parents were under Social Services jurisdiction, further injury seemed unlikely. Second, the mother-infant bond would be disrupted minimally by the arrangement. Although the case was unusual, the style of discussion, the variety of opinions offered, and the heat of debate were not. Every member of the staff who was related even tangentially to the case came and had the opportunity to express an opinion. (This child has since been placed back in the care of his parents, although he is still under jurisdiction. The parents are continuing in therapy.)

PARENT WORKSHOPS

After a course of therapy is decided on, the parents are usually invited to participate in weekly group sessions. According to Marilyn Rigler, parent-education coordinator for the Project and leader of one of the three evening parent sessions, at first the sessions concentrated on frankly didactic goals, such as teaching principles of child development. However, she said, this format did not appeal to most parents and tended to threaten them. Hence, a more informal atmosphere was sought, the major objective being the improvement of parent communication skills.

The workshops span the dinner hour from 5 to 7:30 p.m., the first hour being given to a casual supper during which parents and staff mix freely and engage in small talk. Children are invited and eat with their parents. After dinner, the group breaks up into three parts. Rigler heads a husband-wife group,

Heather Halperin and Jill Pospisil single-mother groups. The topics of the evening center on feelings about oneself and how they affect relationships with other people, childrearing and behavior, and day-to-day problemsolving. The format is an open one, the group leader guiding the topics when parents stray too far from loosely defined goals or, as occasionally happens, when one member of the group monopolizes the conversation. During a recent session involving couples, a woman launched into an open expression of dissatisfaction with her husband's inability to communicate with her. The husband initially reacted by acknowledging the "righteousness" of his wife's accusations with little more than begrudging grunts, but eventually he was drawn into discussion by other members of the group.

As for the dynamics of the sessions, Rigler says that couples who have been coming for a long time tend to loosen up and become more vocal. They tend to form friendships with other members of the group outside the sessions. Hence conversation frequently centers on husband-wife and couple-to-couple relationships. New couples often start out with resentment and hostility. It takes time for them to begin to relax. But once they see the group as an arena for learning about themselves, rather than as a court where they are to be judged, they become active participants. Rigler is hesitant to characterize the sessions as therapy, but she does think that they serve a useful therapeutic function. They increase verbal skills and sensitivity to verbal communications and emotions, and in thus promoting greater self-awareness and understanding of others with similar experiences, may serve to lessen the likelihood of reabuse.

Single-mother sessions also follow a casual format. In a recent one conducted by Halperin, mothers were asked to consider their former roles in male-female relationships. The topic was a not uncommon problem. Many of the mothers admitted that they had embarked on affairs with men who were likely to abuse them and possibly their children. Halperin hoped to raise their consciousness of their own worth and to make them realize that a man-at-any-cost attitude was destructive to themselves as well as their children. Many of the women spoke openly about living in fear of their husbands or boyfriends and of the relief they felt when the relationships finally ended.

While parents are participating in group sessions, children are in therapy and stimulation groups according to age level.

There are separate groups for infants, toddlers, and preschoolers. Nurse-practitioner Finnila and psychologist Katz supervise the children's groups. While the sessions provide them with an opportunity to give the children social stimulation and to encourage social interactions, they also permit informal assessments of developmental status and progress. Finnila and Katz are assisted in caring for the children by volunteer teenage aides from the nearby Hollywood High School and by adults from the community at large.

The atmosphere at the weekly sessions is one of friendly informality. Individual therapy is also conducted in one-to-one sessions with parents by Kent, Katz, and specially trained psychology interns. However, even this degree of involvement probably would not be sufficient to effect long-term improvements in a family's condition were it not for the existence of an important, informal liaison between professional staffers and parents, the parent aides.

PARENT AIDES

The Parent-Aide Program was originated by five staff members, James Kent, Mona Finnila, Susan Curtis, Pat Croot, and Martha Satin. Coordinated by human-development specialist Marilyn Rigler, the program evolved in response to the parents' dissatisfaction with traditional office psychotherapy. For one thing, many of them viewed such therapy as punishment by the court and were loathe to comply with it. Secondly, many had very little faith in the value of the so-called "talking cure" when their primary concerns were so pressing. No amount of conversation and probing could alleviate their anxieties about basic survival issues. Thirdly, some parents were so preoccupied with their missing child that they didn't want to discuss anything not bearing directly on the issue of the child's return home. The Department of Public Social Services caseworker, already overburdened with families, and even the Family Development Project staff themselves, just could not handle all aspects of the parents' situations that required attention. In order to give needy parties additional contact, the staff decided to provide them with someone in the community who would fulfill the role of a good neighbor. For these reasons, the Parent-Aide Program was set up.

The aides are recruited from the greater Los Angeles community. They include mothers with young children, university students studying psychology, and even unwed mothers who have experienced many of the frustrations and burdens that bother the families. They are given only a very modest monthly stipend of \$50 plus their travel expenses. The aides are trained in the causes and problems of child abuse. Initially many of them have to be helped to work through their own anger and hostility toward people who "would do this to a child." To this end, they engage in role-playing of the problems and stresses of abuse-prone families. Finally they are given help in developing their listening skills and in techniques for encouraging parents to solve problems.

Aides meet on a biweekly basis to increase their skills and to enhance their sense of participation in the Project, and they are invited to attend case conferences and group evening sessions. At the evening meetings, they serve to break the ice by bringing up their own problems for discussion. Because many of the parents come to know the aides and like them, their participation diminishes the threatening atmosphere of the sessions.

Each aide is assigned to specific families, but not all families have aides. When a family treatment plan is first discussed in conference, one of the major concerns of those present is whether or not a parent aide will help in attaining therapeutic goals. If the family already "has a built-in neighborhood or family support system—people who can provide concrete help with such things as child care or transportation and who are warm and accepting—then aides are not necessary. If the parents are clearly psychotic, aides are not assigned since this degree of psychopathology is beyond the scope of their ability. However, most of the families in the Project tend to be isolated—socially, physically, and economically—from other people. They need the sort of informal support that an aide can give so well. Every attempt is made to match aides and families on the basis of personalities, economic histories, age, intuitions, and the needs of the parties involved.

An aide's involvement with parents can be extensive. For instance, one invited a mother and her children to her home for lunch. While their toddlers played in a little wading pool, the women discussed the children's behavior and development.

In another case, a mother was trying to brush up on her typing skills in order to get a job. An aide loaned her a typing book and typewriter for 2 months. In still another case, an aide repeatedly took care of a couple's children overnight so that the parents could have some time to themselves.

Aides are there to help in times of real crisis, as when one received a telephone call on a Sunday from a mother who, although not specific as to the purpose of the call, was slurring her speech badly. Even though she was not asked, the aide made a home visit. When she arrived, she discovered that the young mother had taken an overdose of Valium. She took the mother to the emergency room of the local hospital. Since then the woman has emerged from the state of dejection that led up to the incident.

While the parent-aide relationship usually develops into one of friendship and trust, there are some pitfalls. Some of the youngest mothers tend to transfer negative feelings toward their own parents onto the aides, whom they perceive as parent substitutes. Other times aides may come to resent being used only for transportation. Still other times, an aide may become overly involved with a family to the extent that she tries to protect them from the "powers that be." And there is always the danger that parents may become overly dependent on the aide to the extent that they fail to work on developing their own problemsolving skills.

Nonetheless, the aide's role remains an extremely valuable one. She befriends the parents and becomes an advocate of the family, while at the same time she provides informal surveillance of them and particularly of the child. Some parents are at first suspicious of the aide and see her as an informant; but because they are in such great need of friendship and support, most soon develop rapport with her. The double role that an aide must perform in fulfilling her responsibilities both to the Project and to the parent occasionally leads her to complain of a conflicted existence. But all in all, the concrete assistance and emotional support aides provide give the Child Development Project that personal and individualized aspect which sustains the more formal ties between client and hospital staff.

SOME PRELIMINARY RESEARCH FINDINGS: CLUSTERING OF TYPES OF ABUSE

Of all the research goals that the members of the Project have set for themselves, perhaps none has more potential importance than the development of typologies of NAI and FTT families. These typologies, mentioned briefly in an earlier section, consist of profiles that distinguish families on factors of importance for planning therapy and child placement. For example, it is emerging that some NAI families require educational efforts while others require intensive psychotherapy. Children of parents who require instruction are usually at much less risk for reabuse and for long-term development than are children of more severely mentally disturbed parents. Hence, they can be placed back in their own homes more confidently. As the profiles become more and more refined, it will become easier to place a particular family in a category and to make decisions on the basis of what membership in the category implies. In general, knowledge contained in the profiles will enable the intervener to make highly individualized decisions about a particular family that are maximally beneficial to the parties involved, all the while using scarce money and human resources only where they are most needed.

The first analysis was undertaken by Kent and his colleagues and yielded four clusters of NAI families: The first cluster they call "flash point." Flash-point families are the ones that don't resemble the other families in most ways. They have relatively high socioeconomic status. They are middle class. They have not been involved with the police, and there is no particular history of mental disorders. Out of this family all of a sudden comes a severe case of abuse involving a very young baby. The father is somewhat more often the abuser than the mother. The most serious injuries also occur in this group. Children often require weeks of hospitalization, and they are frequently damaged physically for life. Kent thinks that the children in this type of family are at greater risk than in the others, because there probably exists among family members a quiet kind of psychopathology, the parents being borderline schizoid personalities who are isolated from each other and from their community. Treatment is difficult because violence is episodic, covert, and hard to predict. The Family Development Project

team finds these families the hardest to deal with. Kent says, "They scare us. They scare us a lot."

The second group is called "spare the rod." These are families where *all* the children are physically disciplined, not just the child who comes to the hospital. Parents in this group say things like, "If you don't beat them now, they're going to grow up to be juvenile delinquents." They are not beating their children because they hate them but because they love them and believe that they need discipline in order to turn out to be solid, law-abiding citizens. The level of abuse found in these families is chronic but not serious. Children are regarded by the team as at low risk for serious reabuse, and generally the parents are fairly amenable to treatment, once they get over the shock of being reported for doing something they have always done. They are more often arrested than parents in other groups, perhaps because they are the ones who show up at the hospital emergency room and say, "Look, I hit him too hard. You'd better take care of it." This admission triggers the social and legal machinery. Kent finds that the outcome of children in this group is the best of all four groups, because the abuse is not intended nor perceived as rejection from the parents. All the children in the family are receiving it.

A third group is called "you asked for it." This is a group of families, most of them new to the Los Angeles area, and a third of them Mexican-American, where the father is often underemployed. Fathers are usually the abusers. The child who is abused is a 2- or 3-year-old, who is seen by the father as defiant, disobedient, and undermining the father's authority. Father already feels his self-esteem diminished by being underemployed; his position as economic breadwinner is tied to his sense of worth. The mothers in these families rarely work, and they tend to have stable personalities.

A fourth cluster is one that is most common in the Project. It represents approximately 40 percent of all the cases seen. Called "who needs it," the cluster includes boyfriend abuse incidents. A mother, generally the biological mother, is involved in a series of unstable and short-lived relationships with exploitive and sadistic men. She seems to invite abusive treatment by her passive and masochistic "do to me what you will" attitude. She is desperately needy and tolerates abuse of herself and sometimes of her child in order to have companionship.

These mothers have histories of abuse as children. They have always been life's losers, and they are still losing. If a boyfriend isn't beating their children, then *they* are. These families are the multiproblem ones that make intervention very difficult because the parents are disorganized, depression prone, and impulsive. They do respond to support, but it has to be intensive and sustained.

Dr. Robert Jacobs, who deals with FTT cases admitted to Children's Hospital, has also worked out profiles of FTT families in a way that is conceptually analogous to Dr. Kent's profiles. Again he finds that FTT parents, despite several important similarities, are not a homogeneous group, and that important differences exist among them which have implications for treatment.

In all the families, there were few telephones, low incomes, relatively high incidences of low-birth-weight babies and twin births, and low percentages of marriage and planned pregnancy. Maternal health was poorer than average and disagreement between spouses on childrearing higher than average. Families were more mobile and more isolated from their communities than usual. Many had had problems with the local police. However, while most cases showed certain characteristics, important distinctions could be made. Jacobs found that of 32 families seen, 14 fit into one or the other of three groups, while 17 required dual classification into a primary and a secondary group.

In group-one families, mothers were deficient in what Jacobs calls "mothercraft skills." They did not know basic things about feeding and care of young infants. (For instance, one mother fed her infant with his head unsupported and hanging straight down.) The parents in this group had the lowest incomes, and mothers the highest rates of mental retardation and youngest average age. The mothers were less likely than the other mothers to report themselves as physically punished in their own childhood, and they tended not to have problems with uncontrollable outbursts of temper or alcohol and drug abuse. The infants of group-one families frequently were not immunized and often were of low birth weight.

Group-two families were characterized as demonstrating the "sociology of neglect." These people were frequently wiped out emotionally because of very poor living conditions. Mothers had

basic knowledge of baby care but did not use it. They were tired and apparently incapable of much feeling. While they were not mentally disturbed, their problems seemed to overwhelm them, and they could respond neither to their babies nor to themselves. Very few mothers were married or living with a man, and very few pregnancies were planned. The mothers tended to be confined to their homes without a car or even a telephone. While they described themselves as having few problems with their babies and as making friends easily, it seemed clear that they were nonetheless unable to use neighbors and friends as support systems. Of all the infants studied, the infants of group-two families were youngest when they came to the attention of authorities.

Group-three families reflected the "psychology of neglect." Parents were acutely neurotic, or even psychotic. Many were under severe stress and abused alcohol or drugs. Parents in this group were the oldest of all and had the smallest number of persons living in their homes. They were also the most stable in terms of length of residence and least confined to their home environments. They had the highest incomes. Mothers reported themselves as having received more physical punishment as children than the other mothers. Arrests were more common among these families, as was the use of alcohol, drugs, and medicines to alter mood. At the time the infants were diagnosed as Failure-to-Thrive cases, they were older than infants in the other groups and tended to have all the required immunizations.

Kent and Jacobs characterize their family types as first approximations to a system that they hope to refine further, but they believe that they have already gone a long way toward making sense of a variety of characteristics. Even now they are finding the distinctions useful in diagnosis and treatment of the cases of child abuse that they see on a daily basis.

TREATMENT AND PREVENTION STRATEGIES

Kent sees the problem of child abuse in terms of two broad strategies or approaches. The first is a systems approach, which calls for radical changes in those social conditions which predispose people to abuse, such as inequities in wealth, education, opportunities, and quality of life. Proponents of the systems

approach also advocate establishing widespread networks of support for parents so that they could have readily accessible, formal, and clear-cut channels for learning to handle their frustration and aggression. The sweeping alterations in societal structure that the systems approach calls for are not achieved overnight. Even if such far-reaching networks were quickly established, complex changes take time to filter down to the family level, and results might not be apparent for generations.

A second approach to child abuse is a symptoms one, and Kent believes that his Family Development Project program fits this description. Symptoms approaches to child abuse are aimed at earlier and better casefinding and at educating parents about the sources of help—formal and informal—available to them when they feel themselves at immediate risk for abusing their children. Another such program besides the Family Development Project is Parents Anonymous, whose founder, Jolly K., is herself a former abusing mother. Parents Anonymous tries to help people talk out their frustrations in the company of others with similar concerns and problems. Its participation is totally voluntary. The symptoms approach goes hand-in-hand with secondary prevention efforts. While primary prevention tries to prevent conditions which lead up to abuse, secondary prevention tries to nip in the bud problems that, if left untreated, could lead to greater damage to children.

The work at the Family Development Project has aided secondary prevention goals by identifying types of abusing parents, so that it is now possible to differentiate between a parent who disciplines with good intentions but badly thought-out methods and one who disciplines out of frustration with overwhelming environmental stresses. Such parents obviously need different treatment strategies.

The goals of the Project, while they may seem ambitious to the lay person, are characterized by Dr. Kent as modest ones. He thinks that modest goals are in order or else would-be interveners will wear themselves out prematurely. In each family that they see, he and his coworkers hope to achieve a shifting of the ratio of expressed love-punishment toward a child more in favor of love. In their experience, most abusing parents are not individuals with homicidal tendencies, and not all require years or even months in order to change behavior. Kent views the Parent-Aide Program as particularly important

in providing a bridge between formal therapy on the one hand and informal contact with good neighbors on the other. He believes that programs such as the Family Development Project must break down the barriers that interfere with normal expressions of a parent's love and must build on the parent's real concern for the child rather than begin with the assumption that children are exposed to injury out of indifference or hostility. It happens, he says, but it is less common than the reverse.

Finally, he believes that the prevention of abuse or reabuse is only a first step in treating the problem. With so much attention focused on a particular act of abuse, it is easy to forget that a whole social environment fostered it. Children who grow up in such environments may have difficulty in building feelings of basic trust and self-worth. They may come to see models of violence as acceptable forms of expression in human relationships. When they in turn grow up and become parents, they may perpetuate recourse to child abuse. So the children from these environments need as much extra assistance as their parents. Solving the physical abuse problem only enables society to turn its attention to the child. If the social genetics of child abuse are to be altered permanently, Kent believes, it is toward the child that the most sustained efforts must be directed.

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Research Grant: MH 24741

Principal Investigator: James T. Kent, Ph.D.
Children's Hospital
P.O. Box 54700
Terminal Annex
Los Angeles, California 90054

**Part VI. Mental Illness
and the Family**



THE MENTALLY ILL AT HOME: A FAMILY MATTER

Principal Investigator: John Clausen, Ph.D.

Author: Bette Runck, NIMH

One evening during World War II, John Clausen went to the Washington, D.C., home of a black sociologist friend. The friend—call him George Smith—had returned the previous night from a trip to U.S. Army camps. Clausen listened as the agitated and outraged Smith told his guests about the abuses that black soldiers had endured in the camps. The situation had so upset Smith that he'd been unable to sleep the night before. At 5 that morning he had called a top-ranking general to demand that camp conditions be improved immediately. The general, too, became angry. At Smith. He ordered Smith's superior officer to dismiss the sociologist.

That morning in their office at the old War Department, Smith had told Clausen and his other coworkers about the trip. That night, as Clausen heard the story unfold for the second time, he noticed that his friend was embellishing parts of it, recasting others. He knew about the incident with the general. As he listened, Clausen came to realize that his friend was unable to distinguish actual experiences from imagined ones. There was something about Smith's manner, his growing hysteria, and his inability to organize an oft-told story that worried Clausen. Others at the gathering, some of them members of Washington's wartime "Black Cabinet," had not heard that morning's account. They took the story at face value. Because black people suffered grievously throughout society then, they

found even a bizarre report about mistreatment of black soldiers all too believable. They set to work planning how to help the soldiers.

John Clausen sat wondering how to help his friend. Later that evening, he suggested to Smith's wife that her husband might need psychiatric help. "I know," she said. "This happened once before."

She recognized what was happening to her husband because he had already gone through one schizophrenic episode. But how had she known the first time? How does anyone know when a husband or wife, mother or father, child or friend has stepped over that line where everyday emotional upheavals become mental illness? How do they know, when the line itself fades off into a large gray area, shaded by pain suffered and pain inflicted, by moments and days when all seems normal, by the era's agreed-upon codes for reasonable thought and seemingly conduct? How long does bizarre behavior pile up before those who live with it define it as madness? How do family members perceive what is going on? When do they finally seek help? How do they go about getting it? What happens to those left behind when mother or father goes to the mental hospital? What do the children know about their parent's illness? What are they told? What happens when the patient returns home? Is the job still open? Friends still friendly? Does life—for patient, spouse, child, family—ever settle down to normal again?

Searching for answers to these questions has occupied John Clausen during much of his professional career as a research sociologist. His interest was sparked that night at his friend's house, years before he earned his doctorate. His studies are reaching a denouement now as he nears retirement from the Department of Sociology at the University of California in Berkeley. There, Clausen and his colleagues are poring over facts and feelings told to them by mental patients and their families. Some families were interviewed in the 1950s and then again in the 1970s to learn what has happened in the intervening years. Other families in which a husband or wife was recently treated for mental illness have also been interviewed. Clausen's team is comparing the new group's experiences to those of the families of patients hospitalized in the early 1950s—a time when the powerful tranquilizing drugs were not

in general use, and patients were kept in the hospital for months, even years, longer than they are today.

Are the new treatment practices less disruptive to families? Or does the presence of a symptomatic mother or father pose a greater threat to the survival of the family unit or the well-being and emotional development of the patient's children? Along with his interest in the long-term consequences of mental illness for marital relationships, work careers, family cohesion, and children's lives, Clausen is trying to learn if the families of mental patients fare better in the 1970s than they did in the fifties.

PRACTICAL PROBLEMS, HUMANITARIAN CONCERNS, THEORETICAL ISSUES

Clausen's family research began in the spring of 1952, when he was made chief of the newly created Laboratory of Socio-Environmental Studies at the National Institute of Mental Health (NIMH) in Bethesda, Md., a suburb just outside of Washington, D.C. Clausen and his coworkers chose to study, as the laboratory's first major project, the consequences of mental illness for patients' families. Surprisingly little was known about the subject. Until then, the only systematic research attention given to the families of mental patients was often unwanted attention, because it focused on the family members' possible role in causing the disorder, not the problems they faced as a result of it.

At the outset, Clausen was interested in these problems as a practical matter. He had witnessed the ambiguity of mental illness, the uncertainties family members felt, the turmoil they endured. He wanted to learn the details of these experiences, through systematic and impartial research. By describing how mental illness affects family life, Clausen thought he might be able to identify the kinds of support that families needed to cope with the crisis.

His approach was strictly empirical until Marian Radke Yarrow, a research psychologist, joined the laboratory's staff some months after the project began. Clausen credits Yarrow, who became his principal collaborator on the NIMH study, with greatly enriching the conceptual dimension of the research. The objective of the original study remained largely

practical, however. Perhaps, through such research, the investigators could learn how to soften the blow to a family when a member became mentally ill.

If Clausen's landmark research was important for simple humanitarian reasons in the fifties, it has become a potential source of insight into a major social issue of the seventies. The theoretical issues Clausen and his colleagues have addressed over the years—issues involving society's response to mental illness—have acquired more than theoretical interest today.

Clausen and other sociologists have observed that our "heritage of attitudes and practices regarding the insane" has been one of "putting the patient away." During the last quarter century, we have begun to move away from that heritage. In 1979, the treatment of choice for persons who become psychotic involves little reliance on the type of large institution so dramatically criticized by Ken Kesey in *One Flew Over the Cuckoo's Nest*. Today, the mentally ill spend much more time among us, even while symptomatic. Their presence forces everyone they encounter—particularly their families—to come to terms with them. And it forces all of us to come to terms with the irrational and unacceptable strains in our own mental makeup. How we respond to mental illness and the mentally ill—with understanding and tolerance, or fear and rejection—is a subject of theoretical interest to John Clausen, the sociologist. It is a subject that has practical social significance to the contemporary community of which he is a part. And it has day-to-day personal consequences for patients and their families.

Recent History—From Hospital to Community

The transformation in treatment of the mentally ill in recent years came about with little attention paid to the social context. Such neglect is astonishing, since preserving the patient's place in society was the motivating force behind many of the changes that took place. As events converged to move patients into the community—out of the big hospitals that were society's isolated islands of deviance—repercussions were inevitable.

When Clausen and his colleagues began studying the families of mental patients in 1952, a person hospitalized for a psychosis might very well expect to spend many months in a mental hospital. This was particularly true if the disorder was diag-

nosed as schizophrenia. Psychiatrists offered little hope to families. It was common to view mental illness as a permanent condition requiring long-term hospital care for the sake of the patient and the well-being of the family. Another motive was often hidden beneath this altruistic concern, however. As Clausen has put it, large public mental hospitals "served the manifest function of caring for mental patients believed to be incapable of life in the community, but they served the latent function of isolating and hiding the mentally ill." This practice, he says, provided "a form of institutionalized denial of the existence of mental illness while at the same time producing chronic patients incapable of functioning in the community."

Treatment of the mentally ill slowly began to change after World War II when mental hospitals—particularly in Great Britain—experimented with open wards, enlarged their staffs, and adjusted other administrative policies to give patients more freedom and better care. It was the wonder drug, chlorpromazine, introduced into this country in the mid-fifties, that brought dramatic changes, however. The first of the "major" tranquilizers now routinely used to treat schizophrenia, chlorpromazine could ameliorate symptoms—the unseen voices, the bizarre thoughts, the paranoia, the unfitting emotions—in a way that no sedative drug could. By taking chlorpromazine regularly, patients could at least function at home and on the job (albeit with some impairment and discomfort). Before long, other antipsychotic drugs were introduced; among them were powerful mood-elevating drugs that can lift severe depressions, and lithium, a common element that can reduce the frequency and severity of manic attacks. While not without their side effects, some of which are serious, the psychiatric drugs introduced since Clausen began his research have produced a revolution in the treatment of psychotic conditions.

By the early sixties, largely because of the new drugs, it was possible for the Federal government to begin underwriting a nationwide system of community treatment centers where mental patients could receive short-term, in-hospital care and continuing support when they returned home. Separations from the family became much shorter, return to work easier. For some enthusiasts, mental hospitals seemed a thing of the past. Recognizing the chance to save public money, States began closing the hospitals down. Patients were released to the

"community," where theoretically they had access to treatment as outpatients and could expect tolerance from their neighbors.

The possibility of relieving symptoms with psychoactive drugs and the promise of community care together changed attitudes about the prognosis for mental illness. Reformers began to deny society's right to treat the mentally ill any differently than everyone else. A few theorists asserted that *mental illness* was no more than a repressive label used by society to control unwanted behavior. Some suggested that the label caused more serious problems than the deviancy itself and, indeed, stabilized the symptoms. Riding the tide of the sixties' dedication to individual rights, activists took the case of the mental patient to court. In 1975, the Supreme Court ruled that patients could not be committed to mental hospitals unless they received appropriate treatment once they were there. This ruling, plus increasingly stringent commitment procedures, accelerated the trend toward treating new patients in community settings and releasing—sometimes expelling—chronically hospitalized patients into the bewildering world outside.

Clausen and his colleagues are addressing issues that were largely ignored in the early days of the community mental health movement.

Meanwhile, ignoring idealistic expectations, the real community began to notice what was happening. Still-symptomatic ex-patients were wandering city streets. The "shopping bag lady" became the butt of jokes on late-night talk shows. Terrified at newspaper reports about former mental patients who committed violent crimes, the public began to fear all mental patients, not realizing that many of them are more frightened than frightening. In the last few years, reaction has set in. Halfway houses and community treatment facilities have been zoned out of neighborhood after neighborhood.

And many families live with the "patients" in their midst, happy to have her home, relieved that he won't be consigned to a back ward, but still troubled by the events that led to hospi-

talization in the first place, still brooding over the unuttered question: Will it happen again?

Life in the Community

By trying to understand how a family is affected by the mental illness of one of its members, Clausen and his colleagues are addressing issues that were largely ignored in the early days of the community mental health movement. Introduction of the antipsychotic drugs awakened mental health workers to the possibility of community treatment. Reformers worked toward the goal of emptying the mental hospitals and keeping new patients in the community. They too seldom considered the community itself—its fears, its prejudices, its level of tolerance. And they forgot the patient's family, that part of the community most directly affected by mental illness. Clausen and his coworkers, in long conversations with these families, are learning what life is like out there in the community. They are learning how such labels as *mental patient*, *psychotic*, or *schizophrenic* affect patients and their families. And, because "mental illness can be regarded only partly as a private affair," they are also learning how we as a society respond to the mentally ill among us.

EXPLORATIONS INTO UNKNOWN TERRITORY

Clausen's original research on families of patients broke new ground in the study of mental illness. When he began his work at NIMH, so little was known about the impact of mental illness on the family that he and his colleagues were forced to use methods that were "frankly exploratory." Their first sensitively probing interviews were designed to identify the characteristics of families who were coming to terms with a mental illness in the husband or wife. Later, when they understood the dimensions of the problem, they would generate hypotheses that could be tested systematically.

The research and clinical literature provided some clues. Because surveys had consistently shown that the public held fearful and rejecting attitudes toward the mentally ill, Clausen assumed that families of patients would be reluctant to admit—to themselves or others—that one of their own was deviant enough to be hospitalized. Other public surveys, however, had

found that when asked to comment on specific signs and symptoms of mental illness, most people explained the behavior in some other terms—terms within the range of normal experience—even when the symptoms were dramatic or severe. Clausen wondered if a person who confronted these symptoms in a family member would still explain them away. As for the effects of mental illness on families, case histories reported in professional journals had documented that family routines and relationships are disrupted when a member falls ill. Other factors that needed to be explored were suggested by research on families in crisis. Recent work on social role theory, deviance, and social perception was also considered.

The research literature, then, led Clausen and his colleagues to consider such issues as: the family's perceptions of deviant behavior in one of its members; its responses to that deviant person and their consequences; its efforts to maintain morale and cohesiveness; and its shifting of roles (provider, caretaker, etc.) as the illness progressed and resulted in hospitalization.

Guided by these issues and assumptions about the problems families might face, Clausen's group formulated a number of research questions. Among them:

- How does the spouse understand the meaning of a mate's illness and then deal with it?
- How does the illness affect relationships within the family—before, during, and after hospitalization?
- How does the family maintain itself psychologically and materially?
- How does the illness of a husband or wife influence the spouse's relationships with others?

Clausen and his colleagues chose a research strategy that would give them the most insight into specific details of the family's experience. They would use only a few subjects and interview them in great depth. Although some questions would always be asked, the interviews would be open-ended—allowing the conversation to follow whatever direction the family member chose. They would keep their minds open. They would record every comment. What they would hear might come as a complete surprise. They would continue the interviews over a year or more, if necessary, and they would come back to the same questions again and again. Maybe this week's account

would contradict last week's. They would have to sort it out later.

In selecting the patient sample, the researchers were guided by their wish to study, first, how mental illness was recognized and defined and, second, what happened to the family when a spouse and parent was hospitalized. They would choose patients who were being admitted to the hospital for the first time—those least likely to have been previously diagnosed as mentally ill. To minimize gross cultural differences among the families, they would not include minority group members and recent immigrants. The patients, of course, had to be married and living with their spouses just prior to hospitalization. And they had to be permanent residents in the Washington, D.C., area so that the study team could interview their spouses during and after the hospital stay. (This last constraint disqualified several patients who might otherwise have been included in the study. In early pretesting, Clausen discovered that a number of persons experiencing schizophrenic episodes had come to Washington because it was the National Capital; some had come to see the President. They had been sent home as soon as their permanent residences were established.)

The first study included only male patients because Clausen had reason to believe that their families could provide the most comprehensive information over the entire period of crisis. In those days families often temporarily dissolved when a wife and mother was hospitalized; children were cared for somewhere away from the parental home. Wives of male patients, by contrast, usually kept their children with them. Since Clausen wanted to learn how children were affected by a parent's illness and absence, and what they were told about it, he would focus first on families that would probably stay together until the patient returned.

Clausen further decided to limit the original study sample to patients who received a diagnosis of schizophrenia, manic-depressive psychosis, psychotic depression, or severe psychoneurosis. He excluded patients with such organic conditions as senile psychosis or arteriosclerosis because they were "likely to be defined as permanently lost to the spouse and family." He also tried to exclude patients with long-standing drinking problems, but this proved to be difficult (1).

By choosing this intensive approach—studying a small number of families of functionally psychotic or neurotic male patients—Clausen's group sacrificed the prospect of generalizing its findings to families of all mental patients. The study would, however, prepare the way for later research—when the dimensions of the families' experience were clarified, when the investigators understood the variations in the families and the sources of these variations. The next phase of the research could then be more focused and also expanded to include larger, more varied samples. St. Elizabeths Hospital, the public mental hospital for Washington, D.C., agreed to inform Clausen when men who met the study criteria were admitted so that he could get in touch with their wives. During 1952 and 1953, his research team asked 35 women to participate; 33 agreed.

For scientific purposes, the 33 families comprised a nonbiased sample of families of married, white, working and middle-class men who were hospitalized for mental illness for the first time. Judging from their occupations, education, and home addresses, they were fairly typical of Caucasian families living in Washington, D.C., at the time. Three in five were in the middle class, the rest in the working class. All were white, as were two out of three Washington residents in 1950. All were either born in this country or had lived here most of their lives. In many respects, they were like their neighbors—reasonably well-liked, respected and responsible members of the community.

The 33 families had all crossed a line separating them from most of their neighbors, however. They had all witnessed their fathers and husbands change in a way they could no longer understand. Most had finally reached the conclusion that treatment was necessary. All had suffered through the arduous, wrenching process of witnessing or participating in the hospitalization of a family member.

Ideally, to study the process leading to hospitalization, the researchers should have interviewed the wives "as they struggled with the developing illness." Because this was impossible—the problem was not a "social fact" until help was sought—the next best solution was to interview the wives immediately after hospitalization, when memories were fresh. The interviews were repeated—in the ideal case, first at weekly, then monthly intervals—until 6 months after the husband returned home. By scheduling interviews close together, the re-

searchers were trying to obtain "a continuing record of the wife's effort to cope with the 'shifting ground' and the problems attendant upon these shifts." The majority of the women were interviewed at least five times and some as many as 18 times. Most were seen in their own homes when they were alone with the interviewer.

A Short-Order Cook Takes on Einstein

The stories related during those first intensive interviews are full of the bewilderment wives felt about their husbands' behavior. Typically, they found some explanation—any explanation—that would make the changes in their husbands understandable. Mrs. Foster (not her real name) was one of these wives who, over an unusually long period, desperately tried to make sense of her husband's disturbing behavior.

She had been married to Robert Foster, a short-order cook, for about 3 years before he was admitted to St. Elizabeths Hospital with a diagnosis of schizophrenia. Early in their marriage, she had noticed that he was nervous and tense. He was often sick, which, he explained, could be traced to the malaria he had contracted during the war. He perspired a lot. He was crabby. Noticing that Mr. Foster's friends seemed nervous too, Mrs. Foster concluded that "maybe I was happy-go-lucky and everyone else was a bundle of nerves." She got used to her husband's frequent illnesses and sporadic work, but grew annoyed because he wouldn't see a doctor. "I was beginning to think he was getting lazy because there wasn't anything I could see that was wrong," she reported.

Others noticed a change in Mr. Foster. A friend of his told Mrs. Foster that her husband was "more nervous than I have ever seen him," and Mr. Foster's boss observed that he "seemed very much worried about something." Mrs. Foster talked to more friends about her husband's unwillingness to consult a doctor. Her tolerance was strained. She tried to understand him, coming up with one explanation after another. Then she got fed up. "I got disgusted and said if he didn't go to a doctor, I would leave him." She asked Mr. Foster's boss to talk to him. "I begged, threatened, fussed." Mr. Foster then made one visit to a Veterans' Administration doctor. He told his wife that the doctor had said he was all right. On the day Mr. Foster was scheduled for a second visit, he overslept, missed the appoint-

ment, and never returned. Mrs. Foster didn't talk to the VA doctor.

There were periods when Mr. Foster was well and working. Mrs. Foster forgot about his troublesome behavior during those times. "You live from day to day. When something isn't nice, I don't think about it," she told the interviewers. "If you stop to think about things, you can worry yourself sick." She worked as a clerk in a small store and enjoyed meeting people there.

Mr. Foster would occasionally talk of a coming revolution during which Negroes and Jews would take over the world. Mrs. Foster learned that she dare not dissent from these ideas, so she just tried to change the subject.

About a year and a half before Mr. Foster was admitted to St. Elizabeths, he began waking his wife at night to tell her of nightmares about his wartime experience. Three months later, he quit his job. He began to write a book about the war and science. "If you saw what he wrote, you couldn't see anything wrong with it," Mrs. Foster recalled.

While she was at work, socializing with the customers and other clerks, Mrs. Foster could forget about her husband's strange behavior. At home, it wasn't as easy. She found it increasingly difficult to ignore the seriousness of his condition. She was also concerned that he wasn't making any money.

One evening her husband told her that he wanted to discuss his ideas with Einstein. He planned to pay a visit to the great scientist. Mrs. Foster thought it was a silly thing to do. She wondered why he couldn't just talk to someone closer to home. But later she told the interviewers that she had driven to Princeton, N.J., with her husband. She said they had parked outside the building where Einstein's office was located, and when he emerged Mr. Foster engaged him in conversation for about 10 minutes. According to Mrs. Foster's account, Einstein told Mr. Foster to see his secretary, who told him to put his ideas into writing before attempting to discuss them further with the scientist.

The day before Mr. Foster was finally admitted to a hospital he went shopping with his wife, something he had never done before. He worried that he might lose her while shopping, Mrs. Foster reported. Later that

day, Mr. Foster thought he was the subject of a TV program and that the set was "after him." By this time, Mrs. Foster could see that her husband's behavior was "rather strange."

That night, Mr. Foster talked incessantly. He reproached himself for not making enough money to give his wife surprises. After a second thought, he changed his mind. He did have a surprise for his wife, he exclaimed. He was going to kill her. Scared now, Mrs. Foster asked him what he meant. He began to cry. She must not let him hurt her, he wailed, but do for him what she would want him to do for her. She asked him what was wrong with him. He said he had cancer. Then he began talking about the worm growing out of his grandfather's mustache. Remembering that she had earlier seen him watching worms in the fish bowl, Mrs. Foster thought she knew where this idea came from. Mr. Foster said he had killed his grandfather. He asked Mrs. Foster to forgive him. She became convinced that her husband's mental state was not what it normally was. "But I wouldn't say that he was insane or crazy, because he had always bossed me around before," she reported.

Mr. Foster talked all night, but by morning he "seemed to straighten out" and drove his wife to the store where she worked. At noon, he walked into the store. "I couldn't make any sense of what he was saying," Mrs. Foster said. "He kept getting angry because I wouldn't talk to him." Her boss told her to go home.

On the way there, Mr. Foster told his wife that his male organs were blown up and little seeds covered him. Mrs. Foster assured him that she couldn't see them. She announced that she planned to call his mother. At this, he began crying, and she was forced to promise that she wouldn't. "Don't you think you should go to a psychiatrist?" she asked. "No," he responded. "There's nothing wrong with me."

At home, he suddenly chased his wife around the apartment, growling like a lion. She screamed. Her husband ran out, and she slammed and locked the door behind him. "When he started roaring and growling, then I thought he was crazy. That wasn't a human sound. You couldn't say a thing to him."

Later that night, Mr. Foster went to a nearby church and created a scene. The police took him to the psychi-

atric ward of a general hospital. At the commitment hearing that followed, however, he seemed quite normal. It was recommended that she arrange for his hospitalization at the VA hospital. During the days they waited to get in, Mr. Foster again became disturbed. On the tenth day after the hearing, he assaulted a friend. Mrs. Foster then spent 2 hours calling hospitals, and finally she got D.C. (District of Columbia) General Hospital to accept him. A fire department ambulance took him there.

Early Findings

After analyzing the interviews with Mrs. Foster and the other 32 wives, Clausen and his group had a fairly clear picture of the kinds of experience families encountered before, during, and after husbands were hospitalized for mental illness. The most salient of their findings were later noted by Clausen:

- Like Mrs. Foster, most wives had difficulty perceiving the nature of their husbands' problems. They tried to see their husbands' behavior as normal, variously attributing it to weak character, somatic illness, normal response to stress, or passing events. Their interpretations changed as pressure mounted, as conflict with their husbands became more intense and frequent. "Only when alternative interpretations could no longer be sustained was the hypothesis that the spouse was 'mentally ill' entertained seriously."
- If the wife recognized that her husband required treatment, she was repeatedly frustrated in her attempts to get it; usually she encountered roadblocks and deadends such as those Mrs. Foster found. Seldom were these wives able to get their husbands into a hospital without great difficulty. "Most families did not know where to turn for help, and even those professionals who are commonly seen as gatekeepers to psychiatric care frequently rebuffed patient and family in their search for help."
- Although most wives denied that mental illness carried any stigma, their behavior and comments showed otherwise. They avoided friends and acquaintances. They misrepresent-

ed the nature of the husband's illness to young children, distant family, and employers. They worried about the hostility and criticism they and their children would encounter. "Particularly at the time of hospitalization and when the husband returned home, communications with friends and relatives often tended to become a source of great anxiety and ambivalence."

Refinements

Conclusions drawn from the first intensive study of 33 families of male patients were reported in all the richness of detail possible through the investigators' research methods in an entire 1955 issue of the *Journal of Social Issues*. Other reports were published later by Harriet S. Murphy, a social worker and researcher, and Charlotte Schwartz, a research sociologist. Both had worked on the project in the NIMH Laboratory.

After they had analyzed the data on the first 33 families, Clausen and his coworkers were able to define the research questions more clearly. It was now possible to design a series of four structured interviews made up of sharply focused questions. The researchers planned to expand the study to include women patients and draw their sample not only from St. Elizabeths, but also from hospitals serving the Maryland suburbs of Washington, D.C. As Clausen contemplated this larger scale, longer term study, however, he realized that his research staff would have to work less intensively on it than on the first study. "The kind of interviewing we were doing was wearing and often anxiety-producing," he recalls. He found it especially difficult to recruit men who were good at such interviewing and who also enjoyed it. It was their lot to interview the female patients' husbands, who were less willing to talk than were the wives of male patients.

Nevertheless, the work continued. Only Harriet Murphy gave all her time to the project. Throughout the rest of the 1950s, she and her coworkers interviewed 55 more families. In 31 families the wife and mother was the patient, in 24 the husband and father was.

The investigators learned that this second group of families had just as much difficulty in recognizing mental illness for what it was as had the first 33 families. These families also had similar difficulties in getting the patient into treatment and felt as much stigma as had the first 33 families. Although the data were fully analyzed only recently, Clausen did examine the prehospitalization marital relationship of 24 of the new couples in a way that was not possible with the earlier data. He presented a paper based on this analysis at the 1959 American Sociological Association meeting. (Findings from this and the earlier papers will be discussed below.)

Influenced by the initial reports on Clausen's NIMH research, as well as by generally increasing interest in rehabilitating mental patients, other investigators took up the study of the consequences of mental illness for the family. A California group led by Harold Sampson, Sheldon Messinger, and Robert Towne intensively studied the interactions leading to hospitalization in the families of 17 women diagnosed as schizophrenic. Designed in part to complement Clausen's project, the California study was much more probing; patients as well as spouses were interviewed for up to 3 years following a patient's return home. On the average, 50 interviews were conducted with each family. For Clausen, this careful research was later to hold more than the usual interest of one investigator in another's work.

In 1960, Clausen moved to Berkeley, where he became Director of the Institute of Human Development at the University of California. He had planned to get back to analyzing data from the NIMH family study once he settled into the new job. But he found that his new research, along with administrative and teaching duties, took up all his time. For the next 10 years, except for devising procedures for coding his data, Clausen was unable to work on the family study.

A RETURN TO THE FAMILIES

"In 1970," Clausen says, "I realized that if the study was ever to be completed, I should have to get started before retirement." He decided then that, in addition to analyzing the data on all the families first studied in the fifties, the study would be much more valuable if he also did followup interviews with

them. When Sheldon Messinger learned of Clausen's plans, he suggested that Clausen might also follow up the schizophrenic women whom he, Sampson, and Towne had studied in the late 1950s.

In addition to the families originally interviewed in the fifties, Clausen's group would also interview families of a new group of patients hospitalized for mental illness in the 1970s; this time, they would interview both patients and their spouses. New patients would be found in the same areas as those in the original study. Financed by a grant from NIMH, Clausen began the new study in April 1971. His principal assistant was Harriet Murphy, who had interviewed about a third of the families in the fifties. For the first few months, she coordinated the field work in the Washington area. When illness forced her to give up her position, she was replaced by Carol Huffine, who was soon to be awarded a doctorate in sociology at the University of California. Huffine joined the project in early 1972 and has continued to be Clausen's principal professional colleague on the study through the years.

Doing it the Hard Way

For a man nearing retirement, Clausen was taking on an enormous job, requiring a mixed bag of skills and sensitivities. He had, however, already proven himself adept at this type of intricate sociological research. He goes at it the hard way. He insists on working "close to his data." For example, he interviews some families himself. He pays attention to them, hears what they have to say, keeps an open mind so that unexpected responses don't pass by. He and the other interviewers go in to learn about the nitty-gritty details of mental illness from those affected by it—not to "administer a questionnaire." His research design now involves using enough subjects to allow for statistical analysis. In collecting, quantifying, and analyzing his data, Clausen is a hard-headed scientist. He attends to detail, teases out the hidden biases, checks and rechecks reliability. To avoid becoming enamored by these quantitative findings, he then turns back to the cases—the stories told by the people being studied.

The first task Clausen's group undertook in 1971 was to locate the families who took part in the studies in the fifties. Dogged detective work was required to track down the fami-

lies—most on the other side of the country from Clausen's Berkeley headquarters—in rapidly changing urban centers. Public records had to be checked for names of patients who had died, hospital files examined, phone books scanned, rumors pursued. Surprisingly, more than half of the families had remained in the area in which they had first been studied. Most of those who had moved had merely gone from city to suburbs, but many had moved several hundred miles away.

Over the months, Clausen's team was able to account for about 85 percent of the total group of patients—whether living or dead, whether subsequent treatment had been required, and current whereabouts. Once the families were located, Clausen and his colleagues had to step back and consider whether re-interviewing them might entail risks to their welfare. Would recalling their experience with mental illness touch off new reactions to old troubles? In some cases, where a patient had committed suicide or died soon after returning from the hospital, Clausen's group decided not to subject the families to further interviews.

Of those they tried to interview, one in 10 of the patients or spouses refused. When the spouse was dead, refused to be interviewed, or could not be located, the interviewers turned to the patient or a relative such as a grown child.

Sometimes they could find no one. All of the "lost" cases involved female patients. Clausen believes that name changes and the instability of many of the female patients' husbands account, in part, for his group's inability to locate some female patients' families. He notes, however, that these families were difficult to study in other respects as well. Wives of male patients were better educated and much more willing to participate and to respond fully during the interview than were husbands of female patients. Clausen remembers that the wives of male patients in the first study welcomed an opportunity to talk with a sympathetic listener, and many established close ties with the interviewers. The husbands of female patients, by contrast, could talk with coworkers and other confidants. They were not the kind of men who liked to talk about their feelings—with their wives or with an interviewer. At followup, they had not changed markedly. As a result, information on female patients is skimpier than that for male patients.

Interviewing the families took the better part of the first 2 years of the renewed project. In most cases, the spouse was asked about the patient's treatment history, the couple's marriage, the occupational careers and social participation of both spouses, and the children's development and current status. The well spouse was also asked to assess the overall impact of the patient's illness on the life of the family. Those who were separated or divorced were asked additional questions about that experience. Over the next 2 years, the research team spent long hours painstakingly coding and recoding the verbal responses into quantitative form. Clausen was scrupulous about reconciling all discrepancies in the coding, because his sample size was too small to allow room for technical errors in the data. The coding job turned out to require "little short of herculean" effort, says Clausen. In addition to the followup interviews themselves, data from Sampson and Messinger's original California study had to be coded to match Clausen's study. Changes in computer technology meant that his own interviews from the fifties had to be recoded. Background data on the families and clinical records were also coded. Just developing codes that would render data from several samples comparable proved to be a difficult and slow task.

Deadline-defeating gremlins kept popping up. Grant money was delayed and coders had to be laid off. A careless research assistant failed to follow instructions, and some of the coding had to be redone. Clausen's grant was reduced during a period when the NIMH research budget had been cut and all projects were scaled down. As a result, Clausen and his staff were forced to give less time to the project.

New Rules, New Wrinkles

Meanwhile, for the second part of the study involving new patients, Clausen was negotiating with State and local mental health facilities to obtain access to records. One mental health center was closed to him because the city's attorney adamantly opposed such research—perhaps a sign of the public's increased sensitivity to the rights of patients. Clausen, himself acutely aware of the stigma of mental illness, willingly agreed to sign affidavits pledging that all records would remain confidential.

Because treatment practices had changed so dramatically in recent years, Clausen had first to monitor the flow of past admissions to the participating hospitals and clinics to learn where patients meeting his research criteria could be found. When he began the new study in 1971, he had assumed that many of the patients he wished to study would now be treated in outpatient settings. He had, in fact, hoped to compare fami-

Contrary to Clausen's expectations, few of the husbands and wives who broke down in the seventies were treated as outpatients.

lies of patients who were hospitalized to those of patients who were not. His assumption proved wrong. In the counties included in the research—Maryland's Prince Georges and Montgomery Counties and California's Alameda and Contra Costa Counties—very few patients meeting the research specifications were being seen as outpatients. (The new group of patients, like the old, were to be white, married, living with their spouses, between 20 and 50 years old, not previously treated for mental illness, but now diagnosed as schizophrenic, manic-depressive, severely depressed, or psychoneurotic.)

Another difficulty arose as a result of stricter procedures for protecting patients' rights. State and Federal regulations, as interpreted by Berkeley's Committee for the Protection of Human Subjects, required that Clausen obtain the signed consent of both patient and spouse before interviewing them. Several patients refused to sign. Like most researchers, Clausen enthusiastically supports the need to protect patients' rights and privacy. But he thinks that local committees charged with that responsibility too often rely on the signed consent form and fail to consider alternative mechanisms. For his study, for example, he preferred giving the patients and their spouses a statement, signed by him, that would explain what the study was about and spell out their rights as subjects and his duties and responsibilities as investigator. Clausen explains that many respondents, particularly those in the working class, have heard over and over that they should never sign *anything*. Among Clausen's prospective subjects, this reluctance to sign

forms was compounded by the fact that both patients and spouses understood that the research had nothing to do with the services they were receiving. They knew their participation was wholly voluntary and that they would be offered no services by the research team. Clausen's group asked them to take part in the study merely because it might help the researchers understand the problems of families, so that eventually other patients' families might be served better.

Clausen believes that if he had been able to forego consent forms in favor of a statement of explanation and commitment, he would have been able to come up with a more representative sample than he did. Patients who refused to sign consent forms either had strongly paranoid symptoms (a few patients refused because they saw the research as "stealing their secrets") or were from families in which there had been intense conflict before hospitalization. As a result, their families may be underrepresented in the new sample.

The brief time that patients are hospitalized today also introduced unexpected problems. Typically, patients spend only a week or two in the hospital on their first admission. Frequently, they are released only to be readmitted shortly thereafter. In some cases in Clausen's new sample, therapists of patients who had been in and out of the hospital advised against trying to interview them. In other cases, patients persuaded their wives and husbands to end participation beyond the second interview. Some patients were hospitalized for such brief periods that they were lost to the study. Clausen estimates that a third of the potential population meeting the study's criteria was lost.

Of the 41 patients who finally comprised the new group, 18 were men, 23 women. Only one, a woman, was treated in an outpatient setting. The majority were seen in the psychiatric services of general hospitals or local private psychiatric hospitals. After interviewing the new patients and their families, the research team again coded and recoded the information. They also prepared detailed clinical summaries on the patients, which were mixed with similar summaries from the "old" patients and independently diagnosed by a psychiatric consultant, Dr. Carlos Sluzki. Clausen took this precaution to assure that patient groups were similar, because he wished to compare the

new patients' experience to that of patients first hospitalized in the fifties (2).

Reporting Back

In the 8 years since Clausen returned to the study of families of mental patients, few reports on the work have reached professional audiences. The research has required far more time than Clausen had anticipated. He acknowledges that he originally underestimated the complexity and cost of the work he had set out to do. As a result, he has been short of funds and staff during much of the project. He also admits to trying to do too many things at once. While working on the family study, he continued doing research at the Institute of Human Development, directed a large training-grant program, and served as Chairman of Berkeley's Department of Sociology for 2 years.

By its very nature, longitudinal research in the social sciences is enormously time-consuming, however. Unlike physical and biological sciences, where definitive laboratory experiments can often be done in relatively short order, collecting data about social and behavioral processes is slow-going. And as it progresses, hindsight becomes clearer and clearer. Clausen notes that "in the later stages of any research, we wish that we had done some things differently." In the family project, some interviews, inevitably, "would lead to new hunches and to revisions of some of our classifications." But many revisions suggested by the clear vision of hindsight could not be made without starting over. To maintain comparability from one subject to the next, one sample to the next, Clausen, like other social scientists, has been forced at times "to live with imperfect measures."

Clausen resigned his department chairmanship in mid-1978. Now he and Huffine are, indeed, living with their measures—perfect and imperfect. Well along with their analysis of the full set of data, they are examining how each patient's sex and diagnosis are related to the process of defining mental illness and the consequences of mental illness for the patient and the family. They are also attempting to weigh the effects of social class, the quality of the marital relationship, and personality features in both patient and spouse on these same factors. Because of the small number of cases in each subsample (e.g.,

male schizophrenics), each possible source of variability in responses to mental illness is being examined separately.

Much of the analysis of data on the long-term consequences of mental illness has already been done and several articles have been accepted for publication. Comparisons between the fifties and seventies families are well under way. During the next year, Clausen and Huffine will prepare a monograph which will describe the entire project and report their findings. The results given below are drawn from four sources: articles and papers based on the fifties' studies, grant applications and interim reports on the new project to NIMH, several already completed papers reporting analyses of the followup data, and interviews and correspondence with John Clausen.

FAMILIES OF MENTAL PATIENTS—THEN AND NOW

In their analyses, Clausen and Huffine are comparing the experience of the 41 families of patients first hospitalized in the seventies to the 80 families from the fifties who met the study's original sampling requirements in every respect (3). Many of the comparisons contrast the families of schizophrenics to families of patients who received other diagnoses (psychotic depression and manic-depression, severe psychoneuroses, reactive depression, depressive neurosis, or personality or character disorder).

In the new group, proportionately fewer (50 percent) were diagnosed schizophrenic than the fifties group (70 percent). Half of the new patients were 37 years old or younger when hospitalized. The fifties patients were a few years younger at the time of their first admission—perhaps reflecting the fact that there were more schizophrenics among them, and schizophrenia typically appears at a younger age than do the "affective" disorders. The new group, as expected, left the hospital much earlier than did the fifties patients (measured in weeks rather than months), and far more were markedly symptomatic when they left.

Recognizing Mental Illness

In families studied in the 1970s, Clausen's group gave special attention to learning the "grounds of normalcy" in each home. Their earlier interviews had taught them that the process of

recognizing mental illness was always affected by the family's longstanding perceptions of what was "normal" for them. The relationship between husband and wife has a life of its own, influenced by, but sometimes very different from, cultural norms. The spouse is most likely to try to fit unusual behavior into the pattern of perceptions accumulated over the years. As the NIMH group noted: "Symptomatic reactions which are intensifications of long-standing response patterns become part of the fabric of life and are not easily disentangled as 'symptomatic.'"

Before one spouse became mentally ill, nearly all of the families in both old and new groups had been established long enough for the husbands and wives to have developed stable expectations of each other. The fifties patients had been married for an average of 10 years, the seventies group for nearly 15 years. The marriages in which the husband eventually became mentally ill, however, were much happier than those in which the wife became ill.

For those hospitalized in the fifties, four out of five female patients' marriages were unsatisfactory to one degree or another. Many had been torn by pervasive conflict for years. Even before the wives experienced symptoms—hearing voices, for example—their husbands saw them as disturbed. The men characterized their wives as jealous, suspicious, nervous, moody, shy, immature, or complainers. Male patients had much better marriages, rarely marked by longstanding conflict. As often as not, their wives saw them as essentially normal and healthy before symptoms appeared. Some described their husbands as weak in character, spoiled, or physically ill. By and large, however, they saw their mates as mentally normal.

Clausen says that he is not sure if the harsh characterizations of the female patients reflected what were, in fact, very inadequate personalities, or were simply expressions of "the male's stereotypic tendency to see the female of the species as more neurotic than the male."

In the families of patients hospitalized in the seventies, there was far less overt and bitter conflict than in the fifties group. The investigators speculate that, among other factors, this change could be related to duration of psychiatric problems or today's easier divorce procedures. As with the fifties families,

male patients' marriages had been better before the onset of symptoms than had female patients'.

Most of the wives in the fifties group were unable to point to a single strange or disturbing reaction that convinced them that their husbands were mentally disturbed. Most, like Mrs. Foster, endured, unable to separate the bizarre from their overall knowledge of their husbands' personality and family expectations. The problems usually began at home, within the family—physical complaints, expressions of inadequacy or hopelessness, withdrawal, nervousness, deceptiveness, slovenliness, aggressiveness, suicidal behavior, delusions, hallucinations. All piled up and eventually spilled over into more public domains. Excessive drinking and indecent or bizarre behavior in public often occurred then.

Some patients themselves expressed the fear that they might be mentally ill, a fear that family members often protested.

The husbands of female patients were slow to take serious notice of their wives' symptomatic behavior. A wife might accuse the husband of being unfaithful, move out of the marriage bed, withdraw psychologically. Then she'd let the housework go. For many, symptoms went on for a year or more before the husband sought help. "In several instances where conflict had been rife," says Clausen, "husbands maintained an almost incredible tolerance of deviance for many months without communicating with anyone outside."

Like the fifties group, when the well spouses in the seventies first noticed that something was wrong, they interpreted it as nervousness or irritability. "Again," says Clausen, "a majority of wives and husbands initially saw the patient's problem as something other than mental illness or severe emotional disturbance." Again, spouses perceived the onset of problems as gradual. The investigators found that, in the new group, husbands of older women were still often interpreting their wives' distress as a sign of menopause—"an old husbands' tale that

persists," notes Clausen. While one in six wives interpreted her husband's changed behavior as serious emotional disturbance requiring treatment, only one in 20 husbands came to that conclusion about a mentally ill wife. Another fourth of the male patients' wives and a fifth of the female patients' husbands considered the possibility of emotional disorder but found other explanations equally plausible.

In both the fifties and seventies groups, some patients themselves expressed the fear that they might be mentally ill. (It was not uncommon for their families to protest such fears, to deny that they were mentally ill.) In other cases, the patients had told their spouses that they felt either persecuted, seriously ill physically, or guilty of sin or some terrible act. In many cases, the patient simply withdrew, and the spouse was unable to tell the investigators what the patient felt was happening.

In the fifties, if the disturbed spouse's symptoms had been persistent, the household's day-to-day routines became seriously disrupted in the month or so before hospitalization. None of the couples was getting along well by then. If the marriage had been good, the spouse's initial anger might have turned to worry. But in bad marriages, anger, fear, and ridicule continued. Hostile comments that were typical: "You should have your head examined." "If you're not careful, you'll be a mental case." The same patterns were also found in the seventies families. The spouses again dealt with the problems by coaxing, begging, pleading, and sometimes berating or avoiding the troubled partner.

In the fifties, children were not usually involved until this late stage before hospitalization. Especially where mothers were psychotic, child neglect and, less often, abuse prompted the spouse to seek hospitalization. In other cases, assaults on the spouse or suicide attempts were the final straw. But until just before hospitalization, many mothers (especially those in happy marriages) continued to care for their children, and many men continued to perform on the job. "Indeed," says Clausen, "these seem to be the minimal role functions that must in general be sustained if the family is to go on at all."

Just before hospitalization, roughly seven in ten of the seventies patients were showing bizarre or aggressive behavior that reached levels the spouses could not ignore. (Most of the other patients were depressed or acutely anxious.) As with the fifties

families, the marital relationship was impaired long before other major roles became affected. And, as in the old group, the male patients' performance on the job and the female patients' performance as mothers were not markedly impaired until just before hospitalization.

In the 1970s families, Clausen's group asked for details about the patient's effect on the children. The symptomatic fathers tended either to withdraw and not respond to their children, or they became more critical. "Mothers were also sometimes less responsive but more often were reported to be critical, severe, or (occasionally) hostile or bizarre in dealing with the children," Clausen and his colleague, Carol Huffine, report.

Reaction of the Spouses

Clausen and Huffine found that spouses in the new group were more sympathetic toward their mentally ill mates than were those interviewed in the 1950s. But in both groups, wives of disturbed husbands were, on the average, more sympathetic and understanding than were the husbands of female patients. In the new group, where the patient was interviewed, the well spouses' perceptions of their own reactions were largely confirmed by the patient spouses. In the new group, two-thirds of the wives were reported as more accepting than rejecting of their symptomatic husbands, and some of the rest became more accepting once they recognized that their husbands were mentally ill. By contrast, four in ten husbands were seen as rejecting their mentally ill wives in some fundamental way.

As might be expected, the happier the marriage before the breakdown, the more likely it was for the spouse to react sympathetically. In marriages that had turned sour, even the wives could be extremely sarcastic and harsh in assessing their psychotic husbands. In marriages that had been close, the spouses remained sympathetic no matter how annoyed or angry they might be with the patients.

The Search for Help

Wives of the original 33 patients in the NIMH study seldom knew where to turn for help. Many consulted family physicians; but in half these cases, the physicians failed to recognize the psychiatric problem. In several families, the wife turned

her husband over to his parents, who sometimes did arrange for hospitalization. In other cases, clergymen were consulted or the police brought in. They, too, often failed to help the wife clarify what was wrong. As a result, "the paths to the hospital were beset with obstacles and traumata for husband and wife."

Attempting to explain the difficulty these wives encountered in the fifties, Clausen's group pointed out that with mental illness, unlike physical illness, "the diagnostic process must, in general, go much further within the family itself." Even after the illness had been recognized, however, the route to treatment was long and snarled for these families.

Families encountering mental illness for the first time in the 1970s had a somewhat easier time. In the fifties group, spouses often reported that their most difficult problem had been getting the disturbed spouse into the hospital once they had recognized that it was necessary. In the seventies, only one spouse in eight saw the process of hospitalization as the most difficult problem.

Nevertheless, patients still often underwent prolonged symptomatic treatment for physical symptoms or for "nerves," even when they exhibited bizarre psychological symptoms. Nearly 80 percent of the patients consulted a physician about their problems at one time or another. While female patients usually went on their own initiative, male patients went at their wives' insistence. Half saw a physician more than a month before they were hospitalized. And in more than half the cases where seen, the physician failed to advise consultation with a psychiatrist or to actually refer a patient to one.

As with the fifties group, it was most often the spouse or a professional who first suggested that the patient's problem was mental or emotional. Physicians decided that the patient should be hospitalized in the case of nearly half of the female patients. Most often the patient agreed to the move. The great majority of the other patients were hospitalized because their spouses, or they and their spouses together, decided that it would be desirable. A sixth of the male patients decided on their own to be hospitalized. Parents of the seventies patients were much less often involved in getting the patient hospitalized than were parents in the fifties families.

Clausen and Huffine found that, to their surprise, an unhappily married woman was more likely to get into treatment

within 3 months after a breakdown than was a woman who had a good relationship with her husband. They believe that this difference might be attributable, in part, to suicide attempts or other acts that precipitated hospitalization. But another factor may be that husbands whose wives were extremely sick, but who had sound marital relationships, were reluctant to seek psychiatric treatment. Because the sample is small, Clausen says he doesn't want to make too much of this difference. "But there is a suggestion that wives today are somewhat more active in their own behalf, even when mentally ill, than they were two decades ago."

Only one in five of the new patients was committed, compared to three in five of the original 80 patients. In one of ten of the seventies cases the spouse called the police to take the patient to the hospital. The police were also involved in six cases where there was a court order committing the patient. Nearly half of the families had become involved with the police in the 1950s.

Based on their analyses to date, Clausen and Huffine conclude that it is *not* much easier for a husband or wife today to recognize mental disorder in a spouse than it was 20 or 25 years ago. But once the problem is recognized, the mentally disturbed spouse gets into treatment more quickly and with much less trauma than was the case in the 1950s. Clausen believes that today's greater availability of community resources for treating mental illness makes the hospitalization process much easier. "Moreover," he says, "if physicians do not always recognize a psychosis when it is first presented to them, they at least know where to refer the patient once they have recognized it."

An Absent Partner and Parent

Families suffer major disruptions in their normal routines, roles, and relationships while one member is becoming increasingly more disturbed. For those in the fifties, hospitalization brought even greater upheavals. Mothers or fathers, wives or husbands were gone for months at a time. Patients in Clausen's fifties' sample spent an average of 3 to 6 months in the hospital, but six of the 80 patients were there for a year or more. When the husbands in the first group were hospitalized in St. Elizabeths Hospital, their wives were told to prepare for a long

absence. Many were advised to take jobs, unless they had some other source of financial support. Most did not move; most kept their children with them. A few moved in with their parents; a few left their children with their parents during the day.

As Clausen and his colleagues had anticipated, when wives were hospitalized in the fifties, their families frequently broke up temporarily. Children were often cared for by their grandparents or other relatives, who sometimes lived far away. Unlike the families in which the father was the patient, very young children were usually placed somewhere outside their parental home when their mothers were hospitalized. "Even when wives of male patients worked," report Clausen and Huffine, "they gave higher priority to the child's needs than did husbands of female patients."

Families in the seventies suffered far less disruption when a parent was hospitalized. With the hospital stay usually under 3 weeks, children were rarely placed with relatives except for care during the day. Unless the patient remained seriously symptomatic, the arrangements were temporary. Not one wife in the recent group took a job because her husband had been hospitalized. "On the contrary," say Clausen and Huffine, "a substantial proportion of mothers who had been working took time off from the job or put in shorter hours." This was also true of husbands.

Children often have the most problems when their parent returns from the hospital.

Although they did not systematically inquire about children's visits to their hospitalized parents in the original sample, Clausen and his colleagues have the impression that such visits were much less frequent than they were in the recent group. Hospitals are more readily accessible in the seventies. The great majority of the new patients were visited by their children as often as they might have been if they had been physically ill.

The researchers also asked the new group of families how the children responded to their parent's absence. The wives of male patients usually saw signs that their children were upset or concerned, but husbands of female patients as frequently reported that children were not concerned. If there had been longstanding conflict, the children might even be reported as relieved. Clausen and Huffine are skeptical about these reports, especially those of the husbands. Their recent interviews with the now-adult children of patients hospitalized in the fifties suggest that many children are far more distressed than their parents seem to realize.

The wives of male patients hospitalized in the fifties often learned some valuable lessons. When the interviewers asked them how the experience with mental illness had affected them, the wives frequently said they had learned to recognize their own competence. A typical comment was, "It made me realize that I could handle things myself." Some, especially those who expressed a need for autonomy, kept their jobs after their husbands came home and returned to work. Others who had quit jobs when their husbands returned from the hospital went back to work when their husbands' symptoms reappeared. "They wanted to control their destinies, and not have to depend on somebody who might be in and out of the hospital." Few wives, in fact, stayed with husbands who continued to be symptomatic.

Husbands had the opposite experience. They were far more likely to report that they didn't realize until their wives became ill that they weren't able to do many things. They were also more likely to stay with wives who continued to be symptomatic, often participating very fully in some homemaking chores.

Explaining to the Children

Clausen was surprised to learn that when a mother or father becomes mentally ill today, the spouse receives no more guidance in dealing with children's reactions than parents did 20 or 25 years ago. At least this was so for the families he studied. "Despite all the talk about family therapy," he complains, "only a few of the husbands or wives in our new families were called in for an interview by the treatment staff." As far as Clausen has been able to determine, none of the patients'

spouses was even asked about the children. In the past quarter century, mental health educators have made repeated attempts to distribute materials advising families how to deal with mental illness. Some of the 41 families in the 1970s had read books or pamphlets that contained suggestions for coping with mental illness. But none of the material was given to them by the treatment center. In the early fifties, he recalls, "one of the most difficult things for people to deal with was communication with the children as to what was going on." The spouses didn't know what to say. "They tended to shy away from talking about mental illness. They still do."

Clausen describes a typical parental response in a family with several young children. The mother had been taken to a State hospital and diagnosed as schizophrenic after she was arrested for trying to sell what she said were military secrets. Her neighbors noticed her absence and assumed she was away on a visit. Then one neighbor learned that she was in the hospital. He waited for a few days before broaching the subject, and he found that when he finally did, the husband was relieved. The husband said he hadn't been able to bring himself to say anything about it to his friends and neighbors.

The neighbor offered to help with the children. It was then that the husband had to admit that he hadn't been able to talk with them about their mother's breakdown. No one at the hospital had asked him if he needed help with the children. No one offered advice.

While the wife was hospitalized, the husband was relieved to learn that most of his neighbors were supportive. They brought in meals and helped care for the children. The youngest child was especially troubled by his mother's absence. He started sucking his thumb and wetting his bed—habits that he had broken before his mother left. When she returned home, she did not seem to know how to relate to her children. She said that she felt her authority in the family had been undermined. She subsequently abandoned her family.

In the families Clausen studied in both the fifties and seventies, less than a third of the well parents who had children old enough to understand the problem told them what was happening. "The parent will either say, 'They're too young to understand,' or 'They know what's going on.'"

How do they explain the ill parent's absence? The well parent will often tell young children that their mother or father is suffering from some physical ailment—a toothache, a tummy ache, trouble with a leg. "All of the conflict that preceded hospitalization—and there's usually a lot of conflict when someone becomes sufficiently symptomatic to be hospitalized—all that is brushed under the rug."

Older children might be taken into their parent's confidence, particularly their mother's. Clausen says that the mothers seem to find it easier to discuss their feelings with their children and to recognize that they may feel guilt and confusion. "The fathers are much more likely to deny that there's any effect on the children, at least that they've noticed. Fathers typically say something like, 'No, they just take it in stride.' Mothers are much more likely to notice."

Explaining to Others

When Clausen and his colleagues asked the spouses in the fifties families to characterize how their partners' mental illness had affected them socially, the investigators learned that most felt stigmatized. Again and again, these spouses said they expected hostility and criticism. Wives feared for their husbands' jobs, worried that old friends would avoid them, and were anxious that their children might be excluded from play groups or be taunted by other children. They were concerned that their family name would be hurt. With family, friends, and employers, they dissembled, concealed, and denied; in only a few cases did spouses talk openly about the situation.

Two typical comments were: "I live in horror—a perfect horror—that some people will make a crack about it to Jim [child], and suppose after George gets out everything is going well and somebody throws it up in his face. That would ruin everything. I live in terror of that—a complete terror of that."

"Of course it was all new to me. I had never known anyone like this before. At first I was a little ashamed, but now I'm getting to understand it better. I know that mental illness is just like physical illness. I don't think people think about mental illness the way they used to. Of course, I have cut out seeing all but a couple of our friends. There are especially some I have cut out. In fact, Joe asked me not to tell his friends while he was in Saint Elizabeths Hospital."

Two out of three of these families studied in the fifties had parental families living nearby. Most knew of the illness and hospitalization, but the communication between the psychotic husband's wife and her own family differed greatly from that with her husband's family. While wives rarely sought help from their own families before hospitalization, they often turned to them for help and emotional support after they were left alone with the children. Their interactions with their husbands' families, on the other hand, were laced with hostility. "Accusations and counter accusations are made. Patience is short and criticisms are easy and frequent." The wife blamed her husband's family for his illness; they blamed her. "The husband's illness seems to have the effect of consolidating or accentuating the prior relationships between the wife and the parental families," the researchers reported in 1955. Wives frequently complained that in-laws had little appreciation of the difficulties they experienced. As one wife said, "I feel hurt and feel they have not considered me. All they are concerned about is my husband."

In their communication with outsiders, some wives tried "aggressive concealment," cutting out all social encounters. Sooner or later, however, they would have to tell someone—an employer, for example. Lies and evasions were cumbersome and difficult to maintain. Isolation would distort the wife's perception of what others thought.

The reaction of others was sometimes kind and understanding, but at times it was cruel. The wife might be kidded by coworkers about her lack of a sexual partner or subjected to advances from male friends. Also, while the husband was hospitalized, "there was rather thorough-going avoidance by friends and acquaintances," the investigators noted. "Normal expressions of concern for the welfare of one who is ill such as visits, written messages or gifts are avenues little used for the mental patient."

Although Clausen and Huffine have not completed their analysis of the data on the new families' social interactions, Clausen has the impression that they are much less traumatic than they were for families in the fifties. The well partners seem to feel less stigma than did their counterparts 25 years ago. One indication of this difference is that the spouses seem to be more open about discussing mental illness with their

neighbors than they were in the 1950s. The apparent change in attitudes may be attributed, in part, to the fact that far fewer of the seventies patients were sent to State mental hospitals. Clausen says that another reason may be that mental health professionals are themselves more hopeful about the prospects for the future of psychotic patients.

The extended family also appears to be less involved today. Unlike the fifties wives, a wife in the seventies was not likely to blame her husband's parents for his problems or turn him over to them. In fact, three out of four couples either did not inform the husband's parents of his hospitalization until after it had occurred or did not tell them about it at all. About a fourth of the female patients' parents were involved in their daughter's hospitalization, while slightly less than half either knew nothing about it or weren't told about it until afterwards.

The Returning Patient

In the fifties, when patients returned home after a long stay in the hospital, their husbands and wives found them very dependent. They demanded displays of affection. They tried to please the spouse by helping out around the house and doing extra chores. Clausen says that while this phase did not last long, some spouses found the readjustment "unanticipated and unnerving."

Many of the former male patients were anxious about returning to work. Very few men lost their jobs because of their illness or had trouble finding a new job. But, says Clausen, those who did have trouble were devastated by it. Contrary to their fearful expectations, most men who returned to old jobs found few problems in relating to their coworkers.

The men first hospitalized in the seventies were much more likely to return to their old jobs than were those who first suffered a psychotic breakdown in the fifties. This difference, say Huffine and Clausen, is probably partly due to the shorter duration of hospitalization in the seventies group. But other differences in the groups also may contribute to the change in experience. The men in the new group were older, on the average, than in the old—a factor which in itself was positively related to job retention. They also had somewhat higher levels of occupational attainment, another factor which, in both old

and new groups, was positively related to returning to an old job.

Today's Treatment Practices

The revolution in standard treatment practices for the mentally ill has solved some old problems and introduced new ones for families. For the most part, the short hospital stays seem to be less disruptive for families than the long hospitalizations common a quarter of a century ago. The short stay is much easier to handle—like a hospitalization for a physical illness—according to Clausen. Being treated in the psychiatric ward of a general hospital or small private hospital is far less stigmatizing than going to a State hospital. In the earlier study, wives whose husbands were treated in a Veterans' Administration hospital felt less stigma. The wives could just tell friends, "My husband's in the VA hospital." They didn't have to mention that he was on a psychiatric ward.

Long periods of hospitalization did have some advantages, however. There was more time to heal the wounds opened in the period of turmoil before hospitalization. When the patient was gone longer, some families would go through a honeymoon period after being reunited. This is less common today. In some of the families who experienced a first hospitalization in the seventies, the cooling-off period was not long enough, Clausen concedes. "Some patients are returning home while there's still so much turmoil, and they may still be symptomatic or so heavily drugged that they don't relate." The patient more often returns to the hospital in short order. Patients hospitalized in the fifties, on the other hand, "would be allowed to go home for a weekend. Then they might be given a longer pass—maybe an indefinite pass—and be discharged a year or so later. They were kept on a string tied to the hospital." Clausen and Huf-fine also discovered that, despite the reduced chance of breaking family ties because of long separations, the families in the seventies more often dissolved after the initial hospitalization than did those in the fifties.

What is the optimum length of a hospital stay? One that is long enough to allow family frictions to cool down and patients to recover? One that is short enough to prevent patients from becoming chronically dependent on the hospital and/or estranged from their families? Clausen thinks there is no opti-

mum for all patients; much depends on the patient's symptoms, the family's composition and internal relationships, and the resources available to it. "Some studies suggest that patients who have been hospitalized until their symptoms have considerably subsided do better upon return than patients who have been maintained in the community on drugs and psychotherapy," he notes. While this issue is far from resolved, treatment staff must always keep in mind "the alternative considerations of giving the family a moratorium, on the one hand, and yet not completely cutting the patient off, on the other."

Like the patients, many spouses were afraid of psychiatric drugs. They were often concerned that improvements may not be "real." One husband said, "I don't know how much of her personality is her's and how much stems from the pills."

The powerful psychiatric drugs, on which many once-hospitalized patients depend, present problems of their own. Clausen and other critics have observed that drugs are often prescribed indiscriminately or inappropriately, especially for patients in the community. Clausen and Huffine collected some data on drugs being prescribed to patients in both their old and new samples. They also have information on the method of monitoring drug use and how family members influence the patient's use of drugs. Clausen observes that in some instances very high levels of drug dosage are being prescribed with almost no monitoring. "Wide varieties of drugs are used in rapid succession, sometimes for patients whose problems appear to be relatively minor—patients who have been coping quite effectively for a decade or more but have sought help in the face of an extremely upsetting situation."

Female former patients are much more likely to be receiving medication than are the male former patients. Some of the women hospitalized in the fifties and now in outpatient treatment "are being given far more drugs than they need," Clausen

says. "They get what amounts to an open prescription, with physicians saying, in effect, 'Don't bother me, I'll give you what you want in the way of drugs.' It's rather appalling to find out the prescriptions some of these women have—the whole range of major and minor tranquilizers." Clausen learned in one interview that a former patient was taking four times the maximum dosage of one commonly prescribed, addictive tranquilizer. She couldn't function without it, yet she and her husband were very unhappy with her dependence. They arranged for her to go into a hospital for withdrawal, but when she got there, she stayed only one night. The experience of the State hospital 15 years earlier hit her so hard that she couldn't stay, she reported.

In some instances, husbands control and manipulate their wives' medication. They often have qualms about their wives using the drugs. But "only in a tiny minority of cases" have treatment staff explained to the spouse either the nature of the patient's condition or the rationale behind the drug treatment. "In general," says Clausen, "we have found that the family tends to be ignored almost as much now as it was 20 years ago."

An analysis done by Carol Huffine calls into question a common belief among mental health workers that patients who live with others are more likely than socially isolated patients to take medication as prescribed because their intake is supervised. Using data from the followup interviews with the fifties patients and interviews with seventies patients and their spouses, Huffine compared attitudes toward the use of psychotherapeutic drugs to the patients' actual use. She found that, like the general population, many patients and spouses in this study hold negative attitudes toward psychoactive drugs. A minority complained of adverse side effects; but others feared the drugs, felt that taking them carried a stigma, thought that they threatened the patient's autonomy and independence, or denied that they were necessary or effective. Huffine found that the spouses' attitudes largely mirrored those of the patients. Even those who perceived real improvement in the patient's behavior or demeanor were often concerned that the change may not be "real"—that it may reflect only the drug's power to mask symptoms. Huffine quotes one husband as

saying, "I don't know how much of her personality is her's and how much stems from the pills."

Nevertheless, despite the "fears, sneers and side effects," most of the patients in the new group of patients took their medication as prescribed for at least a month after hospitalization. Some patients who appeared not to be complying with a prescription were, in fact, manipulating the medication schedule to minimize side effects that interfered with day-to-day activities. Some patients and their spouses apparently found that the benefits outweighed the negative aspects of the drugs. Others were able to cut down the drugs' costs by manipulating the prescribed regimen.

Huffine suggests that therapists should seriously take into account the attitudes of patients and their families toward medication. Brushing aside fears and opinions is simply not enough, she says. The patients' past experiences and the opinions of spouse and friends are likely to prevail. A clinician should not only take the time to explain what a drug is and why it is prescribed; he should also alter the dosage and timing of medication if patients complain about side effects.

LONG-TERM CONSEQUENCES OF MENTAL ILLNESS

In the analyses of the long-term effects of mental illness, John Clausen and Carol Huffine have focused on the same 80 families from the 1950s samples that they are using for comparisons with the 1970s sample. Interviews with 66 of these 80 families were completed by mid-1973—between 14 and 20 years after the patients were first hospitalized. Clausen's analysis of these families' experience is informed by his years of research on long-range normal development at the Institute of Human Development. He and Huffine are also making systematic comparisons between groups within the study sample: The adaptation of families of schizophrenic patients, for example, is compared to that of families in which the patient had an affective disorder or severe psychoneurosis. Families with a mentally ill wife are contrasted to those with an ill husband. Using these and other characteristics to define groups within the study sample, Clausen and Huffine are examining the effect of mental illness on marriages, the children, work careers, relationships with others, and changes in roles.

There were some differences among the subsamples of patients. Most nonschizophrenic men were older than the schizophrenics. The female patients were less educated than the men, and their families were of a lower social status than those of male patients. The women were first hospitalized after 1955, when tranquilizers were widely used; as a result, their first hospital stays were considerably shorter than they would have been a few years earlier and were slightly shorter than were the men's. But their symptoms at that time and during the succeeding years were more serious and persistent than were those of the male patients.

Whatever life held in store after the patient's first mental breakdown, none of the patients or their families saw the experience as an ultimately rewarding one. It was, says Clausen, "a horrible family trial." Some seemingly denied that it had ever happened. Clausen says a typical reaction in these families was, "Well, we don't know what happened then." But few families could forget the experience, because, in the majority of cases, the patient subsequently needed mental health care.

Mental Illness in the Interim

By the early 1970s, half of the former male patients had received further treatment at some time since the initial episode. By contrast, nine out of ten former female patients, most of whom were schizophrenic, had been treated again. The majority of all patients who received treatment were also hospitalized again—an average of three times. Most spent only short periods in the hospital when they returned. Some, however, remained symptomatic and continued to receive treatment as outpatients after they went home.

At the time of followup, four patients were either in psychiatric hospitals or on their books. Another woman had been transferred from a State hospital to a boarding home, where presumably she will spend the rest of her life. Of the 80 patients in the sample, seven men and four women were dead. Three of the men and two of the women had committed suicide; two men had killed themselves while on leave from their initial hospitalization, and another did so during a subsequent hospitalization.

Less than half of the men diagnosed as schizophrenic in the fifties were currently receiving any form of mental health

treatment—a smaller proportion than any other diagnostic group. Clausen and Huffine point out that married male schizophrenics are, among mental patients, a blest group. They typically have a better prognosis than the other types of patients included in this study. "Marriage (or the establishment of an intimate heterosexual relationship) is undertaken by a minority of males who are at any age diagnosed schizophrenic," they note. "Those who do marry have repeatedly been found less likely to become chronic schizophrenics."

What led to further treatment? In two out of three cases, the interview respondents said that symptoms similar or identical to the original ones had recurred. These symptoms were seen as moderate to severe in two-thirds of the schizophrenic women and the nonschizophrenic men. In most of these cases, the spouse considered the patient to be mentally ill.

Divorced Couples

By the early seventies, a third of the marriages had ended in divorce. Most broke up within the first 3 years after the first hospitalization—almost always when symptoms had reappeared. Most of the later separations came after a subsequent hospitalization. The spouse was usually the one to ask for the separation. In families with an affectively disordered patient, the couples were more likely to have agreed upon the need to separate, and, in a few, the patient initiated the break.

In most of these families, the spouse asked for a separation after the patient's behavior had become intolerable. The wives of most of the schizophrenic men who continued to be symptomatic had left by the time of followup. Persistent symptoms in mentally ill wives did not, by contrast, often lead to a marital breakup. "Separation was not a clear-cut event" in many families of female patients, according to Clausen and Huffine. Sometimes the families just never got back together again after the wife returned from a hospital stay. Husbands didn't seek divorces unless they wanted to remarry. "Some families were so amorphous that it would be hard to say whether or not they remained intact," the researchers remark.

To their surprise, whether a couple remained together until the time of followup seemed to bear no relationship to their ratings of how happy the couple had been before the initial hospitalization. Some conflict-ridden marriages had endured;

some that had seemed rewarding in the fifties had ended in separation or divorce. Another finding that surprised the researchers was that middle-class families more often broke up than did lower-class ones, especially when the wife was the patient.

Several couples who fought constantly finally separated after their children left home—usually at an early age. In one, a schizophrenic mother encouraged her three daughters to be sexually provocative. When she invited the lover of the 16-year-old in, her husband tried to prevent it. He moved out because he was unable to.

Married Life Over the Years

Of the 34 couples who were still together at the time of followup, a few seemed to be happy. Most were either locked in intermittent conflict or had worked out a truce maintained by spending little time or emotional energy on each other. A few were at war. Yet, two out of three spouses characterized their mates in positive terms, sometimes mingled with descriptions of symptoms. A third dwelled on the symptoms and inadequate personalities of their mentally ill spouses.

In the families that remained intact, half of the patients' spouses had considered separation at some time. A number of the wives and one or two husbands of patients are still contemplating divorce, while several patients' wives have resigned themselves to unsatisfying marriages. In most of these families where separation had been considered, the patient's symptoms had persisted and often included violent behavior.

Among those who had never considered separation, a fourth of the husbands and wives go their separate ways. Far more of the couples who expect to remain together are highly dependent on each other, however. Where the wife was the patient, one out of three couples seems bound together by mutual pathological dependence, despite frequent outbursts of hatred. Few of the families where the husband was the patient depend on each other in this way; instead, most "have worked out lives that touch lightly under the family roof." Their mild involvement with each other keeps conflicts and tension at a low level.

"On the whole," say Clausen and Huffine, "wives of male patients seemed to cope much more competently with the dual roles that were thrust upon them when their husbands were

incapacitated." In a few families, roles were actually reversed; the husband stayed home and the wife continued to hold a job. Mr. and Mrs. Foster, whose experience during the early 1950s was described above, are one of these families. They are still together and, by Clausen's estimation, have a good relationship. Mrs. Foster went back to school after her husband's breakdown. For many years now, she has taught school and been active in organizing professional training for herself and other teachers. Mr. Foster has never held another formal, paid job, but has done a good deal of volunteer work. Although he has been very anxious at times, he has never been hospitalized. The couple has no children.

Over the years, the families of male patients were generally less rocky than those of female patients; the patient-husband was not often symptomatic, usually held a steady job, had smoother relationships with his spouse, and shared more interests and activities. "By and large," Clausen says, "their families have been more stable than families of most sociologists and psychiatrists."

Half of the wives of former patients were unhappy about the disproportionate amount of responsibility that fell to them because their husbands did little to keep the household going. These men did "even less" around the house than the typical American male, say Clausen and Huffine. But that pattern had started early in the marriage and hadn't changed much over the years. By contrast, former female patients tended to carry less and less responsibility for household work as the years went by. Their husbands did much of it. But only one in five of these men complained about the arrangement.

Families in which the husband had an affective psychosis appeared to get along "reasonably well except during symptomatic episodes, when the patient was often completely out of control." These husbands were less abusive at home than were husbands of schizophrenic women. During manic episodes, they acted out away from home. When they were depressed, they were depressed at home.

Regardless of the patient's sex or diagnosis, in most conflict-ridden marriages the fighting started over either spouse's objections to the other's behavior or because of disagreements about the children; in more than a third where the wife was the patient, sexual relationships were an early focus of trouble.

Whether the patient was man or wife, the conflict was most often moderate, leading to two-sided screaming sessions or to the wife's withdrawing from the argument.

Despite the continued and often bizarre symptoms in the female patients, their husbands stayed with them more often than not. But, for most, it hasn't been a happy life. The husbands of schizophrenic women often had histories of problems themselves—bigamy, poor work records, assaults, arrests. Several have themselves been hospitalized or treated for mental disorders, and, Clausen observes, several others show marked psychopathology. They often drank to excess, or took off, "leaving the children to cope with their mother's difficulties." They not only berated their wives and children, but physically abused them as well. "One can't imagine why the wives or older children put up with this. Perhaps the wives *have* to stay because they are so often sick."

Clausen recalls one case where, after the father had been interviewed about the mother's history, a daughter phoned and asked if she could come in and talk. She wanted to counter the lies she was sure her father had told. Telling the interviewer that her father was extremely brutal, she described how he beat up her mother, her sister, and herself. She said, for example, that he didn't like her mother's smoking. If she lit a cigarette, he'd stub it out on her face. This young woman was in college, which was rare among daughters of schizophrenic mothers, and she lived away from home during the school year. But she returned to live with her parents during the summer. "We couldn't understand why she came home," Clausen says. "Perhaps she stayed at home to defend and protect her mother." In a few families with a patient-wife, however, the husbands have been "incredibly humane," Clausen adds. A few altered their occupational plans, gave up chances for advancement that would have forced the family to move, took new jobs that gave them more time at home, or retired early.

Some who had led unstable lives settled down. One man, for example, had held 14 jobs in 13 years before his wife's breakdown but has held the same job since she was first hospitalized. "He's gotten his life together. He's organized." His wife has

been in outpatient treatment a good part of the time since her first breakdown.

But this man, like many others, does not give his wife much emotional support. "He manages not to be around the house a great deal. This is one of the strategies whereby most of the families that stay together cope with the patient's symptomatology. The well spouse will have union meetings, church activities, take on extra jobs in the evening, and in that way avoid intense interaction with the patient."

Unwittingly, the well spouses may be helping their marriage partners by avoiding too much interaction with them. Research done by a group of London investigators (Brown, Birley, and Wing 1972) suggests that patients engaged in intense emotional involvement with a spouse or another significant person in the home are much more likely to be rehospitalized. This likelihood is even greater if that significant person is critical of the patient. The more hours per week that the patient interacted with the spouse or a "significant other," and the greater the emotional involvement with that person, the more likely the patient would return to the hospital.

Away From Home

The social life of the former patients and their families appeared to be quite restricted. Few entertained or had a wide circle of friends. Extended families were important to a majority. About half of the schizophrenics were very close to some member of their original families and frequently visited with relatives.

Other than these relationships with close family members, the patients derived most pleasure from their family life at home. This was especially true of male schizophrenics, a majority of whom had no close friends; their social activities were almost exclusively centered on their wives' social life and friendships. Nonschizophrenic men, by contrast, went out with friends alone more often than with their families. Among all the patients, four out of ten were said to have no close friends. Less than half of the families belonged to organizations, usually a church. Church activities were particularly important to the wives of male patients.

Growing Up With Mental Illness

Concern for children of psychotic parents has grown as community treatment has become more common. Mentally ill parents are now more likely to remain at home with their children, except for short stays in a hospital. Many of them are still symptomatic when they return home. Many break down repeatedly. At those times, they may neglect or even abuse their children. Their mere presence offers the opportunity to involve the children directly in disordered thought processes and behavior, or to transmit distorted perceptions of reality.

Several children had been particularly bothered by their mothers' hallucinations. One said of his mother, "Like my father hides his liquor, she hides her thoughts."

Sensitive to these potential hazards, Clausen and Huffine have analyzed reports on 150 children of patients first hospitalized in the fifties. They have given particular attention to the sex of the ill parent, the supportiveness of the well parent, and the patient's diagnosis. The research team has systematically analyzed the development of the children along a number of dimensions—their educational attainment, when they left home, their problems, and their relationships with their parents. Because most of the children have reached young adulthood, they and their parents could look back with some dispassion (and some anguish) at how needs were met and symptoms experienced. It is these remembrances, especially those of 13 of the children themselves, that provide a vivid picture of what it was like to grow up with a mentally ill parent.

Children with a mentally ill father had an easier time than did those with a mentally ill mother. During childhood, they were more likely to have two parents—a father who usually held a steady job (despite occasional problems) and a mother who was sympathetic and supportive. Family life was stable and routine. The mother disciplined the children with little

interference from the father. If the parents separated, the children always went with the mother.

Growing up with a schizophrenic mother was a much less positive experience. Sons had particular difficulty communicating with their mothers. Fathers often failed to provide the support and stability the children needed. Young children were shunted between relatives when the mother was hospitalized again.

Serious Problems

The researchers obtained from the parents' reports and clinical records some information on serious developmental problems. They did not attempt to interview any children except those readily available. From the evidence they do have, Clausen and Huffine conclude that the children of these patients are not "exceptionally problematic." But a number of them have had severe emotional problems or have gotten into trouble.

Because most of the children had not yet reached the age of maximum risk, Clausen's group does not know how many will break down with a mental disorder. At least three had already been hospitalized, however. Clausen and Huffine have evidence that at least seven children (all of whom had schizophrenic parents) have had brief psychotic episodes—far more than would have been expected. On the other hand, eight children, only about 5 percent of the total group of patients' children, had been treated for what appeared to be a nonpsychotic emotional disturbance; Clausen and Huffine believe that a similar proportion of such disorders would be found in the general population.

Children of schizophrenic mothers more often had serious problems than did those of other patients. More than a fourth of this group had attempted suicide, become psychotic, had illegitimate children, or were seriously delinquent, according to reports from parents or other direct evidence. The investigators have indirect evidence that another tenth of the children had similar problems.

Social class was related to serious problems in children of mentally ill mothers but not in children of mentally ill fathers. In working-class families, 44 percent of the children with a mentally ill mother had serious problems, while in middle-class

families, only 9 percent of the patient-mothers' children had such problems. Serious psychological problems and deviance did not occur more frequently in the children of divorced parents than in those whose parents remained married.

Contrary to their expectations, the researchers did not find that serious problems were most prevalent among young adults who were under age 2 when their mothers were first hospitalized. While none of the eight children in working-class families who had been under 2 experienced serious problems growing up, seven in ten who had been 2 to 6 had experienced such problems. Children in these families who were 6 to 12 at the time of the first hospitalization also frequently had problems.

The Children's Accounts

Several researchers who have examined the incidence of mental disorder in the grown children of psychotic patients have concluded that living with the patient made little difference; genetic vulnerability to mental illness seems to be the more powerful influence in bringing on a breakdown in the children. But the stories told by the grown children from several families in Clausen's study poignantly demonstrate that even if living with a mentally ill parent doesn't cause a child to become psychotic in later life, it is nevertheless a stressful way to grow up.

Several of the children mentioned that they had been particularly bothered by their mothers' hallucinations—a mother who talked with someone the child couldn't see, another who couldn't hear her child's questions and comments because she was listening to an unseen voice. One young man related how his younger brother repeatedly became "so bugged" that he'd run away from home. The last time he left the house his mother said, "If you go, I'll kill myself." The brother left despite this coercive threat. And the mother did kill herself.

Two other children who recognized their parents' manipulativeness were greatly annoyed at this "dishonesty." Even recalling such incidents as adults, they could not accept it. One said of his mother, "Like my father hides his liquor, she hides her thoughts." The other was convinced that her father used his symptoms to control her. He became delusional whenever he disapproved of, or was threatened by, something she wanted to do.

The worst memories of childhood came from the young adults whose ill parent had been disabled by symptoms over long periods and whose well parent was abusive or unavailable. One child of a schizophrenic mother and a "hard-drinking, abusive father" reported that, when she gets together with her brothers and sisters, they talk about the "hell" they went through together, and little else. "Such meetings are always followed by nightmares," Clausen and Huffine note. "All of the children in this family appear to suffer from emotional problems." None has received treatment. "Indeed, a daughter reports that no member of the family 'will ever go near a psychiatrist.'"

Some of the young adults recalled being extremely resentful about not being told what was happening, or why certain behavior upset the parent who had been a patient. Clausen interviewed one young woman who was 8 before her mother explained why her father acted in ways she couldn't understand. Her father's initial breakdown came during the McCarthy era. He feared that he would be accused of being a "red." The daughter recalled:

There were many things that were never sayable in this household, and many clothes, many colors, I could never wear in front of [father]. No red, no pink, no purple, no brown. And there were many kinds of jokes that could never be said, and unfortunately I often didn't find out about them until after I had made them. And then my mother would jump down my throat. [Clausen and Huffine 1979, p. 205.]

Several children were old enough at the time of the initial breakdown to feel responsible for it. But many others felt guilty about subsequent breakdowns. The well parents would often control their children's behavior with comments such as, "If you keep this up, he'll end up back in a mental institution."

The Importance of the Well Parent

Clausen and Huffine have evidence from clinical records that a few patients physically abused their children. "One child was brain-damaged when the mother threw it against a wall," the investigators report. The child has remained in a State institution. Another mother, who believed someone was filling the house with poison gas to kill her children, broke windows to let

in fresh air, and then attacked the children with a broom handle.

"On the whole, however, except during episodes when delusions guided their behavior, the patients abused the children less than did some of the spouses, especially husbands who were heavy drinkers," Clausen and Huffine report. In families where the "well" spouse turned to alcohol as a means of coping, "the children have a double burden to bear, and it is our impression that some of these have had the most difficult time emotionally."

In many families, the well parent spent as much time as possible outside the home. The children not only had to cope with the patient's upsets and idiosyncrasies but lacked the support the well parent might have provided in dealing with their own problems of growing up. "In such families," say Clausen and Huffine, "children expressed bitterness toward both parents."

Children whose mothers were mentally ill had particularly difficult times. In the few instances where fathers were supportive and sympathetic, the children were better able to cope with their problems. It was, however, the wives of male patients who most often showed the strength and competence necessary to provide firm regulation and warm support for their children while still coping with the needs and problems of their ill husbands. Children of mentally ill mothers, especially those in the middle class, may sometimes have found support and help with their problems from teachers and friends.

The evidence suggests, say Clausen and Huffine, that children of schizophrenic mothers were more likely to deal with their family problems by turning outside the home for response and intimacy; others rebelled, quit school, then entered the service or drifted. Children of affectively disordered parents were more likely "to throw themselves into their schoolwork," note Clausen and Huffine. "A manic-depressive father might be a terror to live with at some times, but at other times he might be seen as 'a knight in shining armor' to use the words of one of the grown sons we interviewed." Unlike the recurrently symptomatic schizophrenic parents, a depressed or manic parent might function very effectively when not troubled by symptoms.

Whatever else the children of mental patients experienced, they all were profoundly uncertain about what was happening to them. "Conflict and recrimination frequently pervaded the family life space. With no explanation from a trusted caretaker, those children fortunate enough to have siblings seem often to have clung to each other for support and hope," the investigators note.

Many not only survived the ordeal but achieved "a sense of competency and maturity far beyond what would normally be expected at their ages." As with so many other childhood experiences, this achievement was usually possible only where the well parent or another close relative gave the child support. Among working-class families, adolescent daughters sometimes took over the mother's role, caring for younger children and doing the housework and cooking. Some of these daughters took their responsibility in stride and were even, at times, resentful at having to give up their autonomy when their mothers returned. Others, however, felt they had lost their childhood.

Despite "great hardships and uncertainties," many children with close relationships with brothers and sisters and support from their well parents had warm feelings and pleasant memories about their family life. Whichever parent was mentally ill, "children are more likely to retain a warm relationship with the mother," according to Clausen and Huffine. They say that this is especially true of daughters. "Relationships between children and both parents are predominantly warm only in intact families of male patients."

Children of parents who eventually separated were much more likely to leave home permanently before they were 18. Early departures were most frequent in working-class families where the mother was the patient; more than half of these children left before they were 18. The number of children who remained with their parents past 20 is equally impressive, say Clausen and Huffine. It happened most often in intact families. "Several of the most deviant and disturbed of the children" remained past age 18, either because it was convenient to do so, or because they were intensely dependent; some of these dependent young adults were also strongly hostile toward their parents.

The Future

As for the future lives of these children, one aspect that can be predicted is their work careers, which depend largely on their performance in school. Clausen and Huffine note that, in the population at large, social status has been shown to be the "most potent influence" on how well a child does in school. And so it was with the children of mental patients in their study. Among those who were over 18, 78 percent from middle-class homes graduated from high school, while only 55 percent of those from working-class families earned high school diplomas. A few children, mostly from middle-class families, attended college; a few had graduated by the time of followup. Social class was also related to the influence of an intact family on the children's education. Working-class children whose parents separated left school earlier than those whose parents stayed together; this difference was not found in middle-class children.

As in most families in the general population, children of nonschizophrenic parents exceeded their parents' educational attainment. But children of schizophrenic parents reached only the level that their parents had reached. The children of schizophrenics also dropped out of school earlier than did those of nonschizophrenics; this pattern was especially apparent among middle-class children, who would have been expected to continue in school longer.

Clausen and Huffine speculate that growing up with a mentally ill parent may be even more difficult than their evidence suggests. Their data came largely from parents, "who naturally wish to give the best possible account for themselves." The turmoil and trauma the children encountered in these families were probably greater than the parents realized or were willing to recall. It was evident, say Clausen and Huffine, that many of the parents "could not provide role models for competent performance and emotional control."

While Clausen and Huffine were left with no doubt that parental mental illness often impairs a child's normal development, the problems in these families are not unique. As they point out, many families face conflict and disruption, many parents abuse or neglect their children.

While their study leaves many questions unanswered, the evidence that Clausen and Huffine do have attests "as much to

the resilience of the developing child as to the deficits that parental mental illness may entail for the child."

Labeling and Stigma

Most patients in Clausen's study did not suffer serious long-term consequences simply because they had once been labeled *mentally ill*. Nor were their symptoms less serious or more labile before they were recognized as mentally ill. These and other findings tend to discredit a theory that has influenced a good many social scientists in recent years. Offered as an alternative to psychological and psychiatric interpretations of mental illness, "labeling theory" emphasizes social over intrapsychic or biological processes. Labeling theorists assert that social response to deviance not only perpetuates mental illness but causes it in the first place.

Does Labeling Cause Mental Illness?

According to labeling theory, mental illness begins with minor deviations from culturally defined expectations. For one reason or another—organic illness, stress, mischievousness—we all break the small rules governing behavior. These rules are so inconsequential that we take them for granted (making eye contact with someone we're speaking to, for example). When we break the rules, those around us usually just refuse to acknowledge our behavior or find some plausible excuse for it. Most of us stop this "deviance" before it gets us into trouble. But the person destined to be found mentally ill somehow gets caught in the psychiatric net—because those around him get irritated and are sufficiently powerful to force him into treatment, or because the deviance is too publicly visible or troublesome. Once a person is diagnosed as mentally ill, says labeling theorist Thomas J. Scheff, he is "launched on a career" of chronic mental illness.

How this comes about is quite simple in Scheff's formulation. He assumes that, as children, we learn stereotyped imagery of mental illness—the image of craziness—and this view of the mentally ill is reaffirmed as we grow older. The role of mental patient is well-defined and widely recognized. The person so labeled tends to act out the part. He accepts the role because a crisis has made him vulnerable to suggestion. He is encouraged

to continue playing it by being rewarded when he does and punished when he doesn't.

These families rarely saw their members as "crazy." Frequently, a spouse would point out differences between his or her hospitalized mate and other patients who are "really" mentally ill.

Clausen's research discredits this assertion that the label itself causes a person to act in ways expected of the mentally ill. Patients in his study exhibited psychotic symptoms long before their families considered the possibility of mental illness. Their behavior caused the families tremendous conflict. But the families cast about for other explanations for the behavior. "We have overwhelming evidence," Clausen says, "that symptomatology need not be labeled *mental illness* to become stabilized and reach its most florid manifestations."

The "florid manifestations" of symptoms may, however, be fed by the stigma mental patients felt, Clausen says. He and others have pointed out that all societies set the mentally ill apart, assigning them roles that clearly distinguish them from seers and prophets. Modern-day urban America is no exception. At best, social response to the mentally ill is "negative and derogatory," and at worst, "punitive and utterly rejecting." Even to consult a psychiatrist in this society "is to threaten one's public identity as a responsible person." The labeling calls into question the person's ability to control himself and his relationships, according to Clausen. But labeling does not *cause* mental disorders.

Clausen's families rarely saw their members as "crazy," despite the conflict and hostility engendered by the patients' symptoms. The spouses' perceptions of the symptomatic behavior simply did not fit a stereotype of raving madness. And those perceptions did not change once a diagnosis was made. "One frequently finds a spouse pointing out differences between his or her hospitalized mate and other patients who are 'really' mentally ill," say Clausen and Huffine. Patient and family

speak of emotional upset or disorder, or a nervous breakdown, but not *mental* illness or disorder. Instead of collaborating to affirm the stereotype of mental illness, these families tried desperately to deny its presence.

Stigma on the Job,

When the male patients returned home and went back to work, both they and their wives were very much attuned to possible signs of stigma. Few former patients actually experienced it on the job. "Indeed," say Huffine and Clausen, "most men either perceived no change in their relationships with co-workers or found their colleagues to be sympathetic or conciliatory." Only a few felt overt hostility from coworkers. "Apprehension and lack of confidence were common in the early days of return to work, but ability to perform in the job dispelled self-doubts."

Among male patients first hospitalized in the fifties, those who remained free of serious symptoms continued in their work careers without major setbacks. Huffine and Clausen report that nearly half of the schizophrenic men from the fifties' group have been relatively symptom free and have been stably employed at a level equivalent to or higher than that enjoyed before hospitalization.

Men who continued to experience symptoms as the years went by more often were failures on the job. They were also younger than the successful men at the time of their first episode of illness, and they had been symptomatic for longer periods before they entered the hospital. But "even continued symptomatology of significant proportions is not assurance of downward drift" in the work careers of these men.

The most powerful factor that seemed to determine whether a man could continue working and taking on responsibility was his job performance before the breakdown. Those who had established their competence before they were hospitalized stood "a good chance of surviving the ravages of prolonged, even severe symptomatology," according to Huffine and Clausen.

Compared to the husbands of female patients, the former male patients had been on their jobs somewhat longer, held jobs of at least equal status and responsibility, and felt better

about their work; fewer male former patients than husbands of female former patients were unemployed at followup.

One man who has remained as symptomatic as when he was first hospitalized has continued to hold a responsible professional job over the years. He still lives with his paranoid fears. Clausen says that he may be a case of the "old, true paranoid who, operating outside that delusional system, can do whatever he has to do." He does well on the job. He keeps his delusions in check when he's away from home. But the moment he returns, his litany of persecution and abuse resumes. Another patient diagnosed as manic-depressive has, when functioning, been his company's top salesman, Clausen reports. Lithium treatment has kept his symptoms in abeyance in recent years.

Where Labels Count

Huffine and Clausen believe that being labeled mentally ill does not, in and of itself, impair work careers or social relationships. The stereotype of mental illness held by most members of society is so extreme that it rarely fits a real mentally ill person. They cite the work of Walter R. Gove, who has noted that although "the public holds a highly negative stereotype of the mentally ill, there is little evidence of actual discrimination." When an employer and coworkers have known a person for some time before an initial breakdown, the popular notions of what it is to be mentally ill simply do not square with their personal knowledge of this particular person who has been mentally ill.

The stereotype of mental illness held by most members of society is so extreme that it rarely fits a real mentally ill person.

One context where Huffine and Clausen note that the label, *mental illness*, can have a powerful effect is the psychiatric setting. Most of the population is not schooled in what to expect from mental patients and how to interact with them, they say. "Psychiatrists, psychologists, social workers, mental

health researchers; these are people who have learned a pattern of interaction *vis-a-vis* the mental patient." These are the people who can be expected to give undue weight to the status of being a mental patient in interpreting the patient's behavior. "Being a schizophrenic in a hospital is very different from being a nurse or a doctor or even a manic-depressive," they note. Labeling is important, they say, only to the extent that it is taken seriously. "And it's taken seriously by psychiatrists primarily." It is in the hospital or clinic that the course and consequences of mental disorder can be made worse by the label. Wrong diagnosis, premature classification, reified beliefs, together with institutionalization, can cause the patient more problems than the initial symptoms had.

A MODEST PRESCRIPTION

Despite the care John Clausen has taken with his study of the families of mental patients, the research does have limitations. Because minority group members were systematically excluded in both the 1950s and 1970s samples, the study results may not reflect their experience. When he began the study, Clausen was exploring uncharted territory. He wanted the sample of families to be as large as possible without being too large to preclude intensive and prolonged interviewing. The sample also had to be as homogeneous as possible, without the confounding effects of minority status. In addition to these considerations, there were no minority group members on the laboratory's staff to conduct interviews and contribute to the analysis of the data. The same factors, plus Clausen's desire to keep the samples as comparable as possible, made him decide to exclude minority families from the new cohort.

The lack of formal comparison groups also somewhat limits interpretation of a few findings. The children's educational achievements and emotional problems, for example, might be compared to the same characteristics in children with similar backgrounds whose parents did not break down. But such a control group would sharpen the researchers' answers to only one or two questions. Each outcome variable might require a separate control group. Even if it were possible to select a group of "normal" families matched to the patients' families in all respects—and Clausen believes that would be impossible—

the cost of the study would double, while the usefulness of the findings would be increased only slightly. Despite the lack of a formal comparison group, Clausen and Huffine are comparing some of their family data to other research findings, particularly those from the long-term study of normal development that has been going on at Berkeley's Institute of Human Development for half a century. Other comparisons are being made between subgroups of families in the study—schizophrenics vs. nonschizophrenics, bizarre vs. mild symptoms, male patients vs. female patients, old vs. young patients, and middle-class vs. working-class families.

Clausen's study remains among the best—if not *the* best—of its kind done to date. It is possible that, because of the huge amount of time and money that would be required, no better study can be done. Furthermore, it is hard to imagine it possible to find another investigator who could bring to the work Clausen's combination of work habits and personal traits. His scholarship is thorough, his methods rigorous, his attention to details about his subjects unusual, and his patience apparently endless.

"It appears that no one now takes the time to meet with the well spouse and the children, to assess their needs for information and guidance. With all the lip service to community mental health, we find this a distressing state of affairs."

What has Clausen learned about the families of mental patients after all these years? First of all, he's learned that in the face of tremendous difficulty many of these families show resiliency and a tenacious will to make the best of what life has handed them. They learned to cope. Some wives of male patients and some children were especially remarkable in this respect. Second, he has learned of the limited choices that some patients, particularly the women, had available; many of the schizophrenic women seemed especially prone to marrying on

whim, often selecting husbands who were not only unsupportive of them and their children, but cruel as well. Third, he is dismayed by the lack of attention paid to the family even today. "It appears," say Clausen and Huffine, "that no one now takes the time to meet with the well spouse and the children, to assess their needs for information and guidance. With all the lip service to community mental health, we find this a distressing state of affairs."

Clausen believes that few psychiatrists have learned to think in terms of their patients' ongoing social systems. "Too many are preoccupied with narrow aspects of psychodynamics." He thinks psychiatrists should not only take the patient's family into account, but actively involve the spouse in therapy. And they should "drop in on the children and talk with them, to get some feeling for their degree of upset and need for help." In the families that Clausen and his colleagues studied, there was no evidence that such a visit ever occurred.

Many of the patients and families expressed extremely negative views of psychiatry when the interviewers talked with them 15 to 20 years after the first breakdown. They felt that, during the period of crisis, they had no alternative but to depend upon mental health professionals. "Nevertheless," says Clausen, "many of the husbands and wives do not feel that they were really heard." Many felt that, by contrast, the interviewers who had first talked with them for the research project had been sympathetic and had listened well. Clausen thinks the memory of these sympathetic interviews was one reason the families agreed to be interviewed again recently, even when they wished to forget about the crisis that had occurred so many years before.

"Perhaps our research can speak to mental health workers in a way that the husbands and wives of patients feel they have been unable to," says Clausen. He has the impression that there now may be somewhat less tension between the family and hospitals than there was 20 or 25 years ago. The problems that do exist in treatment settings today will be examined in the late stages of Clausen and Huffine's data analysis.

The researchers have a few words of advice to families that might be encountering mental illness for the first time. If one spouse is concerned about the other, he or she should try to discuss the problem and try to convince the troubled partner to

seek help. The couple should shop for a psychiatrist who will agree to see them both and one with whom the disturbed spouse feels comfortable. If the patient sees a psychiatrist as too threatening, a trusted physician should be consulted. And if hospitalization is recommended, the best choice would be the psychiatric service of a general hospital or another, similar facility in the community.

Children should be told as much about what is happening as they can understand. Young children might be told that the hospitalized parent was upset, needed rest for a time, and would be back soon. Older children, who may have witnessed or participated in conflict, need more thorough explanations. If possible, some of the child's own overwhelming experiences might be used as an example of how problems can get the best of people at times. Clausen and Huffine strongly advise *against* telling children that their parent has a physical illness—even using physical illness as an analogy. "At the very least, children should be told that all the screaming and shouting and threats in the home before hospitalization were brought about by emotional upset. The children should be made to understand that they weren't responsible for it."

Children often have the most problems when their parent returns from a hospital stay. Clausen has some doubts about the best way to warn children, or whether to warn them, about conflict that might persist. "Do you suggest to the children that they should act as if nothing has happened? One would hope that they would act as they would if their parent had been in a hospital for a physical illness. But if the parent is still symptomatic, the children must be protected without being alienated." He suggests that the family might have a quiet reunion—just as they might have if someone were coming home from a hospital stay of any other kind. "There's so much apprehension that it's important just to be together and do something."

Clausen thinks that the single most important factor in helping children deal with mental illness—indeed, in keeping the family functioning—is the behavior of the well parent. "If the other parent is so locked in hostile interaction with the patient, then the cost for kids is really tremendous." A warm, sympathetic, and supportive spouse can help a patient, hold a family together, and spare children from the ill effects of mental disorder in a parent. At the moment, it appears that these well

parents get little or no help in meeting such extraordinary demands from mental health treatment teams.

Notes

(1) It was often difficult for Clausen's group to be sure that their original specifications were met. "Some patients, for example, turned out to have had treatment earlier, even though the hospital record showed them as first admissions, and the spouse did not report earlier treatment until we had conducted several interviews," Clausen explains. "This was especially true if the earlier episode had taken place during military service or prior to marriage. Also, occasionally organic conditions were misdiagnosed as severe psychoneurosis or schizophrenia." Some patients were included in the study sample even though they were over 50. And some turned out to have severe drinking problems, even though these were not initially reported as long-term problems. Clausen notes that "since many acutely disturbed patients with functional disorders will go on alcoholic binges, it was sometimes difficult to know whether we were dealing with drinking as a secondary symptom that had recently developed or with patients who had long had problems with alcohol."

(2) Psychiatric diagnoses tend to change with time, location, and purpose. Those made in treatment settings, for example, are less systematically based on explicit criteria than are those made for research purposes, where homogeneous diagnostic groups are important. Dr. Sluzki used diagnostic criteria established in the International Pilot Study of Schizophrenia.

(3) After they were well along with their interviews of the 41 new families, Clausen and Huffine learned that two patients had previously been hospitalized. Data on these two patients' families will be excluded from all analyses of the process of recognizing and defining mental illness. As explained in note 1 above, several patients in the fifties studies were either too old to meet sampling specifications or had eventually been diagnosed as having an acute or chronic organic disorder. The researchers included these patients in their followup to determine at least the patients' present status. The 25 who did not meet sampling requirements were dropped from the analysis of data, however. The proportionately greater number of schizophrenics in the followup sample is largely due to the inclusion of

Sampson and Messinger's sample, made up entirely of schizophrenic women.

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Research Grant: MH 19649

Principal Investigator: John A. Clausen, Ph.D.
Professor of Sociology and Research
Sociologist
Institute of Human Development
1203 Tolman Hall
University of California
Berkeley, California 94720

HEREDITY AND MENTAL ILLNESS

Principal Investigators: David Rosenthal, Ph.D., and Elliot S. Gershon, M.D.

*Author: Herbert Yahraes**

Recent research confirms and extends earlier findings of an important hereditary element in both groups of the most serious mental illnesses—schizophrenia and depression.

Consider schizophrenia:

- The rates of schizophrenia among the parents of schizophrenics have been found by a number of investigators, cited by National Institute of Mental Health psychologist David Rosenthal, to run as high as 12 percent. Among the brothers and sisters of the patients, the rates are somewhat higher. In the general population, the rate is 1 percent.
- When the children of schizophrenic parents are raised by normal foster parents, a greater proportion of them, as compared with foster children whose own parents were not schizophrenic, become schizophrenic, too.
- For identical twins, who have the same genetic inheritance, the chances are about even that if one twin becomes schizophrenic, the other twin will also. When this happens, the twins are said to be concordant for schizophrenia.

Now look at the major depressive illnesses:

*See note at end of chapter.

- A strong genetic element in depression has been documented in numerous studies of depressed persons and their relatives. For instance, Elliot S. Gershon, a National Institute of Mental Health psychiatrist and geneticist, and his associates examined 524 relatives of people in Israel with psychotic depression. Of these relatives, 49 had some form of major depressive illness, as compared to 4 out of 619 normal controls. In other words, there was about 10 times as much depressive illness within families of depressed people as within families that were not depressed. Also, depressed patients had about eight times as many relatives with moderate depression and cyclothymic personality in which periods of depression and elation occur regardless of external circumstances. However, people who tend to be a bit moody and depressed are found no more frequently among the relatives of people with mood disorders than among the relatives of controls.
- If one identical twin has a psychotic depression, the chance that the other twin also has it, or eventually will have it, ranges—varying with the study—from 60 to 90 percent or even higher.

STUDYING HOW HEREDITY WORKS IN SCHIZOPHRENIA

Granted that schizophrenia and depression have a large genetic element, how can it be explained? What mechanisms are involved? And how does one explain the other diseases in what Rosenthal has named the "schizophrenic spectrum"? These include, in addition to the psychosis itself, borderline schizophrenia, paranoia, and schizoid personality disorders, such as oversensitivity, seclusiveness, avoidance of close relationships.

From the standpoint of the number of genes involved, there are two ways of explaining heredity's contribution. One view is the monogenic theory: All the disorders in the schizophrenic spectrum are influenced by a single gene. The extent to which this gene is expressed in a person's behavior depends upon environmental factors. Where there is very severe stress, the genetically predisposed person becomes, according to this theory, schizophrenic. Where the stress is much lighter, he or she becomes the borderline schizophrenic, the paranoid, or the schizoid. Where the stress is still lighter, the person is normal.

If the single gene were dominant, the rate of schizophrenia among the parents and children of schizophrenics—assuming that only one parent carried the gene—would be 50 percent. If the gene was recessive, the rate would be 25 percent. As noted earlier, the actual rate in families where there is schizophrenia is much lower than either of those figures, though much higher than the rate for schizophrenia in the general population. On the basis of studies cited by Rosenthal, the rate among children with one schizophrenic parent is 9.7 percent; among children with two schizophrenic parents, it is almost four times as great—35 percent. If a recessive gene is involved, the latter figure should be 100 percent; if a dominant gene, it should be 75 percent.

... many investigators believe that in an illness as complex as schizophrenia a number of genes must be involved.

(It will be recalled that genes come in pairs, one member of each pair having been contributed by each parent. Assume that the hypothetical gene for schizophrenia is labeled A if dominant and a if recessive and that both parents are schizophrenic. Then, if the gene is dominant, Rosenthal points out, "the parent's mating could be expressed as $Aa \times Aa$, and the offspring would be $1/4 AA$, $1/2 Aa$, and $1/4 aa$. Only the aa children (25 percent) would escape the illness. If schizophrenia was caused by a recessive gene, the parents would be $aa \times aa$ and all their children would also be aa , and all would be expected to develop schizophrenia.")

Such findings do not necessarily negate the single-gene theory. Recall the studies of identical twins. When all the conditions that are apparently related to schizophrenia are taken into account, the concordance rate rises from about 50 percent to about 90 percent.

Nevertheless, many investigators believe that in an illness as complex as schizophrenia a number of genes must be involved. Under their theory, both the apparently normal mother and father who produced a schizophrenic child carry many of the

pathological genes but not enough to be clinically ill themselves; chance combinations of the genes, however, result in various frequencies of the illness among their children.

A parent who is actually schizophrenic carries more of the pathological genes, and the likelihood that his children will inherit enough of them to become sick will be greater. The median rate of schizophrenia among such children is, in fact, almost double the rate for children whose parents, though presumably carriers, are not sick themselves. Chance combinations of the genes could also explain why some children are at risk for schizophrenia itself and others to less severe but related disorders.

Psychiatrist Loren R. Moshier, chief of the NIMH Center for Studies of Schizophrenia, likens the inheritance of schizophrenia to that of height or intelligence. "These are genetically influenced," he explains, "but there is no gene for height and none for intelligence. Multiple genes are involved, and environment has a tremendous influence. You may be predisposed to high intelligence, but if you are raised with poor nutrition and in a poor environment, you may not grow up very smart." He adds: "Madness exists on a continuum, and people who are schizophrenic manifest things that we all have. It is not that schizophrenics differ absolutely but that they have less or more of certain qualities that we all have to some degree."

Under the polygenic theory, a person may inherit all the genes involved in schizophrenia and thus be at risk for a full-fledged psychosis or he or she may inherit only a few of the bad genes and thus be at risk for a lesser disorder. In each case, the trigger that sets off the disorder is assumed to be environmental stress.

Some children with a schizophrenic parent not only remain well but even become outstandingly successful. Jon L. Karlsson, an American pediatrician trained in genetics, studied seven generations of descendants of an Icelandic couple born in 1682. He reported evidence of an apparent association between whatever makes for schizophrenia and whatever makes for outstanding aptitude. This couple had a schizophrenic grandchild, and schizophrenics have appeared in each of the following generations. But many persons of superior quality have also appeared. Karlsson says that, "Individuals so placed in genetic pedigrees that they should be genetic carriers . . . seem not

infrequently to be persons of unusual ability, such as leaders in society or creative persons with performance records suggestive of a superior capacity for creative thinking." In fact, the genes involved in schizophrenia "appear to have a survival value" except when they result in a full-blown psychosis.

Edward F. Foulks, a medical anthropologist, has advanced a similar idea. In view of the worldwide occurrence of schizophrenia, he suggests that, until quite recently, this disorder furthered the course of evolution because schizophrenics had the vision that enabled them to help people cope with social upheavals after traditional methods had failed. As an example, he cites a renowned woman who heard voices—Joan of Arc.

Schizophrenia can be looked upon, Karlsson suggests, "as the price which the human race must pay for its superior members."

The problem with findings like those of the study in Iceland, as Rosenthal points out, is that child production requires two parents. The superior intelligence seen in some offspring of a schizophrenic may indeed be attributable mainly to the genes of the sick parent. But it also may be attributable chiefly to the other parent. Moreover, and most likely, it may arise from some combination of genes from both parents. These last two possibilities have not yet been considered in investigations of the intriguing notion that genius and madness have a common genetic base.

That the higher incidence of schizophrenia is higher among the relatives of patients than among people in general indicates that a vulnerability to this condition can be inherited. Whether or not an inherited disposition leads to the disease depends both upon the extent of the vulnerability and upon the amount of stress encountered by the vulnerable individual.

In the case of mental illness, just what is it that can be inherited? What chemical and physiological processes are involved?

Genes work by controlling biochemicals called enzymes. Enzymes in turn work by controlling the millions of biochemical reactions constantly occurring in the body. For the last few years, many research teams have been paying particular attention to a certain enzyme called "monoamine oxidase," or "MAO."

The function of MAO is to break down one of the chemical substances, called "neurotransmitters," responsible for the transmission of information from cell to cell in the nervous system. The neurotransmitter of interest here is norepinephrine. This brain chemical is closely related to epinephrine, more widely known as adrenaline, the hormone that helps the body respond to stress.

When a message is to be transmitted in the nervous system, norepinephrine (or another neurotransmitter) is released at the terminals of a nerve cell. The chemical enters the space between two cells (called the "synapse") and changes the permeability of the next cell's membrane. This change produces an electrical impulse that leads to the release of a neurotransmitter at the next synapse, thus starting the process all over again. In this fashion, electrical messages are propagated for long distances along thousands of brain cells, without loss of signal. Instead of causing cells to fire, the chemical message may heighten their readiness to fire or may inhibit them from firing. Man's actions and behavior, his emotional state, and his thinking are regulated through the sum total of activity at the synapses.

After the transmitter has done its work, it must be quickly cleared from the synapse to make way for the next message. In the case of norepinephrine, NIMH scientists have shown that the chemical is drawn up again into the nerve terminals, where some of it is stored for future use, *and the rest is broken down by MAO*. In other words, MAO's function is to break down part of the supply of a chemical—one of at least several such compounds—responsible for the transmission of electrical messages from nerve cell to nerve cell in the brain and the rest of the nervous system.

Studies of pairs of identical twins, at least one of whom is schizophrenic, have led to a provocative finding about this chemical. In both schizophrenic and nonschizophrenic identical co-twins, the level of MAO in the blood platelets is lower than in normal controls. (The platelets are tiny protoplasmic elements that assist in the formation of blood clots when needed.) The lower the amount of MAO, the greater the severity of the illness.

A RELATIONSHIP WITH DEPRESSION?

A further provocative finding by NIMH scientists is that MAO levels are also significantly lower than normal in patients with bipolar depression, more commonly known as "manic-depressive illness" (though some patients manifest either mania or depression, but not both). The levels were also significantly lower in the close relatives of these patients—siblings, parents, and children—even among those relatives who apparently were well.

Conceivably, the low level of MAO in the blood platelets of schizophrenic and manic-depressive patients is an indication that something has gone wrong, or may go wrong under certain conditions, at the synaptic junctions between nerve cells—vital elements of man's information system.

Researchers once considered it possible that a low MAO level would prove to be the long-sought biological marker, an abnormality indicating that a person carrying it was either psychotic or very likely to become so. With the discovery that a low level of the enzyme is a widespread characteristic of apparently healthy relatives of patients, this possibility seems to have vanished. In a patient's relatives, though, a low MAO level may serve as an indicator of increased vulnerability to mental illness, a possibility that remains to be studied.

Intriguing research problems now are how and why MAO levels are reduced in people with schizophrenia or manic-depressive illness; what role, if any, MAO plays in these disorders; and how, if at all, these psychoses are related. Adoption, twin, and family studies provide no evidence of a relationship between the two major psychoses, but clinical studies do point to some similarity in their manifestations. Specifically, the symptoms in one stage of mania are often indistinguishable from those of acute schizophrenia. Moreover, the major tranquilizers have antipsychotic properties that are effective not only in many cases of schizophrenia but also in some cases of depression. On the other hand, lithium carbonate, which seems to be a specific for the treatment of manic-depressive illness, is not effective against schizophrenia.

NIMH investigators suggest this possibility: Whatever hereditary element determines the level of platelet, MAO may also determine in part the likelihood that a person will display

some type of psychotic behavior, with other genetic factors determining just which type it will be.

Elliot S. Gershon is one of those investigators who believes that schizophrenia and depression are basically different disorders. Nevertheless, he tells of a man who had an apparently schizophrenic breakdown and with it a change in personality. He became antisocial. He had recurring episodes of psychotic behavior, followed by check forgery and displays of aggression. He seemed to be a classic case of schizophrenic deterioration. Yet he responded to lithium. Moreover, his sister developed mania and depression, and she, too, responded to lithium. Gershon sees the experience of these two as evidence that a person may appear, on the basis of clinical evidence, to have one major type of psychosis, whereas the biological or pharmacological evidence indicates that basically he has the other type.

There do seem to be intermediate forms. A person may have a mixture of symptoms—some depressive, some schizophrenic. Such cases occur in families with schizophrenia and also in families with depression.

There is also the case of a fairly prominent family—in the entertainment field, say—in which either depression or schizophrenia appears in almost every generation. The most recent case is a boy with manic-depressive illness. His parents seem well, but he has an aunt with the same disorder. A woman in the family has a combination of depression and hypomania. One of her sons, though, is a classic schizophrenic. Other cases of schizophrenia have occurred. Does this family carry genes for both schizophrenia and depression? Or are the biological bases of these disorders similar? Our present knowledge is too meager to provide an answer. It is known, though, that members of the family have made a number of consanguineous marriages. The closer the family relationship of the two persons in such marriages, the greater the likelihood that deleterious genes will find expression in their children.

OTHER RESEARCH ON THE BIOCHEMICAL BASIS OF DEPRESSION

In work undertaken more recently than that on MAO, an enzyme known as "catechol-O-methyl transferase" (COMT) has been identified as a possible biological marker. COMT is

responsible for the first step in breaking up biochemicals essential for the transmission of electrical signals throughout the nervous system. Thus, its function is similar to that of MAO, which, as described earlier, has been implicated in the breakdown of one of the neurotransmitters.

Gershon and an associate found that COMT activity was significantly higher in patients with psychotic depression than in normal persons. Usually, it was also significantly higher in patients than in their nondepressed relatives—a finding which seems to stamp it as a better investigatory tool than MAO. Further, COMT activity is inherited, but whether or not the genetic factor is the same as, or closely associated with, the genetic factor in depression is still speculative.

Attempts to define the nature of the genetic predisposition to depressive illness also include the search for "linkage" between the genetic factor and chromosomal markers.

A "chromosome" may be visualized as one long line of genetic information. Each bit of the line is the code for a particular function—not necessarily related to the function of the adjoining bit. Bits are known as *loci* (plural of the Latin *locus*, meaning place). A biological marker is a locus that can be identified at any specific point along the chromosome.

Distances from one locus to another can be mapped by the extent to which inheritance of a characteristic at one locus is associated with inheritance of the characteristic at another locus. For example, if a person with one kind of color blindness turned out to have the same blood type as the rest of his or her relatives who were color blind, the geneticist would infer that color blindness and the blood type apparently associated with it were controlled by loci—actually, by the genes occupying those loci—which were very close together. Either characteristic—blood type or color blindness—would serve as a chromosomal marker, an indication that if one was present the other probably was also. The characteristics would be considered "linked."

In one major type of depressive illness, an association with a type of color blindness has been found. The psychosis is manic-depressive illness, or bipolar depression. Out of 10 manic-depressive men in a recent study, all turned out to be color blind. However, the available information is as yet too slim to say

whether or not the locus for color blindness can serve to identify the location of at least one gene involved in depression.

The locus for the type of color blindness under study is on the sex chromosome *X*. Since a man has only one *X* chromosome (his other sex chromosome being *Y*), any characteristic such as color blindness governed by the *X* chromosome will show up. In a woman, though, the same characteristic may not show up because she has two *X* chromosomes. And the second of these may have, at the same locus as the one for color blindness in the first, a dominant or counterbalancing characteristic. Or it may not have. Researchers must take into account the intriguing fact that more women than men are afflicted by depressive psychosis. The ratio of female to male patients has been found to be almost 3 to 1 in the case of pure depression—known as “unipolar”—and almost 2 to 1 in the case of the bipolar illness. These ratios are compatible with the hypothesis that a disposition to the disorder is indeed transmitted by the sex chromosome *X*, but other findings are not. The difference in prevalence between males and females, NIMH scientists suggest, may turn out to be caused by differences either in environmental conditions or in factors governed by chromosomes other than the sex chromosomes.

An answer to still another question relevant to understanding the strong genetic element in depressive psychosis waits on research: Do the two major forms of psychotic depression—unipolar and bipolar—actually have different bases? There is evidence that they do, since bipolar patients are more likely than unipolar to have afflicted relatives, and since lithium acts more effectively against bipolar illness than against unipolar. Moreover, if one identical twin has one form of depression, the likelihood that the other twin will not only be afflicted but also afflicted with the same type is about 50 percent. Still, a clear-cut diagnosis is sometimes hard to make, and some investigators believe that the two forms are merely different manifestations of the same basic illness, the unipolar form being the less severe.

GETTING ADVICE ON THE ROLE OF HEREDITY

At medical centers genetic counseling is widely available to help prospective parents weigh the chances of producing a child

who may be vulnerable to a serious mental illness. Sometimes, for instance, a couple asks Gershon about the likelihood of their offspring developing a manic-depressive psychosis. If only one of the questioners has that disorder and the family tree of the other is free of major depressive illness, the answer is: "About 10 percent."

The same answer applies for schizophrenia if one of the questioners is schizophrenic but the other is not and is not related to a schizophrenic. In both cases, the child will also be at greater risk than other children for troubles related in some way to schizophrenia, but less serious.

Nongenetic factors, too, must be taken into account. Medicines for the control of manic-depressive psychoses and the less serious forms of depression are considerably more effective than those available at this time for the control of schizophrenia. Moreover, if the schizophrenia is chronic, a normal family life will be just about impossible.

What about amniocentesis, the analysis of the fluid surrounding the embryo in the womb? Many conditions likely to make for abnormality can be thus detected. If a grave abnormality is predicted, an abortion can be requested. And it should become possible to correct some of the diagnosed defects while the child is still in the fetal stage. Despite great advances in our understanding of the psychoses, however, biochemical abnormalities that contribute to them or indicate vulnerability to them have not yet been certainly identified. But investigators are hopeful that one day the enigmas of schizophrenia will yield to scientific efforts.

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* Contract Writer -278-78-0014(SP)

Principal Investigators: Elliot S. Gershon, M.D.

Chief, Section on Psychogenetics
Biological Psychiatry Branch
National Institute of Mental Health
Bethesda, Maryland 20014

David Rosenthal, Ph.D.
Chief, Section on Genetics on Mental
Illness

Laboratory of Psychology and Psycho-
pathology
National Institute of Mental Health
Bethesda, Maryland 20014

POOR FAMILY COMMUNICATION AND SCHIZOPHRENIA

Principal Investigator: Lyman C. Wynne, M.D., Ph.D.

*Author: Herbert Yahraes**

A number of respected investigators believe that a major element in the development of schizophrenia lies in parental behavior, including, in particular, how the father and mother communicate with each other and the children.

Chief among the authorities who stress the importance of family relationships, including both corrective and deviant parental communication, as factors in schizophrenia and its prevention is Lyman C. Wynne, M.D., Ph.D., a professor in the department of psychiatry at the University of Rochester School of Medicine and Dentistry. He was formerly head of the Adult Psychiatry Branch of the National Institute of Mental Health (NIMH), where his research on this subject began in 1954. His principal associate has been Margaret Thaler Singer, a psychologist who is clinical professor of psychiatry in the same department as Wynne's and also a professor in the department of psychiatry at the University of California at San Francisco.

These researchers emphasize the widely accepted view that genetics contribute to the vulnerability, or predisposition, to schizophrenia, but that it does not necessarily produce the disturbing psychiatric symptoms of the illness. The best evidence for this conclusion is that when schizophrenia appears in a pair of identical twins, who have exactly the same heredity, it usually strikes only one twin. If one identical twin develops this psychosis, a number of studies have found, the probability

*See note at end of chapter.

that the co-twin has already become or will become schizophrenic ranges from only a few to about 45 percent. There are a number of conditions considerably less severe than schizophrenia but believed to be related to it. The co-twin who does not become schizophrenic has perhaps a 45 percent chance of developing one of those related afflictions. Something besides heredity appears to be at work.

Oddities in the way parents habitually communicate apparently contribute to increasing the vulnerability of a child already at risk because of his biological heritage.

Wynne and his associates do not believe that family communications alone, even when most seriously disordered, can cause schizophrenic disorders. Rather, they believe that deviant parental communications may lie between the inherited predisposition and whatever is the immediate cause of the schizophrenic breakdown. This immediate triggering cause, the investigators suggest, may be common-life events that have more disastrous effects than usual because the vulnerability has become so high. Loss of a loved one, too much stress at college or at work, or any one of a host of other factors appear to trigger the actual onset. Oddities in the way parents habitually communicate apparently contribute to increasing the vulnerability of a child already at risk because of his biological heritage. Identifying these oddities in the way parents communicate, the Rochester group believes, may prove highly useful in helping to predict the likelihood of schizophrenia in an offspring and also in fostering preventive efforts.

Yale psychiatrist Theodore Lidz, as well as Wynne, Singer, and other investigators, have been reporting for years that parents of schizophrenics, though they have not usually been diagnosed as schizophrenics themselves, usually do possess communication oddities that are difficult to pigeonhole. The Rochester group is attempting to describe these oddities and to discover their effect on offspring. The investigators believe that

a person's form of thinking is related to the way he derives meaning from outside stimuli, such as the black or colored splotches of the Rorschach test, and the way he shares and interprets common foci of attention with others. When parents are abnormal in these respects, the investigators postulate, a child trying to relate to his parents may end up with his thinking and communication processes disturbed—one of the hallmarks of schizophrenia.

The University of Rochester Child and Family Study is designed in part to discover connections between parental characteristics and patterns of family interaction and communications on the one hand and, on the other hand, both competence and maladaptation in the children. The study of communication, which is the subject of this chapter, is only one main aspect of the research.

The researchers first study each parent's communication with a stranger—the person administering a test. Then the researchers study how the parents communicate with each other—for example, when they are asked to reach consensus on the pictures seen in the inkblots of the Rorschach test. Finally, the investigators observe how all family members interact when they work together on such a task.

The 150 families being observed in this longitudinal project—meaning a project that follows its subjects over a period of years in an attempt to identify factors in the earlier years that are related to outcomes later in life—include a group in which one parent has schizophrenia. Children in such families are considered at genetic risk to this mental illness. Another group of families has parents who have suffered from a psychotic depression, and a third group has parents who have had a psychiatric illness requiring hospitalization but have not been psychotic. The child selected for attention in each family is a son who was 4, 7, or 10 years old at the time the family entered the study.

ANALYZING COMMUNICATION

The Rochester team is less interested in *what* a person says than in *how* he goes about saying it. In analyzing communication, the team uses a long transcript of conversation. This may be obtained from a tape recording of a psychological test in

which the only persons present are a parent and one of the investigators. Or it may be a record of both parents trying to reach agreement on a test. Or it may involve the whole family.

From the start of their research, when Wynne was at NIMH, the scientists have used a variety of tests to obtain a record of conversation. These have included the Object Sorting Test, in which a person arranges a variety of objects into groups and explains as he does so why he is assorting them that way—because of their size, their color, their function, or whatever. There is also the Thematic Apperception Test, in which a person looks at pictures on cards and tells what he thinks the characters are doing or thinking. And there is the Rorschach test, in which a person looks at a series of ink blots printed on cards and tells what he sees in them.

None of the transcripts of these tests is regarded in the usual way, as projections of a person's innermost thoughts and emotions, but simply as samples of communication styles, which can be analyzed and oddities noted. Moreover, the transcripts help clarify family relationships.

The investigators consider the Rorschach test, as they employ it, to be especially analogous to what happens in daily life when persons try to establish a shared view of something. As Wynne describes the process, "One person offers a focus of attention, labels what he 'sees' and offers his interpretation to the other. In turn, this person then responds to the offered focus of attention in some way. The Rorschach offers a relatively standardized starting point for sampling to what extent attentional foci and meanings are mutually shared during such a verbal transaction."

Singer puts it this way:

In the transaction with a person administering the individual Rorschach, a subject is asked to say aloud what he thinks each blot looks like. His words can be regarded as the outward, visible products of his attentional processes. First, he has to join the focus offered by the investigator who has proposed the task of telling what he sees in the ink blot; then attend to the images and ideas that come to awareness in his own mind and select appropriate ones to express aloud. . . . Thus, this person's spoken words reflect the orderliness, or lack of it, of his attentional processes as he is using them at that moment. . . . It is assumed . . . that

these samples of attention and language . . . are representative of how a person deploys his attention and uses language in similar labeling and descriptive exchanges with other persons.

Manuals for scoring individual, husband and wife, and family Rorschachs have been developed. In the husband and wife procedure, the spouses are asked to view a Rorschach card together and see how many ideas they can agree upon as to what the card looks like. The procedure is videotaped so that the conversation later can be analyzed. Then their children are invited into the room and are given a second card. In this procedure, known as the family Rorschach, the parents are asked to teach or explain the task to the children, and each person contributes ideas about the inkblot; the ideas are then discussed until the members of the family feel they have reached agreement on as many as they can. Most families find this task absorbing, lively, and fun. The Rochester investigators and others use a variety of other methods also for having families talk together; in one of these, for example, members are asked to plan something they can do together as a family.

Relationships within the family as revealed when members work together on a task are considered more important than oddities in communication style. Nonetheless, 32 categories of communication oddities have been identified that appear in the Rorschach records of parents of schizophrenics significantly more often than in the parents of other psychiatric patients or in the parents of normal persons. The categories fall into the following six main groups or factors:

- Odd, hard-to-follow, ambiguous remarks, such as unintelligible sentences and the peculiar or out-of-context use of ordinary words or phrases.
- Failure to maintain attention to the task, such as forgetting what one has said, hopping around among responses, and interrupting the examiner.
- Unstable perceptions and thinking, such as giving two responses that are incompatible and expressing views with great uncertainty.
- Describing one's own ideas, as well as the whole task, as meaningless or as understandable only in private, idiosyncratic terms.

- Extraneous, illogical, contradictory, or derogatory comments.
- Abstract, indefinite, and wandering vagueness.

One assumption of Wynne and Singer has been that some forms of verbal behavior are strongly influenced by the way the speaker is paying or not paying attention to the subject at hand. Singer reports:

When one person is conversing with another, his remarks reveal aspects of how his attention processes are functioning. To select and arrange his words, he must properly deploy and guide his attention. He must attend to his inner thoughts, keep his listener in mind, handle outer stimuli, and plan ahead to his next remarks. That is, he must deploy his attention to search, select, formulate, and state his ideas. . . .

Many . . . rules of conversation carry the expectation that the listener should be able to attend in regular and predictable ways to what is being said. When a speaker phrases his thoughts in ways that affront such attentional expectancies, his remarks are experienced negatively and a listener, even when he does not comment, is usually bothered or distressed.

These Rochester investigators find two broad types of attentional problems—attentional repetitions and attentional breaks—that can be detected in many parents of schizophrenics.

In one form of attentional repetition, a person seems stuck. He may say: "I uh, I uh, I can't think of anything. Nothing comes to my mind. I just can't think of anything."

In a second type of attentional repetition, the speaker seems unable to drop an idea or a phrase. For example:

A man viewing Rorschach Card IV said: "That looks like a boot. Well you *put your foot* in here. *Your foot*, it fits in there, and it's ok through right that part. Put your foot through the top of the boot. You know what I mean? Just like these boots I got on. *Put your foot* through the top of the boot, slide it in." Here we see the phrase and idea of "put your foot" continuing to intrude into the passage. Such mental processes catch up the speaker's attention, and he is seemingly unable to let go of an idea.

Two other Rochester investigators, in a separate study, have reached the same conclusion. They call this type of dysfunction "the inability to disattend from stimuli."

The second major form of attentional deficit, termed *attention breaks*, occurs when the speaker's words suggest that he "has jumped to another idea without connecting the old idea to what he is now saying." The result is to engender in the listener "a sense of bewilderment because he has not been supplied with the connections" between the ideas expressed. For instance, a young woman's response to a Rorschach card went as follows: ". . . this looks like a part of the southeastern United States coast from side and side, with this being Florida and vaguely this, and the saying that goes: Life is neither black nor white but different shades of grey—which are my sorority colors, excuse me, you know what I'd like to do sometime? Is take all the charts and records and mail them off to a ghost author and get nine-tenths of the property. No, I'll write myself. I want a book that might interest him."

Early in their work with families in which at least one person was schizophrenic, Wynne's group has recalled, the therapists had "singularly different" experiences from those of therapists with families in which another kind of mental disorder was present. Experiences with the schizophrenic families were described as "maddening" and "exhausting." For example:

In a session which was not unusual for this family, the mother of Mary, who was severely schizophrenic and much of the time demurely paranoid, openly dismissed the therapists as lunatics. Her manner was almost disarmingly affectionate, thus both augmenting and obscuring the murderous character of the assault: They were obviously harmless, well meaning and even amiable lunatics, but to take them at all seriously was patently absurd. Both the therapists in this group were men, and the mother had frequently made her position (or something of her position) abundantly clear to anyone who listened to her—a category which seldom included herself—that men were inherently unreliable and abandonment by them was inevitable. Thus, the fact that they were also child-like, ineffectual, and stupid was perhaps less than tragically consequential. It was within the framework of this position, and in the immediate context of the comments about the

lunacy of the therapists that the mother angrily reproached her daughter for "not really wanting to get well," since otherwise she would trust the doctors and confide in them.

The father of this family spent a great deal of time delivering weighty and protracted homilies to his wife and daughter. The tone of his remarks was generally kindly and detached, condescending, and moralistic; their content included pedantic reminders of why they were present, platitudes about maintaining a "positive outlook," injunctions about facing the truth, no matter how unpleasant it might be, and repeated eulogies of the virtues of the analysis of motive and meaning. His decidedly pompous air neatly complemented his wife's uniformly depreciating fondness. He invariably agreed with anything that was said by either of the therapists, and, as invariably, the character of his agreement, as this was reflected in restatement, was—conspicuously outside of his awareness—one of elusive parody, partly in its grave solemnity. He dealt with his daughter's intense distrust by gently lecturing her on the need to rely on others: While it was clear, he said, that untrustworthy persons existed, the majority were decent enough human beings, and her distrust was "just a part of her illness" which she should try to put out of mind. At the same time he maintained a constant vigilance over the therapists, watching them closely during the sessions. He often interrupted his wife, scolding her for having interrupted Mary. He would sometimes sternly reprimand her for failing sincerely to acknowledge the fact that Mary was seriously ill, but otherwise seldom failed to refer to this as anything but "her little nervous trouble."

During one session, Mary launched into a diatribe about her roommate's selfish appropriation of their bathroom and utter lack of consideration for others, which she judged as outrageous. Mary was immediately condemned by her mother for her appalling selfishness "which is not like you" and for "not appreciating that this girl is sick—otherwise why on earth do you imagine that she is in the hospital!" After rudely rebuking his wife for her lack of understanding and sympathy, the father turned to Mary and went on patiently to explain that the other girl was "not very well" and that Mary should really try to be more tolerant.

The transcript is clearly filled with contradictory remarks, but when the therapists called them to the parents' attention, both denied having made them.

Wynne and his coworkers carried out numerous studies in which an investigator, knowing only the results of the tests, would predict whether or not a family contained a young schizophrenic.

PREDICTING UNSEEN WHETHER OR NOT A FAMILY MEMBER HAS SCHIZOPHRENIA

Singer, in particular, scored very well in blindly matching parents and patients. She would first study the transcripts of what the parents had said, while other psychologists were administering tests. Then she would deduce the type of illness suffered by the sick offspring, and also its severity. For instance, of 20 young people who had been diagnosed as schizophrenic, unknown to her, she was right 17 times. Of nine borderline schizophrenics, she was right seven times; of six neurotic patients, four. There was less than 1 chance in 1,000 that her predictions could have been made accidentally.

Then she studied transcripts of the *patients'* tests and predicted to which family each person belonged. She was right 33 times out of 36.

In one study by the Wynne-Singer group three teams separately tested, diagnosed, and scored the communications of 114 families. High scores of communication deviance correctly foretold that 20 pairs of parents would be found in which either one or both had borderline schizophrenia or worse. High scores also correctly identified an additional 24 pairs of parents who had a schizophrenic child even though neither parent was schizophrenic or had an illness related to it. The parents of the schizophrenics, it should be noted, were not totally different from other parents. Rather, they varied along a continuum or dimension so that they overlapped with the parents who had borderline schizophrenic offspring. Moreover, this continuum, related to diagnosis, applied to all members of the families, including those who were not patients. The well siblings, though, had lower scores than the parents. The findings suggest that the family system as a unit is involved.

In another study, the six main factors, summarized earlier, distinguished the parents of schizophrenics from those of borderline schizophrenics, of neurotics, and of normal children. Also, the results for parents of a psychotic child who did not have remissions differed somewhat from those of parents of a psychotic child who did have remissions. The frequency of communication deviations was much the same in one group of parents as in the other. However, the parents of remitting schizophrenics made significantly *more* derogatory, extraneous, illogical, and contradictory remarks than the others. The Wynne group suggests that such parents have communication features which "may be distressing but often are clear enough to permit or even stimulate disagreement. . . ." These parents also had significantly *fewer* instances of failing to sustain the task set. On the other hand, the parents of nonremitting schizophrenics were more vague and ambiguous. Significantly, they were also much more likely to have had a schizophrenic-like illness themselves. This suggests that interaction between a genetic factor and deviant communication can contribute to chronic or nonremitting schizophrenia in the offspring.

Why does usually only one child in a family with deviant parental communication patterns become symptomatically ill? Wynne observes that children in the same family, unless they are identical twins, normally vary widely in their intellectual endowment, temperament, and vulnerability to illness. Additionally, children, partly because of differences in sex and birth order, have different roles in the family. Children's experiences outside the family, as well as physical problems, differ also. Finally, the relationship of each child and the parents differs considerably, partly because of the individual differences already mentioned, partly because parents as well as children change over time, and partly because how each child fulfills or disappoints parental expectations produces great variety in the kinds of relationship and communication. Although Wynne and Singer have shown that brothers and sisters are somewhat more similar to each other in communication styles than they are to children in other families, differences within a family in both vulnerability and actual illness patterns are entirely reasonable and expectable.

HEREDITY AS A FACTOR IN SCHIZOPHRENIA

Many researchers have produced apparently strong evidence of a powerful genetic factor at work in the development of schizophrenia. Wynne believes that an inherited disposition does play a role but not as exclusively as often implied. To throw more light on this question, he and Singer and a coworker, Margaret L. Toohey, recently made a "blind" assessment (meaning that they did not know which parents had a schizophrenic child and which did not) of the transcripts made some years earlier by another group of investigators (psychiatrists Paul H. Wender and Seymour S. Kety, and psychologist David Rosenthal), who hold that heredity is highly important. Three groups of parents had been studied: those with an adopted child who later became schizophrenic; biological parents of a schizophrenic child; and a control group of parents with an adopted child who was normal. Wynne and his associates found that the parents of a schizophrenic, whether the child was their own or had been adopted, all tended to score high in communication deviance. This was not the case with parents in the control group.

The original group of investigators found that the biological parents showed the most severe psychopathology, the parents of adopted children who became schizophrenic showed less, and the control parents the least.

The findings reported in the preceding two paragraphs, Wynne and his associates hold, "are consistent with a gene-environment interaction viewpoint. . . ." In other words, both genetic and environmental factors, acting together, may be essential if schizophrenia is to develop. A child may inherit a gene or genes predisposing to schizophrenia. But the illness may never develop unless some environmental factor interacts with the genetic material. The environmental factor in which the Wynne group is most interested is, of course, family relationships—parental communication styles in particular. Other research suggests that other types of stress may well be the environmental factor in many cases.

Wynne and Singer assume that communication deficits are likely to *predispose* to schizophrenia rather than to precipitate it. Such deficits, they think, increase a person's vulnerability,

brought on by both genetic and other factors. The illness itself may be precipitated by a variety of circumstances.

Vulnerability or predisposition to schizophrenia is defined, in Wynne's words, "as the individual's characteristic threshold beyond which stressful events produce decompensation, manifest in the clinically diagnosable symptom picture."

Like most other investigators, Wynne does believe that heredity plays a strong—and sometimes a central—role in the development of schizophrenia. But, he says:

The genetic components of vulnerability are inevitably shaped from conception onward as the result of transactions of the individual with the psychosocial and physical environments. Furthermore, the transactional point of view implies feedback loops in which the individual modifies the same environment that continues to be formative of his personal qualities. . . . Interchanges or transactions at each developmental phase build upon the outcome of earlier transactions. . . . Constitutional and experiential influences recombine in each developmental phase to create new biological and behavioral potentialities which then help determine the next phase.

This viewpoint implies that prevention and treatment can take place at many stages of development. And it recognizes that the child influences the parent, as well as the other way around.

A person's vulnerability may be either increased or decreased by what Wynne calls "response dispositions," which he thinks are partly inherited. These dispositions include the modulation of attention; the susceptibility to stimulus overload (that is, the relative ability to react healthfully to such stimuli as parental or family discord or to a variety of emotional problems outside the family); and patterns of cognitive and emotional controls, such as degree of impulsivity.

No such factor in itself is probably specific for schizophrenia, Wynne notes, but some or all together "may potentiate, inhibit, or mask the clinical manifestations." As an example, "a high readiness for rage, perhaps inborn, could make schizophrenic breakdown more likely, whereas controls of rage learned in the family environment" could forestall it. Wynne goes so far as to conjecture that the environmental factors may turn out to be the *specific* contributions to schizophrenia. The genetic factors

with which they interact, he suggests, may be *nonspecific*. In any event, he agrees with the general belief among researchers that both heredity and the environment have major roles in the production of this major psychosis.

MAY DISTURBED FAMILY COMMUNICATION BE DUE TO ABNORMALITY IN THE CHILD?

Wynne points out that only longitudinal studies, such as the one his group is conducting at the University of Rochester, can give an answer to what he suspects is probably a chicken vs. egg kind of question. Some critics have argued that the behavior of a preschizophrenic child might be so abnormal as to induce abnormal communication patterns in the parents. And there is some, quite scant, research to suggest that this may indeed be so. For example, Joan Huser Liem, a Harvard Medical School psychologist, used a word game to study communications in 11 families with a schizophrenic son ranging in age from 17 to 25 years and in 11 families with a normal son. In this game, the parents worked together, and the son separately, to describe to a tape recorder a common object or concept. The aim was to make the descriptions so clear that what had been described could be quickly identified when the tape was played. The parents then listened to and responded to tapes made by their own sons, and next—forming artificial families—to tapes made by the schizophrenic and normal sons of strangers. In turn, the sons responded to tapes made by their own parents and by the parents of other young men, either normal or schizophrenic.

As expected, schizophrenic sons showed more disorder in their talk than normal sons and their parents. But the parents of schizophrenics did *not* show more abnormal communication patterns than normal parents and normal sons. Moreover, all parents made more misidentifications in responding to schizophrenics than in responding to normal young men.

The Rochester group comments that the communication disorders studied by Liem were not the same as those studied by Wynne, Singer, and their associates. Also, a study of artificial families cannot sample the longstanding feelings and relationships of natural families. The Liem study does show that people have a hard time understanding psychotic talk.

Wynne also notes that in one of his studies the scores of young schizophrenics on communication deviance, like those of their parents, who were not schizophrenic, were *lower* than the parents' scores. Moreover, Wynne, Singer, and two associates at Rochester analyzed communication deviance in a group of parents of neurotic offspring who were so severely ill that they had to be hospitalized for long periods. Most of the parents of these nonschizophrenics were very upset by the delinquencies and disturbed behavior of their sick offspring; often, in fact, they believed mistakenly that the offspring were schizophrenic. Nevertheless, the parents showed markedly lower scores on communication deviance than the parents of schizophrenics who were housed on the same unit as the neurotics. As Wynne points out, then, psychiatric illness in an offspring is naturally upsetting to parents but apparently does not force them to express themselves deviantly. These findings suggest that it is the parent who is influencing the child, rather than the other way around. However, Wynne emphasizes, nothing can be sure until the returns from the longitudinal studies are in. There are some 20 of these being conducted in the United States, but only a few are concerned with communication deviance as well as with other aspects of family life.

Preliminary findings from one of the investigations that do take into account abnormalities in communicating have recently been reported by psychologists Michael J. Goldstein, Eliot H. Rodnick, and their associates in the University of California at Los Angeles Family Project. This project is studying relationships in the families of emotionally disturbed adolescents seen at an outpatient clinic. The scoring system for communication deviance is based on the one developed by Wynne and Singer. When parents both had about the same number of communication deviations as the parents of a child already diagnosed as schizophrenic, the troubled son of these parents was considered at high risk to schizophrenia.

Five years after the initial tests, the investigators have reported on the psychological health of 23 sons, all 20 or 21 years old at the time of the followup. Five years earlier, they had been troubled but nonpsychotic. Now 11 of them, or almost one-half, were diagnosed either as schizophrenic or as falling within other categories of the schizophrenic spectrum (schizophrenia or milder but related conditions). Moreover, parents

who had high scores in communication deviance were significantly more likely than other parents to have children in the schizophrenic spectrum group at young adulthood.

Still, the investigators report, "We cannot reject the hypothesis that the deviant parental communication styles may have been reactive to the nonpsychotic adolescent psychopathology or to more subtle temperamental characteristics of the adolescent." For a final answer, the researchers agree with Wynne, longitudinal studies starting earlier in life are essential. The Wynne group and a few others are engaged in just such studies.

In a 3-year followup, so far completed for about one-third of their families, the Rochester investigators have found a number of significant effects of family communication patterns. Where these were deviant, as measured in the Rorschach tests of individual parents and of several kinds of interaction of the family as a whole, the children of parents with frequent communication deviations were doing worse in school than other children. The differences in these children were not only in intellectual and academic competence but also in social skills as viewed by their classmates and teachers.

In a few years we should have clearer answers to schizophrenia's predictability, prognosis, and remediability, and to the old question of whether it is the deviant offspring or the deviant parents who make for disordered, "maddening" communication styles in families that eventually produce—for more than one reason, undoubtedly—a schizophrenic offspring.

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Principal Investigator: Lyman C. Wynne, M.D., Ph.D.
School of Medicine
Department of Psychiatry
University of Rochester
300 Crittenden Boulevard
Rochester, New York 14642

LONG-RANGE STUDIES OF CHILDREN AT RISK FOR SCHIZOPHRENIA

*Principal Investigators: Sarnoff A. Mednick, Ph.D., and
Fini Schulsinger, M.D.*

*Author: Herbert Yahraes**

Throughout the world, some 25 or 30 teams of researchers are using a relatively new approach to try to isolate the causes of what is probably the most feared and fearsome of mental illnesses—schizophrenia.

The new approach is longitudinal research—research that follows people for many years, sometimes from birth to middle age or beyond, and tries to observe all the major influences affecting their lives. The eventual goal is to isolate from a host of factors just those responsible for mental illness.

Longitudinal research is costly and difficult, but it offers great hope that some day we shall be able to spot signs early in life of impending trouble and perhaps ward off the threatened disease. Longitudinal studies are in contrast to retrospective research in which the investigator usually has to rely greatly on fallible memories.

The oldest of the long-range studies of schizophrenia, the one with the most findings, began in 1962. Its subjects are Danes at high risk for schizophrenia because they have schizophrenic mothers. This account of it is offered as an indication of the effort required for a comprehensive study on one of the most perplexing problems of mental health, but a problem which—

*See note at end of chapter.

through studies like this and through laboratory research—is beginning to yield its secrets.

Conducting the study are Sarnoff A. Mednick, a well-known American psychologist, and Fini Schulsinger, a well-known Danish psychiatrist. Mednick originally planned to study Detroit children and their parents but found that they probably would be difficult to follow for 20 or 25 years, as planned, because the Detroit population frequently moves. In Denmark, people tend to change residence much less frequently than in the United States. Denmark offers researchers another advantage: The government's excellent population records include information on every person's prenatal and birth situations and subsequent mental and physical health.

Mednick believes that to some extent schizophrenia is an "evasion of life," and that this evasion is learned.

Mednick and his fellow workers began by selecting 200 children whose mothers were schizophrenic. They also selected about 100 controls—children considered at low risk because no family member in three generations had been hospitalized for psychiatric illness. The children in both groups were between 10 and 20 years old when the study began, and none had had a mental breakdown. However, the high-risk children thought less well of themselves, had greater difficulty in making friends, were more tense, sensitive, nervous, and schizoid (a condition marked by shyness, seclusiveness, and, frequently, eccentricity), and had significantly lower IQs. Almost 25 percent of them, compared to 5 percent of the controls, were considered to be poorly adjusted.

According to their teachers, "the high-risk children seemed to react to excitement by withdrawal." The words are those of psychologist Norman Garmezy, who is involved in a longitudinal study himself and has helped to summarize and evaluate such investigations for the National Institute of Mental Health. Further, the high-risk boys, compared with the controls, were more aggressive and interrupted class sessions more often.

"Such findings," Garmezy notes, "are congruent with those of retrospective school record studies of individuals subsequently diagnosed schizophrenic."

A difference in the ways the two groups responded to stress was indicated by the galvanic skin reflex (GSR). The GSR, widely known because it is used in lie-detector tests, is a momentary decrease in the skin's electrical resistance in response to stress. To understand the importance Mednick attaches to this result and to a related finding some years later, let us consider how this investigator views schizophrenia.

Mednick holds that schizophrenia, to a certain extent, is an "evasion of life," and that this evasion is learned. He offers as an example a laboratory rat that is placed in a piece of equipment called a shuttle box.

The rat is first placed in compartment A, and a bell is rung. "Ten seconds later the floor of compartment A is electrified. The rat leaps up, runs around, defecates, urinates, and eventually runs into B and safety. After perhaps 10 trials, the rat will learn to avoid the shock by running into B at the sound of the bell."

What produces this so-called avoidance learning? One obvious and critical factor, answers Mednick, is the shock—and, soon, the bell all by itself—which produces fear. The more fear produced, the faster the rat learns to avoid the pain. Another critical factor is the reward—a reduction of fear—that the rat gets by running into the safe compartment.

The value of that reward or, in psychological terms, "reinforcement," depends both upon its size and the speed of delivery. Under Mednick's hypothesis, this is where the autonomic nervous system comes in, because the speed with which the fear is reduced depends "in large part on the rate at which the autonomic nervous system recovers from a fear state to a normal level. The faster the rate of recovery, the faster the delivery of the reinforcement and the greater the reinforcement."

For a rat that recovers very slowly, Mednick explains, the difference between the shock and the safe compartments will be lessened. So will the rat's reward for jumping from one compartment into the other. However, "if the rat has abnormally fast autonomic recovery, his reinforcement will come abnormally quickly," and he will learn abnormally quickly how

to avoid the pain. Abnormal speed in responding to the danger signal, the bell, and in the recovery of the autonomic nervous system functions, then, "as aptitudes for learning avoidance responses, just as nimble fingers and absolute pitch provide aptitudes for learning to play the violin."

Now, let us consider the human. He or she does not have to run, or move at all, to avoid an anxiety-producing stimulus. A young person or an adult can learn to avoid stress, according to Mednick, simply by thinking thoughts that are not relevant to the anxiety-producing situation. In effect, the irrelevant thoughts will remove that person from stress. The faster a person's recovery system works, the more likely that he or she will feel rewarded for the irrelevant thoughts, and the more likely such thoughts will be elicited the next time the individual faces an anxiety-arousing situation. "Over years, the schizophrenic will learn more and more of these avoidant thoughts." By the time the thinking has become predominantly evasive, "a clinician will be able to note the thought disorder and will diagnose schizophrenia."

In other words, Mednick hypothesizes that, if a person, because of the way his or her autonomic nervous system behaves, responds to anxiety with abnormal speed and to an abnormal degree, and if the system also gets back to normal with abnormal speed, that person will have an aptitude—a predisposition—for learning to avoid anxiety simply by switching into irrelevant thinking. However, the predisposition will cause trouble only "in *response* to unpleasant environments or noxious thoughts." A person who is treated kindly is far less likely to evince distressing overexcitement of the autonomic nervous system "and will have relatively little provocation to learn a massive pattern of avoidant responses." Mednick sums up his idea: "The development of schizophrenia depends then on an interaction of reactive, sensitive, and quickly recovering autonomic nervous systems and unkind environments."

This investigator offers what he considers strong evidence to support his views. The children in the longitudinal study who were at high risk for schizophrenia, it was noted earlier, responded differently to stress, as indicated by the galvanic skin reflex. Two 5-year followups have been made so far, first when the subjects were 20 years old, on the average, and then when they were 25. By the time of the second followup, there had

been two momentous changes. First, eight of the young people in the high-risk group had died, at least four by suicide, but none of the controls, or low-risk group, had died. Second, 13 of the high-risk subjects had developed schizophrenia, and 71 showed evidence of schizoid or paranoid personality disorders or other so-called "borderline states."

In contrast, only one control had developed schizophrenia—and, it was later discovered, this person should not have been included in the control group: Unknown to the investigators was the fact that the mother of this control had been hospitalized for treatment of psychotic episodes before the study began. Moreover, only five persons among the controls had one or another of the borderline conditions; and 30 percent of the controls were judged to be entirely free of any mental disorder, as compared with only 13 percent of the high-risk group.

In electrodermal measures, Mednick and his associates found significant differences between high-risk individuals who had broken down and those who had not, and also between those who had become ill and the controls. The rate at which the autonomic nervous system returned to normal after stress, as measured at the start of the study, predicted "very well" those children who would develop schizophrenia during the next 10 years, particularly those who would have hallucinations, delusions, and thought disorder. The faster the return to normal, the greater was the likelihood of schizophrenia. In a separate study, Mednick and his coworkers have found that this recovery time is significantly influenced by heredity.

In line with the findings of the Mednick group, numerous other studies in the United States, England, and Sweden suggest that heightened psychophysiological responsiveness and fast recovery are important characteristics of chronic, withdrawn schizophrenics. In one of these studies, for example, the stress was the unpleasant effect of a puff of air on the eyeball. The puff was preceded by a warning signal. Schizophrenics learned faster than other people to close an eyelid at that signal and thus to escape the stress. And the schizophrenics whose behaviors were the most withdrawn and avoidant learned the fastest.

A cautionary note is in order. Many investigators question—in the words of research psychologist Garmezy—"the appropriateness of using deviant psychophysiological functioning in children as a criterion of risk." In fact, Mednick's basic hypothesis that a predisposition to schizophrenia is created by an

The mothers of the children who became schizophrenic had developed schizophrenia themselves at a younger age than the other mothers.

autonomic nervous system that is highly reactive to stress is by no means universally accepted. In question are not the findings of the skin-conductance tests but the interpretation of them.

The Mednick team found also that:

- Most of the sick group had been involved in prenatal birth difficulties.
- The mothers of the children who became schizophrenic had developed schizophrenia themselves at a younger age than the other mothers.
- Most of the schizophrenic children, in contrast to the others, had been separated from their parents early in life, mainly because of the mothers' illness.
- The children who became schizophrenic were extremely disturbing in school, easily became angry, and were violent and aggressive.

One finding was surprising, though there have been hints of it in a few other studies: When the investigators grouped their subjects by sex, they found that—for reasons not yet known—*all the results given above applied to males but not to females.* There was one exception: The development of schizophrenia in girls, as in boys, was significantly related to the age of onset of the same illness in the mother—that is, the earlier the mother developed schizophrenia, the more likely it was that her children would develop it, too. In the boys but not in the girls, "this relationship seems to be almost completely explained by the separation from parents which follows the mother's early onset of illness."

Mednick and his associates are also following 200 children in Mauritius, an island country in the Indian Ocean. The children were chosen largely on the basis of their response to the skin

The children with fast recoveries showed not only more anxiety during the testing but also more aggressive and disturbing behavior in the nursery school.

conductance test. More than half of them show a very fast recovery from stress. Half of the children are attending special nursery schools; the others are the controls.

These children were 3 years old when first examined. The children with *slow* electrodermal rates, Mednick reports, were those who did not cry in the laboratory and were less anxious about the testing. The children with fast recoveries showed not only more anxiety during the testing but also more aggressive and disturbing behavior in the nursery school. It will be interesting to see if these, as the research team hypothesizes, are the ones at high risk for schizophrenia.

From the standpoint of activity in the nursery schools, Mednick and his associates find that both groups of children—those with a very fast rate of recovery as well as the others—are functioning essentially well. Children with a very fast recovery rate improve most in attempts to initiate friendly contact. In contrast, those who respond at the average speed improve most in solitary constructive play. These observations make it evident to the researchers that the functioning of the autonomic nervous system, the criterion for selecting the subjects in the study, has some influence on a child's behavior.

In sum, the Mednick group is conducting two long-range investigations. The investigation in Denmark—presently supported by the National Institute of Mental Health and at one time supported by the Foundation for Child Development—has already confirmed that schizophrenia has a strong genetic base and that preschizophrenic boys tend toward violent and other disturbed behaviors in school. Moreover, the research has found evidence that the schizophrenic process in women may differ from that in men; in other words, some of the factors which seem to bear upon the development of the disease in one sex

may differ from those bearing upon it in the other. At first glance, this finding appears to make the researchers' task more complex than ever. But eventually it may help to clarify the role of apparently causative circumstances.

Because schizophrenia strikes in adolescence or later, the Mauritius study may have no important findings for another dozen years. However, it is among the newest of the longitudinal studies on schizophrenia, which, taken together, constitute a giant step toward understanding this mental health enigma.

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* Contract Writer -278-78-0014(SP)

Principal Investigators: Sarnoff A. Mednick, Ph.D.

Professor of Psychology
Social Science Research Institute
University of Southern California
Los Angeles, California 90007, and
Director, Psykologisk Institut
Kommune Hospitalet
1399 Copenhagen K, Denmark

Fini Schulsinger, M.D.
Co-Director, Psykologisk Institut
Kommune Hospitalet
1399 Copenhagen K, Denmark

DETECTION AND PREVENTION OF CHILDHOOD DEPRESSION

*Principal Investigators: Leon Cytryn, M.D., and Donald
H. McKnew, Jr., M.D.*

*Author: Herbert Yahraes**

"I am the biggest troublemaker in my family," said a worried-looking 10-year-old girl. "I cry a lot and feel weird a lot."

Between spells of crying, a 12-year-old boy said, "I think I am the stupidest kid in class I never really try to kill myself, but sometimes I think to drown myself."

A dejected 8-year-old girl declared: "I feel ugly and like a dumbbell Sometimes I would like to kill my friends or my own stomach or arm Friends make fun of me all the time."

These children were talking to child psychiatrists at the National Institute of Mental Health (NIMH). Although none of these children was psychotic, all had high depression scores, as derived from two scales designed to measure depressive symptoms in children. The subjects were among the 30 children or grandchildren of 14 consecutive patients recently admitted to NIMH for observation and treatment of a depressive psychosis. The children were between the ages of 4 and 15. Of the 30 child subjects, more than half were considered "overtly depressed" at the time of the interview.

A considerably lower rate of childhood depression had been reported by earlier investigators—perhaps, according to the NIMH team, because the earlier workers either did not get to know the children or else either did not realize or agree that

*See note at end of chapter.

the symptoms of childhood depression might be less marked than, or even different from, those of adult depression. At any one time, various studies indicate, as many as 20 children in 100 may be suffering from symptoms of depression. Just how many suffer from a formal clinical disorder is, however, open to question. Though the incidence of this disorder used to increase steadily with age, as a recent report points out, "the growing rate of depression in the young has brought about a peak period in youth that outstrips middle age and is exceeded only by the elderly."

MASKED DEPRESSION

Child psychiatrists Leon Cytryn and Donald H. McKnew, Jr., who were two leading members of the NIMH investigatory team, agree with Dr. William E. Bunney, Jr., Chief of the Adult Psychiatry Branch, NIMH, that many children diagnosed as hyperactive may actually be depressed. Certainly, they report, among children with *masked depression*, which is the commonest childhood type in these investigators' experiences, hyperactivity is common. This type of depression may also be masked by school problems, delinquency, and either behavior or psychosomatic disorders. Every once in a while, though, such children are likely to actually look or act depressed. The investigators arrived at their diagnosis when they discovered that many children who were not obviously depressed nevertheless manifested in their dreams and fantasies the same depressive elements—such as frustration, despair, and hopelessness—as those shown by the clearly depressed children.

To gently remove the mask and get at the underlying trouble, these child psychiatrists, who work not only with the NIMH group but also at George Washington University Medical School and at Children's Hospital, Washington, D.C., use several measures. One is a psychiatric interview which notes any background of depressive signs—such as sadness, despair, feelings of hopelessness or helplessness, and thoughts of suicide. The investigators also evaluate what the child thinks of himself; that is, his self-esteem. And they elicit "fantasy material" by having the children make up stories, interpret pictures, and recount their dreams.

As an example of masked depression, these authorities tell about Albert, a 12-year-old boy, who had been sent to them because of his disruptive behavior in school. He was aggressive and hyperactive. His grades were poor and his social adjustment marginal. A look at the home situation suggested two

. . . many children who have a behavior problem may be basically depressed.

major probable causes: The mother held a full-time job, was usually unavailable to her children, and had once been investigated for child abuse; the father was an alcoholic who assumed no responsibility for the family and who frequently beat Albert. In sum, the child, like many others with a similar condition, had experienced both rejection and depreciation.

Throughout the interview, Albert was apathetic and sad. "He described himself as dumb, as the laughingstock of his schoolmates, and expressed the belief that everyone was picking on him." He saw himself as inadequate and helpless. "On the fantasy level the boy showed a strong preoccupation with themes of annihilation, violence, explosions, and death, invariably with a bad outcome for the main figures . . ."

Albert did not improve. In fact, 1 1/2 years later he was sent to a residential school for delinquent boys. The investigators suggest that the boy's delinquency and aggressiveness were attempts to escape from a basic depression. They admit that such a defense is self-destructive, but "it helps ward off the unbearable feeling of despair" and, on the basis of the newest evidence, seems to be far commoner than most of us think. In other words, many children who have a behavior problem may be basically depressed.

If a child is marked by hyperactivity, delinquency or other behavior disorders, school difficulties, or psychosomatic complaints, Cytryn and McKnew believe it would be a good idea to have him or her checked for depression.

The family members of the children with a masked depression, report these investigators, "often presented a picture of disorganization and severe psychopathology, usually in the form of a character defect, but gave no history of a clear-cut depressive illness."

ACUTE DEPRESSIVE ILLNESS

In addition to masked depression, Cytryn and McKnew have found two other types of depression among children: *acute* and *chronic*.

In the *acute* type, there always seemed to be a clear cause, usually the loss of a beloved relative or someone else very close. Though the loved one had died in some cases, usually he or she—for any one of a variety of reasons, such as personal problems or a move—had simply reduced or cut off the love and care that the child had been counting upon and the loss of which was seen as rejection. In the case of 6-year-old Beatrice, the precipitating cause was traced to the rape of an older sister, 17, who had been serving as a mother substitute because the mother herself worked full time outside the home. "After the incident the sister became withdrawn, preoccupied, and less attentive," and within 3 months young Beatrice was admitted to a psychiatric ward because she had gradually withdrawn from activities, was failing in school, slept poorly, and lacked appetite. "Her mood," the psychiatrists report, "was markedly depressed, as evidenced by a sad and tearful facial expression, slowness of movement, monotone voice, and verbal expressions indicating hopelessness and despair."

After several days of hospital care and attention, but with no specific treatment for depression, Beatrice "became outgoing and started to eat and sleep regularly, her mood brightened, and she was sociable, active, and alert . . ." Two years later the mother reported that the girl was still maintaining her gains.

Interestingly, Cytryn and McKnew report that such improvement, "despite the absence of any formal treatment program," has been "almost universal" in cases of acute childhood depression, such as Beatrice's. They suspect that it occurs because the child has been removed from one or more noxious environmental circumstances, "coupled with the rallying of the family around the child who is labeled ill because of the hospitalization." Many such children, whether or not they had availed themselves of followup psychotherapy, were found to "have maintained their improvement, initiated during a brief hospital stay, even after 5 years.

CHRONIC DEPRESSIVE ILLNESS

Children afflicted with the third type of depression, *chronic*, report Cytryn and McKnew, differ from the others in these major respects: They have a chronically depressed parent, evidence that a genetic element is probably at play; they have been separated several times, from infancy on, from persons they had counted upon, evidence of an environmental force; and no single precipitating incident can be found.

Consider Caroline, who was referred to Cytryn and McKnew as an emergency case at the age of 7. She couldn't sleep, couldn't eat, and for several months had had screaming episodes. She had often threatened suicide because she was "a bad girl" and nobody loved her. Part of the problem was the girl's mother, a helpless woman overwhelmed by family responsibilities, poor self-esteem, a tendency toward frequent depressions, and who had conceived Caroline out of wedlock. "Her subsequent marriage was stormy, Caroline's stepfather had beaten the child severely; then he and his wife had separated, but only for a while."

The trouble may have started many years before Caroline was born. For there is evidence that her mother, as a child, had been neglected by her own mother and been brought up in an atmosphere of violence. Evidence has been found that a condition which might be mildly described as "poor parenting" often is passed on from generation to generation, particularly in the case of child abuse. The abusing parent, investigators often have shown, is frequently the individual who was abused himself, or herself, as a child. Some children who were physically assaulted or otherwise maltreated as youngsters manage as adults nevertheless to become good parents; many others do not.

One of the most important persons in Caroline's life as an infant had been her paternal grandmother, but suddenly, when Caroline was 1 year old, her chief care had been shifted to a maternal aunt. The mother herself, when Caroline was 1 1/2 years old and again when she was 4, had left her for several months.

After Caroline had been discharged from the hospital, she again "became depressed and developed abdominal cramps and

diarrhea. When the mother again separated from the stepfather, these symptoms rapidly disappeared."

TWO FORCES: HEREDITY AND PARENTAL BEHAVIOR

In their observation of many children having at least one manic-depressive parent, Cytryn and McKnew found that more than 50 percent of the offspring were at least moderately depressed when interviewed—usually overtly so. Environmental forces were undoubtedly at work, because the shifting moods of the bipolar patient lead to "a sense of uncertainty and bewilderment on the part of the child."

Research by other investigators demonstrates that hereditary forces were probably heavily involved, too. Among the general population, the incidence of manic-depressive psychosis has been estimated at less than .1 percent; among close relatives of manic-depressives, it hovers around 10 percent. Further, studies of identical twins have shown that, if one twin has this condition, the likelihood that the other twin also has it ranges from 50 to 100 percent. All of which is to say that the strength of the genetic element has been demonstrated but is not, usually, the whole story. Obviously, in addition to heredity, the parent-child relationship is of prime importance.

Cytryn and McKnew found that many of their parents had "suffered rejection and depreciation by their parents or loved ones either all during their lives or at least over a period of many years." Such rejection may take many forms: blunt statements stressing the child's inadequacy; attitudes and actions that indicate a lack of respect or caring; a constant barrage of criticism and humiliation. Sometimes there was no frank rejection or depreciation, just "a void in the parent-child relationship." The investigators say that the parents "may or may not be consciously aware of their behavior." They say, too, that "depreciation of the child can be shown through overprotection as well as through rejection; both attitudes convey the basic message of the child's inadequacy and worthlessness." Conceivably, the child's depressive outlook is caused either by "identification with this negative view of himself" or "by a sense of alienation from important love objects," or by both.

Studies in Denmark strongly suggest that the relative importance of the two factors can be readily assessed. In children

who are at risk for psychosis because they may have inherited a predisposition for it, the genetic factor, rather than the quality of the parent-child relationship, is of primary importance. When there is no reason to suspect a genetic factor, however, the quality of the child's mental health seems to be strongly influenced by that of the parent-child relationship.

DETECTING CHILDHOOD DEPRESSION EARLY

Indications of depression in children—particularly when something has gone wrong at home, playground, or school—are quite common, as Cytryn and McKnew point out. Usually, though, they do not last long. The problem is judged to be depressive illness when it continues for at least several months “and is associated with severe impairment of the child's scholastic and social adjustment and with disturbances” in eating and sleeping. “In more serious cases the child's thinking is affected by feelings of despair and hopelessness, general retardation, and, in the severe form, by suicidal thoughts.”

In the best position to detect early indications of childhood depression, these investigators say, is the pediatrician or the family physician. Each knows the family's history and the parent-child relationship “and can observe the child directly for any sign of depressive mood and behavior.” Also in a strategic position is the school or child guidance clinic.

The doctor's role may be particularly valuable in suspected cases of masked depression, “in which the child is usually regarded by the family [and often by the school] as delinquent or lazy.” The doctor may try to investigate the case himself “through the use of simple playroom techniques which will elicit fantasy material in drawings, dreams, or selected projective tests or he may . . . refer the child to a psychiatrist. In either case, if the suspicion of a masked depressive reaction is confirmed, the all-too-frequent mishandling of such cases will have been avoided.”

Any person evaluating or treating a depressed parent, Cytryn and McKnew advise, should “inquire about the emotional status of the patient's children” Conversely, all child psychiatrists, when seeing depressed children, “should consider that a similar disorder may exist in the parents and siblings.”

TREATING DEPRESSED CHILDREN

When the child is younger than 8 years old, and when the illness has not been very severe or of long duration, Cytryn and McKnew select parental counseling as "usually the treatment of choice." Through such counseling an attempt is made to change parental or other family practices, including depreciation of the child and preventable losses of loved adults, which are damaging to the child's feeling of self-worth. Otherwise these authorities advise family therapy, which includes the affected child, often coupled with individual psychotherapy for the young patient. Where the child has lost a major loved one, "the family needs help and guidance in providing adequate substitutes either from its own ranks or from outside resources. Where there have been frequent early losses, the family is encouraged to help compensate by increased involvement with the child."

These psychiatrists point out that many families, particularly those in which a child has a masked depression, "respond better to direct guidance and emotional support" than to the traditional interpretive and nondirective form of psychotherapy. "Of course," they add, "there are situations where traditional psychiatric intervention of any kind is not feasible. In such cases, the psychiatrist may have to collaborate with community resources such as juvenile court, halfway houses, foster homes, and even the police."

In adults, a wide variety of antidepressive drugs—including lithium carbonate, which is virtually a specific for treating manic-depressive, or bipolar, illness and then for preventing or markedly reducing the frequency and intensity of future attacks—have been proved efficacious. Bipolar illness is rare in children, so lithium is rarely used with them. The other antidepressives are being more widely used, but no comprehensive evaluation has been made of their effectiveness. However, in laboratory work with Rhesus monkey babies that had reached the stage of despair (retreating to a corner of the cage, ceasing to vocalize, and refusing food and water), antidepressant drugs have been shown to reverse the symptoms.

Another major question for research, in addition to the effectiveness of antidepressant medication in youngsters, is whether

or not childhood depression leads, or predisposes, to adult depression.

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Principal Investigators: Leon Cytryn, M.D.

Donald H. McKnew, Jr., M.D.

Unit on Childhood Mental Illness

Biological Psychiatry Branch

Division of Clinical and Behavioral Research

National Institute of Mental Health

Bethesda, Maryland 20004.

NEW LIGHT ON AUTISM AND OTHER PUZZLING DISORDERS OF CHILDHOOD

Principal Investigator: Donald J. Cohen, M.D.

*Author: Herbert Yahraes**

Micky at birth weighed almost 8 pounds and appeared to be perfectly healthy, yet he showed no pleasure when held by his parents and did not respond to their smiles or other shows of affection. His motor development was normal, and he walked when he was 16 months old. But he never babbled. When he was 18 months old, he said something that sounded like "no"; it was his first and last word. By the time he was 2 1/2 years old, he was completely uninterested in social relations and totally unconcerned by separation from his parents. During the next few years he remained easily distracted and very hyperactive. He was either extremely anxious or extremely lethargic. He also swung between periods of aggression directed at himself and periods of aggression directed at others.

At 7 1/2, Micky was attractive and bright eyed, but his only attempts at communication were "whining to his mother to indicate hunger" and aggressive lunges toward the medical staff of the hospital where he had been taken for treatment. The doctors could find no specific neurological or biochemical abnormalities. They prescribed one of the phenothiazine drugs commonly used against schizophrenia. For a while he improved, showing decreased activity and increased social relations, "and for the first time he was able to follow simple instructions." After 4 months, though, he lost these gains, and

*See note at end of chapter.

"even with manipulation of the medication, there was no way of reducing his activity and destructiveness." Because life was becoming harder and harder for his family, Micky was admitted to a residential treatment institution.

During the first 4 months in the school, he made educational and social gains. Then, again, at age 8 1/2 years, he had another radical mood shift, which left him uncontrollable, banging his head all day, and bruising himself. During this time, he seemed uncontrollable, and at times he required restraints to prevent him from hurting himself. He then had another shift, and he would sit for hours, holding a nurse's hand, apparently in great distress and muttering "uh, uh." He pulled his hair, leaving wide areas of baldness. A detailed neurological and metabolic evaluation was performed, revealing him to be thinner, more distressed, and even more socially unresponsive than he had been 1 year before, but otherwise with no indications of any central-nervous-system disturbance.

Micky suffers from "primary childhood autism." His story is told by child psychiatrist Donald J. Cohen, Associate Professor of Pediatrics, Psychiatry, and Psychology at the Yale University School of Medicine and Child Study Center. Cohen, who is also Psychiatric Director of the Children's Clinical Research Center, Yale University School of Medicine, is one of the country's leading authorities on autism and several other neuropsychiatric disorders of children which are discussed in this article. Although these disorders still have many puzzling aspects, authorities such as Cohen are making progress in distinguishing one from the other, elucidating subgroups, getting at the basic causes, and testing drugs and other forms of treatment.

In addition to Micky's classical or primary autism, there is a condition known as "secondary childhood autism." Development and behavior in this type may be almost the same as in the other, but the trouble seems to be secondary to recognized disturbances, such as brain damage associated with measles or with lead poisoning, inborn errors of metabolism, and a type of blindness (retrolental fibroplasia) sometimes following the administration of too much oxygen to premature infants at birth.

One child out of every 3,000 has autism. The condition may be noticeable from the very start. The child's attention may fade in and out. He is likely to be uncomfortable when held. He

may cry almost without let up, or he may seem unusually quiet. Around the age of 1, his main occupation may be looking at his fingers or banging his head against the crib—for hours—or he may become occupied with one toy and reject everything else.

Research concerning autistic and other developmentally disabled children requires an integrated team of experts with special competencies and interests. The core research team at the Yale Child Study Center working with Cohen includes a developmental psychologist and educator, Barbara Caparulo; a research child psychiatrist, Dr. J. Gerald Young; and other research associates. They work in collaboration with other clinical investigators—Dr. Bennett Shaywitz, a pediatric neurologist who heads the section on pediatric neurology at Yale; Dr. Myron Genel, the chief of the section on pediatric endocrinology; and Dr. Julian Ferholt, a child psychiatrist who specializes in psychosomatic disorders of early childhood. In addition, neuroradiologists, pharmacologists, psychologists, and human geneticists join in collaborative research projects which no one could undertake alone.

Biologically oriented clinical research with children is expensive. During research hospitalization, disturbed children require private nursing care and the almost full-time attention of a researcher. Specialized tests and laboratory procedures may cost hundreds of dollars. Thus, a several-day research study of one autistic child may cost over \$1,500 in time, laboratory studies, and hospital costs. The research of the Cohen group is funded by several sources, both public and private. The Children's Clinical Research Center is supported by the Division of Research Resources, National Institutes of Health. A special Mental Health Clinical Research Center will be opened as the result of a 1977 award from the National Institute of Mental Health; co-directors will be Cohen and psychiatrist Malcolm Bowers. Private foundations, such as the William T. Grant Foundation and the Ford Foundation, have funded certain aspects of the research. Most gratifying, according to Cohen, has been the support of private donors whose involvement in the research stems from being parents of children who have the disabilities being investigated.

THE SADDEST DISEASE

Of all the afflictions of childhood, primary autism may well be the saddest because its core symptom, in Cohen's words, is "the inability to relate to people and social situations in a normal way." Even to the mother, the autistic infant may respond no more warmly than to a piece of string or a flashlight. This inability is accompanied by aloofness, inaccessibility, and lack of interest "which superficially may resemble the picture presented by the most severely mentally retarded child. However, the autistic child's usually normal developmental landmarks and relatively normal physical development differentiate this type of disorder from mental subnormality."

Yet some autistic children display amazing word recognition skills. They can read very well, and they can also repeat complex sentences read to them. They cannot explain, however, what they have read or heard. "Autistic children," Caparulo and Cohen report, "are notorious for their abilities to repeat strings of sentences, to remember routes to places months or years after first being exposed to them, to notice changes in the placement of furniture or the presence or absence of toys in an office, and to remember dates and numbers . . ." What seems to be impaired "is the *significance* or *meaning* of the objects, events, and people, and relations among them, reflected in the written or aural communication." Examination usually uncovers nothing neurologically wrong.

For many years, as even occasionally today, autism was laid at the parents' feet. Fathers and mothers were judged to be cold, to show little more than a polite interest in their child, to be incapable of extending love. Many parents—in particular, many mothers—grieved for years because of the surmises of child experts.

Cohen puts it this way: "The hope during the 1940s and 1950s that one would find parents to blame was both mean and, yet, optimistic. If autism could be caused by parental feelings and action, we would have a much greater sense of conviction in the power of environmental provision and optimism about what could be potentially undone. Today, however, parents of autistic children are considered to be like the parents of other handicapped children whose care poses inhuman burdens. Parents are usually unhappy, worried, angry, discouraged, and

exhausted. But they are not, as a group, unconcerned or unloving." Many of the parents of the autistic children studied by Cohen keep their children home rather than send them to a residential treatment facility. And for these parents, "marital strife, separation, and divorce are almost expected outcomes," because an autistic child places an "impossible stress" on a marriage.

Instead of environment, congenital endowment may somehow be playing a hand. A number of investigators, including Cohen's group, have found a "relatively high incidence of depression, language difficulties, severe psychological disturbances, and anxiety or eccentricity in the blood relatives of autistic children."

Notions about the root of the trouble are beginning to accumulate, and these have nothing to do with relationships within the family. One basic problem appears to be the autistic child's inability to generate rules for dealing with information received through the senses—or even to understand these rules when they are explained. Caparulo and Cohen, for example, have studied a bright, autistic 10-year-old who liked to draw a popular restaurant over and over again. His drawings were accurate; obviously he had a sense of size. Yet, when he was asked to arrange eight geometric shapes according to size, he was baffled. In other words, he could draw a building according to scale, but he could not understand the concept of smaller and larger.

In some autistic children, another problem seems to be an abnormality or dysfunction in the body's system for regulating the state of arousal and attention. For example, the rate at which the heart works and the blood flows usually changes as states of attention change. But Cohen and an associate found that in the most disturbed children such rates did not follow the normal pattern. Such children apparently were actually rejecting sensory messages that in other children led to higher levels of arousal. Cohen believes that such rejection is not voluntary but is caused by some abnormality in the ability to process external stimuli. Recent work in the laboratories of Cohen and other investigators suggests that the most disturbed of the children may be almost habitually in a state of hypervigilance. Such a state "may be associated with recurrent cogni-

tive confusion and a compensatory withdrawal and turning inward of attention to avoid environmental bombardment."

Far from trying to be contrary or to cause pain and grief, the autistic child, impaired cognitively and attentionally, may be simply trying "to impose order on his world." Many of his symptoms, the Yale investigators point out, "may be seen as compensatory mechanisms." As one 16-year-old movingly explained: "I am sad about my body, but it's no good to be sad. You should try to make jokes when you're feeling sad."

Some aspects of autism, Cohen speculates, may be associated with overactivity of the dopamine system. Dopamine is one of the so-called "biogenic amines" essential for proper brain functioning. It is, in fact, a neurotransmitter. Like other neurotransmitters, each apparently acting in its own portion or portions of the central nervous system, it carries from one nerve cell to another, at an unbelievable speed, the electrical signals propagated in the brain. A transmitter serves in effect as a bridge over the synapses, or the tiny clefts between nerve cells.

Cohen notes that drugs, such as haloperidol and phenothiazines, which inhibit dopamine action, have therapeutic value in some cases of autism, while drugs such as the stimulant, dextroamphetamine, which increases that action, exacerbate the symptoms. Moreover, in the cerebrospinal fluid of severely autistic children, he has found greater quantities of dopamine breakdown products. This discovery suggests that in these children an excess amount of this brain chemical is being manufactured and broken down. Its release and catabolism have been shown to be greatly affected by stress. It may well be that, as seems to be the case in schizophrenia and depression, in autism a disturbance in the neurotransmission system may help cause the stress, instead of the other way around. However, as Cohen is the first to point out, a great deal of research by a number of investigators will be needed to establish the truth or falsity of these and related ideas.

Nonetheless, the recent discovery by other scientists of two groups of neurotransmitters quite different from those found earlier seems only to strengthen the transmitters' importance to mental health. The new groups have been named the "enkephalins" and the "endorphins." Chemically, they are peptides, or combinations of amino acids, which in turn are the building blocks of protein. Cohen and J. Gerald Young point out that

the newly found compounds affect the processing of sensory and emotional signals and "may be involved in modulating pain and pleasure." They have wide implications for understanding and treating a variety of mental illnesses. Among the subjects to be investigated, or re-investigated, as the result of the new findings, these researchers list "the turning away from sensory stimulation and the unusual sensitivities of some autistic children," the hypervigilance of psychotics, the inability of clinically depressed persons to experience pleasure, and the nature of drug dependency.

Other investigators have found that one of the main hormones, triiodothyronine, produced by the thyroid gland, makes for improvement in some cases of autism. Cohen's group, in turn, finds that some autistic children show marked swings—ranging from *hypothyroid* to the *hyperthyroid* level in a few days—in the amount of thyroxine, another principal thyroid hormone. Because of these and earlier findings, Cohen and other researchers are studying the way in which thyroid hormones affect the metabolism of brain neurotransmitters.

One role of thyroid hormone, Cohen suggests, may be to sensitize neurons to the effect of the various transmitting agents. When the flow of thyroid hormones is reduced for some reason, the brain tries to maintain a steady state by increasing their production and use. On the other hand, when these compounds are produced too rapidly, the brain signals the thyroid to ease up.

The marked swings of a thyroid hormone noted in severely autistic children may go hand in hand, under this hypothesis, with broad swings in behavior. Thus the effectiveness of thyroid medication may be related to its "dampening of fluctuations."

Another factor apparently at work in at least some cases of autism is a higher-than-average amount of lead in the blood, which even in normal children can lead to disordered behavior such as irritability and lessened attention. The Yale investigators found these higher levels—in some cases well above the toxic mark—among autistic children as a group. Presumably they arise because many such children take into their mouths a wide variety of inedible material, some of it containing lead. The lesson is that autistic children should be tested for the

presence of lead in the bloodstream, though they rarely are. Lead does not cause autism, but it can add to the problems.

What happens to autistic children as they grow into adolescence and then adulthood? Most of them remain in institutions or are placed there. Cohen and his fellow workers report the feelings of a devoted mother, who had spent every day with her son during his first 17 years, when she first brought him to a residential center. "I knew that as soon as I brought him there," she said, "he would be as happy as he was at home. He didn't seem to miss me for a minute." But Cohen estimates that there are a "fortunate 10 to 15 percent of older autistic individuals with language abilities and improved social relations who may seem merely odd, eccentric, or very immature." In social situations, their behavior:

. . . usually lacks spontaneity and reflects the hard work they and their parents and teachers have put into education. They must be taught social conventions, for example, how to say "fine, thank you," instead of honestly responding with a discussion of their daily lives when they are asked how they are doing.

In school, such autistic individuals may show areas of high intellectual ability and may learn to read well, yet their comprehension may be relatively limited, and the information they acquire may be of very questionable value. The older autistic individual's speech usually remains deliberate and stiff

In spite of major improvements, these older individuals remain anxious and perhaps depressed as they recognize their limitations; they may have odd mannerisms or flapping behavior, especially when they are upset or excited, and they may be unable to engage in imaginative activities or work or play in a mutually meaningful way with others.

For the less fortunate autistic child whose language does not progress, behavior during the school age and adolescent years remains clearly continuous with that of the preschool years. His overactive behavior may decrease with training but his ability to communicate . . . or relate with peers or adults may be extremely limited.

CHILDHOOD APHASIA

Perhaps the most common symptom of preschool children referred to child-development clinics, Cohen reports, and certainly the most common symptom that brings autistic children to child-development specialists, is slowness in beginning to talk. Among such children is a subgroup diagnosed as having primary childhood aphasia, "usually defined as the failure to develop, or difficulty in using, language and speech in the absence of mental retardation, deafness, or a primary emotional disorder." (Other terms used for the same condition are "congenital aphasia" and "idiopathic acquired aphasia," both meaning essentially that the cause is unknown.) It differs from adult aphasia because the latter is a *loss* of language—following brain damage caused by a stroke, tumor, accident, or illness. In childhood aphasia, though, there is a failure to *acquire* language.

Among 30 children with primary childhood aphasia studied by Cohen and Caparulo, many if not most had been diagnosed at some time as autistic. However, "characteristically their gestation and delivery were normal, the first year or two of life was completely uneventful, and the child was thought to be a healthy, socially attentive youngster by his second birthday. Then, sometime between age 3 and 4, the family became increasingly anxious about slow language development. Usually, by the late preschool years, the child began to show increasing activity, difficulties in deploying attention, and irritability. If seen in a psychiatric facility, the diagnosis of childhood autism might have been made, although parents were quite clear that the child showed warm, social attachment, particularly to his mother, and could make use of mime and gesture in a meaningful way" Autistic children, in contrast, "do not establish meaningful affective relations, and they often actively resist making social contact" However, aphasic children do become "increasingly agitated and disturbed as they recognize their difficulties in communicating." Among children with primary or congenital aphasia, some have an additional difficulty: They cannot distinguish environmental sounds, such as a cat's meow or a dog's bark. Earlier investigators designated their trouble as "congenital auditory imperception."

There are several other groups of childhood aphasias, sometimes less severe than the congenital condition. One major group is called "developmental" because it occurs slightly later in childhood. Children with that type may achieve the use of sentences, Cohen reports, while children with congenital aphasia generally do not develop the use of even phrases. In general, child aphasics comprehend language much better than they produce it. They are alike, too, in having more social attachments with their parents than autistic children have, and sometimes with many other people as well. And they give evidence of a well-integrated imaginative life.

Some clinicians believe that autism and childhood aphasia are related, but Cohen points to a fundamental biological difference. The electroencephalograms, or EEG's, of autistic children tend to be "normal or borderline abnormal, often showing some immaturity or lack of symmetry." But the EEG of an aphasic child "most often reveals dramatic, seizure-like patterns of discharge." These "may be most clear overlying the areas of language function, but may also exist in the occipital or in the minor hemisphere. The EEG seizure patterns are not associated with clinical seizures [as in epilepsy]; in fact, they may occur several times a moment without any clinical change."

Interestingly, though, the use of medicines that generally prevent or reduce the number of seizures in an epileptic does sometimes work with aphasic children. Cohen reports: "The reduction of paroxysmal EEG activity by the use of anticonvulsants such as Dilantin has, in our hands, sometimes led to very gratifying improvement in the language and behavior of the aphasic child." This suggests "that the paroxysmal EEG abnormality may represent a cortical disturbance and one intimately involved with the child's organ of language and ability to learn and use language."

This investigator continues:

Aphasic children may create for themselves a rich repertoire of signs and gestures and may often take to the use of the American Language of the Deaf with great facility and pleasure. Learning to communicate opens up new avenues of social interaction and allows the child, sometimes for the first time, to meaningfully express abstract ideas. Mute autistic children may also be instructed in the use of the American Language of the Deaf, and we have seen how several of them have

shown improvement in their general functioning and the ability to learn a reasonably extensive repertoire of signs. However, in contrast with children with aphasia, those with autism remain severely limited in their use of gestures, which they never acquire spontaneously, and their gesture and mime language remain stereotyped and directed by immediate needs, rather than by the wish to make social relationships more accessible.

Still, says Cohen, there are just as good reasons for associating childhood aphasia with primary childhood autism as there are for completely distinguishing between them. "Perhaps the most persuasive evidence of a fundamental relationship . . . comes from studies of sibships." The Yale group is studying several families, each of which has several children. And in each case, one of the children has symptoms of autism, another of aphasia, a third of a delay in acquiring language. Further, "The family histories of children with autism sometimes reveal relatives with delayed language characteristics, and this is a finding which is quite characteristic of the families of children with childhood aphasia."

Continued study of the likeness and the differences among many childhood disorders, Cohen is sure, will lead to enhanced means of treatment. He points out, for instance, that autism, obsessive-compulsive "character disorders," mental retardation, and a condition discussed later, Tourette's syndrome, although all seemingly quite disparate, do have one feature in common—the display of repetitive, stylized behavior. If researchers can find the basis for controlling such behavior in one disorder, they can go on to show how that behavior is biologically linked to or set apart from the other disorders.

As the aphasic child grows older, Cohen reports, "every investigation has found increasing hyperactivity and lack of ability to attend." Other universal behaviors include "aggressiveness, distractibility, memory defect, immaturity and silliness, seclusiveness, social withdrawal, reduced ability to deal with abstract thinking, and variability of performance on IQ tests."

This investigator notes that "the sense of immaturity and silliness observed in most aphasic children is heightened by an intensely clinging and symbiotic mother-child relationship, in which the child sees his mother, who is often the only person

who understands him, as representing the only stable and reliable source of emotional and social support."

Cohen points also to the misery caused by disagreement among physicians. "Disturbances in the parent-child, usually mother-child, relationships also stem from the difficulties encountered in the course of seeking a diagnosis and treatment. As parents persevere in trying to find appropriate education and care for their child, they often receive conflicting and confusing opinions. For years they may be the only ones who remain convinced that the child is not hopelessly retarded or autistic. In the process, they may become progressively more protective and defensive."

As one example of the confusion and misery visited upon parents, Cohen cites a 1969 report by another investigator: During a 5-year period, out of 24 children diagnosed as schizophrenic or autistic and referred by child specialists or psychiatric units to special schools, "26 percent were found to be primarily aphasic with secondary autistic reaction."

What happens as the aphasic youngster grows up? Usually, Caparulo and Cohen agree, the language difficulties persist well into adolescence: "Most often the child increases his word dictionary, sometimes at a startling rate similar to the early vocabulary spurt of normal 2-year-olds. Combining these words into syntactically correct sentences remains difficult, however Words connoting abstract qualities like temporal relations and affective states or emotions remain elusive"

In addition to the treatment procedures mentioned earlier, behavior-modification techniques have been used successfully with aphasic children and also with autistic children to control hyperactivity and to increase attention span. Basically, these techniques reward a child immediately for behavior desired by the teacher, therapist, or parent and ignore other behavior (or immediately punish the child for it).

For the treatment of severe language impairment, whether associated with childhood aphasia or with autism, Cohen offers several recommendations. Such impairment, he observes, requires "intensive, individualized, and often one-to-one special education in which the acquisition of verbal and basic cognitive skills is stressed. With specialized education and a minimal number of interruptions, lasting over years, some of these children may make remarkable progress. It has appeared to us

that 'summer vacations' from special educational programs are to be avoided, as these often lead to loss of skills acquired only with a great deal of energy from child and teacher. Children do best with a teacher with whom they may work over the course of several years. This continuity is especially important for the most developmentally disabled children. For some of the aphasic children, in particular, the introduction of a sign language (American Language of the Deaf) has proven to be extremely valuable Instruction in sign language provides the child, and family, with a broader range of gestures. We have also observed changes in the behavior of several mute, autistic children once they were able to communicate in a more symbolic way with adults."

ATYPICAL PERSONALITY DEVELOPMENT

Cohen calls this name "a grab-bag term." He uses it to describe those children who from the very first years of life seem to have marked deviations in personality development and in the formation of warm and appropriate social relations. Another designation for this group is "early onset, nonautistic, childhood psychosis." At every age these atypical or psychotic children seem to have some deviations in the way they relate to people, difficulties in the control of impulses, and problems in acquiring age-appropriate skills.

. . . children with atypical personality development can be helped to modulate their anxiety and to progress slowly in forming trusting relations with adults.

As the investigator notes, these are very much like the difficulties of autistic children. But the children with atypical personality development do become attached to other people. Moreover, they have discriminating attachments: They become attached to their mother, for example, but not to a stranger. Autistic children, though, will go off as readily with a stranger as with their mother.

Then, too, children with atypical personality development have much more organic impairment. They have a history of traumatic deliveries; their EEGs are abnormal; their facial appearance is often unusual. Autistic children tend to look much like their parents and siblings, while those with atypical personality development "often look as though they belong to another family." Moreover, their disturbance is less severe than the autistic child's, though later on it may develop into childhood schizophrenia. Finally, Cohen has found, the children with atypical personality, unlike those with autism, tend to come from families that are stressed or disorganized.

A variety of causes or of symptoms suggesting a cause has been found in Cohen's group of such children. Among them are brain damage from lack of oxygen at the time of birth, epileptic-like seizures, and hypothyroidism. However, "often, the biological predisposition seems compounded or even overwhelmed by the strains in the family and the stresses imposed on the child." This finding contrasts with what the investigator has found in childhood autism.

Children with atypical personality development, suffering from anxiety, learning problems, and difficulty in forming social attachments, Cohen notes, can sometimes be very much helped by early psychotherapy. In individual treatment or in treatment in small groups, such as done under the direction of Dr. Sally Provence at the Yale Child Study Center, children with atypical personality development can be helped to modulate their anxiety and to progress slowly in forming trusting relations with adults. In addition, their parents can benefit from guidance that helps them to understand their child's individual sensitivities and needs, as well as to deal more effectively with their own interpersonal and psychological problems.

Strengthening the family life and improving parental competence can have immediate impact on the child's development. Some children with atypical development may benefit from medication; many will require special education or education designed to be more responsive to their individual needs.

Recently, atypical personality development has been conceptually related to one end of the spectrum of childhood difficulties known as "minimal cerebral dysfunction" or "minimal brain damage" (MBD). Children with MBD often suffer from cognitive problems, hyperactivity, impulsiveness, and immature

personalities. It has been hypothesized that the most extreme form of this disturbance may be, or may appear to be, one type of atypical personality development. For some children with MBD, stimulant medication may help.

PSYCHOSOCIAL DWARFISM

Yale investigators in the Children's Clinical Research Center and Child Study Center are also working to elucidate the causes and treatment of another peculiar and disturbing condition in children known as "psychosocial dwarfism." It is characterized by a marked reduction in physical development and by immaturity in behavior. It does not respond to growth hormones. And it seems to occur only in families facing an abnormal amount of stress.

When psychosocial dwarfs are hospitalized, Cohen and other researchers have found that they show "a remarkable acceleration in physical growth." Before or at the start of the hospital stay, tests show that their production of the growth hormone has been blunted. With hospitalization, though, this production swings back to normal. "Such children, in hospitals," Cohen says, "often display a voracious appetite, abnormalities of sleeping, and short attention. However, improvement may come within a few weeks, or a few months at most. It brings normalization of sleeping patterns, and appetite, and better social relations."

More and more such cases are being seen at university and other hospitals with large child-care departments because, Cohen suspects, such children used to be diagnosed as having an endocrinological abnormality. "But now," he continues, "we can test much better for pituitary function, and we can say, 'No, they're not like those other children'—those with real pituitary disease, the hypopituitary dwarfs. Those are children from a normal environment who fail to grow. They respond to growth hormone; the psychosocial dwarfs . . . do not."

The condition occurs in all social classes but probably in only the most disorganized families. Cohen's colleagues, Drs. Fesholt and Genel, have studied several such children over long periods of time. One child studied by Cohen was brought to the hospital for evaluation when he was 12 or 13 but looked 6 or 7. Various doctors had suspected a chronic gastrointestinal problem or

perhaps a chronic pulmonary disease. The boy came from a middle-class family and had developed normally during the first few years. But when his father left to serve in the army for several years, the mother became depressed and the child greatly reduced his eating. Just before it was time for him to start school, the boy was eating hardly anything; by first or second grade, his linear growth had stopped. When brought to the hospital, he was very small, very immature, and depressed. But endocrinologically he was sound. His growth hormones were normal.

How do doctors treat such a child?

Cohen answers: "We give them psychological support, love, an atmosphere in which they are not constantly experiencing anxiety, and the opportunity to learn how to take pleasure in normal eating.

"For any long-term success, though," Cohen continues, "the parents have to be educated, or re-educated, to parenting." Among other things, this means they must recognize the need for calmness, order, and discipline in the home; the importance of the parental presence; and the need for parental interest in the child—not feigned but genuine interest so that the child really knows he has someone who will listen to and help him do something about his troubles and worries. And children have more worries than most adults either remember or believe. Where there is no capable parent available, an appropriate substitute must be found.

The investigator calls attention to a disorder known as "anorexia nervosa," or refusal to eat because of psychological overconcern about obesity, which occurs primarily among adolescents and young adults and results in dangerous weight losses. "Why in some ways," he asks, "isn't the appetite disorder in these psychosocial dwarfs similar to what we see in some young people later on?" He and his group have been intrigued by the possibility that psychosocial dwarfism is provoked by the stress and anxiety of the preschool years, while anorexia nervosa is in some way triggered by the endocrinological changes of adolescence. But he is inclined to think that the two conditions are separate rather than related.

At the basis of the trouble in psychosocial dwarfism, Cohen hypothesizes, is a disturbance in the metabolism of the brain chemicals known as "biogenic amines." This disturbance affects

the functioning of the hypothalamic-pituitary gland system, whose many jobs include the arousal or suppression of appetite.

Why, usually, is only one child in a stressed family afflicted? Cohen answers with another question: Why, usually, is only one child in a family autistic? In the former case, Cohen reports, "most investigators have looked for, and have found, difficulties in parent-child relations." But Cohen wonders if psychosocial dwarfism does not, at least in part, result from an aberration in some of the children themselves. In other words, there may be something in the child—something in the workings of the brain chemicals—that with more than average ease goes out of kilter under family stress. To Cohen, such a hypothesis is consistent with the observation of the disturbances in parent-child relationships produced by autistic children. He hopes "it will not be necessary for a generation of parents of children with psychosocial dwarfism to be made to suffer the same torment at the hands of caregivers as have the parents of autistic children from 1943 until the early 1970s."

TOURETTE'S SYNDROME

The Cohen group has also studied and successfully treated a strange and disconcerting condition, less rare than commonly believed, known as "Tourette's syndrome" or "chronic, multiple-tic syndrome." It is first manifested by tic-like blinks and grimaces in the early school years. As the investigator points out, transient tics are quite common in kindergarten and first-grade children. But in children with Tourette's syndrome, the behavior spreads. Instead of involving just blinking and grimacing, it comes to include shoulder jerks, body jerks, and then, often, repeated movements such as shoulder shrugging, hand jerking, or kicking. The person also makes little noises, "which may sound like whispering or the whistle of little mice"; later he may say words aloud; finally, without apparent reason and with no means of control, he may loose a torrent of vulgar and obscene language, to the dismay of those around him and to his own distress—particularly, as is often the case, if he is a sensitive, intelligent person.

The investigator tells of 13-year-old Bernard, whose trouble had first shown itself in kindergarten but who, in spite of his jerking, writhing, and uncontrollable sounds, became expert in

both baseball and basketball. Reports Cohen: "His movements were attributed to 'an allergic or asthmatic personality' by a pediatrician. At age 12, he appeared to be a very husky, friendly youngster, whose language comprehension and production were normal, whose intelligence was within the normal range, and who was able to form warm and meaningful social relations," even though he was teased for his jerks, grimaces, and sounds.

To treat the youngster, Cohen used slowly increasing doses of haloperidol, a drug often used in treating schizophrenia, though probably not to the same extent as chlorpromazine and other phenothiazines. These slowly increasing doses "completely eliminated all the symptoms," Cohen reports. At a certain level of medication, Bernard was able to say that he felt like making a movement or saying a word, but could inhibit it. At a higher level, he no longer felt the urge. When the medicine was reduced, several of the movements reappeared. When it was increased a little, the movements were again controlled.

In the case of this grimacing, jerking, spontaneous sound-making condition, how does haloperidol work? Apparently the same way it seems to work in schizophrenia. Against that major psychotic illness, haloperidol and certain other compounds appear to act by blocking, at least to some extent, the action of the neurotransmitter known as "dopamine." This action was discussed earlier in the section on autism.

Children like Bernard, Cohen suggests, may have a normal amount of dopamine (in any event, their spinal fluid contains a probably normal level of dopamine's breakdown products) but may be abnormally sensitive to it. This reasoning is based on the children's responses not only to a dopamine-blocking agent, haloperidol, but also to a stimulant drug. When a child like Bernard is given such a drug, his symptoms increase, "presumably because of increased dopamine in a system which is already oversensitive to it."

Cohen and Shaywitz have also thrown light on what may be at least one basic biological disorder in hyperkinetic or hyperactive youngsters—excitable children who have trouble concentrating. The dopamine turnover rates in the central nervous systems of such children, meaning the rates of production and use, "appear to be relatively reduced," an indication that their supply of dopamine may be lower than average. Cohen points

out that such children benefit from stimulant drugs, which presumably increase the availability of dopamine, just as in his view they would be expected to do. On the other hand, children with either Tourette's syndrome or autism have elevated levels of dopamine turnover, an indication that they are producing too much of this transmitter. As expected, stimulant drugs make these children worse.

Each of the severe disturbances of early childhood—along with its subgroups—discussed here reflects in Cohen's view "a variety of interacting metabolic, genetic and environmental forces." Basic to each may be disturbances in the brain systems whose proper functioning depends upon the correct amount and functioning of dopamine. And at least one ameliorative factor seems to be medicine that controls the output or use of that brain chemical.

DETECTING AND DOING SOMETHING ABOUT DEVELOPMENTAL DIFFICULTIES

How can parents recognize when they need help?

When the child is an infant, Cohen points to a number of cautionary signs—for example:

- Slow motor development: not crawling by 7 months for instance, or not walking by 16 months.
- Failure to form social attachments, such as smiling at a few months of age, knowing the parents as special people by 6 months, showing separation worries at 8 or 9 months.
- Slowness in comprehending language and in talking: for instance, not saying a single word at 1 year, not responding to his/her name or to voices, not using many words by 18 months.
- Unusual sensitivities and irritability.
- Problems in eating or in sleeping.
- Failure to show normal physical growth.
- Failure to demonstrate normal feelings of pleasure and pain.

During the toddler years, indication that the parents need help is provided, for example, by the child's hyperactivity, aggressiveness, and failure to advance his language skills.

During the preschool and early school years, some of the help-needed signals are troubles in learning, particularly in reading, unusual fears and preoccupations, or problems in paying attention.

When parents notice such problems or are worried about anything else they consider abnormal, what should they do? Cohen advises: Turn to specialists for guidance. The first of these is the child's pediatrician or the family doctor. If the parents feel that the physician has not understood or seems uninterested in the problem, or if both the physician and the parents feel the need for further advice, they should seek out specialists—mainly child psychiatrists and psychologists specializing in children's development—who can perform developmental evaluations.

Just what is involved in such an evaluation? Cohen answers:

The developmental evaluation of a young child should include thorough physical evaluation, including assessment of general health, sensory functioning (hearing, sight), and neurological status. Often, this may require laboratory tests such as urinalysis, screening for genetic disorders, an electroencephalogram (EEG), blood tests, and other procedures, depending on the nature of the child's problems. Careful observation and developmental testing, performed by a specially trained professional, may require several visits to assess a child's developmental level and areas of particular difficulty. Repetition of such testing over the course of months may be needed to determine if there is progress or deterioration. Since children's development occurs in the context of family life, careful social evaluation of the family is generally required. A social worker, physician, or psychologist may spend a number of hours with the parents, learning about their own histories and the way in which the family's current functioning might influence the child. On the basis of careful assessment, a diagnostic team may arrive at a specific diagnosis which can be conveyed to the parent. The major function of the diagnostic assessment is to formulate a plan of action or remediation, not to decide on a "label" for a child. There are several possible results of a diagnostic assessment: The parents may be reassured that their child's development is within the normal range or that his difficulties are transient.

They may be given parental guidance about how to relate to a specific aspect of their child's personality, e.g., how to deal with his sensitivity or irritability, or how to help the child through a particularly difficult period. The child may require special psychiatric, psychological, or educational help, and the diagnostic assessment can help the parents and professionals structure a comprehensive program for a child when this is necessary.

As a child with developmental difficulties proceeds toward adolescence and beyond, Cohen reminds us, his needs must be constantly reassessed to make sure that he is receiving the appropriate type of help. A medicine or other therapeutic procedure that may have been helpful at one stage of growth may be useless at another. Contrariwise, new discoveries may have made more effective treatment available. The best hope is that well-trained professionals—most likely to be found in clinics and other institutions associated with medical schools—will work together as the child's advocate. This means working to advance his cause on all fronts—medical, rehabilitative, educational, governmental, and social.

The challenges are strong and numerous. "While remaining appropriately and judiciously optimistic about further understanding of the biology of development," Cohen notes, "we should keep in mind that the best we can offer most children with severe developmental disturbances today is good humane care." He adds that "for the vast majority of children with autism in the United States today, even these basic needs are not satisfied."

In the long run, as Cohen emphasizes, the best hope for the prevention or amelioration of the major disorders of early childhood lies in research. The training of more researchers and the support—governmental and private, including individual—of more research into the basic causes and treatment of these disorders would certainly pay off. Within a year? Perhaps not. Within a decade? Very probably, particularly if the move toward more and more cooperative research (cooperative both *within* and *among* institutions) continues. Yet within recent years, government policy has been toward *less* support.

CONDITIONS HELPING EMOTIONAL HEALTH

Asked what he would say to a parent who wanted to know what he/she could do to ensure the emotional health of her child, this child psychiatrist replied:

"Oh, I would say, 'Have fun with your child; have fun with your husband or wife.' The most important thing a parent can do—assuming that the child is within the range of normal health—is to enjoy what he or she is doing with their children. I would say: 'Don't worry—there are no gimmicks or gadgets that are really important, and there's no curriculum they should use with their 1- or 2- or 3-year-old child. An overzealous concern about mechanical things will distract them from something very important—the sense of pleasure in doing something gratifying and watching something grow.'"

Among other essentials for a child's healthy development, Cohen believes, are these:

- The parents should be sufficiently available so that the child can form a trusting relationship with them.
- The parents should respect the child's individuality as well as their own special needs and competencies.
- There should be consistency in handling. The child should not have to experience either numerous or disruptive changes but should be given enough new experience to be stimulated.
- The parents should feel comfortable in asking for guidance when they need it.

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Principal Investigator: Donald J. Cohen, M.D.
Child Study Center
Yale University School of Medicine
333 Cedar Street
New Haven, Connecticut 06510

BASIC TRAINING FOR PARENTS OF PSYCHOTIC CHILDREN

Principal Investigator: Eric Schopler, Ph.D.

Author: Bette Runck, NIMH

As the parent of an autistic child, one is more ridiculous than heroic—like a sludging, sloshing infantry soldier in a nuclear age.

—Josh Greenfeld, A Child Called Noah.

TEACCH is, loosely, the acronym for Training and Education of Autistic, Psychotic and Related Communications Handicapped Children. Division TEACCH is the organization that does the TEACCHing. It is something like a boot camp for the parents of troubled children, a training ground where mothers and fathers are shaped into teachers and therapists. At five TEACCH centers scattered across North Carolina, parents learn the techniques that the professionals use to reach and train psychotic children. These parents become their own professionals, experts at helping their own children.

Parents need special training just to raise a psychotic child. Skills and habits that normal children master as a matter of course—dressing, going to the toilet, bathing—are, for some psychotic children, major battles to be won. A word, a gesture, or a facial expression can take months to learn, if ever learned at all. Every week, parent and child go to a TEACCH center for guidance in working out the drills that help the child learn such basic skills. At home, every day, they carry out the

drills—slogging their way toward some sort of imperfect victory.

For a place that depends so heavily on drill instruction, a TEACCH center has an oddly casual air about it. There's nothing in dress or manner to distinguish a staff worker from a parent. There's little to suggest a hierarchy among the staff. Therapists, administrators, and teachers wear their professional credentials like old uniforms grown too snug to be buttoned comfortably.

During their first visit or two, mothers may be noticeably distressed, fathers nervous. Their worries soon subside. Parents learn that they can afford the program, because they pay little or nothing in direct fees. They learn that they will no longer have to be passive witnesses to therapeutic manipulation of their psychotic child, that they themselves can do something to help. They learn that they can nurture this child and are as indispensable to him as they are to a normal one. They are assured that they won't have to surrender their troubled son or daughter to institutions and professionals. But they also are awakened to their child's limitations. Most learn that there is nothing they or anyone else can do to assure normal lives for their children. And they get help in trying to live with this hope-shattering realization.

Division TEACCH is a statewide, largely State-supported program, which is closely allied with the public school system. In addition to the five diagnostic and treatment centers, it operates some 25 classrooms that are located near the centers, in regular public school buildings. Administrative headquarters are on the second floor of an old nurses' dorm across an alley from the sprawling hospital and medical school complex at the University of North Carolina in Chapel Hill.

TEACCH director and cofounder, Dr. Eric Schopler, is a psychologist who has spent the better part of his professional career working with psychotic children and their parents. Like the program itself, Schopler has no discernible pretensions. If he's running the rough equivalent of a boot camp, then he does it with no hint of a lockstep style. He and his staff march to the tune of each child's requirements, each family's resources. His method is pragmatic, flexible, and humane. It seems to work, and it seems to keep Schopler tied to the real world when he steps back to examine the nature of childhood psycho-

sia. Theoretical flights-of-fancy, common in this subject, are not evident in his work.

PARENTS AS THERAPISTS

It was evidently Schopler's down-to-earth traits that first got him interested in training parents as cotherapists. Early in his career he began to question, examine, and finally reject the belief that parents were to blame for their child's psychotic condition. In Schopler's view, that belief grew out of the need of professionals, especially psychiatrists, to find a scapegoat for their scientific and therapeutic failures. He became convinced that if psychiatrists were not wedded to their theories, they could see what was in front of them. What Schopler saw were parents who were "more like the victims than the creators of their child's psychosis." He saw parents who desperately wanted to help their children, who spent time and money they didn't have trekking around the country in search of a cure. Could anyone be more motivated to help a child than his own parents? Could any professional do as well when parents spend so much more time with the child? Does anyone better understand or care for a child? Who, after all, is responsible? Who is most likely to have a continuing relationship with the child 10, 20, 40 years hence? Who must plan for that future? Schopler's questions led him back repeatedly to the parents.

*Could anyone be more motivated to help
a child than his own parents?*

A Pilot Study

By 1966, Schopler was ready to test the idea that if parents were taught the right techniques, they could "treat" their own psychotic children. The idea was compelling not only because parents were highly motivated to help their children, but also because there simply were not enough professional therapists to provide the ongoing, day-to-day treatment that seemed to be required. Few mental health facilities would even consider admitting children diagnosed as autistic or severely psychotic. Schopler started a pilot program for training parents as cother-

apists. Despite his dim view of psychiatric beliefs about psychotic children, Schopler received the blessing and support of the Department of Psychiatry in the University of North Carolina School of Medicine, where he had been Director of Research Development in the Child Psychiatry Unit since 1964. Robert J. Reichler, a child psychiatrist who had joined the department in 1965, collaborated on the pilot project. Except during Reichler's 2-year absence between 1967 and 1969, he and Schopler have together guided the research and treatment program through the years. Their close collaboration ended when Reichler moved to Seattle in 1976 to become Director of the Department of Behavioral Sciences at Children's Orthopedic Hospital and Medical Center and also Professor of Child Psychiatry at the University of Washington.

During the early pilot project, Schopler and Reichler were working toward the goal of preparing very young psychotic children for school—an emphasis reflected in the fact that the project received some support from the U.S. Office of Education. At the time, they and other specialists believed that psychotic children, like those who were otherwise developmentally disabled or “culturally deprived,” would be able to achieve some success in school if only they were identified and trained to overcome their handicaps before they started first grade. The pilot project was directed at specifying the “precursors to school failure in childhood psychosis,” as well as developing training techniques that could be taught to parents and clinicians.

Like other investigators, in the mid-1960s Schopler and Reichler believed that the “first-order handicap” afflicting psychotic children, especially autistic children, was the inability to relate to other people. The assumption was that this fundamental problem in human relatedness produced impairments in the child's emotional life and in his cognitive abilities (that is, in perceiving, recognizing, conceiving, judging, and reasoning). Experience and research have convinced Schopler and Reichler that the social withdrawal characteristic of psychotic children *results* from their impairments of perception, intelligence, and language—rather than the other way around. But the investigators' early emphasis on relationships reflected their commitment to involving parents in the treatment process, and it put them on the right track as they looked for specific techniques.

Schopler and Reichler set out to improve the interaction between parents and child as a first step toward ameliorating the child's handicaps. Their team would approach each child on his own terms to learn his strengths and weaknesses, talents and deficiencies. Then it would guide parents as they learned to reach their child through whatever perceptual channels were open. Schopler and Reichler would also teach parents how to control the troublesome behavior problems—such as wandering away, temper tantrums, and bizarre body movements—that create turmoil in the family and angry and anxious feelings in its individual members.

The pilot project proved that the treatment model had promise. Parents welcomed the training they received. Not only did it seem to help their child, but it helped them to regain confidence in their abilities as parents. Many parents even devised therapeutic techniques of their own. Their children became easier to live with—a source of occasional pleasure and pride. Because of this apparent success, in 1967 Schopler applied to the National Institute of Mental Health (NIMH) for a grant that would allow him to expand the pilot project and test the treatment model systematically. NIMH supported the Child Research Project for 6 years.

Division TEACCH

As part of the treatment program, parents and project staff met together one evening a month. Video tapes of each parent and child were shown and discussed. Though not required, attendance at these meetings was high. Despite the parents' wide differences in education and social status, they all participated in the discussions. At the end of the Child Research Project's first year, Schopler reported that the meetings had given parents the opportunity to share problems and support each other in learning to accept the limitations of their children.

About that time, Schopler and Reichler reminded the parents that the research program would be ending long before they would be ready to give up the help it provided. At the end of the program's second year, Schopler reported that the parents had accepted this challenge by forming themselves into the North Carolina Chapter of the National Society for Autistic Children. At first, the group worked to increase its member-

ship, raise funds, and promote research and special education in public schools. Then the parents became politically active. They pressed for legislation that would provide public education for children with autism and related disorders of communication. Reichler drew up a draft of the legislation. The bill that was finally passed (without a dissenting vote) created TEACCH—the Institute for the Training and Education of Autistic and Communications Handicapped Children. It was to become a division within the University's Department of Psychiatry.

Division TEACCH, as it has come to be called, is one of the rare cases where a successful, federally funded, experimental treatment program was expanded and continued as an ongoing part of State and local services. NIMH paid for a major share of the cost of the experimental phase, and then the State of North Carolina took over to provide continuing services for psychotic children. The importance of this achievement should be emphasized. The transition was orderly, the expansion was gradual, and there were few breaks in service to the children in the experimental program. Even more remarkable, the TEACCH program has been extended to serve most of the State without sacrificing its ability to treat one child at a time according to his or her needs. Because it offers services democratically and has resisted the pressure toward becoming bureaucratic and uniform, Division TEACCH may be the most effective statewide program available to psychotic children in this country.

Elsewhere, many parents of psychotic children continue to be turned away when they seek help. Or they are frustrated and dissatisfied with the treatment their children do receive. Whole families still organize their lives and their bank accounts around taking care of one psychotic child.

It is difficult to imagine how one small child can create such turmoil. What is this disorder? Why is it so intractable? How do these children differ from other mentally handicapped children?

CHILDHOOD PSYCHOSIS

Psychosis in a child may be the most difficult of all mental disorders to understand, the most heartbreaking to witness.

Here is a condition marked by paralyzing fear, an affliction that suggests some awful despair grown out of defeat and resignation. Yet it is visited on the very young, who are inexperienced in the ways of the world, too young to know guilt, too innocent to understand. They may act tortured, as if they suffer unspeakable dread and unbearable pain. They might scream for hours with a shrillness and panic that psychoanalyst William Goldfarb has likened to the crying of a colicky or hungry baby. Or they might close up, turn off, tune out, and spend as many hours quietly rocking their bodies, flapping their hands, twiddling their fingers, spinning their wheels. They are the inscrutable ones, the wanderers in the night, the lonely little creatures imprisoned by one of nature's jailers. It is little wonder that they stir deep passions in their parents and those who try to treat them and understand the nature of their disorder.

Until the turn of the century, psychotic children were probably grouped with brain-damaged or retarded children and treated accordingly. About then, the medical community began recognizing the unusual speech and behavior of these children and came to see them as psychotic. In 1943, Johns Hopkins University psychiatrist Leo Kanner published a now-classic article describing 11 children with a pattern of symptoms which he eventually called *early infantile autism*. Other investigators identified groups of children with other symptom constellations and coined such diagnostic labels as *childhood schizophrenia*, *symbiotic psychosis*, *borderline psychotic*, and *atypical child*.

Even when these groups are considered together, psychoses of early childhood are rare. The best studies to date have found that about 450 or 500 of every million children born are eventually diagnosed as having a childhood psychosis. This figure may be far from accurate, however, because confusion over diagnostic labels makes it likely that many children are misdiagnosed. One puzzling but frequent observation is that children from low-income families are not often diagnosed as autistic or psychotic. Beginning with Kanner, investigators have reported again and again that disproportionate numbers of autistic children come from middle class and professional families (the reverse of the pattern for adult schizophrenia, where working and lower class patients predominate). Children in the TEACCH program, who have access to treatment regardless of

their family's income, come from all socioeconomic groups. Whatever the meaning of this fact, it illustrates that much of what is known about childhood psychosis is open to question simply because diagnostic and treatment practices have been inconsistent even by the standards of psychiatry, where diagnosis and treatment are always controversial topics. (For discussions of this issue see Rutter 1978a, Schopler 1978b, and Schopler and Rutter 1978.)

There is little dispute over two characteristics of childhood psychosis, however. Like other developmental disabilities, boys are affected far more often than are girls. Four times as many boys as girls are diagnosed as psychotic. Investigators also seem to agree that psychotic children are a remarkably diverse group. Each one seems to have a unique pattern and sequence of attaining maturational milestones—when they are attained at all. A psychotic child's abilities range up and down the developmental ladder; he may piece together complex puzzles when very young, yet never learn to speak. Behavior varies widely, too. Some psychotic children are hyperactive, but more are slow and phlegmatic. Some scream and shout and have temper tantrums, while others are abnormally quiet and withdrawn.

The TEACCH Children

Partly because of this variability, investigators have spent huge amounts of time and energy over the years attempting to define just what characterizes psychotic children. Recognizing that the issue was far from settled, Schopler and Reichler developed a "broad but descriptively explicit" system for rating the presence and severity of psychosis in children referred to their project (Schopler and Reichler 1968 and 1971). Their 15-point rating scale was based on nine criteria formulated by E. Mildred Creak (1963) and her "British Working Party." Of these criteria, four were later identified by British psychiatrist Michael Rutter (1978a) as being the cardinal features of young (under age 5) psychotic children:

- Severely abnormal or delayed use of language and "prelanguage skills" (such as the normal 2-year-old's rich babble)
- Seriously impaired relationships with other people—aloofness, negativism, or empty and impersonal interactions

- Strange mannerisms—stereotyped and repetitive movements (such as rhythmic rocking, spinning, and head banging)—and resistance to change
- An onset of these symptoms before the age of 30 months.

Schopler and Reichler followed Rutter's suggestion that the term *childhood psychosis* be used to designate severely disordered children in whom these autistic characteristics are prominent. They came to use the term *autism* interchangeably with *childhood psychosis* because the autistic features seem to be central.

Most psychotic children are seriously retarded.

All of the children in the pilot project and the Child Research Project were psychotic or autistic by this definition. Most were "classically autistic," with the pattern of symptoms that Kanner had described. These are the children who are often the most seriously disturbed. Half never learn to speak; those who do speak usually use language as if they don't know what it means. Some reverse pronouns, using *you* when they mean *I*, for example. Some parrot back whatever is said to them ("echolalia," in psychiatric parlance). Some reverse prepositions. Autistic children are those who seem most alone. They don't greet their parents when reunited after a separation. They don't follow them around the house the way normal toddlers trail after their parents. They don't lift their arms in anticipation of being picked up. They seem profoundly indifferent. Their play is repetitive and monotonous. They rarely imitate adults at work. They can't seem to tolerate the slightest change in routine, room arrangements, clothing, or the pattern of play. Some perform amazing feats of memory and calculation—the children psychologist Bernard Rimland (1978) has called the "autistic savants."

Most psychotic children, however, are seriously retarded—even those who might show islets of normal intelligence or even genius. As many as 60 percent score 50 or less on tests that measure IQ by means that do not require a knowledge of

language; only about 20 percent score over 70 (Ritvo and Freeman 1977). Unlike most retarded children, autistic children have uneven levels of ability. A 5-year-old autistic child whose verbal abilities are comparable to those of a normal 2-year-old might have the arithmetical skills of any child his age.

About half of the children in the TEACCH program today are rated as psychotic. The rest have a wide range of communications disorders and, usually, behavior problems as well. They are accepted into Division TEACCH because their needs for special education are very similar to those of the autistic children. Of the entire TEACCH group, only a few children achieve IQ scores in the normal range. Their retardation, their difficulties with language and other forms of communication, and their troublesome behavior are all problems that the TEACCH techniques were designed to control in children who also have psychotic symptoms.

A visit to a TEACCH center can be a disquieting experience simply because peace reigns there. New parents might show some distress, their children some obvious symptoms. But the wild child of the books is a rarity. And, despite the old and still commonly held notion that parents of psychotic children—particularly mothers—are emotionally cold, there is not a “refrigerator mother” in sight. The children have a disarming appeal and attractiveness, some elusive charm. Many parents and clinicians think that autistic children are unusually beautiful.

Above all, psychotic children are enigmatic. Trying to understand them and to master the anguish they cause, parents have written enough books and articles to fill a small library. These reports and the professional literature illustrate the wide range of symptoms and behavior exhibited by these troubled children. Here are fragments from the experiences of several young psychotic children, as related by their clinicians or parents (including some from TEACCH):

Short Takes

As a baby, Charles was inactive. He lay in his crib just staring, as if hypnotized. Because he seemed to enjoy music, his mother played records for him. By the time he was a year and a half, he could discriminate between 18 symphonies. His mother reported that as soon as the first symphonic movement began, he would blurt out the composer's name. At about the

same age, he started spinning toys, bottle lids, and cylinders, an activity that would cause him to "get severely excited and jump up and down with ecstasy." Later, his interest shifted to light reflections. "When he is interested in a thing," his mother said, "you cannot change it. He would pay no attention to me and show no recognition of me if I entered the room." His mother was most impressed by his detachment and inaccessibility. "He walks as if he is in a shadow, lives in a world of his own where he cannot be reached." He repeated the exact words that others said, spoke of himself in the second or third person. "He is destructive; the furniture in his room looks like it has hunked out of it. He will break a purple crayon into two parts and say, 'You had a beautiful purple crayon and now it's two pieces. Look what *you* did.'" He hid feces around the house. But he never soiled himself in the nursery school. He waited until he got home. "He is proud of wetting, jumps up and down with ecstasy, says, 'Look at the big puddle *he* made.'" (Kanner 1973, p. 25.)

When Sally was less than a year old, she would scream when other family members failed to sit in their usual chairs, and also when "the routine of the daily walk was changed, if the order of the dishes on the tray was altered, or when she was hindered in going through one special door leading into the garden." She was obsessed with body functions. At 6, she had trouble relating to people; she spent a lot of time alone. Her memory was "phenomenal," and she was unusually good at solving puzzles that were too difficult for others her age. (Kanner 1973, pp. 192-193.)

At 3, George would wander out the back door "like a little zombie," not looking where he was going, his head turned up to the sky, his fingers moving as if he were playing imaginary castanets. When his mother had finally taught him to stay in the yard, George suddenly started riding a tricycle "like he'd been riding it for years, like he'd been born to ride it." As far as his mother knew, he had never been on it before. He played in his sandpile. He also started playing with his swingset, which before then only the neighbor kids and his brother and sister had used. He began to swing "like an old pro." One day his mother looked out the window and saw 3-year-old George

blithely marching barefoot over the top of the swingset, perfectly balanced on a metal pipe. At 6, George couldn't speak. He banged his head against the wall for hours at a time. He slept in his parents' bed. Any change in the household's routine would set off a temper tantrum. His mother recalls that "every stitch he put on his back had to be color coordinated, and George had to wear exactly the same little costume every day. He wouldn't wear shoes. He seemed so incredibly dumb in some ways. He was in no way ready for school. But he was so *keen* about other things. He would pick door locks and get out of the house in the middle of the night or in the wee hours of the morning." (Reported by George's mother.)

"Donna was frightened lest her body fall apart. In one instance she was observed to be staring at her hand and crying agitatedly 'Will it fall off?'" (Goldfarb 1969, p. 155.)

Hank and his family came from some distance for their weekly sessions at the TEACCH center in Chapel Hill. They stayed overnight near the University campus in the Carolina Inn. Hank always referred to the Inn as the "Carolina Out." The pun was not intentional, but a confusion of meaning coupled with a habit of reversing prepositions. (Reported by Schopler.)

"Daniel clutched at his abdomen, ran wildly about his room, and screamed with such apparent distress that he was examined for the possibility of an acute abdominal condition. However, in time it became clear that he reacted to bowel urgency with panic and in each instance, he gave no evidence of remembering and grasping the familiar, rhythmic nature of normal bowel stimuli." (Goldfarb 1969, p. 155.)

Richard's mother described her son, who was almost 3, in these words: "I can't be sure just when he stopped the imitation of word sounds. It seems that he has gone backward mentally gradually for the last two years. We have thought it was because he did not disclose what was in his head, that it was there all right. Now that he is making so many sounds, it is disconcerting because it is now evident that he can't talk. Before, I thought he could if he only would. *He gave the impres-*

sion of silent wisdom to me One puzzling and discouraging thing is the great difficulty one has in getting his attention." (Quoted in Kanner 1973, p. 12.)

A few months before he turned 4, Tommy was using about 200 words, one at a time, never in sentences. His parents enrolled him in a nursery school for normal 3-year-olds. They had thought that being around children who used more language than Tommy did would improve his speech. Shortly thereafter, over a period of months, Tommy stopped talking completely. His behavior also changed. He stopped showing affection. His mother thinks she made a mistake by putting him into the school. (Reported by Tommy's mother.)

At 4, Noah could neither eat nor use the toilet by himself. According to his father, Noah never spoke with expression, his attention span was too short to be noticeable, he rarely played with toys, he never came when called by name. "He was almost always lost in a world whose activities consisted solely of thread-pulling, lint-picking, blanket-sucking, spontaneous giggling, inexplicable crying, eye-squinting, finger-talking, wall-hugging, circle-walking, bed-bouncing, head-nodding, and body-rocking." (Greenfeld 1972, pp. 97-98.)

Growing Up Autistic

As autistic children grow up, their psychotic symptoms subside. At or around the age of 5, many impairments that mark the young autistic child's social interactions begin to clear up, according to the British expert Michael Rutter (1978a). Serious social difficulties usually continue, however. A child may be unable to play with other children cooperatively. He may fail to make friends of his own. Many children seem to lack the ability to put themselves in someone else's shoes, or even to perceive another person's feelings and responses.

Some autistic children who are only mildly retarded, if at all, become painfully aware of their limitations during adolescence, Rutter points out. They are often "deeply distressed by the gap between their newly found desire to make close friends and their continuing incompetence." For the most part, these children are unable to regain ground lost during their early developmental years.



George and his family took part in the early experimental projects that led to TEACCH. Captured here at 16, he is now learning skills that will help him to live and work in sheltered settings when he reaches adulthood.



"Lots of times George is a delightful person to be around," his mother says. "But at times he's made me so mad I wanted to knock him into the middle of next week." George has hit her, sometimes just after she had been hugging him. "That's the kind of pain only a mother can feel, only the mother of an autistic or handicapped person."

George's mother, recognizing that her son has some of the "balkiness that teenagers are known to have," tries to give him more freedom than when he was younger. "A teenager has to resist a little bit. He can't be treated like a robot."





Tommy, age 6, works at a blackboard in a TEACCH playroom. Earlier, he had practiced the first steps in taking a bath—turning on the water, picking up the wash cloth, getting the soap.

In a 1977 article, TEACCH associate Jerry L. Sloan and Eric Schopler summarize the findings of a small number of followup studies on adolescents who were diagnosed as autistic when they were young children. Sloan and Schopler observe that:

- The "vast majority" of autistic adolescents are retarded in their intellectual functioning. Many have IQs of 70 or under.
- Probably no more than 5 to 15 percent of the children studied had a "good" outcome—doing well in academic, community, and social spheres. Neither were these children accepted by their peers. Between 50 and 80 percent of the children showed "grossly maladaptive behavior and were at home without adequate programs or were in institutions."
- About half of the children in the followup studies had developed the use of language; the earlier the child had succeeded in using language, the better his chances of a good overall outcome.
- Many had an obvious organic impairment, such as a seizure disorder (a condition developed by 10 to 20 percent of the children by adolescence).
- Few autistic adolescents—probably less than 5 percent—had ever been employed on a job.

In a subject so beset by debate, most investigators do seem to agree that one set of factors—IQ, language, and school performance—is most predictive of the autistic child's chances for the future. If the IQ persistently tests at 50 or below, the child will probably always remain "grossly handicapped" and never develop language or hold a job; he is likely to spend his life in an institution, and he is more prone to epileptic seizures than are other autistic children (Rutter 1978c). Children with normal scores on nonverbal IQ tests are likely to do well in school, but their performance varies widely. The "high-functioning" children, those with normal or above normal intelligence, are the ones who receive the attention of the popular press. Some have gone on to college and beyond. But at best, even these former autistic children often remain socially awkward. A recent report (DesLauriers 1978) describes the case of Clarence, one of the autistic children treated by Kanner. Through agonizing persistence and his therapist's help, Clarence was able to

marry; he may be the only former autistic child described in the literature who did marry.

More typically, the autistic children who do grow up into an adulthood where they can hold a job and live independently show little interest in the opposite sex. When Kanner located 96 young adults whom he had diagnosed as autistic when they were children, he found that 11 were working and maintaining themselves in society.

They have not completely shed the fundamental personality structure of early infantile autism but, with increasing self-assessment in their middle to late teens, they expended considerable effort to fit themselves—dutifully, as it were—to what they came to perceive as commonly expected obligations. They made the compromise of being, yet not appearing, alone and discovered means of interaction by joining groups in which they could make use of their preoccupations, previously immured in self-limited stereotypies, as shared “hobbies” in the company of others Life among people thus lost its former menacing aspects. [Kanner 1973, p. 211.]

THE EVOLUTION OF DEVELOPMENTAL THERAPY

During the 1960s, investigators tried a great many techniques for treating psychotic children—including, as Schopler and Reichler (1971) have noted, “custodial isolation, electroconvulsive shock, drug therapies, psychoanalytic therapy, operant conditioning, electronic typewriters, and megadose vitamin therapy.” Parents were more or less excluded from all of these methods of treatment. In some cases, the exclusion was total: Many psychoanalytically oriented therapists performed “parentectomies.” Believing that parents were causing the psychosis, these therapists thought it was their duty to rescue the children and provide institutional care for them.

Schopler saw no basis in fact for taking such extreme actions. His experience had convinced him that most parents loved their children and wanted to keep them. He acknowledged that, in relation to the psychotic child, parents often “show perplexity, confusion about child rearing, and a tendency to vacillate between indulgence and rigidity.” But he thought such behavior was understandable. Psychotic children caused similar reactions in therapists. Why assume that the parents’

behavior was anything else than a consequence of their child's extreme behavior? After all, these parents seemed to function adequately in other spheres of their lives and usually had other, normal children.

Schopler and Reichler wanted to develop a treatment model that was grounded in experience, observation, and experimental evidence.

Such was the reasoning that led Schopler to launch the pilot program that eventually became Division TEACCH. Aware of the history of overzealous application of unproven theory, he and Reichler were determined to develop a treatment model that was grounded in experience, observation, and experimental evidence. Their assumptions were explicit. In addition to their supposition that parents are normal, research evidence led them to conclude that:

- The *causes* of childhood psychosis are multiple, and it is rarely possible to determine the specific cause of any one child's disorder. In all probability, some brain abnormality is the primary cause. It is manifested in impairments in perception and understanding, which in turn result in the characteristic behavioral and language problems. Just which symptoms appear in any one child depends on the child's age, the time of onset, and the severity of the impairment.
- Every child's *development* is guided by both biological processes and interactions with parents. The psychotic child's biological impairments are bound to upset these interactions. By not responding to attention and care, the psychotic child tends to frustrate and alienate his parents—to give “negative reinforcement,” in behaviorist terms.

Schopler and Reichler believed that if parents could learn to understand their child's abilities and limitations, they could adjust their expectations, rid themselves of guilt, and learn to get along. Then the way would be clear for them to get back to the business of helping their child grow and learn. Schopler

and Reichler called their treatment model "developmental therapy" to underscore the point that all children change rapidly and that developmental therapy was designed to foster growth in children whose development is usually uneven. By emphasizing development, the investigators wished to remind therapists that they could understand a psychotic child and know how to help him by recognizing that, in some activities, he will respond much as a younger child would.

In devising their treatment method, Schopler and Reichler picked from a smorgasbord of techniques used to treat children with other kinds of handicaps. For example, to capture the attention of children who seemed unable either to hear or understand what was said to them, Schopler and Reichler took a lesson from the deaf, who compensate for their lack of hearing by depending on sight and other senses; the investigators believed that psychotic children, too, may be reached more easily through touch and sight. Schopler and Reichler borrowed from the Montessori model and provided play areas and classrooms that allowed exploration within limited boundaries only; they reasoned that psychotic children, who have trouble organizing their experience, would feel and behave better if some structure were imposed upon them. Schopler and Reichler decided to use operant conditioning techniques to control such problems as temper tantrums. Based on the age-old principle of encouraging desired behavior by rewarding it, operant conditioning had recently been used successfully with autistic children; some children, for example, learned to say a few words when they were rewarded with candy for making successively closer approximations to the correct sound. (It was later learned that the words were usually being parroted, not understood. But the conditioning techniques worked well for changing behavior.) The techniques had the further advantage of being easily taught, the kind of procedure parents could learn to use at home.

In Practice

By the time the 6-year, NIMH-supported Child Research Project got underway, Schopler and Reichler's developmental therapy was practiced in much the way it is today. It remains a flexible therapy, one which incorporates new ideas and new practices routinely. Techniques and methods have been refined

over the years, and classrooms have been added to the program. But the experience of the first families, those who took part in the research project, was similar to what it is for families now at Division TEACCH. Perhaps the program's single most important feature is its continued emphasis on the individual child and his or her family's needs. For that reason, there is no *one* treatment plan.

With the first families, Schopler himself conducted the diagnostic session with the child. He would take the child into a playroom with a one-way mirror on one wall. Observers in an adjoining room rated the child's behavior. Using a box of toys, puzzles, and candy, Schopler would lead the child through a standard routine designed to elicit responses that would indicate the child's level of development and specific impairments. For example, to test the child's perception of sound, Schopler would call to him from ever-increasing distances.

While the diagnostic session was going on, the parents would tell another staff member what they had noticed about their child—their everyday observations and experiences. Then, each parent would take the child into the playroom, give him candy, play with him (using the child's own toys), then get the child to help put the toys back in a box. Meanwhile, in the observation room, the treatment team would evaluate strengths and disturbances in the child's relationship with each parent. The sessions also gave parents an idea of how they would be expected to work with their child at home. Not only was the diagnostic procedure used to determine whether the child met the study's criteria for admission; it also gave Schopler and his colleagues some idea of how to start the treatment program.

Once admitted, each child was evaluated for educational potential and assigned to a therapist, who largely determined the direction of the therapeutic program. Treatment decisions were based on very practical considerations: Were techniques available for reaching this particular child, techniques that could also be demonstrated to parents in an understandable way? The first problem was often a behavioral one. Many of the children were out of control by the time they had reached the Child Research Project. The parents, by then, had "adopted an air of resignation in accepting anything the child does."

In 45-minute sessions held twice a week, the therapist demonstrated how to reach or control the child while one of the

parents watched from the observation booth. A "parent-consultant" sat with the other parent and pointed out what was going on or answered questions. The focus for each session was determined in advance by the therapist and parent-consultant together.

Once the child was paying attention, the sessions were likely to be directed at trying to improve the child's responsiveness to adults, his motivation to do well on various tasks, his communicativeness, and his perceptions. To improve responsiveness, for example, Schopler and Reichler would not allow the child to move about the room or use any object—or do *anything*—without the mediation of the adult. "Gradually, as the child takes the adult into account, increasing degrees of frustration are imposed, such as demanding some action or task before satisfying the child's wishes." For some children—those who seemed not to be able to see or hear—the therapists would swing the children or play with them in much the same way that a parent might play with an infant. The goal was to get the children to pay attention and to encourage them to imitate signals or words indicating that they, the children, wanted to play the game again.

Parents "need to become experts on their own autistic child."

In a 1971 article, Schopler and Reichler pointed out the advantages of demonstrating therapeutic techniques to parents:

- It avoids the "mystique and unfounded authority" of therapists reporting back from some private observation.
- It discourages therapists from making recommendations to parents which are "more easily made than carried out."
- It stimulates competition between therapist and parent and gives the parents a model to follow.
- Parents can understand direct demonstrations easier than they can verbal instructions or interpretations.

- It allows parents the chance to see that therapists, too, must struggle, become frustrated, and occasionally make mistakes. As a result, parents "become less self-critical and are better able to resume responsibility for the bond with their own child."

In the same article, Schopler and Reichler observed that before parents can draw on their own successful experience at rearing other children and adapt it to their psychotic child, they must develop "a degree of self-consciousness inappropriate to normal child rearing. Indeed, they need to become experts on their own autistic child."

Besides the demonstration sessions, parents were given a home program, which clearly spelled out objectives, methods, and materials for working with the child in daily sessions. In their work with the first families, Schopler and Reichler found that fathers sometimes were more ready and able to work with the child at home than the mothers were, especially just after treatment began, "when the mother felt most defeated and hopeless." Although both parents were expected to share the home sessions, mothers eventually worked more frequently with the children than did fathers.

Periodically, the parents demonstrated their home program in the playroom while the child's therapist and the parents' consultant observed. Although nervous at first, sooner or later most parents actually asked for additional sessions to show some new, proud development. The parents reported that they enjoyed the home sessions, when they set aside time to help the child control a symptom or learn a skill. Therapists found that designing the home program and training the parents to use such techniques as operant conditioning were relatively easy tasks. By contrast, problems in sleeping, eating, and toilet-training were trials. One example:

One child did not go to bed until eleven o'clock. He sat in the living room rocking himself for a half hour every night, and then slept in his parents' bed every night. This had been going on for several years. The parent consultant helped the parents to divide this bedtime problem into several units. First the rocking chair was moved into the child's bedroom as was a radio he liked listening to. After he became accustomed to this change he was consistently moved from the parents' to his own bed. A difficult struggle

ensued, requiring parents to move the child 15 times to his own bed during the first few nights. Within three weeks, however, he was sleeping in his own bed. [Schopler and Reichler 1971, p. 96.]

Parents were asked to keep logs on the child's progress. Every day, they noted changes in the child's responses to each part of the home program. Once a week, they rated the child's other behavior at home. This log, along with the demonstrations, was used to assess the parents' involvement and effectiveness.

By the end of the first year, Schopler could report that the parents met the heavy demands exceptionally well. Of the sessions that could have been held for all parents, for instance, only 8 percent were canceled, almost always for good reason. The parents were rarely late, and they turned in daily logs for nearly every day. Not only did they participate regularly, but they also eagerly conformed to the treatment structure. At first, when they were most insecure, they tended to be "excessively conscientious." As they became more comfortable with the role of cotherapist, they introduced innovations and occasionally even mustered the nerve to protest against the researchers' heavy demands.

The children progressed at greatly different rates. One child with a successful outcome was rated severely psychotic when he began treatment during the pilot project. He could not speak, was unable to relate to anyone, and had an IQ of 57. After 3 years, he was so much better that he could attend a regular grade school and not stand out from his classmates. His IQ by then was 101. Although he continued to be slightly awkward, his personality was appealing to both his teachers and peers. Schopler and Reichler speculated that it was "quite likely that the traces of this impairment will become sufficiently camouflaged with further development to be unnoticeable."

At the other extreme was a severely impaired boy with very limited abilities. Schopler reported to NIMH that at 3 the boy was unable to make communicative sounds or feed himself. After 2 years in treatment, the boy was able to relate to others and even enjoyed interactions with adults. His self-help skills developed extremely slowly. He could bring a spoon to his mouth but was unable to pick up food from his plate. His progress was slow and tended to disappear unless the task was

practiced continuously. Schopler noted in a report to NIMH, however, that the boy's parents, who had four other children and had previously gone through great marital conflict, "rallied around him." Their marriage became more sound and "they feel that their boy has had a humanizing effect on every member of the family." Clinically, Schopler wrote, "these parents have achieved the delicate balance of accepting the child's limitations realistically without losing the enthusiasm and motivation to help him develop as best they can."

RESEARCH AND INNOVATION

By the time Division TEACCH was established in 1972, Schopler and Reichler were confident that it was both possible and practical for parents to treat their own psychotic children. During the 6-year, NIMH-supported Child Research Project, they systematically tested diagnostic and treatment practices they were using and developed others. Even their studies of the nature of childhood psychosis—such as Schopler's early work on perceptual processes in psychotic children—have clear implications for treatment. All of the work described below influenced the TEACCH program as it functions today.

Perception

Before Schopler went to North Carolina, he had studied the unusual way in which psychotic children perceive and process information. Many of these children seem to have trouble hearing but, when tested, are found to have intact auditory systems. Vision, too, seems to be impaired in some children, but again tests show their physiological systems are normal. Schopler (1965 and 1966) demonstrated that psychotic children tend to process information in ways that are more typical of infants than normal preschool children. They receive information and stimulation from the world around them from touching, mouthing, stroking, and smelling, rather than from sight and sound. "These receptor preferences have a profound effect on the manner in which the child obtains and distorts cues for learning about his environment," Schopler noted in his first grant application to NIMH. The socializing efforts of parents and teachers are especially affected by these preferences, he suggested.

Psychotic children experience sensations "at the sacrifice of learning and integrating the representation of sensory information in the external world." Schopler believed that it should be possible to help the child get beyond these infantile modes of dealing with the world. He and Reichler based many of their first treatment techniques on this understanding of the psychotic child's perceptual processes. They would try to reach the child through the perceptual channels that were accessible.

Research on perceptual processes in psychotic children has now gone beyond Schopler's insights. The best experimental work, according to Michael Rutter (1978b), has been done by British researchers Hermelin and O'Connor, who concluded that autistic children have a general inability to use signs and symbols, "a disability which principally involves a deficit in the coding, extraction, or organization of incoming information." Little research has continued on receptor preferences. Schopler himself lost interest in the topic when he learned that his research was being used to justify treatment techniques such as electroshock.

Parents as Scapegoats

By contrast, Schopler's writings on the parents of psychotic children have become classics in the literature. He was among the first, and the most convincing, to discredit the notion that parents were to blame for the illness in their children. In 1969 he published an analysis of the relationship between professional clinicians and the parents of psychotic children. Using Gordon Allport's formulation of the conditions necessary for scapegoating, Schopler demonstrated that these parents were in an ideal position to become scapegoats of professional failures.

He discussed six motives that clinicians have for using parents as scapegoats:

- The confusion and lack of knowledge about the nature of childhood psychosis put a frustrating burden on clinicians, who clearly need to know more about the disorder to justify their professional position.

- Such confusion "tends to weigh heavily on those clinicians charged with the treatment of autistic children," Schopler wrote. "This burden is often experienced as guilt," and projecting guilt onto others is "as old as history." Since the child can hardly be blamed, "his parents provide a most convenient substitute."
- The autistic child's negative attitudes, irritability, and aloof and destructive behavior produce a sense of helplessness that "is not easily expressed against the child, and considerable pressure develops to explain the child's impossible behavior in terms of his parents."
- When the causes of the child's disorder are unclear and treatment progress is uneven, the clinician's view of himself as an expert is threatened. High fees might put additional pressures on him to justify himself. Already existing parental guilt, insecurity, and desperation "form a convenient handle for explaining and rectifying the plight of both child and clinicians," Schopler observed. "The parents' perplexity may readily be interpreted as a primary cause of the psychosis."
- Colleagues around the clinician probably hold the same view, thus reinforcing the clinician's private views.
- Seriously considering all possible factors that might have caused the disorder is a difficult and time-consuming task. Simplifications and "tabloid thinking" are easier.

Schopler also saw that parents collaborated in this process. Allport's criteria for victims of scapegoating fit them well: They are conspicuous when they are out in public with a child who acts in bizarre ways. At the time Schopler wrote his scapegoating article, the parents had no organization that would give them a chance to object and retaliate. They become demoralized by their failures to get help for their children. They are, Schopler wrote, "ready and sometimes even willing victims." And, they are accessible. The parents also reacted like scapegoat victims: They tried to comply, often by undergoing extensive psychotherapy; they put in extra effort to learn about autism and wrote books and articles and developed their own treatment programs. Eventually they sought ameliorative action by forming their own organization.

Speaking before the second annual meeting of this parents' organization, the National Society for Autistic Children, Schopler noted that both parents and professionals are necessary for the welfare of the psychotic child. Professionals see

***“Though the professional may advise,
only the parent bears the final responsibility.”***

more psychotic children than do most parents and thus have a wider experience in the variations of the problems, he said. Professionals also have the opportunity to compare, speculate, and conduct research with groups of children. But, Schopler points out:

Parents, on the other hand, are continuously involved with the same child. They have the opportunity to observe most closely their child's unique characteristics, abilities, and disabilities. Although many professionals are capable of empathy and understanding of the parents' plight, the stakes for parents are higher than for the professionals. Parents must evaluate and deplete their limited family resources and energies in terms of their total family. They must consider the cost and payoff for special education or therapy for their autistic child against the cost and payoff of the education of their normal children. These are agonizing and difficult judgments. Though the professional may advise, only the parent bears the final responsibility I advocate that parents must become experts on their own autistic child. They have the most complete and relevant information available from their daily life with the child. They have the highest motivation for helping their child and maintaining their family equilibrium. [Schopler 1971b, pp. 75-76.]

Parental Thought Disorder and Understanding

In 1969 and 1970, Schopler, with his colleague, Julie Loftin, also published research into the supposed abnormal thought processes of the parents of psychotic children. At the time, most experts assumed that parents transmitted psychosis to their child through their disordered thinking—illogical concepts, fragmented or blurred attention, and inability to interpret and communicate meaning. In a series of studies, Schopler

and Loftin showed that these parents, especially the mothers, did show more impaired thinking than did parents of normal children, but only when they felt confused and accused about their psychotic child. When asked about their normal children, parents of psychotic children did *not* show significantly more disordered thought than parents whose children are all normal. They suffered from a "situationally circumscribed anxiety" and not from a formal thought disorder.

Schopler and Loftin speculated that mothers are more affected by their child's lack of relatedness because "it is she who feels deeply rejected in her mothering role by a child who does not show the usual pleasures of infancy, the capacity to imitate and develop like other children."

As time went on and Schopler and Reichler had trained dozens of parents as cotherapists, they became more and more impressed by the parents' awareness of their children's strengths and weaknesses. They began to think that the difficulty these parents have in raising a psychotic child is the result of not knowing how to deal with a child whose developmental levels are "uneven and erratic," and is not the result of their inability to perceive the child's functioning realistically. To test these clinical impressions, Schopler and Reichler (1972) asked 87 parents to estimate their children's functioning, before each diagnostic evaluation had been done. Parents were asked about the child's overall level of development, language, motor and social skills, general ability to help himself, and mental age. The parents' estimates closely matched the results of standardized tests that the children later took. Parents of moderately or severely psychotic children estimated their child's development better than did parents of mildly psychotic children. All parents, however, seemed to be bewildered about what to do with, or expect from, this understanding of their children. "They appear to be uncertain about its meaning for the child's future, and what it means for his potential to achieve relative independence in his own life," Schopler and Reichler noted.

The Need for Structure

In another test of their clinical impressions, Schopler and his colleagues did a small-scale, tightly controlled experiment on the effects of structure on psychotic children (Schopler et al.

1971). They noted that in psychoanalytically oriented therapy, children were encouraged to explore and express themselves. Operant conditioning, by contrast, imposed a rigid structure on the child. Schopler and his group confirmed their impression that psychotic children would benefit from a relatively structured treatment setting. The most striking finding was that the children's reactions differed enormously, depending on their developmental age. The lower the developmental level, the more disorganized they were in unstructured settings. "As the children increase in developmental level and organized response capacity, they seem to become less dependent on external structure for maintaining their own organization than do autistic children on a lower level of functioning." The implications of these findings for treatment and education are clear, according to Schopler's group. "Perhaps the optimum learning situation," they say, "is one which has more external structure for acquiring new learning patterns and has relative freedom from structure for practicing these patterns which have been mastered and internalized."

Diagnosis

From the beginning of the Child Research Project, the degree of psychosis in each child was assessed with the psychotic rating scale Schopler and Reichler had developed from Creak's (1963) criteria. During the course of the project, they tested each of the 14 variables on the scale against clinical diagnoses of childhood psychosis. They found that impaired auditory responsiveness, verbal communication, and near-receptor responsiveness (e.g., touch) were better predictors of psychosis than more traditional indicators, such as faulty ability to relate and inappropriate affect (emotion). "The significance of this finding," they say, "is that it suggests that human relatedness may be composed of various specific functions, such as auditory responsiveness or the ability to understand or express language." Identifying such specific impairments, they believe, has greater potential for treatment than the vague construct *human relatedness*. (Further analysis of this construct is reported in Reichler and Schopler 1971.) Their research also showed that by rating a child's behavior on the psychotic rating scale, they could reliably diagnose the presence and degree of psychosis in a child.

But they learned that other testing instruments were also necessary. They wanted to have some idea of the child's IQ because other research was making it clear that children with very low IQs did not change regardless of treatment, while the prognosis for children with IQs over 50 varied greatly depending on education and experience. The IQ score could also provide a basis for judging later improvements.

When Schopler's group began the Child Research Project, most clinicians and researchers believed that it was impossible to test the mental ability of psychotic children. The children were often unresponsive or negative. Some could not use language, some were hyperactive. Analyzing this problem of "untestability" in a 1973 article, Schopler and Reichler attributed it to three factors: the wrong psychological tests were used; clinicians refused to believe that a child's incorrect responses could actually reflect lack of ability rather than negativism; and some children, especially hyperactive ones, are difficult to test even if the right test is used.

Schopler and Reichler and their colleagues learned that most, if not all, children could be tested if they were given the right psychological test and if the staff was sufficiently patient. The tests now used at TEACCH include the Leiter International Performance Scale, a test designed for the deaf that requires no understanding of spoken language, the Bayley Infant Development Scales, and the Merrill-Palmer Scale of Mental Tests, which relies on language less than do most other intelligence tests.

Perhaps the most important diagnostic and evaluative tool used in the TEACCH program is the Psychoeducational Profile (PEP), which the staff developed to make it possible to identify the uneven and idiosyncratic learning patterns so typical of psychotic children. Seven types of functioning are assessed:

- Pathology—the child's ability to maintain eye contact, for example, or abnormalities in the use of the senses, words, or materials
- Imitation—verbal and motor imitative ability, both of which are important for language development
- Perception—perceptual skills, such as discriminating shapes and sizes

- Motor skills—gross and fine motor skills, such as climbing stairs and stringing beads
- Eye-hand integration—skills necessary for learning, such as scribbling, copying designs, stacking blocks, and coloring within lines
- Receptive language skills, such as sorting letters and pointing to pictures
- Expressive language—naming solutions of arithmetic problems or counting, for example.

Trained observers using the PEP rate children on each item as either passing, failing, or emerging (when a child knows something about performing a task but can't complete it without help). It is this last category that is most useful for planning the teaching program. The PEP, which has been widely used by other programs for handicapped children, has recently been published (Schopler and Reichler 1978) and a complete description of the TEACCH diagnostic procedure is now in press (Schopler et al., in press).

TEACCH TODAY

Schopler and Reichler built the results of their research into their treatment model, which has evolved and changed since the first families took part. Therapists, for example, are no longer chosen to represent various professions thought to be necessary for treating psychotic children. Schopler and Reichler learned that specialized training often made therapists insensitive to the child's total needs. One specialist, for example, did not consider it her job as a speech therapist to work on the control problems of a child defecating into the heat vents. Today, the TEACCH therapists are chosen for their interest in and willingness to help psychotic children. They come from several different disciplines, and they leave their professional identity at the door. Once in the TEACCH program, they alternate acting as therapists to the children and as parent counselors, so that they do not identify with either group. This is one of many practical measures Schopler and Reichler have instituted to assure that the focus of their treatment program remains on the individual child and family and not some preconceived notion of them.

Perhaps the most noticeable change in TEACCH since the days of the Child Research Project is the emphasis on education that is now apparent. Once the goal was to treat the child's symptoms so that he or she would be ready to join a normal first-grade class. Now it is known that most psychotic children cannot progress to regular classrooms. Nevertheless, as Margaret Lansing and Eric Schopler recently noted, research and clinical experience over the past decade has led many investigators to conclude that education is the treatment of choice. Recent Federal legislation requiring individualized education for all handicapped children has added an impetus to the trend toward educating rather than just treating psychotic children. The North Carolina legislation creating TEACCH carried a mandate that it provide individualized education for all psychotic children and those with related communications handicaps.

This shift toward education has changed several aspects of the TEACCH program, beginning with the diagnostic system. For educational purposes,

. . . it is less helpful to know the precise catalog of the child's autistic characteristics than it is to know their educational implications. How much individual attention does the child require to function in the classroom? At what developmental level are his language and other cognitive skills? Which of his autistic behaviors are incompatible with his learning or disrupt the other children? This kind of information is needed to decide the degree and kind of classroom structure the child requires . . . the educator also needs to know what skills, if developed, will enable a child to better function—regardless of the environment he is in. [Lansing and Schopler 1978, pp. 440-441.]

The diagnostic system and instruments now used at TEACCH, particularly the Psychoeducational Profile, are geared toward meeting these educational needs as well as clinical goals. Parents are full partners in this process. Test data, for example, are formally integrated with information on the child's functioning at home, information supplied by the child's parents. As with the first families, parents in the TEACCH program today are never excluded from observation and evaluation of their children. They still watch diagnostic sessions through a one-way mirror. Their questions are still answered

fully. They are given as much insight into their child's ability and potential as the TEACCH staff can supply. In fact, the involvement of parents in the TEACCH program is probably greater than it was during the first, experimental years.

Typically, a child now referred to TEACCH comes in with his or her parents for a day of diagnosis and evaluation. Later on the same day, the staff and parents agree to a tentative contract to work collaboratively; the contract sets out goals, responsibilities, and procedures for working with the child. During the next 6 to 8 weeks, the child and one or both parents come in once a week for hour-long clinical sessions. The child therapist and parents decide which problems are most troublesome, agree on techniques to try to overcome them, and set up a program for the parents to carry out at home. The parent consultant acts as an advocate—suggesting management techniques and self-help skills, arranging for medical services, helping with educational planning, and “above all being available to share the parents' burden and struggles in coping.” (Marcus et al. 1977.)

After this extended diagnostic period is over, staff and parents again confer to set up a new contract that might involve less frequent visits. At this point, and sometimes after the initial day of evaluation, the child may be assigned to one of the classrooms that are now part of the TEACCH program. Some children receive treatment at one of the diagnostic and treatment centers first and then move on to a classroom. Some are in both at the same time, and a few only attend classes. Each classroom is staffed by a teacher and a teacher assistant and has five to eight children. Each is supervised by the clinical director of the regional center that it is near.

Classroom programs are, in many respects, like the clinic programs. The teacher, who has full access to diagnostic information, observes and experiments with each child on different tasks and collaborates with parents on the home program.

To illustrate, Lansing and Schopler have described how a teacher/therapist and parents selected tasks and worked with 6-year-old Susan. They knew from the diagnostic assessment that Susan could discriminate the shape and size of puzzle pieces. She knew enough words to label her immediate needs. But she couldn't dress herself. At school she showed no spontaneous interest in the task at hand and typically withdrew

instead. The teacher and parent decided to teach her a task that was both within her ability and useful in daily life—in her case, the difference between *big* and *little* and the skill of buttoning her own clothes. Both the teacher and the parents had noticed that Susan was very interested in her mother's jewelry, that she watched her mother sew, and that she learned best through daily repetition of structured routines.

Susan was quickly frustrated and rejected tasks that were clearly difficult. Buttoning her clothes was too difficult due to poor fine motor skills, poor visual attention, and lack of coordination between both hands. The buttoning task was broken down into steps: beginning with pushing large poker chips through a card-board slot, then to large buttons, smaller buttons, and finally to buttons attached to cloth. Both parent and teacher worked simultaneously and observed Susan's rate of increased skill, keeping the tasks at a level of possible success. Big and little were taught first in sorting tasks using jewelry, serving utensils, and food as well as school materials. The objects were labeled by size, and once descriptive labels were understood, Susan was required to use these in daily routines—asking for a "big cookie," "a big swing," "the little earring," etc. Susan was inconsistent in her performance from day to day. As her mother described it, "Some days she seems to get out on the wrong side of the bed." Both parent and teacher observed that on her irritable uncooperative days they got better cooperation if they immediately simplified the tasks, reducing the number or using bigger buttons and giving increased help with her "big," "little" verbal responses. The process of task analysis continued from day to day. [Lansing and Schopler 1978, pp. 447-448.]

Susan's parents and teachers gradually moved on to other daily routines. The teacher thought the girl should be able to carry her tray to the school cafeteria, for example. Susan's mother began teaching her this task by requiring her to carry dishes to the table at home and to carry groceries from the car. Sometimes Susan tilted the dishes and spilled food. Her mother noticed that she would watch her own hands when she was carrying food she liked, so she taught Susan to avoid spilling her favorite foods by being careful and attentive. Soon Susan was carrying trays at the cafeteria.

It is this kind of respectful cooperation between teacher and parent that is similar to the interaction between therapists and parents in the TEACCH program. In recent years, the classrooms have become an integral part of the effort to teach and socialize the troubled children who come to TEACCH. Besides the classrooms, TEACCH has collaborated to establish a group home for older children, classes for adolescents, a summer camp, and summer recreation programs.

Some TEACCH children, about 20 percent, progress to regular classrooms. One way the staff helps to smooth the way for them is to bring normal children in from other parts of the school system to spend time in the TEACCH classroom. Schopler says that when this practice started, it precipitated a crisis. "The principals and parents thought our kids had something that was catching." After a few weeks, however, the visiting children became so interested that teachers started using the visits as a reward, even for second and third graders. Schopler is pleased. "It gives our kids a chance to have nice, constructive social interactions with capable, normal children. And the normal kid learns about handicapped children in a setting where he doesn't feel compelled to make fun or risk losing a baseball game."

Since the TEACCH program started in 1972, some 500 children have gone through the diagnostic evaluation. More than 600 have been seen since the beginning of the Child Research Project. Between 100 and 120 are now seen each year.

OUTCOME—DOES TEACCH WORK?

The advantages of the TEACCH program over most, perhaps all, alternative methods for treating and educating psychotic children are obvious. Families are kept together and parents are restored to their position as the primary nurturing agents in their child's life. The children are spared life in an institution. The cost of TEACCH is low. During the 1975-1976 fiscal year, for example, the State of North Carolina spent an average of \$2,155 on each of 301 TEACCH families; when Federal and local funds are added, the cost comes to \$2,255 for each family. By comparison, institutional care in North Carolina would have cost about \$18,000 a year for each child; and many private institutions are much more expensive. Considering just

the treatment provided at TEACCH centers, the cost came to about \$8 an hour that year. The going rate for individual psychiatric treatment was then about \$40 an hour.

And what about the children? How do they fare? Schopler and Reichler have reason to believe that developmental therapy may work better—for child and family—than traditional methods. Their own clinical impressions are that most children improve, and most families are more stable after they have been involved with TEACCH for a time. Casual chats with parents and children themselves lead an observer to the same conclusion. Parents voice none of the bitter resentment against TEACCH that they so often express toward psychodynamic treatment programs they have tried. Their few complaints are minor. They seem satisfied, even though they have foregone all hope of a miracle cure for their child.

TEACCH has some formal measures of its effectiveness. One is a small experiment that tested the parents' ability to function as cotherapists. The study, which will soon be published, was done by Lee Marcus, his colleagues at the Piedmont TEACCH Center, and Schopler. They found that mothers could significantly improve the teaching and control of their children in less than 2 months. Ten mothers in a clinic sample were asked to teach their own children an unfamiliar but uncomplicated task on two separate occasions—once before treatment began and the second time after the first treatment phase was over. The children had already been assessed, and a task was chosen if the PEP had shown that a child had emerging skill in performing it. All of the children were autistic and their median IQ was only 34. As the mother helped her child learn the task, observers rated the child for compliance and specific skills, such as behavior control and use of language. After the usual weekly sessions at a TEACCH center for the next 6 to 8 weeks, the mothers and children were observed again at a task at the same level of difficulty. Results showed that all of the mothers had improved as teachers and that they were able to generalize what they had learned. The children were all more compliant during the second testing session with one exception, a boy who had been extremely compliant in the first session. Mothers of younger children improved more than those of older children, which suggests that early intervention is important. Mothers from lower socioeconomic status (SES) groups showed

greater improvement than mothers from more advantaged groups; both had done quite well at the first session, indicating that the lower SES group was actually more competent at the end.

The excellent response of this group to the intervention program is especially gratifying, since historically lower SES families have not fared well in being identified or obtaining services for their autistic children. Clearly, educational or social advantages should not influence treatment decisions involving direct parent participation. [Marcus et al., 1978.]

The investigators concluded that while this small study lends support to the overall effectiveness of the developmental therapy model, it does not make it possible to separate out which parts of the treatment process produced the change in the children.

Another study now underway will show how parents rate TEACCH. All parents in the program have answered a detailed questionnaire, and their answers are being compared to responses to a similar questionnaire answered by all therapists involved with parents. Initial reports show that 84 percent of the parents have found the TEACCH program especially helpful in improving their children's behavior problems, language, and social skills. Details of this study will be analyzed later this year.

In a third study, supported in part by the U.S. Office of Education, observers are going into the families' homes and recording the children's behavior and child-parent interactions before treatment has begun. At several points after treatment has started, the observers again record what is going on in the home. Schopler reports that, so far, improvement has been seen in several dimensions.

What can be learned from such research is problematic, however. As Schopler noted in a recent grant application to NIMH:

Most visitors to the home of a disturbed autistic child will agree that the child is *poorly adjusted* and that the family atmosphere is *unhappy*. These vague descriptors are quite real, and the desirability for improvement is rarely disputed. However, the factors contributing to these effects are more variable and complex than can reasonably be controlled in an experimental design. When changes are observed, any

number of variables may have produced them. On the other hand, specific, contributing behaviors can be identified and modified (for example, a child's inability to tie shoe laces), but the demonstrated outcome may be regarded as too specific to be relevant.

Schopler believes that in a program required to treat all children with a range of handicaps, such as TEACCH, the best way to evaluate how well it works is to measure the consensus between all parties involved:

Treatment outcome for both specific and general goals is evaluated through independent interviews with parents, therapist, and teaching staff. Assessment of outcome is validated by the extent to which they agree on their evaluation of success or failure. This consensual validation . . . incorporates the recognition that family adaptation with an autistic child can have many different forms. What a given family decides they can and want to do for optimum adaptation in collaboration with their professional consultant may be closer to the truth than any external criteria. [Schopler 1978a, p. 4201.]

Schopler might have added that a consensus already exists about the value of TEACCH. In 1972 the American Psychiatric Association gave Schopler and Reichler its Gold Achievement Award for "productive research on developmental disorders of children and the implementation of effective clinical application." TEACCH has been the model for many other treatment programs here and abroad.

There's every indication that TEACCH will continue its practice of flexibly adapting to the children and families it serves and cautiously adopting new techniques and procedures as they come along. If there is one inflexible doctrine at TEACCH, it is that children, their parents, and their families are all unique, and their needs must be found out and met in the best way possible.

Parents repeatedly confirm that this doctrine is practiced as well as preached. Tommy had been at TEACCH for 6 weeks when his mother compared it to other programs Tommy had been in.

There, we spent a lot of time getting Tommy to sit in his chair or stop hitting. Here at TEACCH we come and work on teaching him specific skills and in the

course of the work, his behavior has shaped up. But it's more than that. Here we're teaching him in a way that *he* can learn. The staff doesn't just assume that every child learns something the same way. They know that one method may be harder, another easier for Tommy.

Like many other parents, Tommy's mother thinks that one of the most important things she and her husband learned at TEACCH was to accept their son's limitations. Tommy's autistic characteristics have begun to subside, but he remains seriously retarded. His mother said she will be happy if the autistic symptoms completely disappear, and he grows up to be "a nice retarded person, able to live comfortably with others."

Perhaps the last word on TEACCH should go to the parents. Here is what one of the first mothers to participate had to say after she had been away from the program for a few years:

Certainly, they brought out the best in me. Most parents who come to TEACCH don't have any idea that they have talents and that they can teach and train their own child. None of us, when we get married, think of ourselves as needing to have a unique or special quality in childrearing. They helped me learn to set things in motion and teach George some skills, how to help himself, to help him toward using his potential. I had always felt that inside George there were some abilities that we were not able to tap with an IQ test. He does some problem solving that is at a higher level than his overall functioning. When I'd say this in the yearly re-evaluation sessions, no one ever told me I was wrong or humored me. But they did help me keep George's future in perspective. It took me a long time to accept that there was no way George was ever going to be able to read. No way was he going to be able to understand math or social studies or history. They helped me to refocus my thinking—that it would be better for him to learn functional skills, to go after those things that would help him get along in a sheltered life, a sheltered job, perhaps living in a group home. They never promised miracles. They have been very careful. They learn from parents, then they take what they have learned and give it back to other parents.

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Research Grant: MH 15539

Principal Investigator: Eric Schopler, Ph.D.
Director, Division TEACCH
Department of Psychiatry 207H
School of Medicine
University of North Carolina
Chapel Hill, North Carolina 27514

Part VII. Strengthening the Family



IMPROVING PARENT SKILLS

Principal Investigator: Ira Gordon, Ph.D.

*Author: Herbert Yahraes**

INTRODUCTION

Any parent of normal intelligence and average emotional health can be reasonably confident that an infant who is unburdened by genetic and constitutional defects will develop into a competent and mentally healthy youngster. Consider the work of the late Ira J. Gordon dealing with parents at the lowest socioeconomic level and their babies. It is such children who are at the greatest risk to educational failure, personality disorder, antisocial behavior, and mental illness. If the simple methods developed by Dr. Gordon and his associates at the University of Florida can prevent dire outcomes in such families, they may be equally effective in families higher up the socioeconomic ladder.

DESCRIPTION OF THE PROJECT

The Florida intervention project was directed at the parents because research by other investigators had shown that the effects of working with the children directly, although substantial for awhile, tended to fade and disappear after the extra effort stopped. If the *parents* could be taught how to help the child develop his inborn capabilities, Gordon reasoned, the effects of the intervention program ought still to be felt for a considerable time after the end of the project. And if the disadvantaged children succeeded in entering grade school at the same behavioral and educational level as most other children—

*See note at end of chapter.

instead of incurring the usual lag of a year or 2, which most such children never do succeed in overcoming—the effects might turn out to be permanent; certainly the child's confidence in his ability to stay in the mainstream would be enhanced.

As Gordon points out, there is a definite relationship between self-concept, or how a person sees himself, and mental health. There is also a definite relationship between self-concept and competence. When a youngster knows he can read, for example, the child's self-concept is improved, and the foundations of mental health are strengthened. Events through the years—starting in 1966, when the first families were visited—have shown that Gordon was right.

In addition to influencing the child indirectly through the mother, Gordon's program was marked by two other features. First, work with the mother began when her child was only 3 months old. Second, the people who worked with the mother—they were called "parent educators" (PE's)—were women from the same social class as the families they worked with.

The paraprofessionals taught the mothers ways to stimulate the perceptual, motor, and verbal activities of their babies and to be aware of and to meet their emotional needs. In the investigator's words, the aim "was to investigate the effectiveness and practicability of a home-centered technique for cognitive, language, and personality development of mother and child, based upon the use of parent and child educators who are themselves members of the population served." If effective, Gordon pointed out, this innovation in family services would extend the reach of the professional, upgrade the competence and importance of the nonprofessional, and, in the long run, as participants became more capable of meeting their own needs, reduce the need for intervention.

The experimental group embraced 150 families, about 80 percent of which were black and the rest white, in 12 counties. They included representatives of the urban poor, living in Gainesville and other cities, and representatives of the rural poor, living in small towns and settlements or in isolated, unpainted cabins as much as 2 miles from a water supply. In some cases the new baby was the mother's first; at the far end of the scale, the eighth or ninth. In half the homes the father

was absent because of separation or divorce or because the mother was unmarried.

Visits to the homes showed that, in general, the mothers were taking care of the baby's physical needs, though very often on a haphazard basis, but characteristically did not talk to the baby, did not play with him or her, and did not offer praise for accomplishments. Frequently the homes contained neither books nor magazines. But most homes that had electricity also had television sets, usually turned on high to the soap operas.

"As we looked at the homes," Gordon says, "we felt that the predominant problem was not whiteness and blackness but the cultural poverty. We found poor black homes that were doing a good job with the kids and poor black homes that were doing a terrible job—and the same thing in the white population." The staff did find one racial difference: It was harder to keep whites in the program, possibly because the extra attention they were receiving may have hurt their pride.

There were two control groups of 30 families each. The families in one received no services; those in the other were visited once a month by a nurse, who showed interest in the baby and the family and took pictures. Her activities were an effort to control for the so-called Hawthorne effect—that is, to learn if a simple show of interest would produce changes comparable to those that might occur in the experimental group served by parent educators. (The answer turned out to be "no.")

The parent educators, or PE's, ranged in age from 18 to 55. They had to meet fairly simple requirements: a high school diploma, some experience with young children, a warm personality, and sufficient clerical skill to maintain a record of what they had done and observed in the homes. During the training period, which ran for six 40-hour weeks, they learned to demonstrate and explain the great variety of activities—known to the project as "tasks"—they would be teaching the mothers. They worked at first with dolls and then with children. Once the home visits began, the program added inservice training, 1 day a week, to increase the ability of the PE's to recognize and deal with different types of mothers and children.

In keeping with the distribution of races in the project's families, 15 of the parent educators were black, 3 were white, and it was planned that each PE would visit only families of

her own color. For greater ease in scheduling visits, however, this plan was dropped after the first year, so that blacks sometimes visited white families, and whites sometimes visited black families. The color of the PE, Gordon reports, made no difference either in her acceptance by the families or in the results obtained.

Visits were made once a week and lasted less than an hour. The PE would ask how well mother and child were carrying out the activity introduced during the previous visit, would answer questions, and then would demonstrate a new task and rehearse the mother in it. The tasks, which were based on studies showing how children develop language and other mental abilities and sharpen their skills and senses, were as much the creation of the paraprofessionals as of the project's professional staff. Many of the activities required no material or at most material available in even very poor homes. Equipment not usually available, such as paper, glue, crayons, books, and small toys, was supplied by the project.

Of the following examples of activities, the first two are typical of those introduced during the child's first year; the last, during the third year.

- With the baby lying on his back, hold a rattle about 12 inches above his stomach. Shake the rattle until the baby looks at it; then say, "See the rattle." Move the rattle slowly toward the baby's hand until he looks at hand and rattle simultaneously. Then say, "Get the rattle." When the baby grasps the rattle, smile, speak to the baby by name, and say, for example, "Johnny has the rattle." Purpose: to help the baby connect grasping with seeing and action with action words.
- When the baby is relaxed and happy in your arms and facing you so he can watch your lips, say some sounds he is not familiar with, such as "brr-own" and "ghrr-ate." Give the baby time to make his own sounds. When he does so, respond with a laugh, a smile, or an encouraging nuzzle. Purpose: to help the baby make speech-like sounds.
- Have your child help you use crayons to color some popsicle sticks. Then lay out a color pattern, talking while you do so.

Say, for example, "I put red, yellow, and another red—two red sticks with a yellow stick in the middle." Ask your child to copy this pattern. Then let him make a pattern for you to copy. Primary purpose: to teach the child to recognize colors. This activity can also be used to help the child grasp the meaning of numbers. At least as important as the activity itself was the interaction it brought about between mother and child.

The parent educators also listened to parental problems. In middle-class homes, Gordon has found that such problems generally pertain to childrearing. But in the lower-class homes of this project, most of the recurring major problems related to the families' poverty. "I've got nine kids," a mother would say, "and a part-time job which makes enough money to keep me off welfare, but I haven't got enough money to feed my children." Or, "My husband is making a good living, but he's drinking it all up, so I don't have any money for my kids." Or, "I don't know how to get commodity foods." More than childrearing, the problems concerned basic survival.

Since the project was not equipped to handle such problems directly, it acquainted the parent educators with the available social services and assigned them to be referral agents. Then it had to tell the paraprofessionals where their limits were. "Because they had come out of the same boat the family was in," Gordon recalls, "they'd identify very strongly with a family and want to do what a new and naive social worker often does—try to run around and do everything themselves. We'd have to say, 'Now wait a minute. If you're going to help that mother improve her locus of control—help her feel that she herself is greatly responsible for what happens to her and the family—you've got to work with her so she does things herself.'

"Then the paraprofessional would say, 'But she doesn't have a car, you know, so how is she going to get there?' We'd say, 'Okay, if you want to drive her, but she's got to talk to the man—you can't talk for her.' We did get into all kinds of problems not strictly related to what we were doing."

When the children were a year old, half of the control children were randomly assigned to the home-visit program, and half of the children in the home-visit program were randomly

assigned to the control group. These changes were made so that at the end of 3 years the investigator could make comparisons among groups that had been in the program for varying lengths of time and at varying ages.

In a second and major change, the project used an NIMH grant to set up a number of home-learning centers so that the children from 2 to 3 years old could benefit from contact with peers. The centers were the homes and backyards of some of the project families. Three were established in low-income housing projects in Gainesville and one in each of four Florida towns. Twice a week, 2 hours at a time, groups of five children each would meet there to engage in group and individual activity and to interact with the PE. The mother who lived in the home was employed as the PE's aide. The home visits continued. This program was not day care, Gordon points out; it was more like an abbreviated nursery-school experience.

Part of the inservice training day was set aside for meetings of the Home Learning Center directors, university faculty members, and graduate students to discuss difficulties and to develop ideas for improving relations among those attending the centers. Also, each PE had a private conference each week with a faculty member to review her activities and receive guidance. When a PE wanted special help, a faculty member would make home visits with her.

THE FINDINGS

The project has not been in touch with the children since they were 3 years old, except to administer tests. But it expects to follow them—through those tests, school records, and teachers' observations—until they have finished fourth grade. The findings now available are summed up in the rest of this section.

IQs at 6

Statistically, four out of the seven experimental groups scored significantly higher than the controls on the Stanford-Binet intelligence test at the age of 6. This was 3 years after the end of the program. The groups, together with the differences between each one's average score and that of the controls, were as follows:

1. Children in the program all 3 years scored 7.2 IQ points higher than the controls.
2. Children in the program only the first 2 years scored 9.4 points higher.
3. Children in the program only the last 2 years scored 6.2 points higher.
4. Children who participated only in the Home Learning Center part of the program, which began when the children were 2 and ended a year later and which included weekly visits to the home by parent educators, scored 5.6 points higher.

The differences in the IQ scores among treatment groups are not statistically significant. In other words, it is impossible to say that one treatment schedule yielded better results than any other, as measured by IQ scores. Gordon reports indications, however, that the 3-year program pays off the most consistently and also has the most effect on the home.

The average scores of the children in those four experimental groups ranged from 94.2 to 98; that of the controls was 88.6. (The average IQ of black children of 5 or 6 years of age in five Southeastern States is 80.) White children and black children in the program had average scores that were approximately the same.

Gordon points out that the differences produced by the intervention, though they were not startling, were sufficient to move the children into the range of normal intelligence. The findings suggest that the earlier in a child's life such an intervention program is started, the greater the probability that it will make for a significant rise in his or her intellectual competence. However, Gordon notes that even those children who took part in the program only from age 2 to age 3, when the Home Learning Center was introduced, scored higher than the controls.

Three other groups did not score significantly higher than controls: those who were in the program their first and third years, or their first year only, or their second year only. Least successful was the group that entered at 12 months and left at 24 months. "Our feeling has been," Gordon comments, "that the period from the first year to the second is difficult because so many things are going on at once, particularly in terms of motor development." Also, as found by other investigators, the

child is likely to act negatively during a good part of that period, even to the extent of refusing requests simply in order, it often seems, to aggravate the mother.

Results at Grade 3

Of 30 children who stayed in the program for more than a year, 28 were in regular classes in third grade and only two were in special education classes, which are classes for those who have fallen decidedly below the level of their classmates. This was 6 years after the end of the intervention program. In contrast, out of 20 control youngsters, 6 were in special classes. The difference—6 out of 20 in trouble educationally as compared with 2 out of 30—is statistically significant at the .05 level.

→ Factors Related to Children's Outcome

Apart from the teaching of mental and motor skills by the mother, and the evidence she incidentally gave the child of her love, interest, and expectations for him or her, other family practices were found to be important. Prominent among these was the extent to which the family recognized the influence of the environment in shaping the child. To assess this factor, the project asked, for example: Are there books in the home? Does the family use the library? Is the child taken to the zoo, the museum, other places? When the child uses incorrect language, is he or she corrected? Does the family know how the child is doing in school? The answers to these and other questions were grouped into seven variables. For every one of the variables, there were differences, when the children were 6, between the mothers whose children were in the program and the mothers of children in the control group. The variable dealing with the extent to which the family took advantage of community opportunities for learning turned out to be a particularly potent indicator. Gordon is not sure that the differences between families with respect to this factor can be ascribed entirely to the work of the parent educators. However, when the children were between 2 and 3, the PE's did encourage the mothers to take advantage of the libraries' preschool story-telling hour and to use the bookmobile service.

In other work, Gordon and his associates have further demonstrated the importance of mother-child interaction. The subjects in this research were 128 mothers and their new babies from families below the poverty level. Mother-baby interaction was video taped a number of times, beginning when the child was 3 months old, and tests of infant intelligence were administered at the age of 1 year. The outcome: Children whose mothers talked *with* them rather than *at* them, who gave them interesting things to do, and who encouraged them to stay with an activity were more likely than other children to score well on the tests.

Gordon points out that the findings of his studies are similar to those of other investigators, both in this country and abroad. "The role of the caring adult—I don't want to limit this to the mother—in providing intellectual stimulation, security, and a loving relationship," he says, "seems to make a fundamental difference." More than any other single factor, he believes, such a person's influence early in a child's life, or the lack of such influence, helps determine not only intellectual competence but also emotional strength and mental health.

Also important were the mother's attitude toward the project and her view of locus of control—that is, whether or not she thought a person could influence what happened to her, or to him. The better her attitude when the child was 3 and the stronger her belief that she had some control over events, the more likely her child would score well on the IQ tests at the age of 6.

That's for the children as a group. Sex made a difference. The best predictor in the case of the girls was the extent of the mother's education. With boys, the best predictors were the mother's satisfaction or lack of satisfaction with her appearance and her social relations, and also her attitude toward the project.

Changes in the Mothers

When the University of Florida team was planning the original project, Gordon hypothesized that one of the results would be an increase in the mother's sense of personal worth. Psychological tests given at the end of the intervention, when the children were 3, did not confirm the hypothesis. But interviews with the mothers when the children were 6 suggested that the

project had indeed brought changes. Compared with mothers of the controls, significantly more of the mothers in the project were married; had gone back to school or taken adult-education courses; had moved into better housing; were holding a better job; and were involving their children in neighborhood or community activities. And significantly more of these mothers wanted their child to finish high school at least; thought that the child, when grown, should make his or her own choice of occupation; reported that their child was doing better academically than other children; and said that their 6-year-old was teaching other children in the family things he or she was learning in school.

"To do something with parents, to involve them in some way," Gordon observes, "is becoming part of the general thrust in childhood education."

There were other hopeful findings when the children were 6. Mothers who had been in the program all 3 years saw themselves, compared with mothers of control-group children, as significantly more involved with their children's development and learning; more engaged in self-enhancement; more aware of the child's individuality; and more achievement-oriented and upwardly mobile.

The investigators infer that the mothers in the program for 3 years have higher self-esteem and a greater sense of managing their own lives than mothers of control-group children. Mothers whose children were in the project for 1 or 2 years only were significantly better than control-group mothers on only some of the factors listed.

As an important incidental result, Gordon points to the paraprofessionals who worked as parent educators. "If you want to see what happens with the development of self-concept," he says, "you should look at that group of women. They're proud of themselves, they've grown, and they've sought additional schooling." Two are getting their bachelor's degrees at the

university. Many are working at a large institution for the mentally retarded.

The project has had a wider effect as well. A number of community mental health centers in Florida are developing intervention programs, with the emphasis on visiting the homes of infants; also, the State legislature has called upon each school district to involve parents in the educational process. Further, Gordon's ideas and those of half a dozen other investigators working along similar lines are being applied in a number of communities across the Nation as part of the Follow-Through Program. "To do something with parents, to involve them in some way," Gordon observes, "is becoming part of the general thrust in childhood education."

Now the project will backtrack. It knows which children have been identified by the schools as emotionally disturbed and which ones have been assigned to classes for those who have fallen behind. It will now look at what these children were like earlier.

The project will also investigate the persistency of nonpersistent behavior. This much is known: The nonpersistent and impulsive children in the home learning centers—meaning the youngsters who tended to wander around and not focus on any one activity—were likely to have a lower-than-average IQ score at 3. But this relationship did not hold at 6. Since Gordon views persistence as a highly important characteristic from the standpoint of both achievement and mental health, the children are being rated on this quality by their third- and fourth-grade teachers, who do not know which students were in the project and which were not. When the ratings are completed, a computer search will determine whether or not lack of persistence today is related to the same characteristic years ago, when the children were between 2 and 3.

Class Differences in Childrearing

With respect to the quality of childrearing, the investigator emphasizes, the population under study proved to be heterogeneous. The typical mother in the study does less well than the typical middle-class mother in teaching language, in interacting with the child, in getting the child to read by her own interest in reading, and in taking advantage of community facilities. But there were some families among those studied

that did these things very well and others that did them scarcely at all. "In a middle-class population," Gordon says, "the average would be better, but there still would be parents doing a very poor job."

Why the difference? "One of the clues," Gordon answers, "comes from Mary Ainsworth's work with middle-class families in Baltimore. She was studying the responsiveness of the mother to her children, which is generally held to be an important part of parenting. She found that 43 percent of the mothers were not responsive. A child would cry, and they'd just let him or her cry; another child would ask for something and simply be ignored."

Similarly, in Florida, parent educators who had been visiting the homes of university professors in connection with one of Gordon's studies reported that in some of the homes something was missing. Gordon quotes a typical comment: "Well, first of all, the kid has a room of his own, and he's got toys, and he's got this and that. But I don't see much going on in terms of a love relationship. I visit in our homes, and the kid may not get enough to eat, and he doesn't have privacy, and maybe he is physically punished. But I also see some *warmth*." The investigator adds: "I think all of the families in this country are in trouble in some way. All need support of one kind or another."

He gives another example. "Middle-class families call us up about being involved in a new project, and we tell them, 'We're going to be taping you until the child is 1, and we'll need both mother and father that whole year.' Then we've had the mother or the father tell us, 'Well, we're only going to stick together until the baby is born.' They know that already, and the father may even be into natural childbirth with the mother. What's going to happen to that child?" He adds: "We can't take such couples, of course, so we're going to have a somewhat skewed sample, the skewed sample comprising what we used to think of as the conventional family."

IDEAS FOR A PROGRAM OF PREVENTION

If Gordon were doing the study again, he would begin with a prenatal program—simply because he thinks that the earlier you can get to the parents in helping them understand children, the more you can influence them. Also, he would put

more emphasis on helping the parents to understand "the affective domain"—the world of the emotions—and how it influences health and behavior and to recognize the difference in temperament from child to child. "We know from the works of Thomas, Chess, and Birch in New York," he points out, "that babies can differ on a number of dimensions of temperament. For example, some babies need to be fed every 4 hours and some every 2; some babies sleep more than others; some sleep more in the day than others and are up more at night. Brazelton finds much the same thing in Massachusetts. The differences seem to be constitutional, yet in the information given mothers about childrearing they have often been ignored. And mothers who have had experience with, or been given information about, one or two types of babies may be quite unable, without guidance, to adapt their expectations to a different type. We have to help parents know about their child's activity rate—for example, know about their child's openness to the environment, know about their child's sensitivity."

Gordon would also place greater emphasis on the process of interaction between parent and child and on helping parents learn to be more responsive to the child. "Responsiveness," he notes, "takes a certain level of parental self-esteem, self-assurance, and comfort. It also takes a certain level of support from each parent for the other parent."

The problem with putting such ideas into effect, Gordon points out, is that they are not simple, so the effort might not be cheap. "Yet the tenor of legislation is to look for simple, cheap, and fast solutions—and there are none."

He feels strongly about finding ways to strengthen the ability of parents to develop competent and mentally healthy children on their own. So he is not looking for "solutions that institutionalize children early—that extend school downward to the earliest years as an institution. Rather, I'm looking for ways to develop supportive services that enable families to do better than they can do now."

The investigator points to several trends that make it difficult for families to survive. "How can we put the burden for childrearing on the family," he asks, "if the society is organizing itself in a way that makes it impossible for a family to carry that burden? What are we really doing with the mental health of parents when we say, 'You're responsible for raising

your kids, but if you want to succeed in business, you've got to move'—as in the case of a man I met just the other day, 14 times in 17 years—to go up the corporate ladder? What are we doing to that family? Or to a welfare family when we say to the mother, 'You're a horrible woman because you're not working, but we're going to pay you so little that you cannot hire an adequate babysitter to care for your child, and we are not going to set up adequate day-care services.' What happens to her child if she works?

"I think we have to look beyond education and beyond mental health to the larger picture. For instance, North Carolina is developing a large-scale testing program of 4-year-olds, to uncover children with problems. But once the problems are uncovered, there is no system to do anything about them. Again, we're putting money—through the National Institute of Mental Health, the Office of Child Development, and other agencies—into early diagnosis, but we have no system to treat the children once they have been diagnosed. We really ought to sit down and get a more synthetic—a more comprehensive—view of what the whole thing is about. Basically we need a program of prevention."

As a major part of a preventive program, Gordon would get adolescents involved with young children. "The American high school is in terrible trouble," he says, "because so many of the students think that what they're learning is irrelevant to where they're at and because there is no longer a productive role for an adolescent in American society. It used to be that a boy or girl could get a job at 14, or even earlier, but not now.

"So we have this need for day care, and we have this need for giving adolescents a productive role. We can meet both of these needs to a considerable degree by setting up a child-care program in a junior and senior high school framework. Adolescents would then not only be performing a productive role but would also be learning what is involved in taking care of a child.

"Then a 13-year-old girl might say to herself, 'My goodness, look what it takes to really raise a kid properly,' and she might then think twice about having her first illegitimate child. Maybe not, because there are all kinds of peer pressures on her. But the experience of caring for young children as a part

of her schooling will certainly have some influence on how she goes about caring for her own children."

Gordon points out that the Office of Education and the Office of Child Development fund a program called "Exploring Childhood" that includes academic work in child development and also some field experience but, he says, the program is too small. He advocates the establishment of good day-care programs in connection not only with schools but also with industrial plants and government agencies, places where many women with small children work. "An increasing number of women with children under the age of 3," he points out, "are going into and staying in the work force. So, in the interest of prevention, we've got to do something to help those children have good care and to help those mothers supplement and complement that care—through what they do with those children at home in the evenings and on weekends."

Gordon rates many of the existing day-care programs as very poor, "because a good program costs money and also because many women don't understand the importance of a developmental program," which seeks to help children develop their innate abilities. "Many women are simply concerned with *garaging*—with knowing that their child is being fed and changed. They don't understand that the whole area of interaction, stimulation, and attention is highly important."

EFFECTS OF CHANGES IN THE TEACHING STRATEGIES

In a separate project, the University of Florida team set out to answer, among other questions, (1) whether people who were better qualified educationally than paraprofessionals would get better results, and (2) whether it was more effective to work through the mothers or directly with the child. There were 128 families, plus 30 controls. Half the parent educators, like those used in the first project, were women who had graduated from high school. The others, considered professionals, were college graduates who were studying for a master's or a doctor's degree in education or psychology.

When the children who had received the workers' direct attention were compared with those whose mothers had received it, no differences were found at age 1, when the project ended. Nonetheless, the mothers who had received the direct

attention were judged to be better teachers than those who had been simply onlookers of the activities with their children.

As for the professional-paraprofessional issue the families accepted the professionals and paraprofessionals equally well; the professionals seemed to be more effective than the paraprofessionals in working with the mothers of girl babies and to be as effective as the paraprofessionals with the mothers of boy babies; the professionals were considerably less effective than the paraprofessionals in working directly with boys. In any further studies, Gordon would stick with the paraprofessionals because the work of a parent educator "is a meaningful social job that can be taught to people without advanced education."

"PING-PONG," PERSISTENCE, AND PROFESSING

Associated with high scores on developmental tests at the end of the child's first year, particularly in the case of girls, was a behavior labeled "ping-pong." The investigator describes this as "a you-do-something, I-do-something, you-do-something, back-and-forth activity between mother and child. The mother elicits, the child responds, the mother elicits or corrects, the child responds, the mother elicits, and so on." The activity came to light when video tapes of sessions among parent, child, and parent educator were analyzed. Some of the mother-child pairs often engaged in it even when the child was only 13 weeks old, which was at the start of the study; others at that time engaged in it rarely, or not at all. Since the parent educator encouraged mothers to be aware of and respond to their babies' activities and vocalizations, this interaction gradually increased in all the homes. Beginning at 25 weeks, there was a consistent relationship between "ping-pong" activity and test scores at 12 months.

A characteristic labeled "persistence" also was found to be important. The parent or the parent educator would start the child on some activity and then step back. The longer the child continued with the activity, the higher his or her score on persistence and, on the average, the greater his or her developmental score at the age of 1. "We've been trying to get teachers to do this for a long time," Gordon says, ". . . to show the child how to do something and then step back and let him or her do

it. It's interesting to find that persistence makes a difference even during the first year of life."

Another positive pattern was *mutual gazing*, or eye-to-eye contact between mother and child as recorded a number of times during the first year. The amount of *brief* mutual gazing (between 1 and 3 seconds) at 19 weeks was positively related to language development at 52 weeks in boys. The amount of *prolonged* mutual gazing (over 3 seconds) at a number of points during this 1-year study was positively related to scores on other developmental test items at 52 weeks, but again only for boys.

A negative pattern turned up as well. Gordon labeled it "professing"—"talking at, followed by talking at, followed by more talking at the child without being really tuned in to him or her." It seemed to be more characteristic of parent educators who were at the professional level—those with a master's degree—and who were working with boys. These boys on the average had lower scores at the age of 1.

EFFECT OF SEX DIFFERENCES

Recently the Florida team started work on a new NIMH-supported project to investigate differences in the relationships of parents to their children during the first year of life. The differences are expected to vary both with the sex of the parent and with the sex of the child. The team's earlier work, Gordon points out, seems to show that the mother's view of herself has greater influence on boys than on girls, while the teaching relationship—the ping-pong activity—seems to influence the girls more than the boys.

The new project is confined to middle-class families with their first child—40 with a recently born boy and 40 with a recently born girl. The hope is to uncover some basic processes of parenting that influence a child's mental health and that can be taught to prospective parents.

WORKING TO GET PARENTS INTO THE SCHOOLS

In addition to directing the projects described to this point, Gordon heads a team of 15 faculty members and a number of graduate students, all from the University of Florida, that has helped to institute and guide the Federal and State Follow-

Through programs in 11 communities in 10 scattered States. Included are Jacksonville and Tampa, Houston, Chattanooga, Richmond, Philadelphia, Yakima (in the State of Washington), and one small community each in South Carolina, Arkansas, Indiana, and Wisconsin. Teams from other universities work in other communities. Follow-Through, a followup of the Head Start program, is concerned with children from kindergarten through third grade.

In the intervention projects for very young children, Gordon and his associates were, in the main, training parents to be teachers in the home. In the Follow-Through projects, in addition to increasing parents' skills as teachers of their own children at home, they are introducing parents into the school system as volunteers, observers and learners, and home visitors. They are trying to get the parents involved also in such decisionmaking processes as those concerned with the school system's program and budget. "With such activities," Gordon says, "the school becomes a humane place where people can talk with one another rather than a bureaucratic operation where everybody is at a distance."

Gordon explains why he likes to see parents working in the school. "The more the parents feel that they have some control over what's happening to them and their child, I think the more effective parents they can be. Parents have been told by school people for many years—maybe not in so many words—that they don't know anything about education, so they should keep their hands off. When that trend is reversed, I think the parent gets a feeling of self-worth that is extremely important. Also, I think that very often parents feel that the school is an alien place and that the teachers are getting paid for not doing anything much. When a mother goes into the school and starts to work, though, she gets a different appreciation of the teacher's job and comes to see her or him in a new light. And the teacher begins to see the mother in a new light. When home and school develop a common view, the beneficiary is both society and the child."

A recent report of Follow-Through achievements in the cities for which Gordon is responsible showed that a surprisingly high proportion of parents had volunteered to help teachers in the classroom. The rate ranged from 27 to 96 percent of the families sampled.

Problems have arisen, to be sure. "There are some teachers who say, 'I don't want anybody in my room,'" Gordon notes. "And there are some parents who say, 'Why should I go to work in the school? I'm not a teacher; I wouldn't know what to do.' So we try to begin at the lowest level of agreement. The teacher may say, 'Well, if that mother wants to come and watch how her kid's behaving, okay—she can come.' So we start there. If she says, 'Well, if she wants to help me fix a bulletin board, I'll tell her what to pin up,' we'll start there. We start wherever the two of them feel they could be comfortable with each other and gradually try to move them toward higher levels of work."

The paraprofessionals—the parent educators—have helped the process by talking to teachers about the activities the mothers have learned and suggesting that mothers be invited to demonstrate these in the school.

Gordon calls the Follow-Through program "the best concept the Government has ever had for intervention with school children. Before this program, the Government would give money directly to the school system, with the result that when the money died, the program died, too. Or the Government would fund scholars to develop ideas, with no way of getting the ideas into the real world. In Follow-Through, in contrast, a group of university people with ideas have been tied together with a group of local school systems, and both have worked hand in hand in developing, implementing, and evaluating changes." At the beginning, the Florida team—through which Federal support is channeled—bore responsibility for the programs in its 11 communities, but the team has gradually disengaged itself, and the programs are now mainly in the hands of the local school systems and parents. Most of the systems could go ahead on their own, Gordon believes, even if Federal support diminished.

As an example of what has happened, this investigator cites the Follow-Through program in Yakima, Washington, where the public schools are served by more than 40 parent advisory boards. Many of the boards are concerned with curricular and extracurricular activities at individual schools; fifteen deal with vocational guidance; others serve specialized programs, such as the one for the education of migrants.

Moreover, from September to February of a recent school year, parents contributed more than 14,000 hours of school-

related work. Parental activities included helping students overcome scholastic troubles, advising students with other problems, and assisting in such activities as a book fair. During the same period, school personnel made almost 11,000 home visits to discuss educational opportunities and problems with parents and children. Conferences with the parents of all elementary students are held twice a year. A score of Parent-Teacher-Student Associations have been organized.

The school district's Career Awareness Center lists more than 850 community resource people who have volunteered as classroom speakers, conductors of field trips, and occupational advisors. The center handles 350 requests a month from students and teachers.

To increase communication between the home and the school, the high school has instituted the Guide Teacher Program. Each guide teacher is assigned 30 students, who are counseled at least once a week, on a one-to-one basis, concerning academic, personal, and career questions. Before school opens in the fall, guide teachers visit each home. "One guide teacher to 30 students," said the high school in announcing the program, "is much better than one guidance counselor to 400 students."

IN THE INTEREST OF A COMPETENT AND MENTALLY HEALTHY CHILD

In view of Gordon's experience with children at risk and their parents, what would he tell someone who asked, "What can I do to help make sure that my baby will be of good emotional health and have a sound mind? What can I do to help prevent emotional maladjustment or underachievement?"

Gordon responds: "The first thing I would say is, 'Relax and enjoy your child. Don't get anxious. Realize that over the years you will probably make a variety of mistakes but that what gets communicated to the child is not the trauma of any specific act of yours but your own overall attitude.

"Sit down with your partner and talk openly about what the two of you think is important, what your hopes and expectations for a child are, how you think a child should behave. One thing that gets kids into trouble is differential behavior by the

parents—when one parent allows and the other parent disallows.

“The first things a child needs are order, and continuity, and security. This means that you and your partner have to have some areas of agreement on how to raise this child. Authorities by and large do not agree that there is only one right way to raise a child. But they do agree that the child should not be subjected to varying types of rearing. And they do think, with reason, that a completely chaotic, permissive environment is destructive. There must be some rules, there must be some regulations, there must be some standards.’

“The second thing I would say is: ‘You need to develop some sensitivity as to the individuality of your child and not hold him up against some external norms. You’ll hear a good deal, if you talk to authorities on child development, about the importance of stimulation. You need to realize that the most stimulating thing in a child’s environment is the adult—not a toy, not a mobile, not a fancy crib, but interaction with another human being. Piaget says that the most interesting object in the child’s world is the mother. I would say that the father is just as critical.

“If you choose to have a child, both of you must set aside some portion of the day—even if you are both working—that belongs exclusively to the child. You don’t have to put it on a schedule. You don’t want to say: “Now, kid, it’s 5 o’clock. I’m going to interact with you until 5:15 and then go have my martini.” That child sometimes needs you more than he needs anything else. If you’re going to have a child, that’s your first obligation.

“Even if one of the parents is home, the child doesn’t need constant care. You don’t have to be bothering him 24 hours a day. Some people used to say that the Israeli kibbutz—a communal settlement—would destroy the family. But it has been shown that a child of the kibbutz is just as much attached to the parent as other children are. That’s because a part of each parent’s day is the child’s time.

“Of course, if the parent is home during the day, the interaction—the fun, the play, the dialogue—may be at odd moments: 2 minutes here, 5 minutes there, 30 seconds somewhere else.

“Another thing to realize is that you cannot separate—if you are at home—child care from child development. This means

that while you're changing a diaper, for example, you have an opportunity to look at your child's face and smile. While you're dressing a child, you can rub a tummy. While you're feeding the child, you can talk. These are not simply physical care times; they are also learning times. The things to do are simple, yet they are important to the child's emotional and intellectual development—and they don't require any extra time."

Gordon adds: "Those are the sort of things that typically the lower-class mother does not do. And they are increasingly the sort of things the middle-class mother does not do either."

For instance, Gordon finds middle-class parents more and more interested in books on basic child development. He attributes this to a number of factors, such as the increased isolation of young people from their own parents (who, it is presumed, would have some folk knowledge concerning babies to impart to their own offspring), and also to the fact that many young parents have never handled infants prior to having their own. Given such isolation and inexperience, they turn to the professionals for guidance. While parenting may be in part good intuition, it appears from the work of people such as Dr. Gordon that it can also be given a substantial boost by appropriate, well-timed training. Such training may be vastly improved by the dissemination of understandable information as to how to provide such training.

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Futher information regarding Dr. Gordon's research may be obtained from the Director for Development of Human Resources, University of Florida, Gainesville, Florida 32611.

TRAINING FOSTER PARENTS

Principal Investigator: Patricia Ryan, Ph.D.

*Authors: Vivian R. Isenstein, NIMH, and William Krasner**

Foster parents are discussing a crisis in the life of a little girl in their charge—a crisis that also deeply affects their own lives. The girl's natural mother has appeared after 4 years of absence and demanded that she have her daughter with her for Christmas. The social worker directed the foster parents to comply with the mother's request. When the natural mother came to get the little girl, the child, unable to remember her natural mother, was frightened.

Foster Mother: Al, I'm so mad I could scream! Imagine the nerve of that social worker, telling us that Mary would spend Christmas with her mother. She's our baby—that hopheaded woman isn't fit to touch her!

Foster Father: We've had Mary since she was 1 year old. We're her mommy and daddy and have been for 4 years. Where was her mother then! Remember how dirty, hungry, and scared she was when the social worker brought her to us? That social worker doesn't know what's going on. She's never seen how that woman acts.

The words are not spontaneous. The couple is reading from a script on the table before them. But the actors are real foster parents, and the situation has direct and immediate meaning for them and for the other foster parents who are listening attentively.

*See note at end of chapter.

When the reading is over, the instructor calls for comments. Most of the foster parents have opinions. The majority are hostile toward the natural mother and the social worker. One man tries to take a broader view: "You have the child all year round and you'll have her back. Why can't you be generous enough to let her go for Christmas?" The others disagree. If the mother loved the child, she wouldn't wait 4 years to visit. If she loved the child, why is the child in foster care?

The foster parents move from comments on the script to real life problems and grievances. One woman is about to lose a child she has had for 1 1/2 years. According to another, the courts will take a child away merely at a natural parent's request. One complains that her social worker does not visit enough; another praises her social worker. All the members of the class have foster children and all have run into problems they would like to discuss.

This is a beginners' class and there is a great deal of ground to cover. The role of the social worker and her relationship to foster parents must be explored. The problems of the natural parents must be understood. The network of involved people—foster parents, natural parents, social workers, agencies—needs to be clarified since, in essence, they are all working toward a common goal of what is best for the child.

THE PROJECT

The script is used in a course given as part of Eastern Michigan University's Foster Parent Training Project, which is funded by the National Institute of Mental Health's Center for Studies of Metropolitan Problems. The class is composed of foster parents seeking to improve their skills for the unique job of taking care of other people's children. Part of the class format involves role playing the difficult situations which foster parents frequently experience and discussing how to handle them.

Requests for help from foster parents' associations led to the development of the Project by Drs. Patricia Ryan and Bruce L. Warren, both associate professors of sociology at Eastern Michigan University. They designed a program to equip foster parents in various Michigan counties with specialized skills to meet the needs of the children in foster care. According to Dr.

Ryan, "If any group of parents is justified in feeling the need for help, foster parents should be first on the list."

Many people love children and are willing to take them into their homes, even at considerable personal expense. It costs the State only a fraction of the cost of institutionalization to keep a child in a foster home. The U.S. Children's Bureau estimates that there is a yearly average of 350,000 children in foster-family-care homes. As some children move out of foster care, new ones enter. The quality of their experiences while in care depends largely on the foster parents. Dr. Ryan recognized that many of the families caring for foster children were not prepared to handle the children's special needs. She and her staff believe that foster children are the collective responsibility of the entire community, but that the specific needs of children are best met in a family situation.

Ideally, foster parents provide a family, home, and security for these children. Since all of the children have been separated from the only homes they know, they bear scars that other children generally do not. Dr. Ryan says, "Children blame themselves for what happened to them. Why did Mama die? Why did Papa go away? These events are seen as rejections; and the child feels he must have deserved them in some way . . . It often happens that children seem to get along well in foster care until adolescence when the situation deteriorates. Foster parents, whose training enables them to handle a child's identity problems, can provide a home in which the child will not feel rejection and in which the normal developmental crisis of adolescence will not cause a secure placement to break down."

THE CHILDREN

Foster children are under the supervision of welfare agencies, public and private. Unlike orphans, most of these children cannot be offered for adoption (and thus given permanent homes) because their natural parents are still living and will not agree to release them. Society often helps families in crisis stay together, but it is reluctant to terminate the rights of natural parents to their children if there is any possibility the family may eventually be able to provide a suitable home for

them. Many foster children remain in a kind of limbo of temporary care, with little hope of a reasonably quick solution.

About one-fourth of the national population of children living outside their families are in institutions and group homes. The rest live in foster homes. By definition, foster care is a temporary arrangement. But it may go on year after year—for some children home after home—until the children are grown. Dr. Ryan is opposed to this: "Something must be done definitely, and early enough, to give the child a permanent home before the damage to his feelings of identity and trust takes place."

THE TRAUMA OF SEPARATION

All children removed from their parents, even infants, experience separation trauma, although it may be manifested differently depending on the child's age and situation. Thus, children come to foster parents traumatized in ways that natural parents seldom see. If the children have moved from home to home, their traumatization may be compounded. Some children, after being continuously hurt, deliberately bring on further rejection by creating situations in a new foster home.

What these traumatized children need and are entitled to is a stable home. If the natural parents cannot provide it, adoption would be the ideal alternative. But law and custom make adoption difficult, even when the natural parents consent to such an action. When the natural parents are opposed to termination of their rights to the child, it may take many years from the time action is taken until the child is freed for adoption—and this time is a crucial period of the child's life.

In order to help the foster parents realize what the child is feeling, Dr. Ryan asks the foster parents to remember how it felt when they lost someone. Then, in order to better understand a child's behavior, foster parents are taught the various stages of separation trauma the child goes through. It is a form of mourning with several stages: First, the child protests and denies: "How could it happen? There must be some mistake." This is followed by shock and numbness. Then there is tremendous anger. The child lashes out and, in effect, cries "Why me?" The child blames the parent for dying or the doctor who said the parent was ill. At this stage, the foster parent may easily misunderstand what is happening. When the anger lets

up, the child often sinks into despair. Finally, the child begins to accept the situation.

In addition to recognizing these stages, foster parents are helped to develop techniques with which to handle each phase. They are then able to help the children come to grips with their feelings about themselves and about their natural parents. The classes also teach the foster parents how to cope with the ambivalence that children develop as they become attached to the foster family and help to prepare the foster parents for their own feelings of separation when the child moves.

FOSTER PARENTING

Parenting is not instinctual. Regardless of the experience foster parents have had with their own children, they often find fostering very different. Few have had formal training in child growth and development. According to the Project newsletter, "Foster parenting is parenting-plus." Fostering may involve handling many children of many different ages at one time. (Michigan law allows foster parents to take up to four foster children at a time if they have no more than four of their own.) Foster parents may have children further apart or closer together in age than most families. The children arrive at times of crisis or under extraordinary circumstances. For example, Dr. Ryan tells of a foster family who was called at 2 a.m. and asked if they could take six children at 2:30 a.m. until some other provisions could be made.

Foster parents also have special pressures that normal parents do not have. They are under ongoing supervision. They have legal obligations to the agency, the natural parents, and the children. Although foster parents are reimbursed by State or local governments for some of the expenses involved, few receive full reimbursement for what they spend on the children. Michigan's reimbursement allowance is only 80 percent of what Federal guidelines estimate to be the amount required for expenses of a child on a moderate scale.

Dr. Ryan feels strongly that foster parenting is a job (like any other job) that requires training and formal status requirements. She says, "Foster families shouldn't be considered 'problem families' under agency supervision. Foster parents are really agency staff, providing a service as important as that

provided by most professionals who deal with children For more effective service to the child, foster parents should be included in present and future planning . . . foster parent training should be viewed as in-service training."

Consequently, the Foster Parent Training Project not only offers single courses but also awards a specialized Foster Parent Certificate after completion of four courses or 80 hours of instruction.

In planning the Project, Dr. Ryan also took into consideration that foster parents, with jobs and with children to raise, need to be practical people; they must believe that the time in class is well spent. Therefore, class content must specifically address the problems these parents encounter; classes should be conveniently located so as not to waste travel time and be flexible enough to allow for family disruptions; and the Project should offer some reimbursement for babysitting and travel.

The Michigan Department of Social Services, in recognition of the value of such training, pays the tuition for foster parents supervised by their county agencies, plus \$4 to each trainee for each session attended to defray transportation and babysitting costs. Some of the county juvenile courts and private agencies do the same for foster parents under their jurisdiction. Additional support comes from scholarships offered to foster parents by a few of the community colleges.

CURRICULUM AND COURSES

During the first year, courses were offered for 2 1/2 hours once a week, in 6-week sessions. Course schedules and sites were designed for maximum convenience of the foster parents, and class size was kept small, about 20-25 per class, in order to maintain a personal atmosphere. Instructors were carefully selected on the basis of their professional qualifications and their personal ability to work with foster parents; they were then given curriculum materials, course outlines, evaluation guides, and an intensive training program.

The trainees, most of whom had experience raising children and foster children, helped to determine class content and emphasis, either by request or by their responses to a questionnaire (excerpts in Appendix) administered before the classes started, or by trial and error while the classes proceeded. Feed-

back was encouraged and used to modify course content as the year progressed. "They may lack theoretical knowledge," says Dr. Ryan, "but they bring a lot of commonsense, experience, and concern to their jobs."

The first eight courses offered by the training program dealt with:

- Child development at all ages, both for ordinary children and for children with exaggerated behavior indicating emotional problems.
- Conditions and situations that lead to the placement of children in foster care, and what they mean in terms of future behavior and adjustment.
- The role of foster parents and the function of the agency in helping children.
- The consequences of separation trauma.
- How foster parents influence the child's behavior, both for short-term management and long-term growth.
- Specific needs of children with special problems: retardation, emotional and physical disabilities, problems of adolescence and minority status; what to expect from such children; how to handle and care for them.
- How foster parents meet problems in dealing with schools for ordinary foster children as well as those with special problems.
- Community resources available to the parents.

These courses were then altered, expanded, and modified as information and demand increased. By the spring of 1977, 20 courses had been developed: Issues in Fostering (Course outline appears in Appendix); The Three Families of the Foster Child and Their Role in His Emotional Development; Fostering Infants; Fostering the Pre-School Child; Fostering the School-Age Child; Fostering the Teenager; Guiding the Sexual Development of the Foster Child; Fostering the Mentally Retarded Child (I & II); Fostering the Physically Handicapped Child; Handling Lying, Dishonesty, and Destructive Behavior (Course outline appears in Appendix); Fostering the Child with Emotional Disturbance (I & II); Fostering the Battered and Abused Child; Communicating with the Professional; Working with Natural Families; All Under One Roof; Human Developmental

Stages; Legal Aspects of Fostering; and Planning and Assessing for Your Foster Child.

When foster parents expressed difficulty understanding and relating to the natural parents, the social worker, or the foster child, content and material were again modified to meet these concerns. Foster parents learned that:

The world as they know it is not necessarily the one which the child perceives. In order to help the child, they must learn something about his world. For instance, what are the "Three Families of the Foster Child?" The first is his natural family. The second is the foster family with which the child lives. The third is the child's fantasy. The fantasy family may start as a make-believe family but, as time passes, the child comes to believe in the reality of this family. They may even tell their classmates about this family so they will not be considered different. The fantasy family is a glamorization of the natural family: The father who has stopped drinking and will soon bring the family together again in a new house; the mother who sends many presents and will soon come for the child. Without knowledge of the child's fantasy family, foster parents may fail to understand what lies behind the child's behavior and make wrong judgments or otherwise respond inappropriately. What appears to be simple lying may sometimes be better understood as confusion about how it actually is and how we would like it to be.

Some foster children have problems that require special care and understanding—physical handicaps, mental retardation, emotional disturbances, and adolescent crises. Special courses train foster parents to work with these children as an alternative to institutional placements. Foster families learn how to work with these children and learn about community resources available to such children. They learn how to assess the child's needs, the child's progress, and how to develop plans to help them grow and develop. They learn how to work cooperatively with other professionals to assure that the child has the best possible care.

BEHAVIOR PROBLEMS

To understand a child's behavior does not necessarily mean to accept or condone it. While the classes try to shift the

emphasis away from rigid codes, they also teach foster parents how to handle behavior that hurts the child, hurts others, is illegal, or causes trouble. As Dr. Ryan states, "A child can't be allowed to throw himself downstairs repeatedly. He or she can't be allowed to swallow a whole bottle of aspirin. We can't let one child attack another with a hammer. Our trainees have had children who did all these things."

The foster parents must discover whether their attitudes and standards are consistent

Destructive behaviors are distinguished from the cautionary ("yellow light") or the permissible ("green light") behaviors and are accordingly called "red light behaviors." If the foster parents cannot control these behaviors, they must get outside help.

But all behavior must be evaluated in context. For instance, should a child's calling some other child dirty names always be under absolute prohibition? Says Dr. Ryan, "Although verbal abuse is not condoned, it may be an improvement over the child's former practice of physically attacking others. Thus the foster parents can focus on teaching the child more appropriate ways of handling anger. Another possibility is that a child may have been exposed to such language in his natural family and may not understand that these words are offensive to others."

One of the most popular courses is "Handling Lying, Dishonesty, and Destructive Behavior." A close examination of this class exemplifies the Project's approach to other courses. The foster parents learn to ask, "Why might a child behave like this? Why does this behavior upset me so much? How might I be contributing to the child's behavior? How might I teach the child more appropriate ways to behave?"

The parents are asked to list the reasons they think a child might lie. Are there any reasons why foster children might be more apt to lie than other children? What about wish-fulfillment? Could some of them have learned to lie in order to make their way in an unusually difficult world? What about the lag

in development that might occur in children who are under pressure?

What about stealing? Are foster children more likely to steal? Could stealing objects be a substitute for other needs that are not fulfilled? Could children who own so little have different ideas of property rights? The foster parents explore their own values and attitudes with the aid of questions such as: "Your foster child finds an expensive toy car in the school hall. He brings it home. Permissible? Not permissible?"

The foster parents must discover whether their attitudes and standards are consistent—do they apply equally stern standards to themselves? "You find an expensive watch in the elevator at work. You take it home, but don't wear it at work. Permissible for me? Not permissible for me? Community would disapprove?"

Toward the end of the course manual there is a skit about lying and stealing. It casts two foster parents with two children of their own (J, a boy, and K, a girl) and two foster children (A and B, both boys). A is 15, bright, talkative, likable, and eager to please; but this foster home is his fifth. B is younger and more docile; this is his fourth foster home.

Someone has been taking family possessions, and the father decides that the time has come for a family talk. A responds brightly that in his other foster homes people used to steal a good deal from him because his natural mother, a famous opera singer, would come in for whirlwind visits and give him wonderful gifts from all over. He explains why he has no pictures of his parents—they too were stolen.

K likes A, but, becoming irritated, says that A has been telling similiar stories at school, and it has become embarrassing. The father reprimands K, but he also reminds A gently that he has spoken to the social worker about the mother and knows the truth. A becomes quiet. They go to the living room to continue the discussion. The wood for the fireplace is low, and B, who is normally quiet, suddenly volunteers to get the wood from the garage, insisting that he will do it alone. Curious, the father follows him and finds a paper bag with the missing articles in it.

The boy at first denies stealing; then he asks if the foster parents are going to send him away. "That's what they always do . . . send me away." The boy begs him not to tell the others.

But the foster father insists that families cannot hide things from one another, even unpleasant things. They do not hate him; they will not send him away. Nothing serious need happen. But they are hurt, and they do hate stealing. "We will have to do some very serious talking."

The foster parent has been gentle and reassuring. But he has let the boys know that lying and stealing are not acceptable. In a warm, secure home perhaps such behavior won't be necessary. When children lie or steal, they are trying to say something, and foster parents should be prepared to hear the message they are sending.

"What we are trying to say to the foster parents is that many of these children have had a rotten break, but you can still help the child have a good growth experience." But, Dr. Ryan insists, the foster parents must really listen to the child, to hear what he or she is trying to say, whether with words or actions. "When a child asks why the natural mother doesn't visit, he may really be asking, 'Does Mama really love me?' Foster parents shouldn't raise false hopes, but neither do they have to belittle the natural parents."

GROWTH AND DEVELOPMENT OF THE PROJECT

The first training site was set up at the Center for the Handicapped, run by the City of Detroit Department of Parks and Recreation, where a chapter of the Foster Parent Association was already holding regular meetings. The location was advantageous since it was convenient for the majority of potential trainees on the east side of Detroit.

Lists of foster parents licensed by the Wayne County Department of Social Services were obtained. Questionnaires were sent out. Those in the eight zip-code areas closest to the site were sent invitations to attend the first class. Although foster-parent participation is voluntary, a pattern developed that was to be repeated with each expansion of the program: The response—testifying to the extent of the need—was greater than anticipated. Instead of the single class that had been planned, two classes were started on November 6, 1974. Thirty-six students with a broad range of backgrounds enrolled: The mean age was 50 years, the mean educational attainment was 11.4 years, and 90 percent were black.

Discussions with both parents and workers made it clear that the parents were primarily concerned with two major areas: How to parent the children and how to handle—or work most effectively with—the agencies. The first two classes concentrated on these areas.

When this first group of trainees was questioned about what they thought of the training after completing the introductory courses, a majority found the classes “very interesting.” Only 3 percent responded “not very interesting,” while 87 percent felt that they could do “a much better job” as foster parents as a result of the training. Nevertheless, 25 percent said they would not take the classes next term because of the pressure under which they operated.

However, when invitations were sent out again to westside Wayne County parents for introductory classes to be held at the St. James United Church of Christ at Dearborn, more people applied than had been expected. Instead of the two classes scheduled, three were started in January 1975.

It was decided very early to keep the presentation of the material flexible by developing modules—two classes together—that could be combined into any arrangement that might seem most beneficial for a particular group at a particular time and for an instructor with a particular style. The instructor was to lead, never to dominate. There was to be little reliance on lectures. The foster parents would learn from one another, or together, with the instructor acting as a resource person, moderator, or group leader.

Drs. Ryan and Warren consider it vital that the instructor develop class procedures which enable foster parents to feel comfortably open with one another. To accomplish this, the first session of each course includes what is called “unfolding.” Each person, starting with the instructor, introduces himself, then gives personal information and relates personal experiences that might have special meaning for other foster parents. An instructor who was a foster child, or is a foster parent, can strike an immediately responsive chord.

New courses were developed to be used for workshops at the Third and Fourth Annual Foster Parent Education Conference in 1975 and 1976. The Project staff was invited by the Michigan Foster Parent Association to participate. The conference workshops turned out to be especially valuable as both a source of

new ideas and as a testing ground. They allowed identification of new professionals who could be recruited and trained for the program and were a mechanism for disseminating Project information to a statewide audience. Thus, the workshops contributed importantly to the development of new courses and sites.

During the spring of 1975, new and more accessible sites were chosen for Wayne County, and one site was established in adjoining Washtenaw County, even though there is no foster-parent association there. In the fall of 1975, two sites were added in Genessee County. The Project has continued to grow, adding new material and offering classes over a wider geographical area. Funds from the State of Michigan Department of Education, under Title I of the Higher Education Act, allowed expansion into 15 additional counties in southern Michigan.

By the end of 1977, classes were being offered in 24 counties in cooperation with Michigan's community colleges. This is viewed as the beginning of a statewide program to provide foster-parent training to all of the foster parents in Michigan. By December 1977, it is expected that 1,500 foster parents will have received over 12,000 hours of instruction from over 70 instructors. More than 150 foster parents will have earned their specialized Foster Parent Certificate.

Presently, two half-time field coordinators locate future training sites and potential instructors. They also meet with agencies and foster-parent associations to discuss proposed classes and to obtain information about specific needs in each location. For instance, they recently had to cancel classes in three of the more rural counties when they started too late in the spring and interfered with the planting season. They also ascertained that daytime classes were unpopular in rural and small metropolitan areas and rescheduled them for evening.

The Foster Parent Training Project has an Advisory Board, composed of foster parents from each of the areas served, which meets bimonthly at Eastern Michigan University to review new programs and make suggestions concerning future policy decisions. The Project also publishes a newsletter, *Fostering Ideas*, to keep foster parents informed of new occurrences. Several workbooks, course outlines, and manuals have been completed; these materials are distributed in draft form to

encourage constructive criticism from users in order to reshape them into more effective materials. As time allows, staff members are available to discuss the materials with interested groups or to lead workshops on selected topics.

As Dr. Warren, the Associate Director, says: "The program has demonstrated that an extensive curriculum can be presented over a wide geographical area . . . when cooperation and coordination exist among a university, several community colleges, numerous public and private child-welfare agencies, and foster-parent associations."

Plans for 1977-78 include continued expansion of the Project, with the eventual goal of bringing classes within the reach of every foster parent in Michigan, thereby affecting the lives of many thousands of foster children in the State.

The Project expects to reach the following goals:

- A self-supporting training program available to all foster parents in Michigan throughout the academic year.
- Establishment of a Professional Foster Parent Certificate recognized by child welfare agencies.
- A detailed description of the procedures leading to certification as a Professional Foster Parent.
- A detailed evaluation of the program for use by agencies in other States.
- Training materials and guides such as workbooks, readers, and other aids for use in foster parent training projects.
- Dissemination of curricula, bibliographies, techniques, and other materials through conferences, workshops, newsletters, speeches, and journal articles.
- Special training for foster parents of physically and mentally handicapped children that would equip them to perform as full-fledged members of agency teams dealing with the problems of such children.

It is expected that once the statewide program is operating, the Project will be supported by State and agency funds. At that time the Foster Parent Training Project of Eastern Michigan University and its directors believe that their main function will be to provide resources, coordination, and guidance. Financial resources will be needed to provide six statewide

coordinators to ensure that things continue to run smoothly and to maintain standards.

The Foster Parent Training Project demonstrates the feasibility of providing comprehensive training and support for foster parents. Eventually, it is hoped, the Project will serve as a model for the training of foster parents on a nationwide basis.

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Principal Investigator: Patricia Ryan, Ph.D.
Director, Foster Parent Training Project
Department of Sociology
Eastern Michigan University
Ypsilanti, Michigan 48197

Appendix

The survey form that is used to identify areas around which classes are developed is too long to include in its entirety. Short excerpts of sections illustrate the types of information sought.

Two course outlines used by project instructors in training foster parents are included to show how fostering skills are promoted.

FOSTER PARENT ATTITUDE SURVEY

Please read the following questions and put a checkmark next to the answer that comes closest to expressing your feelings. This is not a test but we will find it helpful to know how the people in the class feel about foster parenting and the areas in which they would like more information.

Foster care is necessary because the natural parent is totally inadequate to care for the child.

Always true Usually true Almost never true

Maintaining contact between the foster child and his natural family assists the child in knowing himself.

Always true Usually true Almost never true

Most foster children should not return to their own home.

Always true Usually true Almost never true

Developing self-worth in the foster child is the single most important task of the foster parents.

Always true Usually true Almost never true

A foster child's misbehavior is an indication that he doesn't like his foster family.

Always true Usually true Almost never true

There is no good excuse for a child's breaking things in anger.

Strongly agree Agree Disagree Strongly disagree

Children who take part in sex play become sex criminals when they grow up.

Strongly agree Agree Disagree Strongly disagree

There is no reason parents should have their own way all the time, any more than that children should have their own way all the time.

Strongly agree Agree Disagree Strongly disagree

Adopting a foster child allows everyone to forget that he once had another family.

Strongly agree Agree Disagree Strongly disagree

Once a child starts on drugs, there is no hope for him.

Strongly agree Agree Disagree Strongly disagree

Foster children have to learn that they cannot have the same amount of clothes and toys that the natural children in the family have.

Strongly agree Agree Disagree Strongly disagree

A child with a bad background is likely to turn out like his natural parents no matter what anyone does.

Strongly agree Agree Disagree Strongly disagree

It is up to the worker or agency to determine if a foster child needs counseling.

Strongly agree Agree Disagree Strongly disagree

Childhood stealing is very likely to lead a child into a life of crime.

Strongly agree Agree Disagree Strongly disagree

A child should never lie to his foster parents.

Strongly agree Agree Disagree Strongly disagree

Unless a child has a physical problem, wetting his bed is a sign of laziness.

Strongly agree Agree Disagree Strongly disagree

Foster children should be grateful to the family that cares for them.

Strongly agree Agree Disagree Strongly disagree

Foster children who have been sexually abused are a bad influence on the natural children in the family.

Strongly agree Agree Disagree Strongly disagree

Running away from a foster home is a sign that the child should not be returned to that home.

Strongly agree Agree Disagree Strongly disagree

Foster children usually need more rules than natural children do.

Strongly agree Agree Disagree Strongly disagree

Connie's foster parents took her to the doctor when she suddenly became ill. The doctor said her appendix must come out in a day or two. What should the foster parents do?

Agree to surgery Call Connie's parents
 Ask friends for advice Call social worker

After not visiting for a long time, Johnny's mother phoned unexpectedly. She wants to see him today, but the foster mother has made other plans. What should the foster mother do?

Call her caseworker about the matter
 Refuse to allow Johnny's mother to visit
 Allow Johnny's mother to visit
 Other: Explain _____

Who do you think should take the most responsibility for handling the foster child in the following areas?

Talking to the teachers when the child is in trouble at school.

Social worker? Natural parent?
 Foster parent? Someone else? Who? _____

Buying clothes for the child.

Social worker? Natural parent?
 Foster parent? Someone else? Who? _____

Deciding which church the child should attend.

Social worker? Natural parent?
 Foster parent? Someone else? Who? _____

We know that children are different but would like you to think of the age at which you can usually expect a child to do certain things.

For instance, at what age would you expect a child:

To be able to sit up by himself? _____

To start walking? _____

To stay dry during the day? _____

To feed himself without too much mess? _____

To stop soiling his pants? _____

To stay dry all night? _____

To play in front of the house or
on the block without constant supervision? _____

To cross streets alone? _____

To be able to take a bus by himself? _____

To be able to count to 10? _____

We would like you to think about some of the problems you have as a foster parent. Let's start with the social workers: What are some of the problems you have with them? (Getting to talk with her; getting help from her; bringing or removing children unexpectedly; understanding needs of child, of parent; making unreasonable

demands.) _____

In the last year, how many different social workers have you worked with? _____

Would you say that your relationship with most of these workers has been generally very satisfactory, satisfactory, unsatisfactory, or very unsatisfactory? _____

About how many contacts have you had with natural parents in the last 30 days?

_____ By phone

_____ In your home

_____ In the home of the natural parent

_____ At the agency office

_____ Other

Is it easier to be a foster parent or a natural parent?

_____ Foster parent _____ Natural parent

Please explain: _____

What are your own feelings as a foster parent—what upsets you most? (Children misbehaving, letting go of children, sense of failure or too little achieved, not being able to do what is necessary, anger with biological parents.) _____

What are some of the things you do well as a foster parent that make you feel good? _____

What are some of the areas in which you could improve—things you would like to do better? _____

INTRODUCTION TO THE ROLE OF FOSTER PARENTING AND THE PROBLEMS OF SEPARATION

General Objectives:

1. Introduce, or clarify for the experienced foster parent, the role of the foster parent.
2. To help foster parents (a) understand the meaning of separation of children, (b) understand the behavior problems and other consequences that may develop as a result of separation, (c) develop skills in interpreting the meaning of separation to children so as to reduce the associated trauma of the experience, and (d) develop techniques to help children who are acting out because of separation.

Specific Goals:

Role clarification:

1. To clarify and increase the awareness of foster parents as to the importance of their jobs.
2. To clarify the duties and responsibilities of foster families in providing substitute family care for children.

3. To explore the limitations of the foster parent role in working with foster children.
4. To increase the awareness of foster parents as to the obligations of the agency to the child and his family.
5. To clarify the types of support that the agency and worker are to provide the foster child and the foster family.
6. To explore the obligation of the community to provide services for foster children and the foster family's role in securing these services.

Understanding separation trauma:

1. To develop sensitivity in recognizing and identifying symptoms of separation trauma.
2. To increase the understanding of the types of reactions that children have to separation.
3. To increase skills in reducing the impact of separation.
4. To develop techniques to deal with the behavior of children who are suffering separation.
5. To recognize the role of the natural parents in the child's life.
6. To develop adequate skills in helping the child come to grips with his feelings toward the natural parents.
7. To recognize the ambivalence of the child as he develops feelings of attachment for his foster family.
8. To develop the skills to prepare the child for separation from the foster family.
9. To recognize the ambivalence the foster family feels as they prepare the child to move to another home.

Important points to be emphasized:

1. Foster parenting is a job, providing direct service to children.
2. Foster parents provide more than custodial care; they also provide emotional support, help the child to feel worthwhile, and help him move to the next developmental stage.
3. Foster parents are not natural parents. There are limitations on the decisions they can make for the child.
4. Foster parents must learn to give up foster children. This is done most easily when they recognize what they have given the child.
5. Foster parents work with a lot of children for a short amount of time.
6. Foster parents can hold agency and community accountable.
7. Agency and workers are limited by State law and courts.
8. In most cases, natural parents retain rights to parent the child and in all cases they constitute an important part of his past.
9. Fostering is a total foster family commitment.
10. Foster parents are part of a team that shares information to assure appropriate service to the child.
11. Foster parents are the immediate people to protect the rights of the child in terms of his right to family life, his right to positive feelings about himself and his natural family, his right to expect his affairs to be treated confidentially, and his right to services.

12. All foster children have experienced separation.
13. The five stages of separation are:
 - a. shock
 - b. protest, denial
 - c. anger
 - d. despair, depression
 - e. detachment or acceptance
14. Many, if not most, foster children blame themselves for the separation.
15. Passive or withdrawn behavior may be as symptomatic of trauma as acting out.
16. Although behavior must sometimes be controlled, reduction of trauma is the long-range goal.
17. Foster parents must recognize and work with natural parents for the best interests of the child.
18. Foster parents must remember the child is with them temporarily and will leave them.
19. Part of the duties of foster parents is to prepare the child to leave them.
20. The foster parent should develop a specific plan for helping the child the first day.
21. The child who must choose to spend holidays or vacations with his natural family or the foster family is caught between wanting both and feeling that either way he will miss something.

SUGGESTED ACTIVITIES

1. Class or small group discussion on one or more topics from A below followed by similar discussions around one or more topics from B.
 - A. What should a foster parent do if
 - ... the worker refuses to answer telephone calls from the foster parents.
 - ... refuses to remove a foster child from the home when requested to do so by the foster parents.
 - ... fails to process payments for the foster child's board, clothing or medical expenses.
 - ... will not share with the foster parent information about the foster child.
 - ... removes a foster child from the home without explanation or warning.
 - B. What should a worker do if a foster parent
 - ... refuses to take a child to medical appointments.
 - ... refuses to let natural parents visit in home.
 - ... uses physical discipline.
 - ... uses money from the foster child's bank account.
 - ... spends foster care payments for new livingroom furniture.
2. Thinking about what it was (or would be) like to
 - ... lose a loved one.
 - ... find yourself among strangers in a foreign country.
 - ... visit your child who was in foster care in someone else's home.
 - ... being lost as a child.
3. Listing on blackboard the needs of a child under various headings.
4. Devising specific plans for a child.
 - ... for the first day in your home.
 - ... preparing him (her) to leave.
 - ... discussing why his mommy didn't come when she said she would.

5. List for each person responsible for the well-being of the foster child (foster parent, worker, natural parent) the particular duties, responsibilities, and rights connected with that position.

SUGGESTED READING & MATERIAL

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Videotapes:

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1. "Foster Parents' Attitudes Toward Natural Parents"
2. "What Foster Parents and Natural Parents Talk About"
3. "Foster Parents' Behavior Toward Natural Parents"
4. "Role Playing: Foster/Natural Parents' Conversation"
5. "How Foster Parents Overcome Negative Feelings"

Foster Families. "The Impact of Persons Who Care." Eastern Michigan University.

Films:

"John: 17 Months: Nine Days in a Residential Nursery," U. of M, Audio Visual.

HANDLING LYING, DISHONESTY and DESTRUCTIVE BEHAVIOR

General Objectives

1. To help foster parents interpret the meaning of lying, stealing, and other forms of dishonesty; to help them determine what the consequences of such behavior are for the child; and to help them develop skills in helping children to move to more mature ways of behaving.
2. To help foster parents deal with acting out behavior, especially destructive behavior and temper tantrums; avoid situations that break down control; help the child to develop controls; provide alternative acceptable behaviors; and teach the child how to deal with his feelings.

Specific Goals

1. To differentiate between different types of apparent dishonesty in terms of the child's developmental stage.
2. To clarify their own values around dishonesty.
3. To understand the reasons why children lie.
4. To develop skills to help the child act more honestly.
5. To understand the reasons children are destructive.
6. To clarify their own values and feelings about anger.
7. To develop skills in controlling destructive behavior.
8. To develop skills in helping children handle anger appropriately.

Important Points

Dishonesty:

1. Children lie and steal for different reasons. At some developmental stages they really do not understand the difference between lying and the truth, your property and my property. Some forms of dishonesty are the ways in which children learn, and proper management of dishonest behavior may help the child to move into the next stage of development.

2. Some of the reasons why children are dishonest include:
 - a. Reality testing: attempting to find out the difference between what is and what they think.
 - b. Denial: a way of handling painful memories, feelings, fantasies, or behavior to protect themselves from feeling guilt or inadequacy.
 - c. Wish fulfillment: a way of making things better.
 - d. Fantasy: pretending, imagination, or daydreaming.
 - e. Protection: to escape the consequences of behavior.
 - f. Modeling: copying the examples set by the adults in his environment.
 - g. Lack of impulse control: slowness in moving to the next developmental stage.
 - h. Replacement: children feel unloved and steal to appease their emotional hunger.
 - i. Need fulfillment: to get things they need or want badly.
 - j. Recognition: to be part of the gang or enhance reputation.
3. Foster families are upset about lying and stealing because:
 - a. Their own moral codes are assaulted.
 - b. Their relationships with the child are disrupted.
 - c. They are embarrassed with the public, school, neighbors, etc.
 - d. They worry about the effect on their own children.
 - e. They worry about the child becoming a criminal or growing up to be an immoral, unethical adult.
4. Lying and cheating are not clearly prohibited in our society. Adults are allowed to bend rules, tell white lies, etc. Why do we expect more of children than we do of adults?
5. Recognizing the stage the child is at developmentally may help alleviate concern and allow the parenting person to use energies more constructively—to help the child to move to the next developmental level. It is important to be aware of what the child is capable of and what his perception of the world is like, to understand his behavior and deal with it effectively (i.e., control the most disruptive behavior and use the situation for growth). Developmental stages are sequential and the person moves from one to another at his own/pace and in line with his experiences. No stage can be skipped and thus the child who is at a level below what would be expected must move to the next stage. He cannot be forced to “act his age.” (NOTE: Problems with foster children are often either exaggerations of behavior that is typical of a developmental stage or they are developmentally behind what might be regarded as typical of their age.) (See Developmental Chart, *Michigan Foster Parent Association Third Annual Educational Conference*, pp. 31-37.)
6. It is important to be specific about the behavior that is labeled dishonest. Is it really dishonest from the child's point of view? Have we put him into situations that almost force him into dishonesty? (Situations that may be discussed here are: stealing food; fantasy—especially about natural parents; borrowing; lying to avoid punishment; stealing one's own possessions or money; confusion over time—I'll do it in 5 minutes.)
7. The foster parent can do many things to minimize putting a child into situations where he/she will react dishonestly:
 - a. Clearly establish property rights in and out of the household with the rights of all (especially the foster child) respected.
 - b. Teach how to borrow and return and give help in getting permission and with disappointment at failures to receive permission.
 - c. When a child steals, insist on restitution but help with personal support. Provide some method of payment when money is involved, i.e., extra jobs, etc.

- d. Remove temptation, i.e., loose change about, unlocked coin collections, piggy banks, wallets, etc.
 - e. Provide a legitimate source of income, i.e., allowance, ways to earn fair distribution of goodies, gifts at Christmas and birthdays.
 - f. Listen carefully to children's feelings—is he/she angry, afraid, sad, empty or needy? Help him find more constructive ways of handling these feelings.
 - g. Demonstrate your own honesty, setting an example and providing a model.
 - h. Do not lie to a child to "protect" him.
 - i. Share your honest feelings of anger, embarrassment, and shame when a child makes a mistake, and help him to see the alternatives to his behavior.
 - j. When he is wrong, let him understand how he could have been right in the same situation.
 - k. Recognize what the child is trying to say and help him say it honestly. I wish. . . . It would have been nice if. . . . I imagined. . . .
 - l. Review house rules to be sure that the child is not put into positions of lying about behavior that should really be within his own discretion.
8. What to do in the short run?
- a. Assess problem. What is the specific behavior that is troublesome? When does it occur? What situation or interaction triggers behavior? What does it mean to the child? Why does he/she behave this way?
 - b. Make a plan. If we remember that our role is to teach children to be able to make their own moral judgments and control their own behavior, then we can base our plan on helping them to control their behavior rather than depending on outside control. This doesn't mean we shouldn't use outside controls. With young children, or with children of any age who have not developed their own controls, outside controls are necessary.
 - c. Implementing plan. Child should be told why specific behavior is wrong and the consequences of such behavior in line with his stage of development. The specific wrong behavior should be named and the specific consequences of that repeated behavior should be given.

Destructiveness

1. Anger and aggression are the natural responses to frustration. All human beings experience frustrations as they grow. The infant or small child reacts with rage. We must teach all children appropriate ways to handle rage.
2. Many adults feel anger of any type is deplorable and are especially concerned about children being angry. Foster families also have to deal with the consequences of acting out behavior.
3. Although behavior can be controlled, all feelings, including feelings of anger, are legitimate.
4. Foster children, because of their life experiences, may feel more anger than most other children. The foster family did not cause the anger and it is not their fault, but the foster child may use them as the target of the anger. All behavior has meaning even if it is not always obvious.
5. Children are likely to express their anger through temper tantrums, deliberate destructiveness, or attempting to hurt others. Although we can empathize with their feelings, we cannot let them hurt themselves, others, or destroy property.
6. Children act out their anger in inappropriate ways because they have not developed appropriate controls, because they have not been taught appropriate ways to relieve their feelings, and because they really want adults to provide some control as an expression of their concern.

7. Self-control is closely associated with developmental stages. Recognizing the stage the child is at developmentally may help alleviate concern and allow the parenting person to use energies more constructively—to help the child move to the next developmental level. It is important to be aware of what the child is capable of and what his perception of the world is like, to understand his behavior and deal with it effectively (i.e., control the most disruptive behavior and use the situation for growth). Developmental stages are sequential and the person moves from one to another at his own pace and in line with his experiences. No stage can be skipped and thus the child who is at a level below what would be expected must move to the next stage. He cannot be forced to “act his age.” (NOTE: problems with foster children are often either exaggerations of behavior that is typical of a developmental stage or they are developmentally behind what might be regarded as typical of their age.) (See Developmental Chart, *Michigan Foster Parent Association Third Annual Educational Conference*, pp. 31-37.)
8. The goals to be achieved with any child who acts out are:
 - a. Immediate control of the behavior to prevent harm to himself, others, or property.
 - b. Alleviation of the anger.
 - c. Development of self-control and acceptable avenues of expression of feelings.
9. Controls that are extremely punitive only make the child more angry.
10. The best discipline is always the natural consequence of behavior. If you break something, you no longer have it and must pay for it if it belongs to someone else. If you hurt children, you can no longer play with them. (NOTE: Extreme isolation may make the child more angry. Temporary removal until he/she gains self-control or for a time period appropriate to his age is better.) Obviously, some consequences are too severe to allow.
11. To handle behavior in the short run, the parent first of all assesses the behavior. One should determine if intervention is necessary. Is the child truly destructive or merely careless with his/her possessions? Is he taking out destructive urges on his own personal property or infringing on the rights of others? Does his/her behavior need control or is it only the expression of anger that is disturbing the foster parent?
12. The parent must determine why the child acts out. What situations trigger acting-out behavior and what is the child feeling? The answers to these questions determine the plan.
13. Working on too many problem areas at one time is bound to lead to failure. The parent should determine which specific behavior areas should be tackled first. Priority would probably take the following order:
 - a. Stop the child from hurting himself or others.
 - b. Stop the child from destroying other's property.
 - c. Stop the child from verbal aggression that is assaultive on others. (NOTE: This is different from stopping the child from expressing his feelings which should probably never be done.)
 - d. Teaching the child to be careful and respectful of property.
14. Whenever there is a need to control behavior, the parent should use a variation of the following statement: You seem to be angry or unhappy because _____, but I cannot let you (specific behavior). If you (specific behavior), then (specific consequences). Why don't you (alternative behavior). The child must be physically stopped or removed from the situation if he is likely to be dangerous to himself or others.

15. When the child is out of control, reason won't work. Probably the best way to handle a real temper tantrum is to hold the child firmly but lovingly until he/she gains control or is exhausted. An alternative is to place the child in a relatively safe place, e.g., a carpeted bedroom.
16. As a child regains control, he or she may be able to explain feelings or reason behind his actions. This is not always possible. When the child is able to explain, the adult is sometimes surprised. Discussion should be initiated (in a concerned way) around the following points:
- Recognition and sympathy for the child's feelings.
 - Restatement of specific behavior that cannot be tolerated and why.
 - Specific consequences that will follow unacceptable behavior.
 - Alternative behaviors the child can substitute.
 - Reassurance that the foster parent is concerned about the child, feels he is worthwhile, and is confident that the child will learn more appropriate outlets for his feelings.
17. Alternative behaviors for children:
- Pounding a pillow, stuffed animal, plastic blow-up toy, etc.
 - Throwing balls, snowballs.
 - Hammering, chopping wood.
 - Expressing feelings through painting, drawing, working with clay.
 - "Hurting" or tearing up magazine pictures.

These behaviors are OK, but many foster parents will find them disturbing unless they have themselves differentiated anger and acting-out behavior.

18. When a situation develops in which a child is losing control, he should be removed. He can be taught to remove himself as he feels control slipping. Going to one's room is often terribly frightening, especially if one's feelings are scary. A place removed from the family but nearby, such as the stairs, a corner of the dining room, a big chair is good. Removal time should be dependent on the child's ability to rejoin activities, rather than a specific time period. He can usually tell when he is ready. As children develop controls, they can be encouraged to take time out when control is slipping. Going to watch television is sometimes useful.

SUGGESTED ACTIVITIES

- Have trainees describe a lie they have told as a child. Can they remember why they told it? How did they feel? Where they found out?
- Have the group list all of the situations when lying might be the better policy. Can they think of how these situations might be handled sensitively, tactfully, but still honestly?
- Have each person write a short essay on "What do I do when I get really angry?"
- Have small groups brainstorm:
 - ... how adults model dishonest behavior
 - ... how adults encourage children to lie
- Have trainees discuss ways of restraining children of various ages who are having temper tantrums.

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DEVELOPING A SENSE OF COMPETENCE IN YOUNG CHILDREN

Principal Investigator: Burton L. White, Ph.D.

*Author: Herbert Yahraes**

Burton L. White, formerly of Harvard University, has been conducting research for almost two decades on how experiences of various kinds during the first few years of life affect a child's ability to get along in *his* world—and, later, in *the* world. Since 1965, when he was director of the Preschool Project of Harvard's Graduate School of Education, he has headed a large research attack on this question, and he is the author of a book for parents on the first 3 years of life. White sees the problem as "how to structure the experience of the first 6 years of life so as to help each child make the most of whatever potential he was born with." The investigator believes that he now has many of the answers.

The project began with systematic observations—in homes and schools, on playgrounds, and at shopping centers—of more than 100 children over a period of 2 years. The result was a list of behaviors that characterize the competent 6-year-old. Such a child:

- Can get and maintain the attention of adults in socially acceptable ways.
- Uses adults as resources in socially acceptable ways.
- Can express both affection and hostility to adults.

*See note at end of chapter.

- Can both lead and follow peers, can compete with them, and can express both affection and hostility to them.
- Can express pride in something he has done or is doing or in something he possesses.
- Occasionally acts out a typical adult activity or in other ways expresses the desire to grow up.

All are *social* abilities. The competent 6-year-old also possesses a number of what White terms "nonsocial abilities," among them:

- Linguistic competence.
- Intellectual competence, as indicated by the ability to sense dissonance, that is, to note discrepancies in the environment; to anticipate the consequences of whatever is occupying the child's attention; to deal with abstractions, such as numbers, letters, and rules; to take another person's perspective; and to make interesting associations between something he sees or hears and something from his experience, whether real or imaginary.
- Executive abilities, as indicated by the planning and execution of activities requiring several or more steps and by the effective use of resources.
- The ability to attend to two things at once—for instance, to concentrate on the task at hand, yet be aware of what's going on.

The investigator found that such abilities characterized not only the competent 6-year-olds in the study but also the most competent of the 3-year-olds. There was, of course, a difference of degree, the various abilities being significantly more advanced in the older children. In order to study the emergence of competence, the research team gave priority to the first 3 years of life, in particular to the second and third years. But-tressing this decision were the findings by a number of researchers: A given group of children, regardless of social class or race, performs much the same as another on developmental tests until about 18 months. Afterward, the averages of some groups begin to decline. In other words, many children do well on developmental tests during their first year and a half, yet enter school with a handicap most of them never overcome.

To learn what kinds of experiences are regularly associated with excellent or poor development, White and his associates selected 39 families with children who were either 1 or 2 years old. There were two groups of families, chosen on the basis of how the older children in the families had turned out. Families having highly competent older children, the investigators predicted, would rear their new children very successfully; the other families, rather poorly. The new children in the first group were designated *A* children; those in the second, *C*. All were carefully observed in their homes for 2 hours every other week. For 19 of the children, the observations were made during the 12- to 15-month and the 18- to 21-month periods; for the others, during the 24- to 27-month and the 30- to 33-month periods. On five widely spaced days during each of these periods, the investigators also made a more intensive study of the children's experiences. They recorded what each child did, second by second, during three 10-minute periods in each of these days.

During the 12- to 15-month period, the most competent children at 3 years had almost twice as much social experience as the others. Important elements of this experience were seeking the attention of someone else, usually the mother, and procuring a service, usually from the mother. The latter was taken to be evidence of the ability to use an adult as a resource.

On nonsocial tasks, the most competent children spent 20 percent of their waking time staring at objects, people, and scenes. The investigators describe this activity as *gaining information visually*. The less competent children engaged in this activity only half as much. The most competent children also had considerably more live language directed to them and overheard more live language. In fact, one of the main differences between the two groups was the extent to which the mother or some other adult talked to the children. When children were between 12 and 15 months old, for example, the top five in overall competence were talked to about three times as much as the bottom five. Six months later, between 18 and 21 months, those children who would turn out to be the most competent at age 3 spent significantly more time than the others in trying to please another person, generally the mother, and in preparing for an activity. The most marked difference between the two groups of children during this period, though,

was in the proportion of empty time—"time spent in desultory scanning or aimless wandering." The poorly developing children spent 26 percent of their time in such behavior; the others, 11 percent. The researchers suggest that the difference can be explained by restrictive parental practices in the poorly developing group; for example, the mothers of these children tended to confine them to playpens.

The children were tested for general development at 12 and 24 months and for intellectual function at 36. At 1 year the difference between the *A* and *C* children, as had been expected, was not significant. At 2 years, however, the *A* children performed significantly better than the *C*'s. Two factors in particular seemed to differentiate the two groups. On a ratio of compliant-to-noncompliant behavior in response to adults' orders or suggestions, the *A*'s rated higher. They also imitated adults in their environment—usually the mothers—more frequently. The investigators view this finding as evidence that, even at the age of 2, some children demonstrate a stronger desire to grow up and be like an adult.

At 36 months, the median for the *A*'s on the Stanford-Binet test of intelligence was 128; for the *C*'s, 92. Such a large difference could be expected to occur by chance only once in a thousand times.

Good overall development, or competence, at the age of 3 was found to be associated with high scores in the following activities during the 12- to 15-month period:

- Procuring a service.
- Gaining attention.
- Gaining information through steady staring at people and objects.
- Listening to live language (or, put another way, being talked to).

Also related to competence were *low* scores in gross motor activity, passing time, and exploratory experiences, mainly with small objects. (Why should exploratory experience be associated with lower competence? The investigators suggest that the finding may reflect the absence of other experiences that would have been more efficacious.)

When the children were 5 years old, they were given another IQ test—the Wechsler Preschool and Primary Scale of Intelli-

gence, which at 5 has been found to predict future academic achievement. The relations between types of experience at 12 to 15 months and IQ scores at 5 years were found to be almost the same as they had been at 3.

HOW THE PARENTS CAN HELP

Was the development of competence influenced by parental action or lack of action? It certainly looks that way, the investigators answer. Effective parents, defined as parents of competent children, performed three major functions in a way that distinguished them from other parents:

Designing the Child's World.

The effective childrearer made the living areas as safe as possible for the child who had started to crawl or walk and then provided maximum access to it. "Such action immediately sets the process of development off in a manner that will lead naturally to the satisfaction of and further development of the child's curiosity; the opportunity to learn much more about the world at large; and the opportunity to enter into natural, useful relationships. . . . The effective childrearer [also] makes kitchen cabinets attractive and available and then keeps a few materials in reserve for times when the child may become bored."

Consulting with the Child

Effective parents "were available to the child several hours each day to assist, enthuse, and soothe when necessary. . . . They would usually respond [to overtures]. . . . They would pause to consider the baby's *purpose of the moment*. They would provide what was needed *with* some language, on target and at or slightly above his level of comprehension. They . . . would not prolong the exchange longer than the baby wanted." Such exchanges, taking from 20 to 40 seconds, occurred "dozens of times a day in the lives of children developing well."

Setting Limits, or Disciplining the Child

"Though loving and encouraging and free with praise [effective parents] were firm. *No matter how young the infant, they set clear limits.* . . ." The investigators report also: "Different

kinds of discipline seem necessary at different stages of infancy and toddlerhood, and a minority of childrearsers in some fortunate way have stumbled across ways that work. Children between 8 and 13 months of age can usually be controlled through distraction tactics. Children 13 to 18 months of age require distraction and physical removal from circumstances at times; and children between 18 and 24 months require distraction, physical removal, and verbal restrictions."

These findings are being tested in an experimental program to learn if the general run of parents can be taught the child-rearing skills used by the parents of the most competent children in the Harvard study.

A research group at the Center for Early Development and Education, University of Arkansas, has reached similar findings from a study of children over the 6- to 54-month period. In its observations of children and their environments, this team used a schedule of 45 items—developed by Bettye Caldwell, the Center's director, and her associates—grouped as follows:

- Emotional and verbal responsivity of the mother.
- Maternal involvement with the child.
- Provision of appropriate play materials.
- Avoidance of restriction and punishment.
- Organization of the physical and temporal environment.
- Opportunities for variety in daily stimulation.

None of those factors was found to relate in any important way to the children's performance on mental tests at 6 months and 12 months. But all of them related significantly to performance on such tests at 3 years and at 4 1/2 years. At the latter age, the relationship between the first three factors and intelligence was particularly strong.

According to the Arkansas investigators, "The data obtained after 12 months of age seem to indicate that perhaps the most enriching environments experienced by the children in our sample may be characterized as those in which a mother (or some other primary caregiver) provided the infant with a variety of age-appropriate learning materials and who likewise consciously encouraged developmental advances by talking to, looking at, and otherwise positively responding and attending to her child."

Statistical treatment of the Harvard group's results showed that 25 percent of the differences between the A and C children could be accounted for by differences in social class. The influence of these differences was limited almost entirely to what the team calls "nonsocial competence," which in this research includes mainly intelligence and linguistic ability. These factors correlated highly with social class, suggesting that the higher the social class of the child's family, the more likely it was that the child scored high.

There were notable exceptions, however. Of five children who the investigators thought would develop unusually well because of their siblings' records, one came out 22nd of the 39, one came out last, and the other three fell in between those two. Further, one child who was expected to develop rather poorly ranked 10th in overall competence at the age of 3.

The correlation between social class and overall competence, including both social and nonsocial factors, was moderately high.

A PARTICULARLY CRITICAL PERIOD

From the research described in the preceding section, the Harvard group has additional findings that should help parents raise competent children.

'. . . it is very difficult to stamp out strong, basic, simple, pure curiosity during the first 8 or 9 months of life.'

The most important years of the child's life, this group reports, are the first 3, because it is then that the foundations are being laid for the development of language, curiosity, aptitude in social relations, and intelligence. Says White: "I honestly cannot think of any task more exciting and more valuable that any of us do in our daily work than the task of providing an early education for one's child under 3 years of age." One part of this period is particularly critical. It begins at 6 to 8 months of age, when most children "first undergo unusually supportive experiences," and runs to about 24 months of age, by which

time the effects, whether good or bad, "have become solidly established." (White acknowledges that the effects of bad experiences during the child's earliest years can indeed be reversed, as other investigators have found, by changing the environment. But the changes needed are not usually made.)

The beginning of this period coincides with the start of the child's efforts to move about and also with the emergence of the ability to understand language. Nurturing this ability is particularly important for building the child's educational capacity.

Then, toward the end of the first year, "babies begin to reveal a growing awareness of themselves . . . as beings with separate identities. The form of this identity appears to be shaped largely through social interactions with the primary caretaker. These interchanges also appear to shape the infant's basic orientation toward people in general He seems to be acquiring his basic style as a social animal." However, whether children score 90 or 115 on tests of developmental status during the first year "doesn't seem to tell us much about levels of function at age 3 and up."

As early as the 12- to 15-month period, "and increasingly thereafter, the environments of the A and C child differ markedly. . . . Mothers of A children interact more with them, engage in more intellectually stimulating activities with them, teach them more often, encourage them more often, initiate activities for them more often, and are more successful in controlling their children.

"The most important implication of these findings," the researchers point out, "is that *children who later grow up to be exceptionally competent intellectually do not seem to become so because of innate capabilities only. Starting as early as 1 year of age, these children have daily experiences in their home that systematically promote their development.*" Particularly important are the developments in language, curiosity, social competence, and intelligence.

The mothers most likely to develop competent children are those who encourage the growth of language "by careful selection of suitable words and phrases and by exploiting the child's interest of the moment." Other mothers "provide a great deal of input but with considerably less skill and effectiveness." And

still others show "minimal attention to the language interests of their children."

Another major element that develops during the first 2 years is curiosity. "Even if a child comes from a miserable home and is beaten regularly," White notes, "it is very difficult to stamp out strong, basic, simple, pure curiosity during the first 8 or 9 months of life." He continues: "It is, unfortunately, not that difficult to stamp it out in the next year or two or, if not stamp it out, suppress it dramatically or move it over into aberrant patterns. For example, the 2-year-old who looks at a new toy and, unlike other 2-year-olds, only sizes it up to see how he can use it to badger his mother: that is not sheer, unqualified curiosity."

The third major element in the foundation of competence is social development. Says White: "We know that human beings will not survive without some sort of strong, protective attachment to an older, more mature, more capable human Between 8 months and 24 months or so, one of the most gorgeous experiences you will ever see takes place: children establish a relationship, usually with the mother. They learn thousands of things about what they can and cannot do in their home, what they can and cannot do in interactions with the primary caretaker, about how to read the primary caretaker's different mood states, and an incredible number of other things."

During those first 2 years a human personality is being formed. The social patterns acquired then, through interactions with the mother and other members of the family, are the ones that will be applied during the next few years to other adults and to children who come into the home.

The fourth major element is the development of intelligence. "From late in the first year," White points out, "children are very much interested in cause-and-effect relationships." They flip light switches on and off to see the consequences, and they delight in working with jack-in-the-boxes. Though such events seem trivial, "they indicate a very deep interest in how things work" and in other characteristics of objects.

SOURCES OF STRESS: NEGATIVISM AND CLOSELY SPACED CHILDREN

During the course of the research, White confirmed what other researchers had reported and observant mothers well know—for a period during the second year of life children are inclined to be negativistic. During that time, "our subjects begin asserting themselves, rejecting suggestions, ignoring commands, testing limits, and generally flexing their muscles." Often the child seems to refuse to cooperate with his mother just for the sake of refusing. "Some mothers cope well with this normal phenomenon," the investigator reports, "others not so well." White coped with it by temporarily halting most tests.

The negativistic period is likely to begin somewhere after the 14th or 15th month and to end with the 24th month, though it may continue for awhile. The likelihood that a child will comply with a request by his mother falls to less than 50 percent during this time—although the child was largely compliant as a 1-year-old and probably will be again during the third and fourth years.

Negativism seems to be triggered by what White calls a "sense of agency" or the child's realization that he, too, can exert power. Since the child has to go "from total dependence to a stance from which he can face reality on his own," the last half of the second year may represent a stage at which some major step in the process takes place. "A second comparable step," White points out, "seems to occur at puberty and takes the form of adolescent rebellion."

At times during the negativistic period it will be impossible to dissuade children from something they are doing, "especially if it is something that they see their mother disapproves of." So what can a mother do? The investigator—whose research convinces him that a strong link exists between firm discipline and competent children—replies: "Firm discipline is still strongly advised but because it is clear that there are very great pressures (on the child during this period) occasionally to contest and to win over authority, *I believe wise parents are well advised to yield occasionally to the child in areas where the stakes are not particularly high (from the parents' point of view)*. This does not mean that I advocate a general permissiveness or a general abdication of responsibility for controlling the home.

The parents we have watched doing an apparently effective job with their children *never* abdicate their control in this regard; but they are wise enough and personally secure enough to occasionally let the child win a minor struggle at this particular stage of life. . . ."

Though negativism is a source of great stress to many mothers, far and away the stress most difficult to deal with during the first 3 years is "the behavior of a not-much-older sibling." Frequently, though not invariably, White has found that "when children are spaced less than 3 years apart, families pay a significant price." As he explains the situation: "A first child reared at home lives (usually) in a loving, protective atmosphere for most of his first 2 years. He rarely comes face to face with aggression or hostility. In contrast, a second child with a sibling a year or a year and a half older inevitably must cope with such forces day after day, once he begins to crawl about Mothers often find themselves into at least 12 months of chronically unpleasant policing activities. . . ."

On behalf of a first child who is only 1 1/2 years old when the baby is born, White points out that the child is still mother-oriented. It is very difficult for him to have to share the center of his life with the newcomer, particularly since the newcomer seems to be getting most of the mother's attention. Consequently, when the new baby begins to crawl and get into things, the mother may find herself spending vast amounts of energy and time simply trying to keep peace.

PREVENTING EARLY-LIFE FAILURE

Failures in the development of language, curiosity, social skill, and intelligence—the major foundations of competence—"are extremely difficult to correct, using any means we now have available" and lead to underachievement or failure in school. As evidence, White notes that "children who enter the first grade significantly behind their peers are not likely ever to catch up." Also, the Head Start program, which has concentrated on helping children in the 3- to 5-age period, "does not often succeed in its prime goal," the prevention of educational failure.

Families who want to do the best they can for their children, in White's view, face three major obstacles. The first is paren-

tal ignorance of the process of child development. The second, stemming in part from the first, is parental stress, particularly when the child enters the negativistic period and starts determining how much he can get away with. The third major obstacle is lack of assistance.

This investigator has a number of suggestions for meeting that situation:

1. Teach all prospective parents—through required courses in high school and through television—about human development in the first years of life. ("Our current educational policy is grossly inadequate," he says, because it largely ignores the family, which he considers the most important educational factor in a child's life. He believes that most people will acquire good parenting skills only if they are trained in them.)
2. Offer adult education courses for pregnant women and their husbands. "Perhaps provide video-cassette or filmed mini-courses in hospitals during the lying-in period," as is being done in Hawaii and has been done, though rarely, elsewhere.
3. Provide a low-cost detection and referral service to every family, starting when a child is born, with a promise that the children of participating families "will not go through the preschool years with an undetected educational handicap."
4. Establish a neighborhood resource center to make available "continuing, low pressure, strictly voluntary training for parents." This resource center might, among other activities, lend books, pamphlets, and toys to parents; make professionals available to talk with parents; provide free baby-sitting a few hours each week for parents' psychological relief; and carry out a home-visiting program, under which parents could elect to have a child-guidance worker come to the house—once every 6 or 8 weeks, say—to observe the child and talk over problems.

In large part because of the Harvard Preschool Program, a neighborhood resource center such as White recommends is already in operation in Brookline, Mass., a Boston suburb, as part of the Brookline Early Education Project, or BEEP. The project had its beginnings one day several years ago in a conversation between White and the Brookline superintendent of

schools. "When I get a child in the first grade who already looks weak," the superintendent said, "I cannot do much for him, even though I have one of the best special education programs in the country." He thought that probably all children should enter school at 4.

White told him that 4 was too late, because even by 3 a child's learning capability has been largely established. "Take a look at what is going on in the first 6 years, not just in the fifth year," White advised. "Try to get at the origin of educational deficits; try to prevent them, and try to help earlier in the game."

As a result, in Brookline a teacher-consultant from the public school system goes into the homes of newborn babies—if the family has volunteered for the program—and helps the parents from the very beginning to raise competent and emotionally healthy children. The teacher-consultant works with the parents until the child is 5. Also, mothers and fathers are free to drop into the resource center, where they may borrow books, pamphlets, and toys, exchange experiences and problems with other parents, and seek advice.

Although the results are not yet known, White would be willing to advise any school system to undertake a similar program now.

Dr. Donald Pierson, BEEP's director, believes that the public school system should educate parents to be their children's first teacher. He suggests that elementary schools could begin doing so by lending parents books on child development, establishing a toy-lending library, and providing physical examinations and developmental testing of young children. Pierson suggests also that high school students be given credit for working with children in a program like BEEP's.

It is clear that the first 3 years of life are extraordinarily important to the healthy mental and emotional, as well as physical, development of the child. Parents can and should do much to make them productive years, for the child's experiences during that period will determine to a large degree how well he or she will be emotionally and intellectually prepared for school and the experiences associated with it.

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Principal Investigator: Burton L. White, Ph.D.
Director, Center for Parent Education
55 Chapel Street
Newton, Massachusetts 02160

SOCIAL LEARNING TECHNIQUES FOR PARENTS OF DIFFICULT CHILDREN

Principal Investigator: Gerald R. Patterson, Ph.D.

Author: Sherry Prestwich, NIMH

A 6-year-old boy causes his parents considerable distress because of his extremely distractible hyperactivity, his inability to learn at school, his destructiveness, and his defiance of authority. The mother complains that she cannot leave him alone for a moment because she is not certain what mischief would next attract him. Without warning and without apparent provocation he has struck or kicked his playmates

When a teacher gently reproved him for saying "shut up" to her, he kicked her in the shins, much to the chagrin of the mother who witnessed the incident. At the table the child frequently indulges in throwing silverware at the china or at his brother and sister rarely missing his target

In the first grade of the public school the child had a tolerant, accepting teacher, who reported that he seemed at the end of the year to be gaining some self-control, some "conscience about his errors," and was becoming somewhat more observant of common courtesies. Nevertheless, he rarely sat still, continually interrupted others, disrupting classroom activities, talked loudly, and exaggerated stories to keep the attention of others

His second grade teacher found him so unmanageable it was necessary to send him out of the classroom daily

and to exclude him from class trips, though without effect. The child, consequently, was socially unaccepted by his peers. The mother still took him to school and called for him every day. The boy's incorrigibility gave rise to much tension not only between the parents but was the cause of much concern between them and school authorities.

What is the prognosis for an antisocial, aggressive, hostile, out-of-control, oppositional youngster who continuously presents a magnitude of problems to parents, siblings, teachers, peers, and society at large? Such children constitute about one-third of the referrals for child mental health services, but there is generally little in the way of appropriate or effective services for them. Yet appropriate services could improve parent-child relationships, alleviate distressing, immediate problems and potentially have long-range value in preventing such children from later experiencing problems for which they are otherwise at high risk: mental illness, crime and delinquency, vocational difficulties, social problems, etc.

At the Oregon Social Learning Center in Eugene, Oreg., Dr. Gerald R. Patterson has developed a treatment program, based on social learning principles, particularly operant conditioning concepts, that is designed to help parents, such as illustrated in the above narrative, to master child management skills.

"Extremely simple" is Dr. Patterson's description of his concept and approach, "and the program can be understood in a relatively short period of time; in fact, most people do it intuitively," he says. "The most difficult part of the approach is getting parents to incorporate it into their lives and to be consistent. They can understand it; they can pass the test; they can talk to you about it; and they can even give other people a lecture on it. However, it's getting performance—not learning the concept—that's difficult."

Dr. Patterson describes the behavior of the socially aggressive child as "a direct reflection of events occurring in his natural environment." According to Dr. Patterson, the families participating in his research are all members of a violent system, and the function of aggression in such families is to turn off the attacks by other people. Consequently, aggression becomes a coping device. Dr. Patterson believes further that in

such a social system a normal child would quickly learn to ward off the aggressive behavior of other family members by imitating their maladjustive violence. Some of the children who have been treated had become so violent that they attacked their parents and other persons with scissors, for example. Others broke furniture, stole, and set fires. They were determined to control the world in which they lived. Almost every time such a child has a confrontation with his parents, the child wins. Oddly, although these children are used to having their way, they are extremely unhappy.

Dr. Patterson's data indicate that the mothers in his treatment program are more aggressive than mothers from matched, normal families, as are the fathers and the siblings, too. The whole family is deeply committed to aggression. And as the family's aggressiveness increases, the time members spend talking with each other diminishes and finally stops. This makes sense: One avoids people who are constantly inflicting pain.

Patterson sums up the characteristics of the typical mother of an aggressive child as "a diffuse and noncontingent person with her child." By "diffuse" he means that she is probably warm and loving sometimes but that such behavior is not contingent upon the child's being good. "When he misbehaves, and sometimes even when he behaves, she becomes diffuse again by screaming at the child. He reacts against this inconsistency. This disrupts her marriage and her life, and she becomes a miserable, anxious, angry person."

On the other hand, Dr. Patterson also suggests, "In most of the families we have seen, the parents genuinely wanted to help their children; usually they wanted very much to love them." The treatment program of Patterson and his colleagues is aimed at helping parents regain control over their children's behavior. When this happens, the love and the self-esteem of the parents improve—a sure sign that their mental health has also improved.

THE SOCIAL LEARNING APPROACH

Because Dr. Patterson, along with many other authorities, believes that behavior is learned, his program is directed at

training parents to teach the child to unlearn wrong ways of acting and at the same time to learn to behave in more acceptable ways. This form of treatment, a form of behavior therapy, emphasizes the use of rewards and punishments, mechanisms crucial to the application of the therapy, to shape desired actions. Unlike psychoanalysis and related techniques, behavior modification does not delve into the "unconscious causes" of deviant behavior. It is content simply to correct such behavior.

Learning is probably the most significant factor in the development of childhood aggression.

While improved behavior can be interpreted as a reward in itself, the social learning theory relies for its success on using an extrinsic consequence to alter established maladaptive behavior habits. What one is rewarding is the performance of altering old habits and supplanting them with new ones.

Learning is probably the most significant factor in the development of childhood aggression. For example, the child notices that if he has a tantrum his parents give him what he wants, so the next time he wants something he again has a tantrum. If giving in to the tantrum teaches the child to repeat it, why not just ignore such behavior? Patterson and his group answer that these children are emotionally disturbed and that their behavior is rather deeply ingrained. Consequently, when their behavior is ignored, they are apt simply to accelerate it or use other pain-controlling techniques, thus giving their parents still further punishment.

Inasmuch as these disorders of aggressive behavior occur more frequently in boys than in girls, Dr. Patterson's program, with a few exceptions when girls have been admitted, has thus far been primarily focused on the treatment of boys not older than 15. Programs based on the same principles have been shown repeatedly at other research centers to shape the behavior of adults, too, but Patterson and his colleagues consider this social learning approach ideal with children. With adults the therapist must consider the rewards and punishments offered

not only by the spouse but also by coworkers, neighbors, and relatives, all of whom exert influence on a client's behavior. With a child there are fewer outside influences.

In working out a program for a particular child and his family, the staff of the Oregon Social Learning Center (SLC) asks itself such questions as:

- What seems to be supporting the maladaptive behavior?
- What are the immediate causes?
- Does the mother give in to the child's tantrums?

The following is a case history of a child and his family who were referred to the Center:

Fred's mother . . . six years previously had been married to an angry, physically assaultive man whom she later divorced. She described herself as having been overly permissive, partially as an attempt to compensate for her husband's rigid control of the family From her previous and current interactions with the children, it seemed she preferred to be a friend rather than a mother As such, it was difficult for her to set rules, limits, and contingencies. However, she believed that if she could be warm and loving enough, the children would mature. Unfortunately, *all* of the children were out of control; and she was finding it commensurately more difficult to be *loving*.

Fred, age 11, was one of five children. He had an older brother, age 16; an older sister, age 14; a younger brother, age 10; and a younger sister, age 7

During the past year she had sought psychotherapy for herself and for Fred. He presented the general picture of a sullen, unhappy boy whose out-of-control behavior was becoming increasingly dangerous. During the previous week, in a fit of rage, he had tried to shove his mother down the stairs. He frequently attacked the other members of the family

The school presented specific complaints about him, such as attacks on peers and widely disruptive behavior in the classroom Many attempts had been made to change his behavior, but to no avail. As a last resort, the school requested that the superintendent transfer Fred to another school in the district. The second school accepted him with the condition that he receive treatment prior to his entrance to school in the fall.

Fred had previously served as a subject in a sample of 15 children working in a "token culture" classroom (in which tokens, exchangeable for gifts, are given for desired behavior); of that group only two were not controlled by the procedures. Fred was one of those two. As his mother said, "We have already had behavior modification, and he was too smart for it." The mother was deeply pessimistic about the project being of any help and disagreed on philosophical grounds with the procedures used by behavior modifiers

Observational data were collected by observers in the home for 12 days. From the data it was clear that Fred was not necessarily the most aggressive of the family members. The entire family exhibited what were recorded as deviant behaviors at the rate of 1.89 instances of aggressive behavior per person per minute The observation teams reported that the resulting noise level was similar to that found in a machine shop.

Apparently, this family rarely experienced a respite from chaos. The mother, in particular, was distraught, disillusioned, despairing, and, indeed, desperate. Yet, at the end of treatment, she "was able to return to college and acquire a teaching certificate in art."

Through the intervention program set up by the SLC staff, the mother's goal was first to obtain control over the behavior of the youngest children, who were exhibiting the highest rate of undesired conduct. Achieving this aim, she went on to the "more difficult problem, that is, Fred's hitting." Carefully following the techniques and principles that constitute the social learning theory, the mother set up contingency rewards for Fred's good behavior and punishments for bad.

If Fred did not hit anyone, he was permitted an extra half hour of TV at bedtime. However, if Fred did hit someone, he would be placed in time-out [time-out is explained in detail later in this report] as his punishment for a given period of time. Fred did not waste much time in testing the contingencies his mother placed upon his hitting. Immediately after his mother explained the procedures which it was hoped would curb his hitting, he gave his younger brother a hard blow on the arm. Fred's mother instructed him to go to time-out; immediately he hit the younger boy three more times. While in time-out, he continued to be vocally abusive and disruptive—beha-

viors which earned him an additional 75 minutes time-out and separation from TV, his reward or positive reinforcement. The next day Fred repeated his performance: He continued his obnoxious behavior during time-out, thereby increasing by an additional 40 minutes the time to be spent in social isolation. After testing his mother to her limits to see how much he could get away with, and realizing that she fully intended to adhere to the newly implemented program, Fred's hitting practices rapidly decreased and soon ceased to be a problem.

Eventually, with the assistance of the Center's staff, the mother set up a plan that included chores for each family member, and they carried them out. The family is now one cohesive unit, each member doing his share in making their home a pleasant place to be. Yet the total cost of the treatment program in terms of professional time, Patterson reports, was 13.9 hours, which includes intake interview, staff conferences, group meetings, and telephone contacts.

TREATMENT

In the social learning approach, parents or other key persons who interact with the child are taught skills that reduce rates of undesired behavior and increase rates of acceptable behavior. The key to success is that the parent be able to control most of the reinforcements (or rewards) and punishments in a child's environment. That is why the program has thus far been limited to boys and girls to age 15, although the aim is to extend the program eventually to include boys up to 16 years of age. Dr. Matthew Fleishman, a member of the Center team, explains the cutoff age as follows: "Whereas the young child is wholly dependent upon his parents, the young teenager, on the other hand, can probably find his own food and shelter. Therefore, we work on a program where we assume that the parents have the ability to control the rewards and punishments that a child receives. One example of getting control over a child's behavior is by providing necessities for the child's well-being. An obvious example is that the child is dependent upon his parents to provide him with regular meals. However, if the parent isn't dependable about providing meals and merely says there is bread and peanut butter in the cupboard, that parent really has no control over the child's behavior in eating nor

over other behaviors that might be controlled by dependably providing meals. It isn't always strictly in terms of discipline that parents have control but also in terms of impact on the child's life."

The treatment procedures used for families enrolled in the Center's program include the required reading of a programmed text on social-learning-based child-management techniques (either *Living With Children*, 1968 [Patterson and Gullion] or *Families*, 1975 [Patterson]). The assignment of the test is dependent upon the educational level of the parents and must be completed before treatment can begin. In simple and nontechnical terms both books stress that the behavior of the child can be managed and explains social learning principles such as reinforcement, shaping, generalization, coercion, extinction, and punishment.

After the parents have read the required text, they are taught to define carefully, track, and record a series of targeted deviant and/or prosocial behaviors. During this period, and during all other steps of training, the parents are frequently monitored via telephone by experienced data collectors. In addition, parents are systematically observed in the home during the baseline period, before treatment, or intervention, begins, and finally during several stages of the 12 months of followup. During observation sessions, which are generally conducted during the dinner hour, each family member is "targeted" for 10 minutes. The targeted person's behavior and the response of other family members are noted over repeated 6-second intervals.

Interestingly, little difference exists in the rates of maladaptive behavior performed by normal as opposed to aggressive children. One behavior labeled deviant is emitted every 3 minutes by the so-called normal child as contrasted, on the average, to about one deviant behavior emitted every minute and a half to 2 minutes for the socially aggressive child. Consequently, pinpointing the deviant child, especially in troubled families, can be difficult. Therefore, the program is not necessarily geared to treating a target child, but in the final analysis, the entire family benefits from intervention.

Used in the home by the observers and parents are two data-gathering systems: the Behavioral Coding System (BCS) and the Parent Daily Report (PDR). The BCS, used by home observ-

ers, contains 29 categories, 14 of which describe negative or deviant behaviors (e.g., negativism, noncompliance, teasing, humiliation, and destructiveness); 7 are positive behaviors (e.g., working, playing, making positive physical contact, laughing, and complying); the balance are neutral behaviors (normal and attending). The PDR, developed by the Center, is a system used by parents in the home setting to identify other less frequent but important aggressive behaviors. Using a reference list of deviant and prosocial behaviors, parents track behaviors, by recording each deviant or prosocial behavior demonstrated by the child. During a series of semiweekly phone calls from data collectors at the Center, the parents report which of the targeted items occurred the previous day. Thus, the parents and therapists are able to "analyze changes in both frequency and severity of such behaviors." The parents are then taught how to reinforce and encourage prosocial, acceptable behaviors and how to reduce rates of undesired behaviors. A behavior is described as a noncompliance on each occasion that the parent presents a clear request, or command, that is followed by an argument, refusal, or an acquiescent verbal response unaccompanied by actual compliance.

Objectives are reached by both parents and children in negotiation sessions which result in the creation of family programs designed to establish reinforcement and punishment contingencies. Frequently, when treatment is initiated, the parents may become disillusioned as the child's condition worsens, an event that occurs because, in effect, the parents are now telling the child that what he has been doing in the past is no longer acceptable. On the other hand, the child is desperately struggling to maintain his former status in the household, which he considers to be a more favorable position. The parents are constantly encouraged by Center staff to endure, and results indicate that endurance eventually brings favorable effects.

The Point System

One of the major objectives of the program is to help meet the child's individual needs, an outcome accomplished by a system of rewards based on a point program. The parents and child decide together on the behavioral goals and on the reinforcement, or reward, that the child will receive when the goals are reached. Such agreements involve exchanges between all

parties concerned; that is, the child entering into the contract consents to alter his own behavior, and the parent agrees to furnish reinforcement for changing the behavior. For example, if a child plays by himself for 15 minutes, he might receive 3 points. Each time he doesn't disobey, argue, throw a tantrum, tease his younger brother or sister, or cleans up his room, he receives the number of points previously agreed upon by all parties during the negotiation session. When the child has reached his goal in the point system, he is rewarded in the way he has chosen. That is, he may have decided to see a particular movie, stay up longer to watch a favorite TV program, have a family outing at the zoo, or receive a gift within the family's budget.

Time-Out

Unacceptable behavior is dealt with not through physical punishment, which often has an emotional aftermath and is therefore highly discouraged by the Center staff, but through a technique known as *time-out*. Time-out means isolation or a short separation from pleasurable activities ongoing at the moment the child becomes unmanageable. It is an arrangement in which an undesirable response is followed by a brief period during which activities of a family group are denied him and the child is separated from family, friends, and pets. The purpose is to make the child uncomfortable and unhappy within reasonable bounds because of his separation from the group. The investigators say that the parents should not be concerned with whether or not the child is having a good time in isolation: The object of time-out is simply to restrict the child for a time from his social reinforcers, or the pleasure he gets from being with the group.

An environment for time-out in the home may be a relatively barren room; examples may include the bathroom (without any glass items) or the bedroom or the back hall (without TV, books, or toys). Patterson's group cautions parents that time-out should be used for only short periods of time, no longer than 30 minutes at any one time, and not for long periods of isolation in small quarters. The environment should never be frightening; for instance, there should always be a proper amount of light and ventilation, and the child should never be made to stand or sit in an uncomfortable position.

An alternative to the time-out procedure is the application of another form of mild punishment, such as household tasks, given in a nonabusive but firm manner for inappropriate behavior. For instance, the child may be told that his penalty for noncompliance is to mop the kitchen floor and that he will not be allowed to resume normal activities until his assignment is completed. If the child balks and refuses to mop the floor, the parents are instructed to inform the child that there will be no TV, dinner, or social activities until he has finished his task. Too frequently parents tend to overpunish or underpunish the child; they are more apt to say, "no allowance, no friends, no bicycle, no movies for the next 2 years," or on the other hand, merely, "empty the trash can," "feed the dog," "sit still for 2 minutes," etc. The child soon learns not to take his parents' threats seriously, and consequently the overall objective of the program is defeated.

Other examples of appropriate punishment for undesirable behavior include:

- Disruptive behavior at the dinner table means that the child stands across the room for 2 minutes.
- Interruption of a parent's conversation with another adult means that the child must stand off to one side while the conversation proceeds.
- Destruction of household items means that the child is given a physical chore (such as pulling weeds) lasting from 15 minutes to an hour, depending on the age of the child.
- Refusal to comply with a parent's request means that the child is placed in time-out for 15 minutes.

Author's note: Time-out is also an effective and efficient means of controlling the child with behavioral problems in the school setting. An example of this can be found in the Mark Twain School of Rockville, Md., which serves the Montgomery County School system. Under the skillful administration of its principal, Dr. Ronald S. Laneve, Mark Twain is specifically geared to educate the child with behavioral problems. In a school whose enrollment is 80 percent boys, the staff relies on time-out as a rapid method to curtail classroom disruption.

Within the comfortable and aesthetic interior of this school are a number of time-out rooms, each measuring 4 feet by 5 feet. Each is barren except for a desk, is well ventilated and lighted, and every door, always unlocked, has a window. Dr. Laneve states that time-out is absolutely necessary in order for the teacher to maintain discipline in an environment highly conducive to classroom disruption. Each time a student enters a time-out room, separate entries are made for both the teacher and the child. The teacher's entry is to help ensure that the system is not being inappropriately used by staff; the child's entry, to track his progress. Walking through the corridors of Mark Twain, one is astonished to discover that, by and large, the students appear better behaved than those attending the usual school.

The Program for "Stealers"

Besides the main program geared to treat the unmanageable child who is a threat to the cohesiveness of the family, the Oregon Social Learning Center conducts a program, under the supervision of Dr. John Reid, designed specifically to treat the problem of stealing. This program was initiated to study children whose treatment by staff members dealing with hyper-aggressive children had been unsuccessful.

The staff found earlier that stealers tended to exhibit less deviant behavior—meaning, primarily, lower rates of aggressive behavior—than nonstealers. This finding may have accounted for the staff's failure with the stealers, since the original program had been designed to control high rates of aggressive behavior. As Dr. Reid puts it, ". . . the reason the parent training program produces minimal results in the case of stealers is that there is little of this deviant behavior occurring within the actual home setting upon which the parent of the stealer can work." Because of this low-rate behavior, parents, too, are possibly not motivated to try to alter or restrain their child's deviant behavior. Also, stealing is such a socially undesirable trait that the parents find it difficult to admit their child engages in it. Eventually, though, the community begins to exert pressure upon the parents to take some form of action.

Mark was a socially unskilled, unattractive, obese youngster of 12—and a stealer. Mark's father was extremely negative toward him, not only because of such undesirable traits but also because Mark did not meet his father's expectations about masculinity or athletics, and did not share mutual interests. The father frequently humiliated Mark by addressing him as "fatty," or "thief," frequently in the company of others.

Mark was referred to the Oregon Social Learning Center initially not because of the poor relationship that existed between father and son but because of the boy's food-stealing habits. Though considerably overweight, the boy would sneak out during recess, run down to the supermarket, and steal such items as cookies, candy, and cakes.

Mark had been previously treated for approximately a year and a half at another mental health facility for neurotic behavior. The idea then had been that Mark was absorbed in food as the result of his parents' failure to meet his so-called dependency needs, or his needs for better parental care. Despite treatment, his stealing continued at a very high rate, and he attempted suicide.

Eventually Mark was referred to the Center, where the staff focused on his stealing problem rather than on his underlying neuroses. The treatment suggested was extremely simple. Mark's father agreed to cease his degrading remarks or, if he did not, to contribute an agreed-upon sum of money toward a prize for his son. Mark saw immediate gains in this program, inasmuch as his father would stop "putting him down," or else "pay him off." In return, Mark would cease his stealing. Whenever Mark's parents found in his possession anything for which he couldn't account, he would have to do a given chore—1 1/2 hours of garden work.

The stealing ceased almost immediately, but the father needed help from the staff in recognizing a positive change in his son. One interesting result of the agreement was that, after the stealing stopped, father and son spent more time together. At first the two engaged in many arguments and confrontations. With further treatment, the aggressiveness stopped. But not all treatments are entirely successful. Despite this progress, one day without warning the father abruptly told the Center staff: "I don't care about this stealer; he's a fat, little, queer kid, and I don't like him."

So the case was by no means an overall success in terms of the family. But it was not a total tragedy so far as Mark was concerned. He was placed in a foster home and at last report was doing very well.

Another Case History:

The target child in this family was a rather obese, angry, socially unskilled 13-year-old boy. He had a long history of stealing and fire-setting. There were four other children in the family (boys, ages 4, 8, 14, and 15), none of whom showed significant problem behaviors. The parents were extremely uncooperative with the project, to the point of not allowing home observations. The father was working full time and attending college. The mother was attending college and was engaged in civic activities. Neither parent supervised the children carefully. The primary task during intervention was to teach the parents to track the boy's activities. Both parents were quite willing to apply time-out contingent upon stealing and fire-setting. It took approximately 10 weeks of intervention for the parents to complete the textbook and to participate in the program, at which time they reported stealing stopped.

Essentially, treatment for the children who steal is the same as for the social aggressors. However, before parents of children who steal can use the same behavior-management procedures as those used with socially aggressive children, they need to learn to label each stealing event as such and not to place a value on the article stolen. Parents tend to become upset in direct proportion to the monetary value of the stolen item and to overlook the fact that each stealing event, regardless of value, is a theft. As Dr. Reid explains, "We have the parents document the accusations of stealing, which is not difficult to do because teachers are complaining about items being stolen out of lockers, the neighbors are informing the police of thefts, items are missing from mom's purse, and so on. Consequently, we change the focus from stealing itself to the report of stealing, and we define that as the problem. Stealing . . . is almost impossible to detect . . . and the one thing that goes invariably with stealing is lying, because obviously, the boy has to deny committing the act.

"We tell the child that he has already been labeled a thief and the stopping of his stealing habits is not going to convince everybody, as they probably suspect that he has gone underground or has become more sophisticated. The child's problem is not only to get other people to *notice* he is no longer stealing, but also to *convince* them that he is not." Therefore, the project works on reported stealing only. Whenever a stealing report is made by a credible individual (e.g., teacher, parent, police), the child receives a consequence. Whether or not the child is actually guilty of the theft, and there are times when he is unjustly accused, the action is recorded as a theft, even if the child argues that he is not guilty. It is harder to persuade the parents than the child to support the program, Dr. Reid reports, because parents tend to be more liberal and believe in the judicial system that requires proof of guilt. "But," Dr. Reid adds, "the children have already been labeled, and it doesn't matter whether they are stealing or not. Everyone thinks they are, and that is why they get excluded from social activities with other children." Dr. Reid finds that his treatment stops or severely reduces stealing in approximately 90 percent of the cases. Dr. Reid additionally supports his outcome data by checking on the rate of stealing referrals to the Juvenile Court. Thus far, none of the children in the stealing project has been picked up by the police *after* intervention.

SUMMING UP

Besides the problems experienced in the family, aggressive children have difficulty learning the social skills required to obtain and maintain satisfying social contacts. Many aggressive behaviors are of a nonphysical sort: humiliation, teasing, crying, whining—all ways of inflicting pain on others. In *A Social Learning Approach to Family Intervention*, Dr. Patterson and his coworkers state, "Peer groups tend to reject the aggressive child. Such children tend to receive three times as much punishment from their social environment as do nonproblem children. Additionally, socially aggressive children tend to acquire academic skills at a slower pace than nonaggressive children. And what is discouraging is the finding in other studies that such highly aggressive children are unlikely to outgrow their problem." Thus, the desirability for parents to maintain control

over their child's behavior *for the child's sake* becomes apparent, not only because of the need for harmony in the home and concern for the child's future, but to avoid the deleterious effects such a child may ultimately have on society. The goal of treatment, then, is not only to bring out-of-control behavior under control but also to produce effects that will persist.

Dr. Patterson additionally has found, ". . . analysis of the siblings in normal and clinical families show that at the age of 3, the normal child performs coercive behaviors at an even higher rate than does our identified clinical sample" But what is an acceptable level of aggression in 3-year-olds is no longer so in 6-year-olds. Dr. Patterson's 6-year-olds have not learned to control this aggression. In effect, the older aggressive child is doing what is socially acceptable for a 3-year-old. These findings in turn suggest "it is crucial to employ effective parenting skills for the control of coercion around the age of 3." Patterson's findings suggest that families with hyperaggressive children should be provided proper training early, to avoid producing troubled, disordered children. Patterson's staff hopes eventually to develop an intervention program for 3-year-olds.

Dr. Patterson's program for modifying undesired aggressive behavior in children has thus far been rewarding. At the conclusion of treatment, the vast majority of participants felt that the entire family had been altered for the better: The child was happier, and the parents' attitudes toward the child had improved. As the child's behavior improves, through application of the social learning theory, the relationship between parent and child improves as well. As a result of a reversal of negative to positive attitudes toward the child, he becomes viewed, by other family members, as an esteemed and integral part of the family, thereby lessening his need to be aggressive.

The program boasts success in two out of three cases referred to the Center. The failure in the one out of three cases is attributed by Dr. Patterson and his staff to "poor parental cooperation, inability of the parents to be consistent with their children, a tendency for the children to demonstrate low rate but highly aversive behavior, and stealing to be a referral problem in cases which were difficult to treat." Conceivably, if the results continue to be as successful as they have been in the past, Dr. Patterson's approach to the social learning theory

could be a treatment of choice for many young children who end up being seen in courts and in child-guidance clinics.

Moreover, this type of treatment can be economical because the average length of behavior therapy is approximately 16 weeks—the total amount of client-contact time. Compared to the average amount of 2 years one might spend in other forms of therapy, the saving in time and money is considerable. Dr. Patterson adds that, since parents can be trained to master the program and gain control over their child's behavior, it should be possible to train an intelligent, warm, perhaps retired house-mother to perform the duties and responsibilities currently managed by Ph.D.'s and M.D.'s at the Oregon Social Learning Center and elsewhere. Buttressing Dr. Patterson's opinion, paraprofessionals, under the supervision of a psychologist, are now utilized at the Family Learning Center in Helena, Mont. Here they employ well-tested social learning principles, techniques, and procedures to help parents be a constructive influence on their children, making the home into a pleasant environment for the entire family. Furthermore, the training of paraprofessionals should further reduce the cost of therapy a family undergoes in the social learning approach.

Approximately one-third of all mental health referrals from teachers and parents are for problems of delinquency and aggression. Obviously, then, strategies to help children who show aggressive, delinquent behavior are necessary. Nevertheless, says Dr. Patterson, "if we try to address ourselves to the problems of delinquency in children, we must develop methods for changing the situation of the social environment which elicit, shape, reinforce, and maintain delinquent behavior. Rather than treating it symptomatically (i.e., trying to treat the delinquent child who is the end product of the system which creates delinquency), a successful solution to the problem of delinquency will require a frontal assault on the homes, neighborhoods, and classrooms in which these behaviors are taught."

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Research Grant: MH 15985

Principal Investigator: Gerald R. Patterson, Ph.D.
Oregon Social Learning Center
220 East 11th Avenue
Eugene, Oregon 97401

GAMES THAT HELP SOLVE LIFE PROBLEMS

Principal Investigator: Elaine Blechman, Ph.D.

Author: Eunice Corfman, NIMH

Chris and his mother, Gail, are playing a board game, a little like Monopoly, on the floor. Mother and son are using the board game to learn and develop skill in solving the problems that come up between them. Chris is red, and Gail is blue. Chris has just drawn a risk card that made him pay \$50 into the bank because Gail refused to accept his "Please" (stop nagging me about my homework). Unless he can think of another "Please" she will accept, they will both have to pay another penalty. You can tell from his squirming that he does not want more penalties. The rules are that neither can discuss or argue a decision of the other, since that deflects from their task. Each can only say "yes" and go forward on the board and win bonuses or say "no," suffer a penalty, and follow the direction to go back and try again. Chris comes up with a new "Please" (help with his homework) which Gail accepts, and they both advance two spaces, and Chris gets \$50 and Gail wins \$100 from a bonus card. In the same way they negotiate when and how often Gail will accept. As they advance on the board, encountering bonuses and risks, they step-by-step negotiate the reward (I will pick up my things) and decide who will track the "Please" (keep a day-by-day performance record at home). They reach the last space together, fill out and sign a Contract (see exhibits 1 and 2), advance to GO, and collect \$200 from the bank. Time elapsed: 12 min., 30 sec.; each is ahead \$550. Chris is smiling; he thinks picking his things up will be a

Exhibit 2.

Contract # _____

Family # 038

Game # 3/3 3c

Date 6/30/76

CONTRACT

Red, please fill out this contract.

Red's Name: Chris

Blue's Name: Gail

PROBLEM:

- 1) What is the problem? My parent nagged me about doing my homework
- 2) How often does problem happen? when I have homework
- 3) When does problem happen? " "
- 4) Where does problem happen? at home

PLEASE:

- 1) What do you want Blue to do more of? help me with it. stop nagging me about it
- 2) When do you want Blue to do it? when I have it
- 3) How often should Blue do it? " "

REWARD:

- 1) What will be the reward? I pick up my things
- 2) When will you give the reward? when I pick up my things
- 3) Who will track the please? me

Signatures: Red: Chris

Blue: Gail

cinch, if it will keep his mother from nagging plus require her to help with his homework. Gail lets him think so, amazed at how quickly, after seven other contracts, Chris has learned to change his "Please" to solve the problem instead of just sullenly balking.

Chris and Gail are two of the people in a study directed by Dr. Elaine Blechman-Beck that is designed to train single-parent families to solve problems. This work is one of a series of Dr. Blechman's investigations in developing and testing forms of behavior therapy (Blechman 1974). There are a number of types of behavior therapies, variously defined by different partisans, and all of them distinguished from non-behavior therapies. Psychoanalytic, Gestalt, social learning, and cognitive schools all have their practitioners; within schools there are further subdivisions of theory.

Although Blechman has had eclectic training, she sees herself as partial to learning theory, yet hospitable to any intervention that carefully specifies the result the intervention is supposed to achieve, that chooses its goals and makes them explicit, and that then carefully redesigns and recalibrates the process of intervention until it is clear the results are achieving goals. Blechman thus meets a common definition for a behaviorist: one who breaks down behavior into units that can be quantified and measured, thereby producing clear-cut results.

A slight, gentle, reflective person, Blechman is wary of being identified with any single school. She suggests wryly that each therapy system has its own devices and escape clauses for explaining its therapeutic failures. These are concepts used to explain that if the client doesn't change when the therapy is given, then there is some defect in the client, not the therapeutic system. The requirements of specifying goals and what will count as result, of stating what the behavioral units are and how they will be measured make the effectiveness of therapies easier for the researcher to assess. But even more, the requirements are themselves rules for a therapy, a behavioral one, which Blechman and her colleagues have developed, directed to specified, limited goals, that Chris and his mother, Gail, are learning.

Some other therapies may suffer not only from vagueness that results in failure to meet these requirements and, hence, are difficult to assess, along with having escape clauses to help explain failures, but also they may have successful clients who

are helped, not because of the system of therapy, but from the charisma and concern of the therapist. This situation is good for the particular client but not for succeeding generations of therapists and clients of similar faith vainly seeking the same successes and wondering why they are such failures.

Finally, the requirements of specifying units of behavior, goals intervention results are procedural; they do not specify what the therapeutic goals should be, only that they should be made explicit. In this they differ from other systems that do claim some forms of behavior—heterosexuality, independence, warmth, for example—are healthier or more “normal” and more desirable than others.

But the behavior therapy Blechman embraces allows for specifying a goal and then abandoning it if it is unsuccessful. Its negative side effects may prove worse than the benefits. It may not have benefits. It may benefit in some contexts but not others. She believes we do not know enough at both the individual and social level yet to be confident that we always know what “good” behaviors are.

Behavioral therapy looks at many interpersonal problems as amenable to experiment and improvement through problem-solving skills that can be taught quite quickly to clients themselves. They do not need a charismatic therapist. Thus, this approach avoids raising the fear of control or manipulation by others sometimes incited by other varieties of behavior modification, since this one aims to transfer a skill directly, for people to help themselves. The theory is that what they learn is not the solution to a single problem but a skill which they practice by successively applying it to many. The skill has long-range applicability, and they can generalize it in their own way.

But what are these skills? What are the steps in this process of problemsolving? How are they taught? And how is behavioral therapy designed so that the clients themselves are empowered to help themselves? These are some of the questions Blechman has addressed in her work. She has elected to concentrate on the relatively young discipline of behavioral family therapy, which concerns itself with marital conflict and child-related problems and has focused on the latter (Blechman and Olson 1975).

In the last few years especially, applied behavior analysis has moved out of the laboratory and beyond animals to apply its operant principles to the real world of people with real problems by developing interventions for them. In *parent training*, parents learn to use behavioral principles to diminish a child's undesirable behaviors and strengthen desired ones (Berkowitz and Graziano 1972). In *parent-child contingency contracting*, the desired change in behavior is translated into a written contract between the parent and child, making the child an active participant. A third kind of intervention, called variously *family negotiations*, *systems*, or *problemsolving training*, teaches to both parent and child a skill which they learn and practice together. It is this type of intervention that Blechman has chosen to explore.

TRAINING IN PROBLEMSOLVING SKILLS

Behavior therapy is usually thought of as a way of achieving a solution to a specific behavior problem. But this is not the only goal. Another goal may be to transmit a skill in family problemsolving, which is not itself a solution but a *process* for achieving one. Which of these goals should be emphasized depends in Blechman's view on three factors: how specific the problem is, the source of the complaint, and how many of these skills the clients already have. Behavioral interventions can be designed to place emphasis on means (the problemsolving process) or ends (the solution).

The solution emphasis is often most appropriate when the problem is specific. Bedwetting, stuttering, obesity, a phobia, an addiction are examples of specific problems. Everyone involved recognizes the problem and needs a solution; the sole criterion of success is the measure of change in the target behavior; the therapist functions as an expert directing the clients. But if the problems are vaguer—nagging, school adjustment, quarreling, depression—target behaviors to be changed must be pinpointed and, in doing this, therapists' own theories of personal adjustment and social class values may influence their choice of solution. This influence is ethically questionable and practically may decrease the client's compliance.

Similarly, if the source of the complaint of the problem behavior is not the client but family or friends or other external

figures, who view the client as incapacitated, inadequate, or threatening, the client may not consider the complaint justified, any imposed solution is unlikely to be popular, and its maintenance will require unrelenting surveillance. Transfer to self-control may be an unrealistic goal. A solution emphasis is likely to have limited success.

The client's repertoire of problemsolving skills also helps determine emphasis. Some families are good at solving most of their problems but will snag on a new one or one kind in particular. Here a solution emphasis is appropriate. But other families have a very limited repertoire of such skills and repeatedly fail at many kinds of family problems. But Blechman's assumption here is that such people are *not* therefore poor candidates for therapy, only that they are poor candidates for therapy as usually conducted. Treatment technology should be altered to suit the clients' capabilities.

The design of the intervention should take all three of these factors into account. In all three such cases—with vague or diffuse problems, external figures pressing for change, the presence of low problemsolving skills in the family—we see under some conditions that a solution emphasis may be inadequate and probably ineffective. Under these conditions an emphasis on means, the *process* of problemsolving, is more appropriate.

A CASE STUDY

The treatment of a severely depressed woman illustrates emphases on both solutions, and the process of gaining skills for training had to take place in order that solutions become accessible to the client (Blechman 1976). The focus during treatment was on acquiring problemsolving skills to equip the client to deal with new crises and ward off recurrence of depression.

Methods

The client, named Mrs. Jones, was a 43-year-old, high school-educated Catholic woman with six children. Two years earlier she was hospitalized briefly for depression at the height of a crisis in her marriage. She was separated and divorced from her alcoholic husband. For 2 years Mrs. Jones moved through individual and group therapy with five different nurses and psychiatric residents. When behavioral treatment and study began, Mrs. Jones lived at home in a continuous at-

mosphere of emotional and financial crisis. She said that she was unable to manage her finances or her family. Her three adult sons (two of whom lived with her) included one who abused alcohol, one who was drug dependent, and one who was AWOL from the Navy. She could not meet the mortgage payment on her house, and she had neither heat, electricity, nor a telephone. She appeared completely overwhelmed and constantly burst into tears. Her medication (200 mgs. of a commonly prescribed mood elevator) provided little help and had unpleasant side effects.

Mrs. Jones was given tests to establish some baseline data about her capacities, which could then be used to measure her progress. She scored 73 on the Cattell Culture Fair Intelligence Test before treatment. Her own report about her life provided little evidence that she had ever functioned self-sufficiently for a prolonged time. To assess how well she was progressing, Mrs. Jones completed the Eysenck Personality Inventory and the Bernreuter Self-Sufficiency Questionnaire before and after treatment.

The therapist was a college-educated young woman with no formal training in psychotherapy. A study was designed to measure Mrs. Jones' progress and the effectiveness of her treatment, which occurred in three spaced periods, called "interventions." The design of this study alternated three periods that established baseline data (A) with three periods of intervention (B), six phases in all. The first period of intervention consisted of 17 training sessions over 21 weeks. After 13 weeks another intervention reinstated training for a further seven sessions. After 15 weeks, three "booster" sessions comprised the third intervention period of fading-out therapeutic contacts. These alternating periods allowed training to be introduced, interspersed with periods when its effects could be measured. As Mrs. Jones acquired skills from the training, her improvement could be measured, even as training was attenuated. The study gradually prolonged the intervals between therapeutic contacts during interventions, gradually escalated expectations of Mrs. Jones' self-sufficiency, and included a year-long followup period during which there was no contact with the therapist; Mrs. Jones was by then expected to do well on her own.

Two measures were selected to assess the intervention's impact. One goal of intervention was to have

Mrs. Jones feel better. Another was to make her more effective in solving her own problems. First, Mrs. Jones had long relied upon mood-elevating drugs to combat unhappy feelings. Drug use before, during, and after treatment was chosen as an indicator of her subjective emotional state. If the client felt better, it was expected that she would take less medication.

Second, routine conversations with Mrs. Jones revealed a hopeless, passive orientation to problems. She repeatedly cried, raised problems, and ruminated about consequences. She elicited advice but listened halfheartedly and never followed it. Therefore, her inclination to solve her problems was assessed in this way. Mrs. Jones talked with a different, unfamiliar staff member during 19 video-taped discussions, called "probes," scattered throughout baseline and intervention periods. Trained raters coded the frequency of Mrs. Jones' complaining and problemsolving statements during these video-taped probes. Her problem-solving inclination was measured by the frequency of her problemsolving statements divided by these statements plus complaints. The ratio was expected to increase as Mrs. Jones gained experience and confidence in her ability to solve her own problems.

Mrs. Jones' behavior with other people was sampled in a series of 19 video-taped discussions or probes. Ten-minute-long video-taped probes were scattered throughout baseline (A) and intervention (B) phases of the study. During each probe Mrs. Jones was asked to chat with one unfamiliar staff member. Staff members rotated over probes and were told to treat the interview as a casual social contact. If a probe and a training session were scheduled for the same day, the probe was conducted first to avoid an ephemeral impact caused by that day's training.

Intervention Procedures

Early intervention sessions (B1) began with a recitation of problems by Mrs. Jones: her own, her children's, and her neighbors'. Each time she raised a problem of her own, the therapist asked her to suggest a feasible solution (e.g., "What would you do about that?"). The trainer ignored Mrs. Jones (by not responding verbally or nonverbally) when she discussed others' problems or when she denigrated herself.

Whenever Mrs. Jones suggested a possible problem solution or said something good about herself, the trainer showed interest with assent, approval, or agreement or with humor and laughter.

The trainer acted out models of problemsolving, thinking out loud about issues and presenting alternative solutions from which Mrs. Jones was encouraged to choose. The trainer elicited self-approving statements by asking Mrs. Jones at the beginning of each session what she had done well during the week.

The latter portion of most training sessions was devoted to the development of a homework assignment. Typically a solution which Mrs. Jones had decided upon was thought through and made concrete: An assignment to contact legal aid included a list of questions to ask the lawyer; an assignment to decide about selling her house included the development of a pro-and-con list; an assignment to list her own good qualities followed a session in which Mrs. Jones explored how she thought worthy people act.

The concepts of assertiveness, self-esteem, and decisionmaking were used by the trainer to label the steps Mrs. Jones was taking. And Mrs. Jones reported reading and rereading *Your Perfect Right* by Alberti and Emmons for encouragement.

During the second intervention phase (B2), the trainer was gradually removed from the problemsolving process by substituting a programmed game board for the discussion with the trainer. The purpose was to "wean" Mrs. Jones from dependence on the trainer as she increased in competence. The game board guided Mrs. Jones through steps leading up to selection and evaluation of a solution. Assignments during B2 focused on setting priorities and formulating plans of action independent of the trainer.

During the third training phase (B3) the trainer administered three booster training sessions in which she once again elicited and encouraged active problemsolving and self-approval by Mrs. Jones.

Results

Interpersonal behavior was observed and coded over the 19 10-minute-long video taped probes. The observer watched every other 10-second interval and counted every problemsolving and complaining statement that

occurred in the interval. Problemsolving statements related to solution of a problem and included general or specific mention of a solution as well as statements of confidence in the solution. Complaining statements included descriptions of problems, consideration of the causes and implications of problems, and statements of hopeless attitudes about problems. Raters overlapped on one out of five probes.

Figure 1 displays Mrs. Jones' problemsolving and complaining statements before, during, and after intervention. Before treatment (A1), problemsolving statements represent 38.5 percent of problem-relevant remarks. During the first intervention phase (B1), 48 percent of remarks were problemsolving statements. This ratio held constant during the subsequent baseline (A2). During the second intervention phase (B2), problemsolving statements increased from 48 to 59 percent. Problemsolving statements declined to 53 percent during the subsequent baseline (A3) but rose again to 59 percent during the fading-out period (B3).

Figure 2 shows dosages of a mood-elevating drug which Mrs. Jones had taken at the rate of 200 mgs. a day for the 2 years preceding treatment. In the middle of the second intervention phase (B2), Mrs. Jones asked for a reduced dosage from her physician. During Baseline 3 (A3), she cut down to one pill a day. By week 83 and through followup she was totally drug free.

On the tests of her progress, Mrs. Jones increased her extraversion score (from 7-pre to 9-post) and decreased her neuroticism score (from 17-pre to 12-post) on the Eysenck Personality Inventory. On the Bernreuter Self-Sufficiency Questionnaire, her score increased (25-pre, 32-post).

By week 83, Mrs. Jones had sold her house, paid her outstanding bills, and rented an apartment which she occupied with her two youngest children (the older children were now on their own). She bought a car and obtained a part-time job. In a final interview conducted by an interviewer whom Mrs. Jones had never met before, Mrs. Jones reported that self-confidence was no longer a problem and that childrearing problems were few.

Mrs. Jones spontaneously sent a letter to the trainer 3 months after the last fading contact and wrote, "I still have goals to reach and will work on time limits to accomplish them." Phone calls placed during the

fourth, fifth, and twelfth followup months indicated that positive change had been maintained.

Figure 1. Changes in Problemsolving and Complaining Behavior As a Function of Problemsolving Training

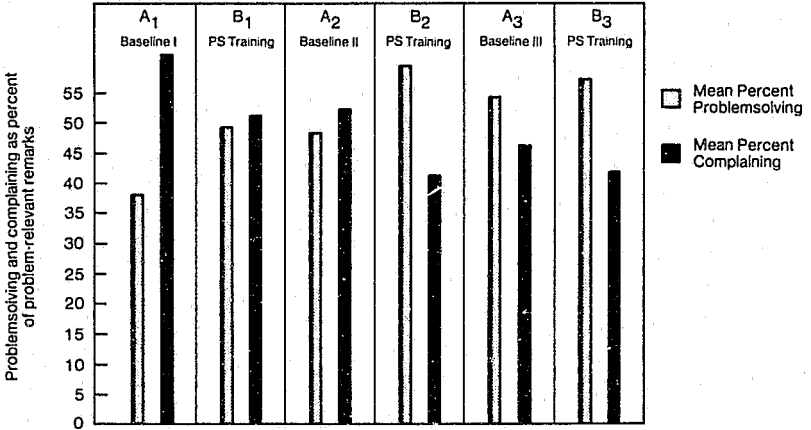
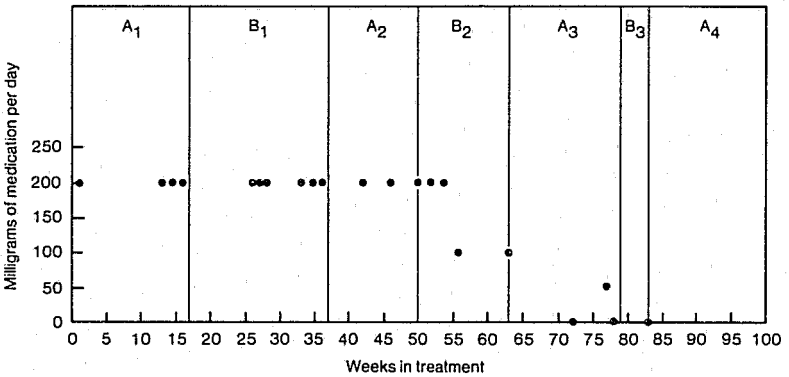


Figure 2. Changes in Use of Mood-Elevating Drugs



Discussion

The hallmarks of behavior therapy, both as a solution for a particular problem and to teach problemsolving skills, are present in this case study (Blechman et al. 1976). In the design the

problem is "operationalized," that is, translated into a specific set of behaviors for this case that can be observed and measured: complaining behavior and taking medication. The goals are to replace the complaining with problemsolving behavior and to forego medication. The problem behaviors are not punished but recorded and ignored. Desired behavior is reinforced with praise. In this case the therapist also spent a great deal of time and care in "modeling" problemsolving by doing it herself; Mrs. Jones' attempts at it were "shaped" through her homework assignments where she practiced doing it herself. Gradually Mrs. Jones took over the problemsolving procedure, beginning with selecting the next problem to work on and culminating in compliance with the selected problem solution.

It is not a great exaggeration to suggest that as the power of chemotherapy lies in the drug, the power of behavior therapy lies in the measurement.

The care and devotion given to measurement are perhaps what most distinguish behavior therapies from other kinds. Measurement is not only a recording tool for the therapist to assess change; it can itself be an instrument of change as it becomes part of a feedback loop of information for the client. It is not a great exaggeration to suggest that as the power of chemotherapy lies in the drug, the power of behavior therapy lies in measurement. The milligrams of Mrs. Jones' medication were measured, and thus the drop in dose during the second intervention was visible evidence of progress. Complaining and problemsolving behavior were video-tape recorded and then coded in very detailed and specified ways to ensure uniformity so that there was *evidence* of improvement. This evidence of improvement provided motivation for further improvement. The design of the intervention, interspersing phases of baseline (A) with intervention (B) in an A-B-A-B-A-B pattern provided a way to measure the effect of each intervention on the selected target behaviors.

During all this while, a transfer of power from therapist to client was taking place, perhaps the most precious gift of the behavioral approach. Positive changes occurred in every measured and observed aspect of Mrs. Jones' life: in interpersonal behavior, self-ratings, use of medication, and, most important, in her life situation. Over the weeks she learned and practiced a skill so that she could do it herself.

What evidence suggests that these changes were attributable to the training procedures? First, Mrs. Jones suffered from unremitting depression for a period of 2 years before treatment began, as indicated by a careful reading of therapist notes. Further indication was provided by the manner in which Mrs. Jones was transferred from one therapist to another and maintained at the same high dosage of medication.

Second, measured changes in interpersonal behavior coincided with the onset of training phases. The first phase in training brought with it a greater equalization of complaining and problemsolving behavior. This change was maintained during the subsequent baseline (A2). The second phase in training was associated with a reversal in the relative standings of problemsolving and complaining behavior—the former predominated. There was a slight reversal in the subsequent baseline (A3) and a recurrence of improvement in the final fading-out period (B3).

Mrs. Jones' decision to cut down her medication was regarded as a positive change by the client. This change coincided with the second phase in training and was maintained thereafter.

This case study was designed to shed light on the effects of problemsolving training on interpersonal behavior and psychotropic drug use. So much measurement took place (the interpersonal probes) that we cannot rule out its *reactive* effects, that is, the possibility that *the measuring process itself produced some of the changes*. Since Mrs. Jones knew her behavior was being monitored and scored, she may have complained less and solved problems more, in part simply to up her score. Therefore, we must tentatively conclude that both intervention and measurement procedures contributed to the positive findings reported here.

Even if measurements were reactive, it would still be desirable to introduce the (A-B-A-B-A-B) design of this case study

and its measurement procedures into the clinical setting along with the problemsolving intervention. First, the intervening and recurring baseline phases alternating may promote maintenance of change. Second, measurement of interpersonal behavior also provides feedback to the clinician, who typically cannot directly observe subtle shifts in client behavior with people other than himself. It can tell him how well the intervention is working. Third, measurement also informs the clinician of changes in social behavior that may precede changes in the depressed client's subjective self-reports, that is, before the client is aware of them, and this may be useful feedback.

Pragmatic problemsolving, encouragement, realistic feedback, and structured assignments are not new intervention procedures. They have been used in nursing and social work (e.g., Miles and Harp 1975). Although more time-consuming than drug therapy, a structured problemsolving intervention may be preferable for women low in self-sufficiency and beleaguered by financial and childrearing problems. It offers dual benefits: resolution of immediate problems and acquisition of enduring skills.

PROBLEMSOLVING WITH SINGLE-PARENT FAMILIES

The success of Mrs. Jones in learning problemsolving that enabled her to help herself, even though initially she seemed to have a very limited repertoire of skills, suggests further development of such therapy along several lines. First, one cannot help wondering whether, if the intervention had come earlier, the sad history of the family and her depression could have been avoided or at least mitigated. Mrs. Jones had six children and an alcoholic husband. Of three adult sons (two still living with her), one abused alcohol, one was drug dependent, one was AWOL from the Navy. Might earlier intervention within the family itself have prevented some of this pain and unhappiness?

Some more traditional "talking" therapies have not been too successful with clients who are not middle class, not used to unstructured situations, not highly verbal or sophisticated. Mrs. Jones herself spent 2 years in psychiatric and group therapy. As often as not, attempts at therapy have been characterized by high dropout rates and low compliance.

In behavioral family therapy, one tool for interpersonal problemsolving has been the contract between spouses or between parent and child. This has been used successfully with adult clinical populations (Tighe and Elliott 1968; Boudin 1972), with normal child populations (Homme 1970; Cantrell et al. 1969; MacDonald et al. 1970; Dinoff and Richard 1969). But Weathers and Liberman (1975) have described an unsuccessful effort to use contracting as an intervention with delinquents and their parents.

Blechman believes the contract device used imaginatively can be very useful for some early interventions in family interpersonal problems, even and especially where other therapies have been less successful. She believes the Weathers and Liberman findings may be due to four conditions not present in their study, which may be necessary for a successful contract approach.

A first condition is that the therapist's praise be valued by the clients so that it matters to them whether their efforts and contract compliance please or displease the therapist (or trainer). Thus, at the beginning of each training session the trainer can set up a small, specific goal that structures the session as goal directed and makes it easy for family members to earn credible and contingent praise from the trainer.

A second condition is that the child should regard contracting as a way to increase his or her power in the parent-child interaction. Both parent and child behaviors must be seen as amenable to change, or there is no reason to "buy in." The child does not typically have access to the rewards and reinforcers the parent has, only the threat of "aversive behavior" that can disrupt. In training, *both* parents and children identify problems to solve and alternate in raising problems and writing contracts to solve them.

A third condition is that family members should feel pride when contracts succeed. This is far more likely if the contract is not mainly the work of the therapist but is the result of their own efforts in goal setting, tracking desirable behavior, and meeting goals. To increase the probability of these, during the task of working out the contract, antagonistic or diversionary off-task behavior must be minimized, while on-task problem-solving behavior must be accelerated. To accomplish this,

Blechman has developed a board game played in training that takes families through each problemsolving step.

A fourth condition necessary for any long-term change is that families must learn these steps so that they can themselves apply the process to new problems on their own. To increase the likelihood of this independence, Blechman provides that the family in training negotiate two contracts at the board game and carry them out on their own during training weeks, until each contract is 70 percent successful or is renegotiated at the board. Other contracts written during training can be stored for use after training ends.

Contract approaches that build in these four conditions appear to promote successful family interventions. This is illustrated in the work of Weiss, Hops, and Patterson with married couples (1973), by the work of Alexander and Parsons with delinquents (1973), and in Blechman's and her colleagues' own work with single-parent families (e.g., Blechman, Olson, and Hellman 1976).

Blechman's choice of single-parent families as a proving ground for developing a family intervention that teaches problemsolving skills may seem, at first glance, a case of picking the hardest possible case. Moreover, in her most recent studies not only have clients been predominantly single parents, but also the single parent has been predominantly female and poor and the family likely to be what social workers call "multiproblem."

The female single parent is likely to command fewer of the material, financial, and social reinforcers available to a family of two parents, which comprise our cultural norm and provide the basis for many of our economic and social exchanges and arrangements. This lack may isolate the family socially. Some female-headed, single-parent families are additionally handicapped by social disapproval. Widows and widowers may head families that are socially isolated, but they will not feel the subtle or explicit condemnation an unmarried female head of family may. Finally, when the roles tradition allots to two parents now fall to one parent, something called "role strain" may result, as the single parent must now start carrying out unfamiliar tasks that formerly were inconsistent with his or her role.

These conditions may produce for the single-parent family, as they did for Mrs. Jones, an overwhelming number of problems that may make family members conclude they are helpless and hopeless failures. What follows may be family and individual disintegration, as with Mrs. Jones and her family. Their repertoire of skills may be limited. They are less likely to benefit from traditional therapies that assume some sophistication with psychological concepts and verbal facility in interpersonal affairs.

Training in the process of problemsolving may be one of the few ways out. It cannot, of course, solve every problem, nor is it designed to. It cannot "solve" congenital problems, psychoses, addictions, or problems so dire, immediate, or symptomatic, such as child abuse or self-mutilation, that emergency intervention is required. Family members must be capable of organizing information, planning, evaluating alternative plans, and choosing one with a good chance of success. But even with these conditions and caveats, there are a great variety of problems and great numbers of people for which this training may be appropriate. It is the limits of these conditions that Blechman is exploring.

THE FAMILY CONTRACT GAME

The family contract game was designed by Blechman and her colleagues to be an enjoyable and effective way to resolve family interpersonal problems: A board game leads them through the basic steps in problemsolving and negotiating a written agreement or contract. The game is actually what is called an "algorithm," a step-by-step path to the solution of a behavioral complaint. Players choose a problem, a desirable replacement behavior, and a reward for it and agree on the details of the contract. With each agreement, and only if there is agreement, they move to the next step. Players may accept or reject each others' proposals, gaining mutual rewards or penalties for doing so, but they may not *discuss or justify* their decisions, since doing so diverts attention from the task. Further, to keep attention on the task, there is a 15-minute time limit to getting around the board and negotiating the contract. The game is a useful tool for solving immediate problems and with practice provides the family with a long-term strategy for

solving future problems, without making the family dependent on a therapist for advice and expertise.

There is a set of basic assumptions, for each of which there exists sometimes anecdotal but still persuasive evidence, that undergirds and directs how the game rules were formulated. The first is that, given *no* constraints or directions, families in conflict are unlikely to resolve their problems creatively and effectively.

Second, given no constraints or directions, families in conflict, far from reinforcing each others' problemsolving behavior, will undercut and block it by being unresponsive, by interrupting, by denying or excusing their own behavior, or by attacking each other with insults, criticisms, and complaints.

Third, a game designed to signal to players exactly how and when to receive and give token and social rewards for selected desired behavior can bring players under the game's stimulus control. This is on-task training in solving a problem together.

Fourth, under the game's stimulus control, the family's rate of off-task or nonproblemsolving behavior should decline drastically.

Fifth, players initially need training and assistance in implementing a solution. These can be given through prompting, monitoring, modeling, and reinforcement by the trainer.

Sixth, conflict behaviors are functionally related so that measurable improvement in problemsolving should also bring measurable improvement in other areas of conflict behavior such as parents' evaluation of child's behavior or voluntary participation in joint family activities. Thus, there should be a spread of effects from the intervention.

Seventh, the game is meant to provide such powerful inducement to problemsolving behavior that, while playing it, players *temporarily* greatly increase desirable behaviors in a structured and dramatically altered social setting. To test whether and how much the game itself was changing the players' behavior, an A-B-A or reversal design was used (where B is the intervention and A is when the family is on its own). If desirable problemsolving behavior increases during B and is due to playing the game, then a reversion to the level of A should occur after B, when the game is removed. So three additional assumptions address how training may build transfer and main-

tenance of changed behavior into the process, since it is not assumed this development occurs automatically.

Eighth, the game's stimulus control in changing behavior can be transferred to other settings if it can be taken and played outside the lab or clinic where training occurs. The game is designed so that after players have been trained and have mastered playing it, they can take it home and use it for problemsolving there.

Ninth, use of the game should be maintained as long as the experience is rewarding to all family members. Immediate rewards are the fun of playing the game and the rewards from changed behavior specified by the contract. Delayed rewards come from having problems solved, an increased sense of competence in solving them, and approval from people outside the family, including the therapist, for the increased competence. The device of the game and the fun of it "sell" the contract that requires real-life changes, as sugar coats a pill that has real physiological effects. Then the contract device requires and begins to provide evidence and a tracking record to each player that the other can be trusted in a *quid pro quo* to solve a problem. The building of trust over a series of contracts provides a reservoir of confidence in each other's behavior in problemsolving as, at the same time, the repertoire of skills is gradually increased.

Tenth and lastly, family members who become skilled should be able to transfer their improved skills in problemsolving to untrained family members and others. Because game players have not been taught simply a solution but have had training and practice and success in a process made explicit at each step, they can transfer the new competence to introduce others to the process.

The game board is divided into 14 squares or steps that the players move along together. These run along the four sides of the board, grouping the four basic components of problemsolving: *Problem Choice*, in which players select a target behavior to negotiate; *Please Description*, in which they agree on a more pleasing behavior to replace the problem behavior; *The Reward*, in which they decide on the event, activity, or commodity which will be the reward; and *Contract Settlement*, in which a specific contract is agreed upon, written, and signed.

In the center of the board are four decks of cards: problem cards made out by the players, from which the target behavior is chosen; reward cards made out by the players, from which the reward is chosen; risk cards, which impose game penalties when a player says "no," regardless of the reason; and bonus cards, which give players game rewards for saying "yes." When players agree on the question posed within each unit, and before they move on to the next unit, the board instructs them to reward themselves with money and a bonus card draw. When they disagree, the board instructs them to repeat the unit, pay a fine, and draw a risk card. In this way the game reinforces cooperative problemsolving, helps players to express their requests constructively, and keeps the attention of young players.

Players take turns with the red and blue markers in successive contracts. Red raises a problem and writes the final contract; blue is the target of the complaint and the banker during the game. The contract, once signed, is honored and tracked for a week and then discussed to see if it is working or needs changes, in which case it may be re-entered into the problem cards.

There are three rules of thumb for writing problem cards. The problem card should describe an action or event that can be observed and counted ("You're incredibly stupid" is not as good as "At dinner you invariably disagree with my football views."). It is open rather than disguised ("I want to stay up till midnight on Saturdays" is better than, "You never let me stay up late."). It happens fairly frequently ("You always forget to observe Mother's Day" is not as good as, "You were late for dinner three times last week."). In this way players learn to translate feelings and attitudes about each other into specific negotiable behaviors.

Similar rules control turning a problem behavior into a "Please" (a request specifying the new desired behavior) during the first phase of the game. Good "Pleases" are so clearly and positively specified anyone can perform them ("Stop leaving your room in such a mess" is negative; "Keep your room picked up" is vague; "At 5 p.m. every day hang up your clothes in the closet and put your toys on the shelf" is good). Good "Pleases" do not introduce new behaviors that are only new problems. If the problem is, "You talk to me when I'm on the phone,"

"When I'm on the phone, write me a note and I'll write you an answer" is not as good as, "When I'm on the phone, write me a letter and deliver it when I get off telephone." Good "Pleases" try to give the same social, emotional, or material rewards as the problem behaviors they displace. For the problem behavior, "You hit me when you're angry," a good "Please" might be, "When you're angry, tell me in a loud voice that you're angry. Then sit down and talk about what made you angry for at least 5 minutes."

The rewards play an important role in the contracts of novice players who do not yet have enough evidence to trust each other that their efforts at changed behavior will be worthwhile to them. For experienced players problemsolving and arranging mutually satisfying behavior become intrinsically rewarding. At times parents are skeptical about rewards ("He ought to be good without rewards" or "The *reason* for her misbehavior must be removed or the treatment is superficial"). But some of these parents are persuaded by discussing the difference between bribes and rewards and by the argument that all behavior reaps consequences whether by plan or chance, and this is by plan.

During the fourth unit, players negotiate the contract schedule: when the "Please" and the reward should occur, and what the ratio of behaviors to reward should be. When the new behavior increases significantly, players may want to renegotiate the ratio and eventually drop the reward altogether, because for one player the new behavior is now built in and no longer inconvenient and has gotten rid of conflict, and because for the other player rewarding such now frequent behavior has become tiresome. Tracking is cumbersome and easily neglected but important to establish how well the contract is working, so it should be made as easy and convenient as possible.

THE NEW HAVEN STUDY

Building on several years of work developing family-therapy interventions that included a board game for training and practice in family contract negotiations, Blechman and colleagues at Yale University designed and developed a project to train single-parent families in problemsolving as a method for resolving conflict. The method had to be enjoyable, spread responsib-

ility over all the family members, encourage the open statement of needs, and provide intrinsic rewards for compliance with the negotiated contracts. It should use a procedure that could be taught to nontherapy-trained professionals. The method should be applicable to poorly educated and nonmotivated clients. It should use a procedure which the family would be likely to go on using after training was over.

A clinical-research unit was set up as a branch of a community mental health center. One-parent families were referred by schools, courts, and agencies. Advertisements encouraged self-referrals, and in time there were a number of family and friend referrals. Over the 2-year project, 90 single-parent families requested information, advice, or clinical help (84 mother-headed and 6 father-headed). The age range of the children who participated was 5 to 17 years, with a mean of 10.5 years: 58 boys and 32 girls. The main problems the families wanted help for were, in order of frequency: the parent-child relationship, the child's self-control, the mother's behavior, the child's disturbed social relationship, the child's antisocial behavior, and the child's physical disability.

After an intake interview to determine whether problemsolving training was appropriate for the problem—the clinic offered other kinds of help as well—and whether the family's level of interest in training was sufficient, 47 families were offered and accepted treatment.

The families were randomly assigned to one of four groups. Group FC learned problemsolving with the Family Contract Game and received approval (social reinforcement) from the trainer for success at specific goals. Group FCM had the same treatment but received a small cash reward (a maximum of 50 cents per family per session) for its success. Group IE (Intensive Evaluation) went through the same *measurement* procedures as both groups but had no *treatment* training. This group was a control and, as we shall see, raised both a methodological and ethical issue for Blechman and her investigators, which triggered a change in design and nicely illustrates a dilemma that confronts a scientist whose research subjects are human beings with needs that can confound research design standards. Group WL was a Waiting List control, and these families waited the length of FC and FCM training before starting their training.

The procedure is this: the families bring in lists of their problems and answers to a questionnaire. During the first session a clinically experienced interviewer spends considerable time eliciting family complaints and opinions about what to do. Near the end of the interview in the first of a series of 5-minute video-taped probes, the family is asked to discuss one of their high-priority problems, and the tape is then coded by a trained rater. If problemsolving training seems appropriate and they are willing, the family is assigned to a group. The goals of the treatment are: the success of two family contracts (one a parent's, one a child's), defined as 70 percent success, and observable improvement in problemsolving behavior. Those starting training are given assignments to record at home the daily frequency of the top three behavior problems to establish pre-treatment baseline data along with two subsequent probes.

At the second session a paraprofessional trainer demonstrates the Family Contract Game, which the family is seeing for the first time, having parent and child select one of their problems and go through the steps of the game, making sure the result is a realistic and positive contract. Nothing but game-related comments are allowed; time is allowed for discussion later. When the game is successfully finished and the players have been congratulated, the trainer goes over each step of what is required by the contract in detail until each member agrees it is likely to succeed.

The family goes home and continues to record and count problem behaviors and to track contract performance, too. Each week a clerk makes a phone call on a day chosen at random to collect the day's count from each member. A probe is collected between every two subsequent sessions. The probes are coded and analyzed to see what changes in behavior are taking place.

Enormous care goes into nurturing success of the first contract (and the second, one each for parent and child). If by the third session it is not 70 percent successful, it is reworked or even replayed on the board. If record keeping is deficient, members are reinstructed.

For the second contract the trainer leaves the room, and the game play is video taped while the players negotiate their contract independently. After 15 minutes the trainer returns and congratulates them if they have been successful and, if not,

assures them they can finish at the next session. Again, discussion extraneous to the contract is postponed until the session's end, when the home records, behavior, and first contract are carefully reviewed. These first sessions are painstakingly detailed, highly structured, and highly reinforced. In subsequent sessions a new formal contract may be written, but two are the most that should be worked on at one time. Therefore, the family learns to thin rewards and fade from formal to informal agreements after session six. At that time home training is introduced. This is the beginning of generalization, "weaning" the family away from the setting where they depend on the therapist and building confidence in their own powers of problemsolving, substituting weekly home family meetings for the clinic appointment. Probes are still collected and coded to measure their progress, and family members still come to the clinic to discuss home meetings and report results. Later, they do not come to the clinic, but the trainer calls to check success of the home meeting; still later, the trainer calls only if needed by the family. This is the process of fading. Finally, the family returns 3 months and 6 months from the last session (the 10th) for followup. Families can always call in the event of problems and use the game and home meetings as they see fit.

This was the therapeutic or clinical aspect of the study. Meanwhile, the research aspect was proceeding. For each family, video-tape probes had been collected and coded over the course of pretreatment while the baseline was established. Further tapes were taken of those undergoing training in the Family Contract (FC) and Family Contract with Money (FCM) groups. The tapes coded 28 verbal and nonverbal behaviors in order to be able to quantify behavior changes with subtlety and precision. A Family Problem-Solving Efficiency Scale assessed the degree to which discussion brought a mutual solution, with implications overtly considered, revised, and accepted by each family member. Using it allowed the rater to assign a score to each problem discussion. Third, a Topic of Discussion Record cataloged, put in sequence, and timed topics within the process of discussion.

This staggering commitment to capturing observations of behavior units and quantifying them strikes some critics of behavioral research as tedious beyond compare at best and at worst as a soulless travesty of the true richness and complexity

of human communication. One reply to such critics might be that for a family deeply in conflict, for whom other forms of therapy are ineffective, something that works cannot be called a soulless travesty. Another reply is that, precisely by virtue of tedious (behaviorists usually prefer the term "painstaking") specification and data collection, behaviorists can lay claim to findings that are firm, public, and replicable.

AN ETHICAL DILEMMA OF RESEARCH ON HUMAN SUBJECTS

Behavioral interventions occur at an interface between scientific rigor and competing requirements due to human subjects. Sometimes these do not reinforce but, on the contrary, cut across each other. An illustration of this occurred with the Intensive Evaluation (IE) control group. This group underwent the same pretreatment baseline measuring procedures as the two treatment groups, so that the effects of the two treatments could be measured by comparing changed behavior of the two treatment groups against the behavior of the treatmentless IE group.

Unfortunately and unexpectedly, the pretreatment measurement had a reactive effect, which showed up in the video tapes. Families asked to come in repeatedly to discuss their problems without training or a structured approach to problemsolving became *more* hostile and *less* constructive. Video-coding showed them over time to spend less time "on-task" (solving the problem) and to exhibit more negative social behavior. Thus, the procedure that was supposed to simply measure their conflict may in fact have been increasing it. This is both an ethical and a methodological dilemma.

The Hippocratic injunction, "Above all, do no harm," weighs heavily on researchers investigating clients who need help. The procedure not only denied treatment to the IE group; it was harming them. When this result was discovered, the group was put on the waiting list for treatment. Still, this was a significant and unexpected finding, evidence that simply "talking out your problems" can do more harm than good, which is important to know.

Methodologically, the remedy was more complicated. This was not a factorial design study (to elucidate which variables contribute to the effectiveness of treatment) but one to assess

the relative effectiveness of two treatment variants: Family Contract and Family Contract with Money, and two control groups, the Intensive Evaluation and the Waiting List. All families except the WL group were studied in an A-B-A reversal design, where B was the intervention period and A the baselines, three video tapes of 10 minutes each period for a total of nine video-tape probes for each family.

When the key control group (IE) may no longer be used in a design for ethical reasons, the research problem is to design an alternative. Additionally, because families in this control group actually became worse, the measuring process was not measuring a baseline but *producing* a declining performance. One design alternative recently developed in detail by Hersen and Barlow (1977) is the use of designs time-lagged over clients. With such a design every group is guaranteed treatment sooner or later, but groups started together on baseline measurements are time-lagged or staggered into treatment. Thus, group 1 starts treatment, and these results can be compared not only to their baseline but to the other groups' baselines that are continuing. Later, group 2 starts treatment, and those results can be compared with the first treatment as well as the other continuing baselines. In this way the relative effects of the two variations in treatment can be teased out. There is some question whether measurements of behaviors such as family conflict can ever be truly neutral and not reactive. One might argue that, if so, video taping an extended pretreatment should not have been done. But without the taping, one would never have known the damage was being done. Knowing it, one can turn to altered designs such as multiple baseline designs or other single-subject designs.

FINDINGS

- Learning to solve problems by playing a contract game to reduce a family conflict heightens the commitment of family members to change. A monetary incentive (extrinsic reinforcement) seems to *reduce* this commitment. Perhaps to be paid implies you are satisfying someone else's goals instead of your own.

- Repeated discussion of problems *without structured guidance* tends to *increase* family conflict. This disconfirms a prevalent belief in the therapeutic value of "talking things out."
- School-age and early adolescent children can become partners in the problemsolving process, despite inexperience and their power disparity, by training with a tool such as the Family Contract Game, accessible to all ages. Because of this, they are more likely to buy into the process.
- The Family Contract Game was shown to be effective for low-income, single-parent families in conflict, a group for which many therapies have been less effective.
- If used repeatedly, the game promotes rehearsal and command of a new style of interaction for continued use independent of a supervising therapist.
- The training was successfully administered by nonprofessionals with bachelor's degrees and training only in these procedures.
- Some advocates of role-differentiation theory have argued that in female-headed, single-parent families, father-type decisions (the instrumental leadership role) may not be carried out. This was found not to be the case. Single-parent mothers did fill this role in problemsolving with their families.

OTHER USES FOR PROBLEMSOLVING TRAINING

Blechman and her colleague Frank Chu have extended the use of the contract game beyond single-parent families. The game process has been used successfully in a study of conflict resolution among normal disadvantaged youth in a fresh-air camp (1977). It is now being extended to marital conflict situations. It is being introduced in Big Brother programs and in several juvenile justice system programs.

Two variations of the game have now been developed by Blechman: one called "Autocontract," for one player to work out formal contracts with himself, to define the problem behavior, the desired change, the reward, and then to track the change. A second variation is called "Solutions," designed to solve a problem that is not an interpersonal conflict but a solution to another kind of problem. For example, Elechman's

current research project uses this game with underachievers in grade school.

Behavior modification, for so long feared as the creature of dark manipulators, may become the gift we can all use to help ourselves.

Blechman believes that the uses of contract games for training in problemsolving have yet to be fully exploited. With some modest amount of training, teachers could use them in schools. Physicians, who may see a child with a potential problem long before it has grown big enough to need the attention of a psychologist, might use it in their clinics and offices. Similarly, social workers and school counselors might use it with clients and students; the pastor and the priest with people who come for help amenable to problemsolving; the police with, for example, runaways; the court system with offenders who may not be dangerously criminal so much as overwhelmed by problems they are unequipped to resolve by themselves.

The problemsolving techniques learned in the Family Contract Game are somewhat foreign to the way we in our culture are accustomed to approach our interpersonal problems, loaded as they are with feelings and anxieties that make us very wary. We have often preferred to embrace the psychic spelunking of far more elaborate therapies or rely on drugs to assuage our symptoms than try something so prosaic and homely and simple as defining and counting and recording our behaviors in order to change them bit by bit.

Moreover, although Blechman believes the trainer must have a position of status for the game and process of problemsolving, to be effective the trainer need not be a highly specialized therapist. But we may also be put off that something so important as our interpersonal problems can be helped by anyone less than a highly specialized expert.

Yet because the power of the therapy lies in the process and the process can be taught, it can empower us to help ourselves, though we are not experts. Blechman has captured the process

in something as simple and as much fun as a game for almost any age and any capacity. Behavior modification, for so long feared as the creature of dark manipulators, may become the gift we can all use to help ourselves.

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Principal Investigator: Elaine A. Blechman, Ph.D.
Director, Family Interaction Laboratory
Psychology Department
Wesleyan University
Middletown, Connecticut 06457

FORTIFYING FAMILY TIES

Principal Investigator: Bernard G. Guerney, Jr., Ph.D.

Author: Charlotte Dickinson Moore, NIMH

To get along with others is a normal desire. At work, at school, on a bus, receiving agreeable responses to one's words and actions is rewarding. At home, where the commitment is greater, so are the rewards. So, too, should be the daily effort.

Getting along is not really enough. As a catchy tune needs harmony and development of a theme, each individual and family unit needs harmonious relationships in which to flour-

Relationship Enhancement aims at replacing vicious cycles with auspicious cycles . . . people learn to be accepting, honest, and compassionate with each other.

ish and develop in a positive direction. Bernard G. Guerney, Jr., Ph.D., has been hard at work designing, modifying, and broadening the scope of a technique he calls Relationship Enhancement (RE) and has drawn a number of eager colleagues and graduate students into the work. He feels the technique is useful in many areas of interaction—husband-wife, parent-child, therapist-patient.

RELATIONSHIP ENHANCEMENT: EASING THE TIES THAT BIND

The breadth of the method is illustrated in this definition by Dr. Guernsey and his colleague and former pupil, Dr. Edward Vogel song (in press): "Relationship Enhancement (RE) attempts to eliminate dysfunctional patterns of interpersonal interaction . . . by teaching participants skills that will enable them to relate more effectively and constructively with each other." In a technique designed to build a harmonious relationship and provide an enduring climate for the positive development of the social unit and the individuals in it, RE aims to change the ways each of those individuals "views the deepest emotions and most important interpersonal behaviors." Each individual will be able to bring into awareness emotions and behaviors which, once conscious, can be expressed in ways that are constructive for the individual and others important to him. Once this ability has become part of the person's repertoire, that individual can make fundamental changes in those important relationships and then can exert a positive influence on his/her own life and the lives of those who matter significantly. There is the *caveat*, of course, that the process is easier if these others have made similar gains. "The systems approach used in RE Therapy deliberately aims at replacing the *vicious cycles* with *auspicious cycles*. In essence, the goal is to have each person learn to be honest and compassionate with significant others and to elicit honesty and compassion from them."

The Theory Behind RE

Relationship Enhancement can be considered a descendant of the Humanistic Psychotherapy of Carl Rogers, who believed that every person wants to grow, to be healthy, or, as Rogers expressed it, to be a "fully functioning individual." This, in turn, is melded with the social learning theories of Albert Bandura, B. F. Skinner's principles of reinforcement, and the work of Harry Stack Sullivan and Timothy Leary, with their emphasis on learning and interpersonal processes as the prime causes of emotional distress.

In his book, *Relationship Enhancement: Skill-Training Programs for Therapy, Problem Prevention, and Enrichment* (1977), Guernsey acknowledges a debt to all of these theorists. Certain-

ly, a description of some of his methods sounds "behaviorist," with use of modeling, covert and behavioral rehearsal, prompting by the leader, and reinforcement. He adds, however (p. 2), that in RE reinforcement is used in a "free-flowing fashion that many behavior modifiers would consider very loose." To Dr. Guerney, *all* therapy is *education*, the more specific in objectives and methods the better, and nonbiochemical techniques which have been labeled "psychotherapy" are, actually, education that is unsystematic and unstructured.

The founder of RE makes clear his belief (pp.3-4) that his model and its implications can be revolutionary for the mental health professions. He contends that for the last half-century, mental health workers have tended to view as "sick" people whose interpersonal thought and behavior patterns are considered *undesirable* by others and possibly by the client, as well. Guerney adds that troubled *relationships* between people were often considered sick even when no biochemical factor was present to make the charge plausible. He says that he concurs with Thomas Szasz in his view that social and interpersonal determinants of ways of life that were unsatisfying or socially disapproved have not been sufficiently distinguished from biochemical determinants; people who were simply troubled or troublesome have been treated according to terminologies, concepts, procedures—and fees—based on the private practice of medicine. He hopes that the term "psychotherapy" will eventually disappear, mental health professionals attempting only "to change people in order to achieve an ideal or objective of the client, or the professional, or both"—an *educational* concept.

The Benefits of RE

According to Guerney, the cost-benefit ratios of Relationship Enhancement are superior to more traditional methods of dealing with relationship problems. In the first place, problems can be solved more quickly if client defensiveness related to the therapist is not an impediment; second, rivalry between family members is reduced, individual members no longer feeling compelled to prove themselves right and the others wrong in the eyes of the therapist. In addition, fundamental relations can be focused on efficiently and early with this structured, systematic method. Most importantly, clients are urged to resolve their

own problems and not to expect the therapist somehow to provide solutions.

Another potential which he believes will be proven, not only in cost benefit but in very human terms, is the use of the principal persons themselves as the change agents for each other, and the use of other *non*professionals as change agents. Group members are trained to help one another as they have observed the leader doing, and groups which meet for longer periods can, after special instruction, function with relative independence.

The group format, which is used whenever practical, is an efficient use of time, space, and equipment. Further, teaching aids are easily developed within an educational model such as this. The RE method is similar to that used by many behavior therapists in requiring that participants practice and try to perfect their new skills at home. This makes particular sense in RE, since home is presumably where the new skills are needed and where continued use in resolving and preventing problems will grow easier with practice.

Dr. Guerney refers, also, to the moral values implicit in this method of building and cementing better interpersonal attachments. The client chooses the treatment goals and the kind of person he wants to become. In general, these goals are "*the capacity and willingness to appreciate relationship-relevant needs, desires, preferences, aspirations, values, motivations, and emotions of one's self and one's partners.*" Relationships with a high degree of this kind of understanding are referred to as *empathic relationships*.

A tall order? To hear Dr. Guerney and his enthusiastic colleagues, RE is reasonable, its underpinnings of *honesty* and *compassion* desirable and, at least in the abstract, valued by most people. And, if one does one's homework and honestly tries to "follow the leader," the rudiments are not difficult to acquire. Parenthetically, with RE it seems possible that one partner need no longer follow the dictum of "turning the other cheek" to the other to keep the peace, with accompanying sensations of resentment and frustration.

As with other methods designed to heighten humanness and joy in living, RE is most valuable to those who, having learned, keep in practice, since the skills can be used adaptively, as each new occasion requires.

HOW HE BEGAN

Guerney is professor of human development and head of the Individual and Family Consultation Center of The Pennsylvania State University, of which he is a graduate. After graduation he became deeply interested in family therapy, a new approach at that time. He continued evolving his own family therapy theories at Rutgers University and later when he returned to his *alma mater*.

At Rutgers he began to develop his idea of training parents in the techniques of therapy which, as he says, "seemed to represent an advance over what was going on at the time In general, the concept is that you could train a parent to have some of the attitudes and skills in relating to children that therapists have and that you could do a lot more, since the parent means so much more to the child than an outside therapist ever could. Our orientation was Rogerian, in that the parent would not be required to do interpretations, or anything that might be threatening to the child, but rather the methods would be built around acceptance, compassion, understanding, and helping the child to express himself fully—in general, dealing empathically and sympathetically."

Filial Therapy

Guerney marks 1962, at Rutgers, as the beginning of his Filial Therapy and, although he did not realize it then, of the other therapies which have evolved from Relationship Enhancement. He and his colleagues, one of them his wife, Dr. Louise Fisher Guerney, Ph.D., developed this innovative method slowly and carefully. Dr. Louise Guerney (in press) has defined Filial Therapy as "a behavioral method of intervening in the psychosocial development of children under eleven years of age which uses parents as change agents. Parents are either individually or in groups of 6 to 8 taught to conduct non-directive play therapy sessions with the instruction and supervision of professionals." The early sessions were usually composed of mothers, who successfully learned to use the play therapist skills. Their children, who were tested both before and after the sessions on their psychosocial adjustment, showed marked benefits.

Louise Guerney has continued her work in Filial Therapy with emotionally disturbed children at The Pennsylvania State University and, in addition, has adapted it for use with normal children. At the present, she teaches it in an abbreviated form in the preschool there. By 1970, success with the method led to the training of graduate students in its use. Parent groups may be composed of couples, single parents, or foster parents, in any convenient grouping.

The Technique

As suggested in Axline's work on non-directive play sessions (1969), the therapist must exhibit and use such helping skills as empathy, warmth, genuineness, and positive regard for each child, a regard with "no strings attached." Usually, it is the children who direct the session's activities, but with limits built in, so that the play sessions furnish both broad opportunities for self-expression and a framework within which each child learns to accept responsibility for his own behavior.

Parents learn in a variety of ways with sessions conducted along the lines of the first Filial Therapy Project, in which the mothers of 71 children under 10 years of age met regularly two hours each week in groups of six to eight. One or two mothers each week conducted 20- to 30-minute play sessions at the clinic with their children after receiving therapist training. After the training sessions, parents conducted play sessions at home, generally one-half to three-quarters of an hour once a week, and kept notes for discussion at group meetings.

Eventually, after six to twelve home sessions, depending on the progress of the parent-child partners, the leaders direct the parent's attention to the behavior of the child outside of the play sessions. Those sessions are continued, but the parent begins to observe applications of parental play-therapy behavior in "real life." She learns to reinforce the child's acceptable behavior and her own expressions of love and acceptance. In short, play sessions extend beyond child therapy to the parent's acquisition of new behavior skills.

"Limits"

Bernard Guerney explained discipline in Filial Therapy. "It enters in in something called 'limits.' There are methods of

imposing limits. First of all, we teach the parent to express herself very clearly to the child in terms of why things are done this way rather than that way, and also how to impose a limit in discipline, making it clear to the child what the consequences will be if he chooses to violate a limit. Most important, as far as discipline is concerned, is always to separate the behavior of the child and the statement, 'I will not tolerate that behavior,' from acceptance of the child himself and his needs and feelings. If the two types of messages are not linked, the child need not feel rejected even when he must be disciplined for unacceptable behavior."

Filial Therapy as a Help to Parents

"Discipline is part of it," continued Bernard Guerney. "And the interesting thing about Filial Therapy is that there is very much of a task orientation to it. It's not like traditional therapy where, no matter how you try to put it to a parent, you still convey, 'Well, you did a bad job. Somehow you fouled up, and you fouled up the child.' Instead of that, we say, 'There are things we can teach you, and once you know them you'll be able to do them very well.' We make the parents our allies and eliminate many defensive feelings.

"When we get into the situation and ask them to do things like setting limits, showing empathy, and so on, different parents have difficulties in different areas. The parent who has been overly harsh initially will have trouble being permissive. Another parent may have trouble setting limits. In either case, they approach the needs to acquire new behavior patterns as a skill-learning task, not as something caused by a personal flaw for which they need 'therapy' and about which they might feel inferior or guilty. They are, therefore, very frank about their difficulties and we can freely demonstrate new behavior patterns for them which will help overcome their problems. Eventually, they can master it and see, through the play sessions, how it works and how to help their children."

Evaluating Filial Therapy for Disturbed Children

The parents were pleased with Filial Therapy. Their children seemed to show improvement. The Drs. Guerney and their

colleagues were convinced of its efficacy. How strong were the objective findings?

Unfortunately, not all the cases carried through to completion, although the drop-out rate was only 25 percent, compared with the 70 percent expected on the basis of earlier child-therapy studies. Two groups terminated after 12 months, when the initial research project ended. In the seven groups which completed the full 18 months of treatment, progress on all measures continued in the third 6-month period at the same high rate as in the first 12 months.

Since the children showed gains at a high level of statistical significance on all measures of improvement, the rate of gain was 100 percent, according to therapist judgment. Of the 51 who remained in therapy, 11 were regarded as somewhat improved, 22 much improved, and 18 very much improved, as assessed by the Des Moines Maladjustment Index. Indeed, according to this assessment scale, the average child moved from a rating of "treatment required" to "treatment helpful but not necessary."

Other tests, such as the Des Moines Parent Rating Scale and the Wichita Guidance Center Check List, demonstrated improvement in the children's general adjustment and a significant decrease in the mothers' dissatisfaction. There was improvement, too, in the children's social adjustment and a reduction in conflicts with parents.

The researchers wanted to determine that it was the Filial Therapy and not just the passage of time or some other variable that brought about these changes, difficult to check because there was no randomly assigned no-treatment control group of children and parents with similar problems with whom to compare progress. Still, they are confident that the treatment itself did effect improvement. A non-clinical control group showed no such improvement. The final posttreatment scores were at the level one would expect in a normal population. Improvement advancing at a fairly steady rate tended to rule out improvement due to a "placebo effect," which often shows signs of progress piling up early. The steady rate also tended to rule out the spurt of improvement at the end of treatment, called the "thank-you effect." Thus, the course of treatment alone could be plausibly credited with the gains.

Recently, this interpretation received further support in a dissertation by Andrea Sywulak, who demonstrated highly significant adjustment gains in a 2-month period of Filial Therapy. No such gains took place during an equivalent waiting period. The adjustment gains continued to increase over time, thus showing a strong correlation between amount of therapy and amount of gain.

Overall, in the initial study, behavior in play situations when treatment began corresponded with that described by other researchers as characteristic of abnormal children, but patterns at the end of treatment were like those of normal children. Another significant finding was that, in general, the treatment was as effective in one socioeconomic class as another. Further, no difference in effect of treatment could be attributed to the kind or degree of a child's or a mother's maladjustment or to differences between mothers as shown in the many pretreatment maternal attitude and personality variables which appeared in testing.

The Uses of Filial Therapy

Results of the study and subsequent observations show Filial Therapy to be equally effective in bringing about change in psychosocial adjustment problems, be they phobia, aggression, anxiety, withdrawal, or some combination of difficulties, and whether these problems be mild or severe. Not only are symptoms often reduced, but self-esteem is increased, and the child is better able to meet the world and deal with larger problems. Parent-child communications and cooperation are improved, so the child has a greater sense of well-being and the parent a greater feeling of competence as a parent.

Dr. Louise Guerney's adaptation of Filial Therapy for normal children is not the only modification in use. She has employed it quite successfully in training foster and other substitute parents to handle or prevent problems which might occur with children coming into a strange new home. It has been found useful, too, in dealing with children who have lost a parent through death or divorce or have gained a new one through remarriage. Low-functioning families have been helped by child welfare workers using Filial Therapy. Children who need special attention at school are sometimes aided by teachers or other staff skilled in the intent and use of this technique. For

the older child, the same ambience as that of the play session can be preserved by a parent, but with a choice of more activities.

RELATIONSHIP ENHANCEMENT IN ACTION

During the early days of Filial Therapy, the parents—mostly mothers—often told the Guerneys that they were using the approaches they had learned in play sessions on other occasions and with other family members. They were discovering how pleasant and helpful showing empathy and clarifying their feelings could be in everyday situations. "That's when we got started in a serious way, developing the Relationship Enhancement method for husbands and wives. And from husbands and wives we went to teenagers and families," said Bernard Guerne.

Throughout the years since, Guerne and the young graduate students, many now Ph.D.'s and colleagues of whom he is very proud, have been evolving the basic tenets of RE, along with the procedures for its administration and a battery of tests both for checking the clients throughout the treatment period and for evaluation of the programs. In general, the approach is similar whether for conjugal, parent-child, or premarital therapy and counseling, or for special applications.

The Basic Skills

Although additional sets of skills are taught, RE has only four *basic* new behavioral patterns. The first two are specific types of communication; the third is the ability to use the first two behaviors effectively in dialogue with someone else; and the fourth is the ability to help others learn to use the skills effectively and appropriately.

These four skills, or behaviors, are called *modes*, a word Guerne prefers to *roles*, which is associated with *acting*. The use of these modes is not to be confused with manipulative techniques employed, for example, by a spoiled child. The point is not to receive something, nor to get one's way. It is, rather, to achieve harmony in living and being with someone, for the good of both involved individuals and the family group.

The explanations and demonstrations of each of these modes are presented over a period of time, during intake and in later

sessions, rather than all at once. Practice must be continued even after the sessions are ended. Some understanding of the modes and how they work can be gleaned from RE's vocabulary, illustrated by examples of their use in conjugal therapy.

The Empathic Mode

Communicating in this way means accepting another's communication and identifying with that individual's thoughts and feelings—with the way he/she perceives things. *Empathic responding* is clearly drawn from Carl Rogers' client-centered therapeutic response techniques. According to Bernard Guerney (1977, p. 26) this term "connotes the depth, the intensity, and the giving, illuminating, enhancing qualities of a Rogerian psychotherapeutic response better than the phrases 'reflective listening' or 'active listening.'"

It is *not* necessary for the Empathic Responder to *agree* with the person who is striving to express how what's been happening appears to him. It *is* necessary that the Responder be attentive and listen respectfully, accepting the statement as the other's view, and trying to help the speaker to be more open, honest, and specific. In other words, a receptive attitude is a requisite.

The Responder, after all, will very soon have an opportunity to speak, even to disagree, if his perception is different from that of the first speaker. To be helpful and empathic, and to receive empathy in return, the Responder must, as Webster says, have "the capacity for participation in another's feelings or ideas." Empathic listening and responding, then, will include both what is said and the way it is expressed.

There are some "don'ts" for the Empathic Responder:

- Don't ask questions. Asking questions, particularly seeking new information, may divert the partner's attention from his main thought or indicate that the Responder is trying to get more information than the speaker wants to divulge just then.
- Don't present an opinion or viewpoint about what the speaker is saying. There will be time to present those perceptions when the modes are switched.
- Don't interpret things for the speaker, trying to explain for him why he thinks as he does, thus altering the perspective.

- Don't make suggestions of solutions or changes in viewpoint.
- Don't make judgments. This is no time for the Responder's evaluation of what is right or true, or even workable, in the partner's statement.

After all, the individual expressing these needs and worries may feel a sense of risk-taking, a fear of being cut off, criticized, or rejected. There will be an awareness, also, that the emotional toll is too great to be repeated soon if the response is cool or hurtful. It is the mission of the Empathic Responder to elicit the needs and wishes of the Expresser in such a way that communication will continue more comfortably and effectively whenever the need arises. For this reason, the early phases of the training are given more to the skills of empathic responding than effective expressing, although both are part of the program from the beginning.

The Expresser Mode

The mode in which the speaker attempts to express thoughts, emotions, and wishes honestly and clearly, without arousing unnecessary hostility and defensiveness in the listener is the Expresser Mode. To clarify the Expresser Mode, let us take, as an example, a situation in which a wife feels that her husband was unnecessarily critical of their children during a dinner conversation earlier in the evening. In a typical unskilled response the wife might say to her husband, "You're always criticizing the children. You're discouraging them and making it hard for them to share their ideas with us. You're too moralistic with them. You're trying to make them just like you are and that's not going to work. You're just turning them off and making them angry at both of us." From the perspective of the Expresser Mode, there are a variety of ways of improving this statement to bring about a more constructive response from the husband and to better set the stage for constructive problem-solving.

A sharing of views has to begin with a recognition that the listener is likely to perceive what's happening from his own perspective. The Expresser wishes to avoid unnecessary defensiveness and hostility and also unnecessary argument from the person so that they can mutually reach a better state of affairs. The Expresser, therefore, should make allowances in advance

for the natural desire of both participants to protect their own self-images. If the Expresser's perception of an event casts the listener's self-image in a light different than the one he or she probably prefers, the listener's experience or memory of the event will be different from the Expresser's. Calling into question the listener's soundness of judgment, virtue of motives, or correctness of behavior will almost certainly alter negatively the listener's perception of the circumstances and his motives. Agreeing on what actually happened in such problematic circumstances is difficult, and attempts of each person to establish his own version as accurate generally lead *away* from a successful resolution of the issue.

The first rule, then, of the Expresser Mode is to state things in a way that acknowledges the statement to be subjective, colored by the Expresser's own judgments and idiosyncrasies. By avoiding the temptation to speak in terms of what is "real" or "natural" or "good" or "right" or "true," the Expresser becomes, automatically, the ultimate authority on the subject under discussion—his/her own perceptions of the world and his/her own feelings about those perceptions. Following this rule, the wife should say to the husband something like, "*I viewed you as being very critical . . .*" To be sure, this is not a sensational improvement or in itself likely to lead to a very favorable response on the part of the husband. However, it does avoid certain problems and sets the stage for further improvement.

The second rule in learning the Expresser Mode is to include a statement of one's feelings if they should be taken into account when dealing with the situation. This would change the statement so far into the following, "*I'm feeling upset because I viewed you as being very critical . . .*" Such a statement includes more of the pertinent information which the husband needs in trying to solve the problem; namely, the effect of his behavior on his wife's emotions. Additionally, for some husbands some of the time it would open the door to a concern or compassionate feeling toward the wife and a desire to consider the problem from the standpoint of helping her. Previously, such a response was much less likely: The husband probably would have perceived the statement as an attack aimed at him.

A third guideline for the Expresser Mode is to describe the specific incidents or behaviors which triggered reactions rather

than to deal in generalities or inferences about the character or motivations of the other person. Overgeneralizations like "you always" and "you never" are especially ubiquitous in family arguments, are almost certain to anger the listener, destroy the Expresser's credibility, and make compassionate response nearly impossible. Even more dangerous generalizations are those which impugn the person's character or motive. Instead, being specific as to time, place, and behavior furnishes the listener with concrete statements on which to base a response and indicates how the Expresser arrived at such discomfort. The Responder can be more attentive and the discussion can start on a firm basis with less likelihood of childish exchanges of "I am not," "You are so," "Oh, no I'm not," "Oh, yes you are."

Getting quite specific begins to change the whole character of the initial statement towards something like the following: "The kids did get a little loud at dinner, giggling about how to spot a 'narc' at school. I thought your comment about that not being a funny subject made them feel rebuffed. That upsets me because I feel they need to discuss what's happening with us so that they can make sure of our standards. I'm afraid that comments like that may discourage them from talking openly with us."

A fourth rule of the Expresser Mode states that if there are any implied criticisms in the statement the Expresser should also try to include the basic, positive, underlying feeling or expectation which usually gives rise to anger, frustration, or other negative feelings in intimate relationships. Naturally, not all of these guidelines need be followed at once or at the same time, but they rather serve to guide a continuing dialogue or discussion. Sometimes a person would find it difficult to make a positive statement early in the discussion, but would be able to recognize and state it later on—the earlier the better.

In the present instance, the wife might have stated her concern along the following lines: "I believe the children really look up to you and are very strongly influenced by your reactions to what they say. I'm very pleased about that. I think you're a good model and a good influence on them. I want them to continue to feel free to talk to you and to get your reactions so that they can know more about your standards and what lies behind them. It's very upsetting to me when I see anything

that threatens to undermine that. Tonight, the kids did get a little loud" Such a presentation is actually a much truer and more complete account of the situation. As such, and because it speaks to the positive self-image the husband is likely to have of himself and of the relationship, it allows him to listen much more openly, compassionately, and objectively to the wife's concern.

The inclusion of positive feelings, perceptions, and attitudes is one of the most important, yet one of the most difficult skills for people to learn in Relationship Enhancement. (It also is one of the most difficult skills for RE trainers to learn to teach.)

A fifth aspect of the Expresser Mode is the inclusion at some point in the dialogue of an "interpersonal message," a clear-cut statement of the behavior one would like to see from the other person. This message incorporates all of the previous principles when it is well done; it is specific as to time, place, frequency, and behavior; and it includes a statement of the positive attitudes and feelings the desired behavior will probably elicit in the Expresser. In other words, "What behavior does the Expresser want from the Responder? Precisely, how can the Responder provide this behavior?" The interpersonal message has the great advantage of focusing on specific solutions rather than on discontent. For this reason, it can be a fine starting point for solving problems and for making personal relations more satisfying. In many cases, if it were emotionally feasible, omitting implied criticisms and proceeding directly to the interpersonal message would speed solutions of a problem. Unfortunately, our emotional needs as human beings make such a sudden leap into the positive very difficult.

In our example, the wife might include in her statement, or in a future statement, something like the following: "It would really make me very happy if you tried to reduce comments which the children might perceive as critical and shared with them more of your positive feelings and some of the confidence you do have in them. If you were willing to do that, I am confident that we could preserve dinner time as a time when the children speak freely to us. Then I would feel much more relaxed and also very positive toward you."

Guerney has commented that the interpersonal message is difficult for many people to learn because they are acculturated to ask for things on the basis of right and justice, rather than

on the basis of their desires and happiness. For many of us it is frightening to state a feeling or express a wish in personal terms. What if one is rejected? This is a psychological risk, and refusal could be devastating to one's sense of self-worth and assurance that the partner cares. Refusal on an objective basis, on grounds of right and justice, however, can be interpreted as a lack of character or an inadequacy in the *other* person, not a personal rejection. Playing with smaller stakes may guarantee keeping one's self-respect intact. But greater fulfillment can come from playing more daringly, putting one's own values, wishes, and needs "on the table."

The sixth, and last, guideline is at the heart of Relationship Enhancement. This rule says: *Convey empathy to your partner at the same time that you are expressing your own feelings and/or your interpersonal message.* Begin with the premise that there is a reason for the person to behave as he/she does. Putting oneself in another's shoes often saves a lot of grief in any case. By the RE plan, showing empathy for the other person's viewpoint can result in a reciprocal, productive conversation that makes it easier for both parties to achieve their goals. Eventually, the Expresser can learn to show empathy even when the other has not yet spoken.

Everyone has had the experience of letting small disappointments and irritations build and build, until the rivulets that could have been stemmed at the start have formed a flood that breaks the dam. This is not to advocate "blowing off steam" at hapless listeners at every small provocation. It is a reminder that wishes, feelings, and expectations should be expressed early, before anger and disappointment accumulate; they are easier to verbalize and communicate constructively before they are entangled with emotions. RE shows the way.

A *vicious* cycle in ordinary, unskilled communication is set in motion, according to Dr. Guerney, when a chain of speaker-listener responses begins poorly and leads away from problem resolution. This often occurs because the Expresser delays voicing desires and needs until they explode in anger and accusations. The other person, threatened, answers in kind, inciting still more anger, thus magnifying the probability that the outcome of the interchange will be negative. The negative outcome, in turn, increases the chances that future communica-

tion of needs will be delayed until they explode in a negative way.

Through RE skills, needs are expressed early in a positive, understanding way, making a favorable reception and response more likely. This, in turn, is likely to lead to a positive outcome. The positive outcome will lead to easier, earlier expression of needs the next time, and, therefore, to a more positive reaction in the Responder. Thus is established an *auspicious* communication cycle.

Mode Switching

After their clients learn the Expresser and Responder modes, the leaders teach them how to switch modes, employing demonstration or modeling, structuring situations for practice, and reinforcement:

Demonstration must precede any attempt at the use of a new behavioral skill by a participant. The group leader never asks a participant to try a new behavioral skill until shown the way by the leader, nor does he ever model behaviors he does not want participants to imitate. *Modeling* means providing a participant with a more suitable response than he has been able to furnish; sometimes that may mean modeling entire sentences for the Responder. As the weeks go by, modeling, and all leader activity, for that matter, are less frequently a part of the sessions.

Structuring is the term used to describe the leader's explanation and clarification of the skills the clients learn, and the reasons for using them.

Reinforcement, that is, praise or some other reward, verbal or nonverbal, given in a spontaneous, uninhibited way, encourages participants and sets an example for them in the use of praise to encourage others to use the skills at home. Group leaders are trained to appreciate the benefits of showing genuine appreciation of even small gains the clients make. Through observing this reaction, and being encouraged and reinforced to do so, most participants will adapt it in working with their partners.

Clients learn gradually to be alert for messages within themselves or from the Expresser that signal the need to stop being a listener and to respond. RE leaders caution clients to make sure that the Expresser's last statement has received an em-

pathic response before switching from Empathic Responder to Expresser. The trading of modes goes on, much like any discussion, except that each is sure the other understands and accepts the point of view being expressed, even though agreement is not necessary. The Responder should indicate a desire to become the Expresser after realizing that he is no longer able to be empathic or recognizing that he can add to the communication perceptions which will keep the discussion more "on the track."

Frequent mode switching is important to the plan when both parties have reached a point of working out concrete ways of handling conflict or solving a problem, or when both are trying to make changes leading to a higher level of satisfaction in a relationship. Knowing each other's reactions to who will do what, why, and when requires learning immediately what each is thinking and accepting, or whether reservations and doubts remain on either side.

The Facilitator Mode

In RE, the word Facilitator designates *group members* who are teaching others how to use empathic, expressive, and mode-switching skills, *not* the professional. The purposes of this mode are to help clients teach each other RE skills in the group sessions and to instruct and encourage members of their families in the use of the skills at home, much as the group leaders are taught. After groups have met for a longer period and the members have become more versed in using the modes, leaders become less active and turn primary supervision over to members.

Demonstration of facilitator skills by the group leaders includes asking for positive reinforcement from participants when the practicing pair do well, with praise only for their use of the skills, not for the views they express; suggesting that participants practice thinking of expressive and empathic responses that might be better than those used by the couple performing the modes at the time; and calling on the participants, more and more often, to suggest better responses that the couple might use. Through this means, the group leader is able to eliminate nonfacilitating responses and promote mutual teaching and skill-reinforcement by the clients.

Teaching is itself a great teacher, so imparting what one has learned increases one's own learning. Further, facilitating the practice of mode usage by others maintains attention and interest among those who are not actively participating as expressers or responders.

Most importantly, instruction and practice in the group aids in use of these skills at home. Their use at home should begin only after role-playing practice. Supervised exchanges at group meetings provide the training ground for handling longer partner-to-partner encounters, but only after the other skills—empathic, expressive, and mode-switching—can be used with relative success.

In speaking of clients who have completed the program, Dr. Guerney remarks “. . . we don't intend for them to use it constantly . . . I certainly don't interact that way within my own family. Sometimes, someone has a decision to make and you can help him to clarify his feelings. I think one of the key things people learn here is that it doesn't pay to rush in too early with suggestions and tell others how to solve their problems, but rather to help them develop solutions on their own. Sometimes, you can help somebody else work through feelings or come to a decision using these skills which are, in fact, helpful in many situations. I believe they are almost always

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useful when there are negative feelings or attitudes or, indeed, desire for a change in interpersonal behavior patterns, whether the change be to solve a problem or create a higher level of happiness. But there are many times that you wouldn't want to use them. Sometimes at work or play they would just get in the way by consuming extra time.”

There are guidelines for determining when to use facilitating techniques in daily life: first, the use of expressive skills whenever a person is annoyed or makes a demand; second, reinforcement of every skilled statement by an appropriate skilled response; and third, facilitator skills when one of the partners is upset by the other's statement and feels that RE modes have not been followed.

CONJUGAL RELATIONSHIP ENHANCEMENT (CRE)

The reports of mothers whose training in Filial Therapy had spilled over into other family relationships suggested another application of RE, which became Conjugal Relationship Enhancement. Subsequently, many other new applications have been designed by doctoral candidates working under Guerney's aegis, along with new inventories, questionnaires, and scales used in the assessment and evaluation of Relationship Enhancement as a therapy and a new way of interacting.

Development and Evaluation of CRE

The first study in CRE, conducted by Austin Ely in the late '60s, was designed to determine whether married couples whose marriages were in difficulty could be trained to use these new communication techniques. During the 8-week course, 12 couples who received the training were compared to a similar group who received no RE training. Those who received CRE training showed improvement in their ability to express feelings openly and constructively and to have insight into their spouses' feelings. Even the brief 8 weeks brought improvement, too, in measures of general communication patterns and harmony. Though comparison of the Enhancement and Control groups was not as refined as has been the rule in more recent studies, the trainers believe the value of the CRE training was demonstrated.

A second study, conducted by Jerry Collins in 1971, lasted for 6 months. Twenty-four couples receiving RE training were compared to 21 couples who were evaluated for the entire period but were not in the program. Using a two-by-two analysis of variance of difference scores, Collins concluded that CRE couples noticed greater improvement in communication and in marital adjustment than did the control couples. Collins points out that CRE differs from many marital counseling endeavors in involving client as well as therapist in the practice of non-

possessive warmth, genuineness, and accurate empathy, all qualities which research has shown to be the most effective in positive therapeutic change. Experimental evaluation of the 6-month conjugal therapy and Relationship Enhancement program furnished evidence that husbands and wives, as non-professionals, can learn to provide higher levels of warmth, genuineness, and empathy to each other and can become psychotherapeutic agents for their own marital relationship.

Rappaport conducted a study in 1971 aimed at developing an intensive RE program: a more structured program, more efficient use of therapeutic time, greater emphasis on communicating in areas of threat and conflict, and more general application of the skills in the home setting. This program was set up with two 4-hour sessions and two 8-hour sessions, held on four weekends during a 2-month span. Twenty couples finished the program, learning and practicing skills during the sessions and completing heavy assignments of home practice. For 2 months prior to treatment, the 20 couples served as their own controls. A number of measures showed more change during the treatment period in: speaking more effectively and listening more empathically with spouses; improvement in marital adjustment and communication; more trust and intimacy in the marital relationship and satisfaction with it, and improved ability to resolve relationship problems successfully.

CRE at Home

During an informal discussion about the every day use of Relationship Enhancement, Edward Vogelsong indicated that often the most constructive way to be empathic at home is to "see what condition things are in and do something about it . . . not talk that way, but act that way. I've had many people say to me that, even though they don't use the skills on a day-to-day basis . . . just the awareness of the other person is so heightened that the way they deal with each other is profoundly affected. And whenever there are problems, there is a system to use."

In reply, Bernard Guerney said, "I think that applies equally well with the expressive skills. Though you may not stick to the rules in every case, you are sensitive about overgeneralizing in the things you say about another person, attributing things to his character, trying to anticipate for him what he's

going to say or how he's going to think. You become sensitive to all these things in yourself and you tend to drop them out, reducing a lot of hostility. And you tend to state things from a subjective point of view, without saying 'this is a fact,' or 'everybody does this,' or 'this is what you should do.' Once you become trained, you become aware of the negative impact these things have on people, making them angry or annoyed."

"You've acquired a piece of knowledge that you know will work," said Dr. Vogelsong. "Once you've done that, you tend to do certain things and avoid other things, almost as a matter of course. For instance, I don't ride a bicycle every day, but it helps me balance in other things, and whenever I want to ride, I can."

When asked about a hypothetical but familiar situation, withdrawing or "closing up" at a spouse's angry comment, Vogelsong said, "I would want you to say, 'You seem to be real angry with me.' And then, you become the Expresser and, if you want to be that open, you say, 'I'm very uncomfortable with that and it makes me all tight inside. I'd like to talk about it and work it out.'"

He continued, "That happened to me last night with my wife. We had company for supper and she didn't like the way things went. After the company left, she said, 'You know, I feel some tension, and I don't want to feel that way toward you. I don't think it's fair that I do, but I want to talk about it.' So, we sat down and talked about it, and it worked out very well. We both got a good night's sleep.

"That's the kind of thing we want people to do, to be above the table on those issues. It is taking a risk, in a way, because it makes you seem vulnerable. We have found, however, that people take it as a response that they want to work on constructively. That's one of the things we try to train people to do when they are not in a session—to say, 'I want to use these skills because I don't like the way things are going.' It's what we call 'facilitating.'"

"The Facilitator in the home context," explained Guernsey, "is the one who encourages the other person to use skills and helps him to do it, who makes it easy."

To sum up, using Conjugal Relationship Enhancement successfully at home is simply having the skills so well ingrained

that speaking and listening empathically is no more than "doing what comes naturally."

CRE for One Partner

Guernsey mentioned another aspect of Relationship Enhancement which has not yet been employed extensively but which can be handled effectively in helping troubled marriages. It is possible, using role-playing techniques, to train one partner to relate to the absent one with empathy and to be expressive in a constructive way.

At his colleague's request, Vogelsong told a story that is typical of many couples unable to talk about the real wants and fears which they try to mask with bluster or fighting:

The wife from a home filled with accusations and defensive reactions, tired of the shouting and recriminations, finally told her husband that she felt she needed therapeutic support. His reply, "That's up to you, because I'm not going to go," prompted her to come in alone.

To aid this wife in initiating conversations which would not "set him off" and end up in a fight, she and the therapist practiced different ways of talking and listening to her husband until she became confident that she could begin, in a non-threatening way, to implement Relationship Enhancement in her home. As a beginning, instead of shrieking, "Here you are, late for supper again. You told me you'd be home at 5:00, and here it is 6:30," she tried her new expressive skills (with perhaps more assertiveness than was her custom).

The new approach was something like, "I'd like to know if you're going to be home late, and I wish you'd tell me ahead of time. I don't like it when I have dinner ready at 5:00 and you're not home until 6:30—I get mad, and I don't like that. I wish both of us could be more realistic."

Finally, she got to the point of sitting occasionally and listening to her husband talk about his work and his financial worries. Then they each made a discovery. She had wanted to get a job but had been afraid that he did not want her to and would "blow up" if she broached the subject. Her husband had never felt comfortable in suggesting that she work because he would appear irresponsible and unable to support the family.

The happy ending included secretarial school, a better job for the wife, and the beginning of a more shared relationship.

PARENT-ADOLESCENT RELATIONSHIP DEVELOPMENT (PARD)

The next program, evolved from Filial and Conjugal Therapy, is known as Parent-Adolescent Relationship Development (PARD). Family therapists frequently see parents and their teenage children polarized by differences in attitudes. Often the parent is recognizing that early dreams—business success, social achievement, blissful marriage—will not be fully realized. Simultaneously, the adolescent is establishing a sexual identity, building a value system, choosing goals for life and work, and sorting out family and peer relationships. Add to these differences the sense of alienation experienced by many adolescents and their qualms about identity or rivalry with one or the other parent. Compound these stress factors with the ordinary conflicts and frustrations of people living together, no matter how loving, and the strain on all family members is considerable.

The objective of enhancing parent-child relations, whether making a good relationship better or solving tortured communication problems and family conflicts, is "to use the potential capacity for mutual aid inherent in the family's emotional attachments." This method differs from some other clinical approaches, which attempt to separate adolescent from family and make more use of peer attachments (Ginsberg, p. 229).

PARD for Fathers and Sons

A cornerstone of PARD is the belief that an accepting father can help a child grow in independence and in feeling good about himself. Equally important is the conviction that this paternal attitude will lead to greater acceptance of the father by the adolescent and, in turn, to the father's greater satisfaction in the parental role. Improvement in this role might be expected to lead to improvement in the marital role and, in turn, to a more harmonious family situation.

Barry Ginsberg has described his work in the early days of father-son PARD as dynamic but difficult, exciting but frustrating (1977). Many adolescents come into the program unwill-

ingly, feeling over-controlled and unfairly treated. Parents come feeling unsure, unworthy because they have not handled problems adequately. Fathers are perhaps saddened because their almost-grown sons no longer view them as omniscient beings who can fix everything. PARD methods are designed to minimize the defensiveness and anxiety exhibited by most fathers and sons alike.

The Sessions

PARD is similar in most respects to other programs in RE and, like them, offers a variety of time and meeting formats for differing numbers of pairs. Naturally, sessions designed for the therapy of severe relationship difficulties or serious emotional problems will continue for a longer period than will those for enrichment or problem prevention.

The first session is a time for introductions of leader, members, and their reasons for coming, for explanations and descriptions of the modes. As in other RE groups, PARD participants complete the Relationship Questionnaire (RQ), which asks them to list in order of significance the three most important things about the relationship "that please you now," "that you have valued highly in the past," and "that you would like to see developed or enhanced." Other questions concern which matters would be difficult and which comfortable to talk about in the group just then. These RQs form the basis for the first Expresser's opening topic but may be revised, deleted, or added to as the weeks go by.

Careful structuring is a part of all RE sessions, but particularly in those concerned with parent-child pairs. A feature not used in other programs but worked out especially for the group format of PARD is *Doubling*. Reminiscent of a psychodrama technique, this procedure begins in the second PARD session, with one pair acting as Expresser and Empathic Responder in talking about mutual concerns, and with another pair doubling immediately thereafter. It works like this: Father A may want to express his son's unwillingness to conform to certain house rules. Father B is asked to express the same concern, possibly phrasing it even more closely to the intent of the Expresser Mode. Son A is supposed to respond empathically and Son B to rephrase the response and improve on it. Each speaks in the first person singular, as if he were the father or son.

There are advantages to the doubling technique. Participants seem to learn the expressive-responder skills more readily and to become more comfortable about voicing their own problems when their turn comes, since acting for and with others has involved their own feelings as well. The leader also may ask a father to double for a son or a son for a father, thus intensifying the empathy of one generation for another. As use of the skills increases, the usual Facilitator Mode takes over, and doubling is no longer used.

Special Problems

Problems voiced by the fathers and sons are little different than those expressed by mothers and daughters. Nor are the kinds of problems very different than they were 10, 20, or more years ago. They are trust (very important), choice of friends, dress, independence, and boy-girl matters.

These are problems for the pairs to work out. The problems of leaders include client defensiveness, anxiety, and sometimes resistance. Another problem is the reticence of the younger partners, whether due to shyness in general or domination by parents. Guerney says that he and the other leaders handle this by continued empathy and understanding and by responding to nonverbal cues. In extreme cases, with the young person's permission, the leader tries to speak for him to the parent. The leader checks to see whether he has obtained an accurate reading of what is actually on the teenager's mind and eventually gets him into the discussion.

"I think that once the parents learn how to respond well so that the young people become less afraid and really sense an equality in the situation, PARD begins to work very well. The system is one that helps them overcome their fear, once they really believe what's happening," said Guerney.

He added, "RE gives them skills in communicating so that socially they now have things to say if they just apply the skills. Not only saying them well, but responding empathically, or using reflective listening skills, if you prefer that terminology, gives people a way of relating when they may not have known what to say. Good listeners are in rather short supply and in much demand, so I think that helps them."

Evaluation of Father-Son Treatment Groups

In 1971, Ginsberg compared 14 father-son pairs who were taking part in a PARD program with 15 similar pairs who had been randomly assigned to a waiting-list control group. The program for the treatment group consisted of 10 weeks of 2-hour sessions. Not only was the Experimental (E) group compared to the Control (C) group in relative terms but absolute changes in the E group were assessed; later, the Control group's findings were compared to its own results when it, in turn, became the Experimental group.

The results were considered significant in areas of observed communication; unobtrusively observed communications; self-report of general communications and of quality of the relationships; and, quite importantly, change in self-perception. What's more, Guerney, Ginsberg, and the others heard the comment they were to hear again and again throughout the years: "This has been extremely helpful. We wish we had known about this earlier." This feeling was especially apparent if the child was the youngest in the family.

PARD for Mothers and Daughters

Guerney *et al.* were anxious to test RE with a new population. Their first experimental PARD treatment/study for mothers and daughters, however, was conducted with an added dimension. To ascertain whether RE methodology was superior to the more traditional group problem-discussion approach, they devised a program testing the effect of three conditions—No Treatment (NT), Traditional (TRAD) problem-discussion approach, and Relationship Enhancement (PARD). Clients were recruited through schools, letters, or newspapers; all were randomly assigned; and all went through the same intake procedures and tests at the same intervals during the treatment period.

Another goal was a valid, controlled followup, since few such studies with families have been evaluated, owing largely to practical difficulties and poor controls. To study the impact of Relationship Enhancement over a period of time, only participants who indicated that they would be available for followup were accepted. Sixty-six mother-daughter pairs still indicated interest in participating after being told that they could receive

one of two kinds of therapy or none. For their trouble they were recompensed financially for completing all research measures after the initial testing of all 132 persons. Each pair was given an envelope containing the assignment and received further explanation of the project from the intake worker.

A statistical study of the entire program revealed that the typical daughter in the study was 13 years and 4 months old. The initiative for entering the program was usually taken by the mother, whose typical profile was a 40-year-old white Protestant who had never attended college, who went to church frequently, was from a low social stratum, had been married 17 years, and had 3 or 4 children.

Both PARD and the Traditional subjects met weekly for 2 hours in groups of two to four pairs for a period of 10 to 15 weeks, with groups set up according to similarity in age of the girls participating (11-14 and 15-18). All groups were led by two doctoral students, Edward Vogelsong and Jeanette Coufal, who each took an almost equal number of PARD and TRAD groups. Prior to the study, they had jointly led one TRAD and one PARD group in order to standardize their procedures.

How PARD and TRAD Differed in the Sessions

TRAD was similar to PARD in many respects, both programs being aimed at improving and enhancing mother-daughter communication and getting-along-together. PARD used learning and practice of the five RE modes plus programmed home exercises, developed by Vogelsong, which required about an hour each week of tape-recorded homework and written and verbal feedback from the leaders at the following session. In later training sessions, participants maintained a log of occasions when the skills were used outside of formal sessions and of when they should have been used but were not.

The Traditional program allowed its participants more freedom than did Relationship Enhancement. In both, the therapist modeled openness, warmth, and genuineness and encouraged group members to react to each other in the same way. In TRAD, every technique in the therapist's repertoire was used—positive reinforcement; attentive listening; and attempts to keep the topic on the track, to have participation from even the shyest group member, and to prevent domination by any individual or group. It had all of PARD's components except skill-

training in expressing one's needs and listening empathically and in sharing viewpoints with one's partner. Group members could question one another, make suggestions, and share experiences in similar situations, none of which PARD members were allowed to do.

As in the PARD groups, TRAD topics were preselected, but, in TRAD, discussions could roam freely and widely, the only constraint being the therapist's attempts to keep the conversation focused. The TRAD groups had homework, too: Each pair read each week at home a chapter of Fremon's *Children and Their Parents* and discussed it together, which furnished stimulation and helpful ideas for discussion at the sessions.

When the training program ended, members of both groups were assigned (randomly, again) to "booster" or "no-booster" situations. The assignment tested the learning theory that followup contacts and occasional meetings with the leader would strengthen the gains clients made during training. In the beginning, booster groups were contacted by phone, and mothers and daughters were encouraged to set aside time each week to discuss issues important in their relationships. As the weeks went by, these calls were decreased, but booster groups met every 6 weeks during the 6-month followup period. Members of no-booster groups were not contacted and did not meet during the 6 months.

Skill Measurements

Each skill attainment was measured by analysis of variance of pre- and posttreatment objective tests and also quasi-behavioral tests scored by independent judges who had not been told the hypotheses, the source, or the sequence of the tests. As regards interactions between mothers and daughters—both specific and general communication patterns, and general relationship quality—the hypotheses were that the TRAD group and the PARD group would show greater improvement relative to the NT group, and the PARD group would show greater improvement relative to the TRAD group.

The specific communication skills, empathic and expressive, were measured behaviorally by the Verbal Interaction Task (VIT), in which each mother and daughter engaged in four 4-minute, structured, audio-recorded interactions. Each was told: "Discuss something you would like to see changed in yourself,"

and "Discuss something you would like to see changed in your partner." The partners took turns at these and at the other part of the instructions: "Openly express your feelings about the issue" and "Help the other person express her feelings."

Empathic skill as shown in the VIT was measured by the Acceptance of Other Scale (AOS). This scale was designed to measure the understanding and acceptance conveyed by one person in response to another's communication when discussing topics of importance to both of them. It assesses the Responder's willingness to stick within the Expresser's field of interest and awareness and his/her sensitivity to the Expresser's feelings and motivations. On an eight-point scale, responses at the lowest level are accusative and argumentative, the middle are ordinary social conversations, and the highest convey complete acceptance of another.

Another measure of empathic skill was taken from the Mother-Daughter Situation Questionnaire, composed of 16 kinds of problems commonly encountered in mother-daughter interactions. Following each descriptive paragraph is a space for the respondent to write the exact words she *would* say if she were the mother or daughter in the situation. Next comes a space for the exact words she thinks she *should* say. Some items were scored on the Acceptance of Other Scale (AOS), others by whether they restated content or clarified feelings.

The Verbal Interaction Task was measured for expressive skills, also, by means of the Self-Feeling Awareness Scale which tests whether the speaker's statements will elicit a truly empathic response. This eight-point scale rates speaker statements in the upper range when they are expressions about the self or the listener in which the speaker states his/her own feelings, wishes, or thoughts, with the affective area rated higher (7 or 8) than the cognitive (6). In the lower range, the speaker is being accusative (1) or demanding (2) without owning up to his feelings.

General communication patterns and the quality of the relationship were also measured in a variety of ways on scales developed by Dr. Guerney and his student/colleague group. Most of these, such as the Family Life Questionnaire and the Relationship Change Scale and Satisfaction Change Scale are described in detail in his book *Relationship Enhancement*,

which Dr. Guerney feels is an adequate guide for experienced family therapists who wish to adopt RE for their use (1977).

How PARD and RIP Measured Up

The results of posttreatment compared to pretreatment testing generally confirmed the hypotheses. On specific communication skills of direct expression of feelings and empathic responding, the three groups did not differ initially. After a treatment, neither the subjects in TRAD nor the NT participants showed significant improvement, and they continued to be equal to each other in their average skill level. From pre- to posttesting, however, PARD participants showed significant improvement in both expressive and empathic communication skills.

In general communication patterns, as measured by the Adolescent/Parent Check List, the three groups did not differ initially. Neither NT nor TRAD subjects showed significant improvement from pre- to posttesting and participants in both groups continued to be equivalent in their general communication patterns. However, the participants in the PARD groups did show significant improvement with treatment. Also, mothers and daughters in the PARD groups showed that they had a significantly better general communication pattern than did the mothers and daughters in the NT and TRAD groups.

With respect to the general quality of the relationship, there was not complete uniformity on all of the measures used, but the following general conclusions could be drawn. TRAD participants improved more than the mothers and daughters in NT. With treatment, mothers and daughters in the PARD program showed significant improvement in the general quality of their relationship. Also, after treatment, PARD participants had significantly better relationships with one another than did the TRAD or NT mothers and daughters. These comparisons apply in such variables as: (1) empathy and genuineness toward each other; (2) intimacy, trust, openness, and understanding; (3) ability to deal adequately with interpersonal problems; and (4) personal satisfaction derived from the relationship.

Followup testing done 6 months after the termination of treatment revealed that in empathic and expressive skills the TRAD group still showed no greater gains than did the No Treatment group, while the PARD group showed more im-

provement than either of the other two. The same results were found with respect to general communication. With respect to the five measures assessing the general quality of the relationship, no significant differences between any of the groups were found on two measures. On the remaining three, however, the TRAD participants continued to have scores equivalent to those of the NT subjects, while the PARD participants showed greater improvement than did the NT subjects; on two of those measures PARD participants showed a greater gain than TRAD participants as well.

Other Differences

In other statistical analyses, mothers and daughters responded differently to the PARD treatment only on measures which tested their ability to respond empathically in typical problem situations with each other. Where there was a difference, it was the mothers who showed the greater gains, especially in the should-say and would-say statements. Both TRAD and PARD participants showed genuine interest in the program, had relatively few drop-outs or absences, were eager to express themselves in class and conscientious about their homework assignments. (For that matter, the control group members held up their part of the bargain, in finishing the testing series.) The leaders perceived more enthusiasm among PARD clients and attributed it to a sense of accomplishment in learning skills and an awareness of the future usefulness of these skills.

Topic selection was much the same in both groups. Problems with authority, discipline, love, respect, trust, and sibling rivalry were typical. PARD proved to offer more chance for the withdrawn or shy to express themselves, and there was greater self-disclosure and emotional expression. Both methods, however, succeeded in attaining in both mothers and daughters greater mutual understanding and respect for each other as sensitive, thoughtful individuals.

THE MANY USES OF RELATIONSHIP ENHANCEMENT

Spouses, fathers-sons, mothers-daughters—pairs from all of these populations have received help from RE. Some seek to ease troubled relationships, others to keep trouble from starting. The latter category and those who seek enrichment for an

already satisfactory relationship are new and growing and no longer come solely from the better educated or well-to-do. RE "works" for persons of any socioeconomic class.

There are protections built into the system to keep the sensitive person from being hurt by having the rest of the group focus on his shortcomings. The RE group is supportive, because neither therapist nor group members make judgments or challenge anyone; everyone helps everyone else to learn the skills, and nothing more. More uses for this approach in therapy are being tried and found valuable.

Premarital Relationship Improvement by Maximizing Empathy and Self-Disclosure (PRIMES)

A survey of the literature on marriage might reveal a negative attitude, one that could be construed as pessimistic. Except for some generalized articles by family sociologists, there is little about premarital relationships, positive or negative. It is far easier to find articles on divorce and divorce counseling or essays, many facetious, on the "relationships" of the unmarried than on improvement of the interpersonal relation and problem-handling skills of a couple contemplating marriage.

The First Study on Premarital Counseling the RE Way

Stephen Schlein initiated the PRIMES variant of Relationship Enhancement. The program helps dating couples who are planning marriage by furnishing communication skills which can help them plan the future of their relationships, heighten awareness of the effect of their behavior on their partners, deepen intimacy, and guide in constructive handling of present and future problems. The insecurity an individual experiences when becoming more aware of another's needs and emotions while, at the same time, developing more self-awareness indicates the need to foster both the relationship of the dating/premarried individuals and the personal growth of each.

To evaluate the effectiveness of RE for premarrieds, Schlein assigned one randomly selected group of couples to the learning series for an 8-week period of 2-hour sessions. The other 29 couples, "a waiting list control group," were compared to the learners. The findings of change were not as uniform as were those with married couples, probably because of the high level of acceptance and optimism in the premarital couples. The

study showed, however, that the learners revealed greater empathy in listening and openness in expression, firmer ability to handle relationship problems, and a higher degree of trust and intimacy.

RE for Newly-Weds

Guerney commented, "One of the things we'd like to look at a little more is how people select problems; in other words, what problems each member of a couple sees as the most significant. This might be particularly revealing in the premarital couples, when they discover areas where they thought they were in agreement but really weren't."

Most ministers include counseling for the wedding couple as a part of the wedding planning, in the midst of selecting the music and the color of the bridesmaids' gowns. Guerney and Vogel song plan to sponsor a series of workshops which will expose ministers not only to the RE approach to premarital counseling but to a new RE program, Neomarital Relationship Enhancement. During the first year of marriage, a young couple may be more realistic about what sharing and growing together entail and, therefore, receptive to learning more effective ways of handling their emotions and psychic growth as individuals and as a couple.

RE For Delinquents

One of Bernard Guerney's current graduate students, Patricia Daubenspeck, told of helping a mother-son pair who had been referred by a probation board. The young man had spent several months in a detention home and was paroled, on condition that he have some kind of family therapy, a requirement which he resisted at first. Daubenspeck saw the pair alone for 12 meetings and told this story:

Her first job was to get the mother, a divorcee, to *listen* to her son, rather than fumble in her purse for a tissue or a grocery list. The mother had been so disappointed over her son's behavior that she appeared slow in recognizing the change which came over him within six or eight meetings, when he became quite open with his mother and shared much more with her than he had thought of doing for many years. The son had been notable for the large hat he wore down over his face, which "used to drive his mother crazy."

Daubenspeck commented, "I think one of the milestones was that he didn't wear his hat the last couple of times. He was more comfortable, I think, looking at people."

RE For Drug-Related Cases

Guerney reports on a graduate student who has used role playing and trained other staff members to teach RE skills to residents of a treatment center for drug addicts. He has found these skills useful in staff-resident relations. In fact, residents comment that they expect to find RE useful on re-entry to the outside world. Edward Vogelsong reports working recently with drug and alcohol addicts who are more receptive to the RE approach than to the confrontational, confessional sort of group therapy. Helping addicts is another context in which Guerney and friends hope to do more work.

RE For the Mentally Retarded

Vogelsong related a mother-daughter case study which he felt was among the most challenging in his experience and illustrative not only of RE with special populations but of RE in establishing specific solutions:

A 55-year-old widowed mother and her 22-year-old retarded daughter were referred by a concerned older sister. The daughter worked in a local sheltered workshop but was unable to read and write the forms, so the therapist had to read the questions and write her answers. The mother, who had assumed it was her job to do everything for her daughter, never took seriously the girl's desire to do things for herself and had not realized the extent of her daughter's unhappiness. The girl's latest wishes were to drive a car and to date, requests to which she had received a flat "no," without discussion or explanation.

When it was the girl's turn to listen empathically, the therapist had to help her more than is usually the case. To assist her in articulating her feelings, it was necessary to use those special feeling words that were a part of her limited vocabulary. The mother learned a great deal about her daughter that she had never been able to learn, or perhaps tried to learn before.

Some compromises were worked out using the mother's and daughter's newly learned skills. The daughter was allowed to start driving on back roads accompa-

nied by the older sister in the sister's car, and was permitted to entertain a young man once a week at home, watching TV and making popcorn. These privileges seemed to satisfy the younger client, whose assumption of some personal responsibility gave a tremendous boost to her self-esteem, and the mother was relieved at the removal of tension and the growth of shared understanding.

RE For Inpatients and Their Families

The RE method tries to change the characteristic patterns of interaction between patient and family which, otherwise, may continue to be destructive to family harmony and to individual self-esteem. One goal is to replace these patterns and messages with attitudes and actions designed to promote both self-understanding and better understanding of others. Another is to help the individual sort out priorities, aspirations, and expectations, the better to know what to seek for himself and what to expect from family and friends. RE seeks, also, to make honesty predominate over deceptions, conscious or (more likely) unconscious, and to establish mutual compassion.

The RE approach seems eminently reasonable for this particular population, since its three-pronged accomplishments—therapy, prevention, enrichment—are applicable both in and outside a residential setting for patient and family members alike.

RE In Public School Settings

Can children as young as the age of ten be trained in the same empathic skills which have proven successful in enhancing relationships among older individuals? Dr. Vogelsohn (1978) conceived a study to find out, since his reading of Piaget and others suggested the possibility. He paired randomly 6 boys and 10 girls in a small, rural public school and gave them an audiotaped dialogue pretest with the instructions: "I want you to talk with each other for 5 minutes about which TV programs you like and don't like. Try to understand each other as much as you can. I'm leaving and will be back when the 5 minutes are up to turn off the recorder."

The children were then assigned randomly to Skills-Training and No-Training groups, identical in sex and nearly identical in age, the mean being 10 years, 3 months. After training, the

children in each group were again paired randomly to take the dialogue posttest, with the same instructions as the pretest. Once a week for 10 consecutive weeks the training program went on during a 45-minute activities period at the end of the day. The trainer met with the Skills-Training group in one classroom, while the others worked in another room on teacher-assigned craft projects.

During the first 2 weeks, the children learned nonverbal ways of showing and recognizing emotions by identifying those the trainer portrayed with gestures and facial expressions and by volunteering to portray words from lists of familiar feelings. They acted out and identified at least one emotion at each of the sessions, and a discussion period followed. During the third and fourth weeks, they learned the importance and ways of showing empathic acceptance of another's statement, each child restating the trainer's statement in a declarative sentence.

During the fifth and sixth weeks, each child was given a different list of several topics—"My favorite pet" or "The school subject I like best." One pair at a time, the children practiced with one discussing a topic, the other responding empathically, and the trainer giving verbal reinforcement and helping with responses if necessary. Sometimes they traded partners and changed topics. In the last 4 weeks, the children selected specific partners and discussed their own topics at length. They took turns in both roles and the group discussed how it feels to know that the person you are talking to understands you. Near the end of the sessions, each child stated in a sentence or two his feeling at the moment and discussed the importance of being aware of one's own feelings.

Because of the small number tested, there was no separate analysis by sex nor did the data suggest any differences. Using the AOS, testing revealed that change did take place in the Skill-Training group. There were no significant differences between the two groups at pretesting nor between the pre- and posttest scores of the No-Training group.

The enthusiasm of the Skills-Training children was the best endorsement. They volunteered eagerly and came with topics to discuss without being told, often commenting, "I wish more people would talk to me like this." They asked for the program to continue and, on their own initiative, gave a party for the

trainer/experimenter on the last day. Vogelsong admits that further research is required to expand the period and the skills taught. The study suggests to him, however, that active, specific, concrete skill training can become a significant part of affective education even in the elementary grades.

Whole Family Therapy

For Guernsey, some of the excitement of Relationship Enhancement lies in finding new uses for the method, or modifying it for new populations—addicts, business groups, high school groups, and whole families. Patricia Daubenspeck is planning her doctoral dissertation on the family, with research centering on the whole family unit, as opposed to filial, parent-adolescent, or couple. The pilot study has been encouraging, with strong, positive results, so Daubenspeck and Guernsey are looking forward to the full-scale study. They hope, in fact, to arrange a comparison with a more traditional family-therapy approach, possibly going into a treatment center where family therapy is done, training some of the counselors with the RE method, and testing the efficacy of each.

Helping and Training Other Therapists

From intake, the first contact with potential clients, to the final sessions, when the leaders ideally do little more than observe, the procedure is relatively structured. RE programs require well-trained leaders, but, because of specificity and the clarity of the teaching techniques and methods, the time required for training is short, compared to other methods of family therapy. It includes appropriate reading, observation of live or videotaped groups-in-progress, and supervised playing of both client and leader roles. There are training films available on conjugal and parent-adolescent therapy, with clear, low-key demonstrations of each of the modes, even an occasional "off-stage" prompting of the Facilitator by the leader. The situations presented are absorbing and true-to-life.

Graduate students without previous practicum experience can become junior coleaders within 80 hours; generally, after ten sessions of short postgroup session supervision, a junior coleader is ready to be a senior coleader and a cotrainer. Experienced professional persons usually need no more than 3 to 5

days of intensive workshop training, often in their own agency setting, followed by a period of supervision.

Dr. Guerney and his colleagues have held many such workshops, both in the Individual and Family Consultation Center at The Pennsylvania State University and in many other locations, for individuals from many parts of the United States. There is now, in fact, a nonprofit institute presently directed by Dr. Vogelsong for the conduct of on-site training and/or continuing supervision anywhere in the country of mental health programs based on an educational mode. It is the Institute for the Development of Emotional and Life-Skills, a name which forms an inspired acronym, IDEALS (P.O. Box 391, State College, Pa. 16801).

What of the Future?

Guerney isn't sure what may develop after the family study. As he says, "There's a lot of research to be done yet, I think, on process. That is, what kind of problems do people select, do they begin to talk more about what might be classified as deeper problems as they get further along in treatment? We may want to assess massed sessions further. We may want to do more marathon work with people who have serious problems, meeting 4 hours every other day, up to 8 hours, let us say, so that problemsolving with new skills can start right away."

Bernard Guerney's vision now is for a School for Living, that is, institutions located throughout the country either in fixed locations, "without walls," or as extension courses. However set up, and whether financed by fees, communities, or a combination, such a school could serve people across the whole life span: *preparing for a change*, such as parenthood and retirement, to name two; *coping with change*, such as divorce, widowhood, or job loss; and *creating change*, the aspect which covers relaxation, addictions, sexual problems, acquisition of desirable traits, and ridding oneself of undesirable habits—achievement of personal and interpersonal ambitions, in other words.

To the creator of RE and IDEALS, the prototype for a School for Living, the dream is entirely possible.

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Principal Investigator: Bernard G. Guerney, Jr.,
Individual and Family Consultation
Center
The Pennsylvania State University
University Park, Pennsylvania 16802

FAMILIES AND PUBLIC POLICY

Author: Mary C. Blehar, Ph.D., NIMH

This chapter provides an orienting description of the current context of growing interest in the status of the American family. Although concern for family members has long been reflected in Federal laws as well as in research such as that represented in this volume, intensive and focused interest is newer in the family as a functioning social unit and in the influence of institutional practices and laws on families. This more recent development is witnessed by the burgeoning number of organizations with an announced interest in having the family protected or strengthened. Presented here is a sampling of some beliefs about the family which provide a conceptual and value framework for the current upsurge of concern for its well-being; a discussion of some general family policy issues; and a schematic map of some current research and advocacy networks dealing with family issues.

DIVERSE VIEWS OF THE FAMILY

Different current conclusions concerning the health of the American family reflect a range of prevailing beliefs. In *All Our Children* (1977), Kenneth Keniston describes a popular "myth" about the family, that ideally it should be self-sufficient, insulated, almost autonomous, protecting offspring against the corrupting influences of the outside world. According to this myth, if the family fails, parents are at fault, and if it succeeds, they are to be praised. Keniston believes that this limited focus on individual parents is misplaced, since the causes of family success or failure are more complex and rooted deeply in economic and social conditions. He sees parents not

as abdicating their responsibilities but as dethroned by forces they are helpless to alter.

Another view is provided by U.S. Census Bureau demographer Paul C. Glick who sees the quality of family life as improving. In a report entitled "The Future of the American Family" (1978), he casts recent social changes such as the postponement of marriage, lower birth rates, and the increased number of working mothers (lamented by many as a major reason for family decline) as responsible for *improvement* in the quality of family life. In his judgment, fewer offspring signify more time to appreciate each one, and the employment of women is a change of pace that makes the time that mothers spend with their children more enjoyable.

Differences in value judgments are also reflected in definitions that have been proposed of what a family actually is, a preliminary and apparently simple venture into family analysis. Most definitions make mention of two or more individuals related by blood, marriage, or adoption, as well as of other relationships that are continuing though unformalized. To stress the importance of extended family and kinship networks, and of the relationship between the individual and his or her relatives, most definitions do not require co-residence. While it may be argued that definitions of family have become so all encompassing as to be meaningless, and while ordinary use of the term most often implies a household with children, the care given to formulating definitions underscores the extreme sensitivity of the topic.

Despite disagreement about the state of the family and its definition, a consensus might be reached on three points: (1) the family is currently in a state of flux precipitated by economic and social pressures; (2) imperfect though it may be, it is difficult to imagine substituting an alternative that could perform all its functions as well; and (3) it is more desirable to bolster families than to attempt to supplant them with untried structures.

VIEWS ON FAMILY POLICY

The heterogeneity of the United States' population and the diversity of its interests have contributed to an historic pluralism and consequent difficulty in formulating comprehensive

governmental responses to families and their needs. The very diversity that makes it so difficult to legislate any uniform *family policy* has, on the other hand, led to an appreciation of regional, cultural, and religious values represented by different family structures. Along with this respect for variety has come a call for returning to families the means for participating more directly in making decisions about matters directly affecting them, rather than having solutions generated at a more centralized level where sensitivity to the needs of various factions may be dulled by distance or disinterest. While the means for achieving this goal have been cast into liberal and conservative solutions (e.g., Keniston 1977 versus Berger and Neuhaus 1977), advocates of family "re-empowerment" agree on the desirability of the end.

In an analysis of family policy in 11 Western European countries (1978), and in the U.S., Canada, and Israel, Columbia University researchers Sheila Kamerman and Alfred Kahn point out that historically the very diversity of the United States' population has led to opposition to governmental interference in matters considered to be in the private domain. Foremost among these are family matters. While outsiders might intervene in families defined as deviant or failures, they should leave so-called "normal" families alone. Governmental intervention was a last option after church and secular agency intervention had failed, and help was limited to the underclasses and the deviant, no matter how extensive the provision might become.

In *Government Structure Versus Family Policy*, Kahn, Kamerman and Dowling (1979) note a more recent trend toward increased societal responsibility for certain risks in life, a trend that has accelerated since the New Deal, along with a growth of governmental roles in protecting the individual against such threats as income loss and the consequences of retirement, old age, death of a wage earner, etc. While such policies may have had their most direct effect on individuals, they also indirectly affected families and tended to encompass a broader range of families than previously.

Hence, including "normal" families as proper subjects of governmental purview and action has been gaining increased respectability. In research and analysis has come a parallel "new" view of the family as one interdependent element in a

system of interrelated structures. These structures, such as neighborhoods, churches, places of work, and, of course, Government, are seen as defining the boundary conditions within which personal family life is enacted. Consonant with this view is the notion that all elements in the system influence each other and that the family is a product, not only of the peculiar interactions of members' psyches, but of a social milieu. It has complex relationships with an ever-widening circle of related structures.

One result of this systems approach is a conservatism in the face of change. This caution stems both from an appreciation of how change may lead to a course of action that could bring about unintended and perhaps unwanted side-effects and from a realization that the complex, value-laden human context of change defies consensus about what changes are desirable.

Governmental policies have been cited for their unanticipated influence on the family. For example, when the Social Security program was instituted during the Roosevelt era, the average lifespan of a worker was shorter than today. Now the increased longevity of the population and the greater tax burden needed to fund the expanded program threaten to siphon off income from younger families at a time when they are trying to rear their own children in an inflation-ridden economy. Cash benefits aside, Social Security to the elderly provides them with a degree of independence seen by some as weakening the extended family by making it possible for aged parents to live apart from their children. Others view it as encouraging some older persons to live together rather than to marry, which may encourage the same pattern among younger family members.

A second example of the unanticipated influence of governmental actions on family life can be found in the effects of the so-called "marriage tax" levied on married earners of approximately equivalent amounts of income, who end up paying more in taxes than people earning similar amounts but merely living together. The marriage tax may have discouraged matrimony among young dual workers and allegedly has encouraged at least a few to divorce in order to avoid paying out more money to the Federal Government. This tax situation again underscores the difficulty encountered in legislating in value areas. While couple-based units are penalized, individual-based ones

are favored, and arguments about the equity of either situation are difficult to resolve.

Hence, the promotion of value is present, implicitly or explicitly, in almost every institutional action taken by Government, by virtue of discouraging some reactions among citizens and encouraging others.

Because so many institutional actions influence family life, *family policies* can be conceived of existing at all levels of Government and even in the private sector. The Federal Government, because of its size and influence, is the greatest potential and actual effector of change. Tax policies concerned with home-mortgage deductions, credits for child care during periods of parental employment, and personal exemption allowances for dependents directly affect families. Less obviously, so do decisions to build four-lane highways, thereby limiting or increasing families' choices about where to live, work, play, or send their children to school. While Federal actions affect families, they affect some more than others. Legislation concerning aid for dependent children, Head Start programs, and school lunches influence lower-income groups most directly and have relatively less impact on middle- and upper-middle-income families, except insofar as their tax burden is increased to support the programs. Conversely, many aspects of tax policy benefit these latter groups disproportionately.

While a cursory analysis of Federal programs and legislation can uncover actions which have impact—direct or indirect, intended or inadvertent—on families, the issue of what the Federal role in family-policy formulation should be remains unresolved.

In their analysis of family policy in 14 countries, Kamerman and Kahn (1978) contrast two views of it—one as a *field*, and the other as a *perspective*. The first view is derived largely from the European experience, where governments have brought together measures, most often directed at disadvantaged and dependent families, and have assigned them to one or two related agencies, bureaus, or departments. Where family policy is a field, the authors find, it usually becomes a modest one, only attempting what can reasonably be integrated under one umbrella. Since so many aspects of Government affect families, myriad rules and regulations defy compartmentalization in one bureau or agency.

By contrast, the perspectival view of family policy would seek to develop a set of explicit criteria by which institutional actions are evaluated from the point of view of their potential family impact. While such a perspective could conceivably attempt to define specific goals and standards and attempt to shape family motives and behavior in a uniform fashion, the authors believe that this uniformity would meet with opposition from diverse segments of the American population. Rather, they conceive of a successful family perspective as one that avoids institutional acts of commission or omission that could harm families and one which protects individual environments in which children are raised and adults find fulfillment, meanwhile not imposing on families any one model, one mode, one pattern, or one value system (Kahn, Kamerman, and Dowl- ing 1979).

Family-impact analysis is a method being developed currently to report the actual or potential impact on the family of administrative rules and laws. Analysis leads to "family-impact statements" which can be used by policymakers to determine further courses of action. Earlier interest in impact prediction was moderated and replaced by *ex-post facto* program/policy assessments in more specific domains when value conflicts, knowledge gaps, and technical limitations underscored the unreliability of predictive efforts (Family Impact Seminar, 1978). While increasing in popularity, family-impact analysis still provokes doubt about its feasibility (Kahn, Kamerman, and Dowl- ing 1979). Difficulties aside, family analysis is becoming something of a booming growth industry.

THE FAMILY POLICY NETWORK

Interest has greatly increased lately in family research, in evaluating and describing the influence of Government and other institutions on the family, and in advocacy on its behalf. The first survey reviews new private sector institutions and programs that define as their specific goal the explication of relationships between family functions and broader institutional, social, and economic forces; those receiving NIMH support are identified. The second describes some private-sector advocacy networks. Finally, the broad Federal network concerned with child and family services and research is described.

Family Policy and Think Tanks: A Sampling of Institutes and Programs

The Family Impact Seminar is located at the Institute for Educational Leadership, The George Washington University, Washington, D.C. During the Seminar's brief existence since 1976, the group of 22 members, who represent a wide range of disciplines in academic life and experience in policymaking, have been testing the feasibility of systematically assessing the effects of selected Federal policies on families. They have analyzed the effect on families of two Federal policies—Government employment schedules (flexitime versus standard time) and programs for pregnant teenagers. These pilot analyses are attempts to iron out difficulties in family-impact analysis and to see how well it works. In June 1978, the Seminar issued a preliminary report that cautioned against hasty actions and highlighted the need for more basic and applied research to draw accurate relationships between policy and family life. The funding for the Family Impact Seminar comes from the Foundation for Child Development, New York City, and the Lilly Endowment, Indianapolis.

The American Enterprise Institute for Public Policy Research, a publicly supported research and education organization based in Washington, D.C., and New York City, is conducting research into the role of institutions which stand between the individual in private life and the megastructures of institutions and Government. Of paramount concern is the status and role of the family as a mediating structure. A book has been produced, *To Empower People*, by sociologists Peter Berger and Richard John Neuhaus, which describes the value and role of mediating structures—families, churches, neighborhoods, and voluntary associations—in empowering people to have more control over their own lives. The sociologists also suggest some directions for future policy research. Future research will be directed into the role of mediating structures in five critical areas of domestic policy. The areas are health, child care, education, housing, and law enforcement. Each of five panels will publish findings and recommendations in separate volumes.

Canadians have long been considered in the vanguard of studies of the relationship between public policy, social influences, and the family. Prominent among their groups in this area is the *Vanier Institute of the Family*, located in Ottawa,

Ontario. Among current projects is an analysis of the family, including its contribution to the economy, the impact of economic patterns on family life, and the impact of familial patterns on the economy. Special emphasis is given to the Canadian experience.

The *Columbia University School of Social Work* is undertaking several cross-national studies of family-related issues. A recently completed volume, *Family Policy: Government and Families in 14 Countries*, is based on the proceedings of a conference funded by the Carnegie Foundation and a critique of the Federal role in family policy formulation. Research on a six-country study of policies concerned with the care of children under age 3 and of maternity benefits currently available in European nations is also currently under way.

In the Southern United States, *The Center for the Study of Families and Children* at the Institute for Public Policy Study, Vanderbilt University, is examining policies related to the empowerment of parents through child care and parent-education programs. Funded by the Carnegie Corporation, the Center is developing a specific set of educational policies that can be expressed through Federal- and State-level legislation and through regulations in private sector organizations. It is also studying the transfer of knowledge between universities and policy communities, while seeking to establish a two-way bridge between university-based policy analysts and individuals responsible for formulating and carrying out policies that affect children and their families.

Training in family-policy analysis is the focus of a series of four related, privately funded programs. In St. Paul, Minnesota, the *Bush Institute* has awarded grants to university-based centers to support the development and training of doctoral and postdoctoral students interested in family and public-policy issues. The Bush Institute aims to broaden the interests of students who are specializing in research fields that have policy implications. The centers are: *The Center for Child Development and Public Policy*, Yale University; *The Center for Child Development and Public Policy*, University of Michigan; *The Center for Child Development and Public Policy*, UCLA. Recently, a grant was given to the *Frank Porter Graham Child Development Center* at the University of North Carolina in

Chapel Hill to develop courses and workshops to support pre- and postdoctoral fellows.

The Boys Town Center for the Study of Youth Development was founded in 1917 as a single dormitory site for boys in need of alternative lifestyles and has grown today into a national research and service organization devoted to family and youth. Boys Town has several family-oriented projects under way, among them one, described in this volume, by Glen E. Elder on social change in the family, a program of treatment for troubled youths in a family-type environment, and several others focusing on youth development and problems. The Center, as well as its research and other programs, is funded from the Boys Town Endowment and annual contributions.

Three major NIMH-supported programs are currently engaged in research and policy analyses of American family life.

- *The Center for the Study of the Family and the State*, Chapel Hill, North Carolina, examines public policy from a regional point of view. Established in 1977 with a grant from NIMH, the Center is training social scientists to identify and analyze laws, policies, and regulations affecting American families. Major policy components of the training program are welfare and income-transfer programs, health policies, housing and land use, family law, family and child relationships, corporate responsibility to the family, rural poverty, and the Southern family. Currently, the Center is producing a volume entitled *Life Cycles and the American Family: Current Trends and Policy Implications*. Other Center work includes a study of the role of employment in family life, with emphasis on corporate responsiveness to family needs, and two family-impact statements, one on President Carter's Welfare Reform and another on child custody.
- Training in family-policy analysis is the focus of programs at *The Minnesota Family Study Center* at the University of Minnesota. It recently received a 3-year training grant from NIMH to establish a program for family-impact analysts. At Penn State University, NIMH is also funding a training program in the *Department of Individual and Family Studies*. This program places explicit emphasis on the family as the unit of analysis and its multidisciplinary approach.

- NIMH has provided funding for some of the work currently under way on the family at the *Wellesley Center for Research on Women*, at Wellesley College. The Center has developed innovative research into the changing educational and work needs of women. One, on women and the family, will be overseen by Joseph Pleck (whose work on men and the family is reported in this volume). Laura Lein, who has just completed a study on families and work (also in this volume) is beginning a two-part project on women's social networks and their impact on the quality of family life. Other research initiatives undertaken by members of the Center's staff include projects on family timing, changes in child-care patterns, separation and divorce, and family law.

Advocacy Organizations

A growing number of advocacy groups made up of coalitions of interest groups have been organized to provide support for the proposed White House Conference on Families, now scheduled for 1981, and are now also organizing on the State level.

The major group among them is the White House Conference Coalition, at last count comprised of 46 family-oriented organizations, with several other applications pending. The Coalition's stated aims are to ensure (1) that diversity is represented in the White House Conference; (2) that a primary focus be on the impact of public policy at the Federal level; (3) that recognition be given to the family impact of major nongovernmental organizations; and (4) that serious consideration be given to informal and natural systems of support to the family.

Members include groups representing diverse family forms (e.g., Parents without Partners), diverse religious and ethnic backgrounds (e.g., Synagogue Council of America, Americans for Indian Opportunity), families in various stages of the life cycle (e.g., National Council on the Aging), and diverse lifestyles (e.g., National Gay Task Force), as well as a number of professional and child/family advocacy organizations.

Within the Coalition has arisen a smaller independent coalition made up of professional family organizations—The American Association of Marriage and Family Counselors, the American Home Economics Association, The Family Service Association of America, and the National Council on Family Relations.

The White House Conference Coalition is also offering guidance to states which are planning conferences to complement the White House Conference; the development of state coalitions, similar in purpose and form to the national one, is contemplated.

Other coalitions represent cohesive ethnic, cultural, or religious groups and have formed (1) to monitor the Conference and keep their constituents informed or (2) to represent specific issues.

Two coalitions represent black and Catholic interests respectively. The HEW Coalition, convened by the National Black Child Development Institute, is composed of nine national organizations, which collectively claim to represent the interests of a majority of black families in the United States. The purpose of the Catholic Coordinating Committee for the White House Conference is to promote Catholic participation and viewpoint in the Conference.

The National Parents' Rights Coalition, founded under the auspices of Catholic Charities, aims to promote a certain viewpoint of family life by (1) persuading policymakers to work for the good of the family; (2) ensuring empowerment of parents; (3) raising parental consciousness; and (4) restoring dignity to family life.

The Federal Network

A complete description of the Federal network of programs affecting the family in some way might ultimately encompass virtually the entire Federal bureaucracy. On a more modest scale there are available to the public two documents describing Federal family activities in two areas: *assistance programs* and *research*.

In preparing its catalog of *assistance programs*, The Family Impact Seminar (*Toward a Catalog of Federal Programs with Direct Impact on Families*, 1978) deliberately broadened the inventory beyond programs administered by DHEW (the most prominent locus of family-program activities) and/or programs aimed directly at poor families. The inventory was limited nevertheless to programs with direct family impact, defined by the Seminar to include policies or programs whose primary goal is the provision of financial assistance, in-kind subsidies, or services to individuals or families, such as Social Security benefits,

subsidized school lunches, or health services. With few exceptions these benefits or services do not go straight from Federal departments to families, but pass through administrative bureaucracies and institutions. The inventory excluded indirect Federal policies that could have significant impact on families, such as tax policies, court decisions, the Federal Government's own employment policies, regulatory policies, or macro-economic policy decisions.

Table 1 shows a total of 268 programs administered by 17 different Federal agencies considered to have "potential impact on families." A subset of 63 programs is separately identified as having explicit family impact. While HEW heads the list of individual agencies both by number of programs and dollar obligations, HUD, Interior, Justice, Labor, USDA, and the Veterans Administration collectively account for just as many programs. Table 1 belies the assumption that family-related programs are the exclusive concern of HEW.

Table 2 provides an Inventory of Federal programs with potential or explicit family impact by target group—i.e., by elements within the family. The highest single category is the "family" itself, with 63 programs, but if subcategories of "child," "child/youth," and "youth" are added together, they account for 64 programs. The smallest category is the "aged."

The Inventory contains a discussion of each Agency's programs in some detail (including a breakdown of the five sections of DHEW, with NIMH falling under the Health or Public Health Services category) and provides recommendations for programs.

The *research* segment of Federal family-related activity as it was found to be in fiscal year 1976 is represented in table 3. Family projects are divided into aspects of the family relating to society (work roles, social norms, family structure, etc.) and relationships among family members (sex roles, communication, power structure, etc.).

Table 3 shows that NIMH leads Federal agencies in supporting research focused directly on the family and is second to the U.S. Office of Education and the National Institute of Education in research indirectly focused on the family. Although DHEW in general leads in family research (as it did in family programs), agencies as diverse as the Department of Agriculture, Department of Labor, and the National Science Foundation are also active in the area.

While we have described the leading issues and some Federal and private sector activities centering on the family, this chapter is perforce abbreviated. But it reflects widespread interest in the changing nature of the American family. This interest, given official sanction by such events as a call for a White House Conference and by increased funding for projects such as those detailed in this chapter, reflects a desire, expressed by a Secretary of DHEW (Califano 1976), to restore the family to a position as cornerstone of the national well-being.

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Table 1—Inventory of Programs With Potential Direct Impact on Families*

Agencies	Potential Family Impact No. of Programs	Total Obligations (\$ Million)	Explicit Family Impact No. of Programs	Total Obligations (\$ Million)
DHEW:				
Education	59	5,881	2	75
Welfare	25	18,336	9	15,568
Health	25	1,387	6	348
Social Security	8	93,473	2	17,761
Office of the Secretary	2	151	1	124
<u>Total</u>	<u>119</u>	<u>119,228</u>	<u>20</u>	<u>33,876</u>
VETERANS (VA)	31	28,385	7	11,331
HOUSING & URBAN DEVELOPMENT (HUD)	24	8,440	19	8,410
LABOR (DOL)	21	6,695	4	485
AGRICULTURE (USDA)	19	12,191	9	7,005
INTERIOR/Bureau of Indian Affairs	14	350	2	10
JUSTICE	13	697	—	—
ACTION	9	81	—	—
CIVIL SERVICE COMMISSION	5	85	—	—
COMMUNITY SERVICES ADMINISTRATION	4	401	1	28

APPALACHIAN REGIONAL COMMISSION	3	91	—	—
RAILROAD RETIREMENT BOARD	1	3,639	1	3,639
TREASURY	1	124	—	—
TRANSPORTATION	1	116	—	—
NATIONAL LABOR RELATIONS BOARD	1	68	—	—
COMMISSION ON CIVIL RIGHTS	1	8	—	—
PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED	1	1	—	—
TOTAL	268	180,600	63	66,794

Table 1 summarizes the tabulations of the inventory based on the *Catalog of Federal Domestic Assistance Programs. (1976)*. When a program's title or objectives stated that families or at least two family members as a unit were intended beneficiaries, this information was entered under Column 3, "**Explicit Family Impact.**" The term "Obligations" used in Columns 2 and 4 is a technical, legal term used to describe Federal legal, financial commitments but may not represent net outlay of a program to a department accurately in all cases because of the inclusion in the figure of indirect costs.

* Reprinted from "Toward an Inventory of Federal Programs with Direct Impact on Families." Institute for Educational Leadership, George Washington University, Washington, D.C., 1978.

Table 2—Inventory by Target Group*

Legend: 324(10) = \$324 million
10 programs

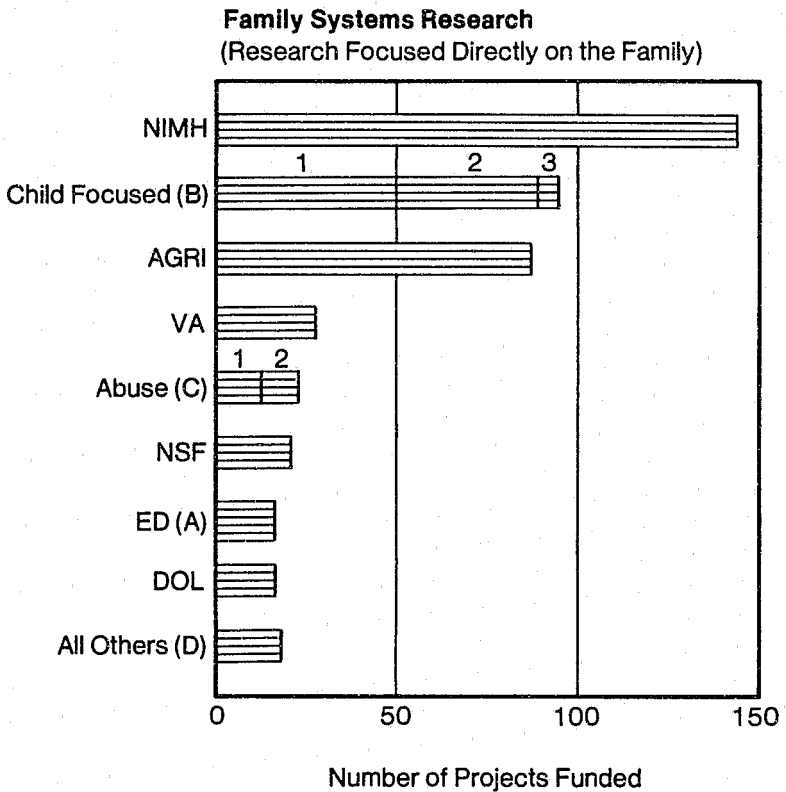
Agencies	Child	Child/ Youth	Youth	Youth/ Adult	Adult	Aged	Diverse	Family	Total
HEW:									
Education	144(5)	2,634(28)	873(5)	2,061(13)	3(1)	—	91(5)	75(2)	5,881(59)
Welfare	72(2)	—	7(1)	—	—	131(3)	2,558(10)	15,568(9)	18,336(25)
Health	108(3)	—	—	—	—	—	931(16)	348(6)	1,387(25)
Social Security Office of the Secretary	—	—	—	—	—	62,085(3)	13,627(3)	17,761(2)	93,473(8)
Total	324(10)	2,634(28)	880(6)	2,061(13)	3(1)	62,216(6)	17,234(35)	33,876(20)	119,228(119)
Veterans	—	—	—	5,664(1)	11,314(22)	—	76(1)	11,331(7)	28,385(31)
Housing & Urban Development (HUD)	—	—	—	—	—	6(1)	12(4)	8,422(19)	8,440(24)
Labor (DOL)	—	—	142(1)	5,151(4)	654(5)	30(1)	233(6)	485(4)	6,695(21)
Agriculture (USDA)	1,780(3)	—	—	—	—	—	1,408(7)	9,003(9)	12,191(19)
Interior/Bureau of Indian Affairs	183(5)	—	33(1)	—	3(1)	—	121(5)	10(2)	350(14)

Justice	—	—	48(4)	—	—	—	649(9)	—	697(13)
Action	—	—	N/A(2)	—	—	51(3)	30(4)	—	81(9)
Civil Service									
Commission	—	—	84(2)	N/A(1)	—	—	1(2)	—	85(5)
Community Services									
Administration	17(1)	—	—	—	—	—	356(2)	28(1)	401(4)
Appalachian Regional									
Commission	20(1)	—	—	—	—	—	71(2)	—	91(3)
Railroad Retirement									
Board	—	—	—	—	—	—	—	3,639(1)	3,639(1)
Treasury	—	—	—	—	—	—	124(1)	—	124(1)
Transportation	—	—	—	—	—	—	116(1)	—	116(1)
National Labor									
Relations Board	—	—	—	—	—	—	68(1)	—	68(1)
Commission on									
Civil Rights	—	—	—	—	—	—	8(1)	—	8(1)
President's Committee									
on Employment of									
the Handicapped	—	—	—	—	—	—	1(1)	—	1(1)
TOTAL	2,324(20)	2,634(28)	1,187(16)	12,876(19)	11,974(29)	62,303(11)	20,508(82)	66,794(63)	180,600(268)

* Reprinted from "Toward an Inventory of Federal Programs with Direct Impact on Families." Institute for Educational Leadership, George Washington University, Washington, D.C., 1978.

Table 3—Federally Funded Family Research: A Profile

Family Research Projects Being Supported by External Grants and Contracts by Federal Government Agencies Active in Fiscal Year 1976



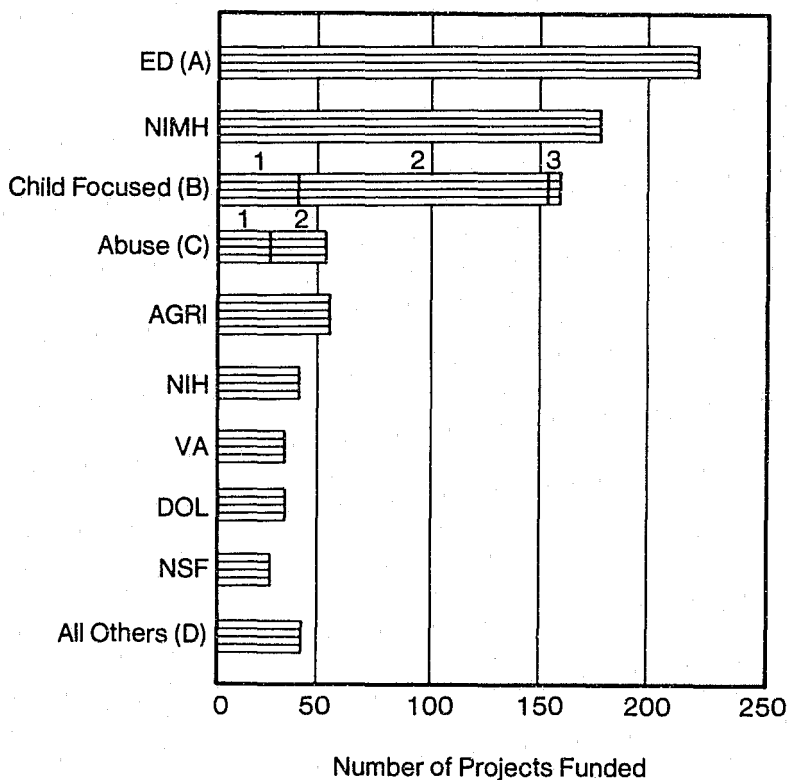
A. Education Agencies (U.S. Office of Education; National Institute of Education)

B. Child Research Focused Agencies (1=National Institute of Child Health and Human Development; 2=Office of Child Development; 3=Office for Maternal and Child Health)

C. Substance Abuse Agencies (1=National Institute on Alcohol Abuse and Alcoholism; 2=National Institute on Drug Abuse)

D. All Others: National Institute on Aging, Social Security Administration, Rehabilitation Services Administration, National Foundation on the Arts and Humanities, Department of Housing and Urban Development, Department of Justice

Family-Related Research
(Research Indirectly Focused on the Family)



Abbreviations:

NIMH — National Institute on Mental Health

AGRI — Department of Agriculture

VA — Veterans Administration

NSF — National Science Foundation

DOL — Department of Labor

NIH — National Institutes of Health

*This table appeared originally in *The American Family*, Feb.-Mar. 1978 and is to be published in *Family Research: A Source Book, Analysis and Guide to Federal Funding*, Allen, K.; Wakefield, R.; and Washchuck, G., eds. Westport, Conn.: Greenwood Press, in press.

ABSTRACTS

FAMILIES IN HARD TIMES: A LEGACY. Runck, B. Research of Glen Elder, Jr. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

This is a study of the change in family and individual life brought about by the Great Depression. Elder is examining the process by which economic hardship influenced families and, through their adaptations, individual family members. Long-range and prospective in design, the study uses archival records on Oakland and Berkeley, Calif., families who originally took part in studies of their children's development half a century ago, just as the Depression was starting. Elder's study of the Oakland families, whose adolescent children were able to help out during hard times, was published in 1974 as *Children of the Great Depression*. Elder is now studying the Berkeley families, whose children were infants in 1929. He is comparing their experience with the Oakland group's, examining the sources of the Berkeley parents' adaptability, observing changes in family life over generations. So far, as expected, Elder has found that the Berkeley children were more vulnerable to the effects of their parents' financial hardship than were the Oakland children. Equally dramatic and long-lasting was the difference between the boys and girls from deprived Berkeley families (those that lost a third or more in income). In deprived households, mothers grew in importance as a source of income and emotional support, while fathers became estranged and peripheral. Ties between father and son were weakened, while those between mother and daughter were strengthened. As a result of this common pattern, the developing Berkeley children were greatly affected by economic hardship. Boys felt incompetent and powerless and tended to meet life with indecision and withdrawal, while girls were self-confident, goal-oriented, and assertive. Harmony in the parents' marriages lessened these effects. Men who grew up in deprived families were at a disadvantage in their education and early career beginnings, but by middle age they had regained lost ground, largely because of their military experiences. They were still more troubled psychologically than the men from nondeprived homes, but the effect was small compared with their disabilities in adolescence.

LA FAMILIA CHICANA. Moore, C. Research of Jaime Sena-Rivera. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Four cases of three generations of Mexican-descent families in the Michigan-Indiana-Illinois region were studied to examine *la familia chicana* as a special case of the modified-extended or kin-integrated family. The research investigated the contribution of extended family structure to the individual's sense of well-being and to the *familia* as a social organization. Same-culture interviewers explored this contribution, both subjective and material, by interviews of household heads from each generation and by limited direct observation. Individual family trees were charted, with each individual placed as a second-generation member and each household, or *casa*, delineated within each *familia*. Brief biographies showing generational changes are presented. Typical findings of this in-depth sample appear similar for all four families and include: larger size of second-generation families because of better, more extensive health care; marked increase in out-marriages in younger generations; a relationship between out-marriages and upward mobility; assimilation of non-Mexican-descent spouses into the *familia*; and almost total Catholic religious affiliation. Among particular attributes stressed are the lifelong strength of same age/sex peer relationships and of *familia* norms, which emphasize volunteerism supported by duty. This research contributes to theory on the extended family in urban industrial society. It adds to an understanding of Chicanos as part of the larger Hispanic-American population and of class and culture in the United States. Internalization of self-worth within the primary social group is seen as basic to Chicano mental health at all ages.

TRANSMISSION OF PARENTAL VALUES. Yahraes, H. Research of Lauren Langman and Richard Block. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

This study identified factors that lead children to adopt parental values and lessen the generation gap. Four hundred families were selected randomly by drawing students from six urban high schools. A questionnaire measured parents' and adolescents' actual values on such topics as morality and religion as well as each group's expectation of consensus on these same values. Elements which mold young people's values, such as parental or peer identification, social class, religion, geographic mobility, and occupational plans after high school, were also assessed. Langman and Block considered the following findings especially important: Parents and youth may hold similar values and still perceive a wide generation gap. Also, par-

ental qualities were found to be a more important influence on the transmission of values than early socialization practices. High interpersonal warmth was the single most determining factor in producing adoption of parental values, while parents who were "kvetchy" (irritable) produced lowered feelings of mastery and different values in their children.

PREPARATION FOR CHILDBIRTH AND PARENTING. Blehar, M. Research of Doris Entwisle. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A study was undertaken of 120 couples awaiting the birth of their first child. Couples were interviewed in person during the wife's pregnancy and immediately after their child's birth. At 6 months postpartum, the wife was interviewed by telephone. A description of worries, physical difficulties, and expectations during pregnancy is given. A model, developed to predict the quality of a woman's birth experience, indicates that intensive preparation for childbirth was associated with a higher level of consciousness during labor and delivery; consciousness in turn was associated with positive reactions to the experience. The husband's presence made an independent positive contribution to quality of the birth experience. Highly prepared women (defined as those who had taken courses in psychoprophylaxis) also required fewer obstetrical medications than did less prepared women, even though the former group reported as much physical discomfort. Judging from the women's reports, the fewer drugs used, the higher the quality of the birth experience. Highly prepared women reported more positive reactions to their first encounter with the infant, earlier occurrence of maternal feelings, and a longer duration of breastfeeding than women at low levels of preparation. A theory concerning the role of preparation is presented, and it is suggested that preparation may aid in the formation of the new family unit. Also reported are data on the frequency of cesarean section, which suggest that mothers delivering during the day and those with good medical insurance coverage are more likely to undergo sections than other women. Further topics discussed are the role of obstetrical interventions in affecting the birth experience, early parent-infant bonding, the couple's adjustment to the parent role, and the woman's return to work.

FAMILY STYLES OF INTERACTING. Blehar, M. Research of David Reiss. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Family groups consisting of mother, father, and adolescent child were observed in a laboratory problemsolving situation. Measurements of the family's contribution to the complexity of the individual's solu-

tion and of the degree of coordination among members in arriving at solutions were obtained. On this basis, families were classified into four groups labeled (1) environment-sensitive; (2) consensus-sensitive; (3) achievement-sensitive; and (4) interpersonal-distance-sensitive. Environment-sensitive families were characterized by a mutual effort to achieve the best possible solution, while consensus-sensitive families tended to sacrifice complexity in order to maintain a united and unconflicted front to the experimenter. Achievement-sensitive families were composed of persons attuned both to environmental cues and cues from family members who competed among themselves rather than working together. Interpersonal-distance-sensitive families were composed of members neither oriented to the environment nor able to achieve a solution mutually agreed upon. Other findings indicate a relationship between the family typology and a family's perception of the social environment. For instance, environment-sensitive families were more likely to arrange board figures of family members closer to "outsider" figures than were consensus-sensitive families. Discussion focuses on family interaction as a unique form of group dynamics based on a long history of shared beliefs that can color perception, on the value of the different kinds of families in past and present societies, and on the implications of differences in family style for mental health. Therapeutic applications of research findings are suggested.

FAMILY AND FRIENDSHIP IN OLD AGE. Blehar, M. Research of Gregory Arling. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C. Superintendent of Documents, U.S. Government Printing Office, 1979.

This study, a survey of 239 Richmond, Va., residents over age 65 and living in their own homes, concerns their mental health and their relationships with family and friends. A questionnaire was designed to assess a number of variables (such as personal morale, efficacy versus powerlessness, age identification, and expectations for assistance from family and friends) and to evaluate the respondents' interpersonal relationships. Findings indicate that older people who had a large number of persons with whom they exchanged support had higher morale than those with only a few. Black respondents were more likely to endorse reciprocal support norms than white respondents. They were also likely to engage in reciprocal exchanges with family and friends despite residence in neighborhoods with higher crime and unemployment rates, factors others have cited as contributing to social disorganization. It is suggested that relatively unfavorable socioeconomic conditions may have less negative impact if strong support networks have been developed throughout an individual's lifespan. Discussion focuses on the role of formal and informal social supports in promoting the mental health of the elderly.

FACTORS SUSTAINING MARRIAGE; FACTORS IN ADJUSTING TO DIVORCE. Spanier, G., and Fleeer, B. Research of Graham Spanier. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The divorce rate in the United States has been steadily increasing over the years, but since the mid-1960s it has more than doubled. In 1978, the divorce rate was 5 per year for each 1,000 individuals in the population; over a third of those now marrying are likely to experience at least one divorce; half of all present-day marriages of young Americans can be expected to end in divorce. Dr. Graham B. Spanier and his colleagues undertook an extensive review of the literature on marriage quality and stability and a two-part study, based on interviews with recently separated or divorced people, designed to gather data on the emotional and socioeconomic factors related to marital failure. From the literature review, the investigators derived a theory that attempts to relate the mutual influences of quality and stability in marriage and to explain why some marriages of high "quality" fail while many poor marriages endure. In the first of two parts of the study, 50 in-depth, unstructured interviews with the recently divorced provided a detailed picture of the problems and events leading to separation and divorce. From these case studies, an interview schedule was constructed for the second part of the study, in which more than 200 recently separated people were interviewed. Most separated and divorced people encounter two basic problems—those associated with dissolution of the marriage and those arising in the course of establishing a new lifestyle, the latter problem being by far the more difficult of the two. Another discovery was the widespread opinion that the professional behavior of attorneys and the nature of divorce law itself often lead to needless pain and inconvenience.

IMPROVING COMMUNICATION IN MARRIAGES. Yahraes, H. Research of Gary Birchler. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

In these studies, Birchler distinguished factors that differentiate good from bad marriages and also discussed various methods of treating unhappy couples. One study looked at 24 middle-class couples matched closely for factors such as age, length of marriage, and educational level. Couples interacted in a laboratory problemsolving situation, first with their spouse and then with a stranger. The Marital Interaction Coding System (MICS) measured both verbal and nonverbal behavior of couples. Birchler found that (1) happy couples exhibited more positive behaviors such as cooperation and compromise and (2) married people, regardless of marital happiness, were more positive

with a stranger than a spouse. A later study examined couples who were defined as either *very* happy or *very* unhappy. Among very happy couples, the most common problem was sex, perhaps because other worries were minimal. Among very unhappy couples, interpersonal communication and self-expression ranked highest as problems, sex being rarely mentioned as a primary difficulty. Birchler recommends several goals for treatment related to marital styles of interaction. Many marriages can be helped through social learning techniques such as positive reinforcement and negotiated contracts.

MARRIAGES THAT ENDURE. Moore, C. Research of Clifford Swensen. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The marriage relationship was investigated in terms of sex, retirement, commitment, and propinquity and frequency of contact with children. Two scales and personal interviews were used to examine 224 couples, half of them retired, all over 50 years of age, and married for 20 years or more. One scale measured the expression of love and the other marital problems. Expression of love was found to be lower the longer a couple had been married and to be significantly less for postretired than for preretired couples. The number of marriage problems was lower overall the longer a couple had been married, but if goalsetting, problemsolving, and decisionmaking had been problematic, that situation rarely changed for the better. Increased marriage problems appeared to be slightly related to increased interaction with children. Other findings were that sex was not related to love expression in marriage and that marriage problems were less for couples with high commitment. An adaptation of Loevinger's theory of ego development was used to examine the expression of love, which was found to be higher in the postretirement years for couples at the postconformist stages of ego development. A similar study conducted in Bergen, Norway, is described. These studies suggest the need for a new form of marriage counseling to help couples solve longstanding problems in order to maximize the quality of their remaining years together since, statistically, today's couples have many more postchild-rearing years than did preceding generations.

PARENTS AS LEADERS: THE ROLE AND CONTROL OF DISCIPLINE. Yahraes, H. Research of Diana Baumrind. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Studies conducted over the past two decades have demonstrated how various types of parental control affect children's behavior. In her

initial studies, Baumrind observed normal preschool children and their parents and noticed that competent children had controlling, demanding, communicative, and loving parents who exercised firm discipline. The third longitudinal study, still in progress, looked at 150 middle-class families in order to determine the effects of different kinds of parental discipline on the social competence of children. Three types of parental discipline are defined: (1) *authoritarian*, described as restrictive with arbitrary limits set upon behavior; (2) *permissive*, which aims to give as much freedom as possible; and (3) *authoritative*, which values not only firm, rational control but also self-assertion. Authoritative parents produced the most competent or self-reliant preschoolers. A followup study with 8- and 9-year-old children confirmed this finding. Sex differences were found related to paternal discipline, competent boys having relatively nondirective fathers and competent girls having directive fathers. Corporal punishment was common and not considered harmful when used by authoritative parents. Although children of different temperaments can be affected dissimilarly by like childrearing practices, firm, reasonable guidelines from parents will most likely create competent, responsible, independent children.

WORKING COUPLES AS PARENTS. Blehar, M. Research of Laura Lein. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Twenty-five predominantly middle-income Boston area families, in which both husband and wife work and in which children, usually preschoolers, are present, were studied intensively to determine how they coped with work and home life. Their main concerns were found to be child care, division of household labor, coordination of work and family life, and supports for parenthood in modern urban society. The paper describes innovative child-care arrangements, such as split shifts in which the two parents alternated between working and acting as caregivers, an arrangement that allowed children to remain in their own homes. Care of home and children was usually considered by both husband and wife as the woman's responsibility. Although men were willing to "help out," most resisted assuming responsibility for domestic tasks formerly performed by their wives. Women, on the other hand, were more willing to assume a breadwinner role. Working women were viewed as subject to more stress in coping with increased demands on their limited time than were men. The choice of women's jobs reflected their primary identification with the mother and homemaker roles. Many women limited job options in order to be close to home and accessible to children. Men sought jobs that offered security, sometimes at the expense of opportunities for stimulation and advancement. Both parents worried about outside influences on their children and sought to define their own standards of good parenting.

Findings are discussed in terms of changing roles. The families are viewed, at least in the short term, as coping successfully with a situation for which few models are available.

DEPRESSION AND LOW-INCOME, FEMALE-HEADED FAMILIES. Corfman, E. Research of Deborah Belle et al. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The continuing studies of this research group have had several phases. The first was an analysis of treatment and general population data to investigate the validity of the common impression that many more women suffer from depression than do men. An outcome of this study was the finding that disproportionately large numbers of low-income single and married mothers of young children are depressed. A second phase of the research scheme, intensive investigation of a small sample of these mothers, was designed to elicit the primary causes of depression and to develop promising intervention strategies. Separate interviews obtained information on the following topics: depression, life stresses and life conditions, race and sex discrimination, social networks, coping strategies, social services available, nutrition, parenting attitudes, and the parent-child relation. Forty-three low-income mothers and their children were interviewed. Mothers varied in age from 21-44 with a median age of 30; 21 black, 22 white; 20 single (unmarried, widowed, separated, divorced), 23 coupled (12 legally married, 12 not); two-thirds had a high school diploma; median number of household members was 4.6; median per capita yearly income was \$1,452. The study showed that half the mothers were rated as depressed, and that the mean depression scores for the entire sample of mothers was very high. Over half reported being victims of crime or household violence or rape within the past 2 years of the study. Life-stress event scores and life-stress condition scores were very high, correlating strongly with depressive symptom scores. Depression was not significantly correlated with length of neighborhood residence, number of friends and relatives seen at least a few times a month, or number of close friends. In six half-hour observation sessions of mothers with their children, depression correlated with high ordering and demanding behavior and low nurturing. Though correlated with depression, stress does not appear to provoke low nurturing behavior.

STEPFATHERS AS PARENTS. Yahraes, H. Research of Paul Bohannan. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Children living with their natural fathers were compared to children living with stepfathers on the following measures: academic achievement, school behavior, interaction at home, and peer relations. A survey questionnaire was administered to 190 volunteer families, 84 with natural fathers and 106 with stepfathers, matched as to race, religion, income, education of parents, and age and sex of children studied. Despite possible problems faced by the stepchildren, measures used revealed no discernible difference between the two groups of children, an outcome attributed to the power of social expectations, the mothers' positive attitudes, and the stepfathers' efforts. Analyses of two other studies confirmed the findings. Different styles of fathering, such as instrumental, expressive, autocratic, and patriarchal, are discussed, as well as dilemmas faced by stepfathers. Included are findings on discipline from the Bohannon study and from that of P.N. Stern, who suggests solutions for conflict over parental discipline.

MARRIED WOMEN: WORK AND FAMILY. Blehar, M. Research of Louise Hauenstein. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A survey study of 508 Detroit married women, housewives and working wives, residents of environmentally stressful and settled neighborhoods, blacks and whites, was undertaken to compare their attitudes toward husbands, children, working, and economic conditions. Very few differences were found between women in the two occupational roles. While housewives had less money to spend, they were as content with their economic situation as working wives. Wives in environmentally stressful neighborhoods reported more economic worries but no less general satisfaction with life than wives from more settled neighborhoods. The most striking differences emerged between women of the two races. Black wives endorsed more strongly attitudes indicative of mental health than white wives, and the former were also more concerned with economic issues and advancement. Considering the range of differences in occupation, place of residence and race found in the sample, it is notable that married women were similar on the great majority of attitudes.

MARRIED MEN: WORK AND FAMILY. Corfman, E. Research of Joseph Pleck. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Pleck analyzes the assumptions underlying the psychology of sex differences that he claims have conditioned our sense of what is desirable or possible in defining sex roles. He reviews new studies that call these assumptions into question. The male sex role is understood as

made up of the two roles of work and family and the responsibilities and social expectations that accompany them. Pleck evaluates the importance of the family role for men according to three parameters: (1) *performance*, or the actual time spent in family-role activities, usually recorded by some diary technique; (2) *psychological involvement* in the family role as compared with the work role; and (3) *satisfaction*, or how rewarding the actual living of the family role is felt by the male to be. Findings show that all but a narrow segment of men feel a more pervasive psychological involvement and satisfaction with their families than with their work. Pleck suggests that men's commitment to their work may be motivated by wanting to satisfy a cultural norm that expects men to demonstrate mature manhood by the capacity to support a family. If so, a large adjustment may be required if women begin to meet or exceed men in the role of primary breadwinner. Pleck's most recent work investigates the phenomenon of *role strain* if both spouses must now meet performance expectations designed when each specialized only in breadwinning or in taking care of spouse, children, and home.

FAMILY ADJUSTMENT TO UNEMPLOYMENT. Blehar, M. Research of Louis Ferman. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Detroit area workers were surveyed over a 24-month period, beginning with their registration for unemployment compensation, concerning their reactions to job loss, the period out of work, and their readjustment to working again. Among married men in the sample, seven categories reflecting distinctive career patterns were identified, and a small group of 21 men, 3 fitting each category, were interviewed intensively. Results indicate that unemployment is an extremely heterogeneous experience. Its impact varied as a function of certainty of re-employment, marketability of skills in the "irregular economy" while technically unemployed, economic buffers available, economic deprivation suffered, and social supports available. The reactions of men in the different categories to job loss varied from extreme anguish to nonchalance or even actual enjoyment of their nonworker status, depending in large part on the above variables. Generally, uncertainty over future availability of work was more traumatic to most men than the unemployed status per se, and while economic deprivation suffered was probably the single most important factor in determining the individual's reaction to job loss, diminution of self-image as a breadwinner was a source of psychological distress for many men. Older men tended to suffer more shame over job loss than younger men. Immediate and extended family support, both of a functional and an emotional nature, was seen as alleviating the severity of adverse reactions to job loss.

THE NATIVE AMERICAN FAMILY: THE URBAN WAY. Moore, C. Research of Dorothy Miller. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A Native American Research Group conducted three studies of American Indians relocated from reservations or the fringes of cities near their tribal areas to the San Francisco Bay Area in order to find better work and educational opportunities. The first study, "American Indian Socialization to Urban Life," involved interviews with 120 families, 30 each from Sioux, Navajo, the California tribes, and an aggregate of other tribes, to determine degrees of Indian identity, stages of child development, degrees of urbanization, and socioeconomic adjustment. Measures of intergenerational use of native language, teaching of tribal ways at home, and the mother's marriage preference for her children indicate that the majority seek to maintain their Indian identity in the city. The second study, "Native American Children: The Urban Way," reported results of random sample interviews of 109 staff persons of all levels from various social agencies. A principal finding was that sizable segments of respondents in all types of agencies and at all classification levels were either misinformed or uninformed about Indians in general and, in particular, about urban Indians and the public resources available to them. A major objective was creation of a "feedback loop" to help develop and implement more effective social policy and programs for Indian children. Using original baseline data, the third study, "Urban Indian Children: Five Years Later," obtained new data on survival and adaptation in the city. The researchers empirically classified the modes of adaptation as Traditional, Transitional, Bicultural, and Marginal and assigned each family to a group on the basis of response and attitude. Preliminary findings substantiate the Bicultural hypothesis: Families at home in both Indian and white worlds have greater survival capacity in the city than do those at home only in the Indian world or in neither.

ANTISOCIAL CHILDREN AS ADULTS. Yahraes, H. Research of Lee Robins. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

To determine the origins of antisocial behavior in children and predict adult psychopathy, long-term studies of children referred to child-guidance clinics were conducted. Followup of these patients, along with matched controls, continued well into adulthood; the investigator then looked at the police records of many of the original subjects' children. These studies indicate very early onset of antisocial behavior, especially in boys, with signs such as truancy, poor academic achievement, theft, discipline problems, and poor peer relations. In

adulthood, less than half of even the most highly antisocial children were diagnosed sociopathic, but virtually none was psychiatrically healthy. The number of symptoms was a better predictor of adult sociopathy than any particular sign or set of symptoms. Causal factors discussed were sex, race, and parental behavior. Other factors often thought of as important in the development of antisocial personality, such as a broken home, low-social class, and peer-group pressure were not found significant as isolated factors. Rather, excessive leniency and inconsistent parental discipline contributed to adult antisocial behavior. Other theories discussed include the link between earlier parent-child separation and later antisocial behavior and neurological predictors.

PRESCHOOL INTERVENTION FOR CHILDREN AT RISK. Isenstein, V., and Krasner, W. Research of Jon Rolf. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The Vermont Child Development Project (VCDP), started in 1973, was designed to investigate the etiology of behavior disorders in early childhood and to develop early intervention strategies for these disorders. An epidemiological survey sampled a broad cross-section of over 1,000 preschool children to obtain basic data on the developmental patterns of large nonclinic populations. Additional studies of 50 high-risk families and an equal number of controls investigated the competency of preschoolers identified as vulnerable because their parents had received mental health treatment. From these studies, the VCDP created a developmental risk profile program which quantified normative behaviors among preschoolers and allowed a comparison between the high-risk children and controls. A therapeutic day-care program was initiated to assess the effect of early intervention on high-risk children and those already with problems. Program goals centered around developing social, intellectual, and physical competency through creative play and work. Lack of parental participation and cooperation has been a considerable problem. Followup studies of the children as they enter the public schools are helping to assess the impact of therapeutic day care. The VCDP, still an ongoing project, will identify specific age-appropriate behaviors of preschool children, provide insight into behavior disorders, and demonstrate the importance of early intervention.

RUNAWAYS REVISITED. Blehar, M. Research of Lucy Olson, Elliott Liebow, Milton Shore, and F. Vincent Mannino. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Fourteen young men and women, who as teenagers had run away from home, were the subjects of an intensive clinical case study which was a follow-up of a larger-scale survey of runaways conducted in the early 1960s. A major purpose of the research was to determine how former runaways had fared as adults and whether or not their early behavior had foreshadowed later adjustment problems. Intra-family comparisons between the runaway and a sibling were also made. Findings suggest that two factors are most prominently associated with differential long-term outcomes: (1) whether or not the youthful act was a repeated or an isolated occurrence, and (2) the individual's social class. In general, repeaters most nearly fit a model of running away as a sociopathic act, indicative of severe disorders. A single act of running away was associated with little long-term disability. As adolescents, runaways had experienced school failures, and as adults, they had little success in obtaining and holding jobs. Many still lived with parents and were dependent on them or on social welfare agencies for support. Middle-class runaways suffered more shame over their poor school and job performance than did working-class runaways, and the former's parents were less accepting and more critical. Middle-class runaways felt more ostracized by other members of their class than working-class runaways who managed to engage in more social activities, although these were usually of a diffused and transitory nature. The siblings of runaways, with one exception, had managed to make successful adjustments to adult life. Discussion centers on the prognostic value of repeated running away for the prediction of psychosocial disability, the influence of the era in which the runaway act occurs, the contribution of individual psychology to the outcomes observed, and on the irony of the finding that premature separation from adult authority has led to a prolonged and ambivalent dependence on it.

PSYCHOSOMATIC ASPECTS OF DIABETES IN CHILDREN. Segal, J. Research of Salvador Minuchin. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Severely diabetic children, suffering from recurrent ketoacidosis and resistant to medical treatment, were studied to determine the role of family stress in the development of their illness. Stress reactions of the psychosomatic diabetic children and their families were compared with those of two other groups of diabetic children and their families in a lab setting designed to evoke family conflict. The measure of stress was the blood level of free fatty acids (FFA), which rises in response to stress and can cause diabetic ketoacidosis. In comparison to the FFA level of the control children, FFA in the psychosomatic diabetic children rose significantly more during family conflict and remained significantly higher after conflict had subsided. In another study, the investigators used a technique called the "family task interview" to assess the unique characteristics of families with severely

diabetic children. In performing a routine task, these families exhibited (1) interaction that pathologically enmeshed the diabetic child in family conflict; (2) overprotectiveness; (3) extreme rigidity; and (4) an inability or unwillingness to resolve conflicts. Minuchin and his team found characteristic patterns of family conflict that affected the diabetic's ability to respond to stress. The patterns of triangulation, parent-child coalitions, and detouring are described. As children's FFA levels rose in response to family conflict the parents' FFA level dropped. So, by maintaining his illness, the diabetic child plays an important role in the family's pattern of avoiding conflict.

PHYSICAL VIOLENCE IN FAMILIES. Yahraes, H. Research of Murray Straus and Richard Gelles. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

In order to determine the extent of physical violence in American families, Straus and his coworkers conducted a national survey of both child and spouse abuse. Through questionnaires, such as the Conflict Tactics Scale (CTS), and extensive interviews with over 2,000 representative couples with children, the investigators reported on severe acts of family violence. An estimated 1.7 million children are subjected to extremely violent acts in the home, and 3 or 4 out of every 100 parents are estimated to be abusers. Factors influencing the incidence of child abuse include the sex and age of the child and the family's social class: The more violent forms of abuse occurred most often in low-income families. Approximately 1.8 million wives are severely attacked by their husbands at least once a year, with 1/4 of the respondents agreeing that spouse abuse is sometimes permissible. Prevention should center around changing the cultural norm that violence among family members is acceptable, along with (1) reducing violence in the mass media; (2) eliminating physical punishment in childrearing; (3) sponsoring research dealing with the causes of violence; (4) recognizing the legitimacy of family conflict; and (5) reducing sexism. The researchers give advice to battered wives and discuss factors that keep an abused wife home, including joblessness. Straus emphasizes that violence is learned and need not be a part of normal family conflict.

CHILD ABUSE: A REVIEW OF RESEARCH. Segal, J. Review of child-abuse literature. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

As is now well documented by history, children have always been the frequent victims of abusive treatment by parents—the more or less helpless targets for the venting of the frustrations, conflicts, hatreds, and smouldering anger of the adults who dominate their

lives. Though the phenomenon of child abuse and neglect is anything but new, only in recent times has it commanded a wave of national attention and become the subject of a growing volume of applied research in the behavioral sciences. Author Segal provides a survey of the important literature on child abuse, including an estimate of the extent and gravity of the problem and an appraisal of the known short- and long-term effects on the lives of abused children. Causes of abusive behavior in parents and other elders are discussed, it being pointed out that abused children themselves often grow up to become violent and abusive adults. A brief review of the presently accepted methods of dealing with abusive parents and the objects of their destructive acts is presented. An outline of new and largely experimental ways of identifying prospective abusers in time for effective intervention is included.

HELPING ABUSED CHILDREN AND THEIR PARENTS. Blehar, M. Research of James Kent. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A child-abuse project at Children's Hospital in Los Angeles applies research findings to the treatment of young children at risk and their parents. Profiles of families in which nonaccidental injury (NAI) to a child or failure to thrive (FTT) have occurred are being developed based on cases seen by hospital staff. Abuse is seen as a multidimensional behavior, indicating varying degrees of family dysfunction, ranging from parental psychosis at one extreme to parental ignorance of healthy child development practices at the other, and one which, correspondingly, carries different risks for the child's development. The family distinctions are used to predict the child's risk for reabuse and the likely outcome of a given course of therapy as well as to decide whether a child should be placed back in the parental home or put into foster care. A research evaluation of the project's efficacy involves a comparison of families experiencing the specialized interventions developed by the team with those experiencing the usual kinds of social-service interventions. Discussion focuses on primary and secondary prevention efforts in the abuse area.

THE MENTALLY ILL AT HOME: A FAMILY MATTER. Runck, B. Research of John Clausen. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

This study explored (1) how families recognize and deal with mental illness in one spouse and (2) the short- and long-range consequences of the illness for the family. Families studied in the 1950s were compared with those in which one spouse was first hospitalized in the 1970s.

Clausen found that, compared with the 50s families, the 70s families had just as much difficulty recognizing mental illness but a much easier time getting the family member into treatment. The 70s patients were hospitalized for a much shorter period—usually less than 3 weeks—and closer to home—often in a general hospital's psychiatric ward. These two changes accounted, in part, for other differences between the 50s and 70s groups: The 70s patients found it easier to return to work, and they and their families seemed to feel less stigma. Their return home was made easier because family roles and schedules had not changed during their absence. But in many cases, the reunion was made more difficult because patients were still symptomatic or heavily medicated, and because the tensions that had led to hospitalization had not had time to abate. As in the 50s, the well parents found it difficult to explain the illness to their children, and mental health treatment staff gave them no help. In the second part of the study, Clausen found that the long-term consequences of mental illness were most severe for schizophrenic women and their families. Children in these families had a particularly difficult time as they grew up, largely because their fathers were unsupportive; in many cases, these men had severe problems of their own, such as heavy drinking, and they often abused their wives and children. Male schizophrenics, by contrast, were not seriously affected. Half had continued advancing in their careers as they probably would have if they had never been ill. Unlike the schizophrenic women, who had been repeatedly hospitalized over the years, the majority of the schizophrenic men remained symptom-free after their first hospitalization.

HEREDITY AND MENTAL ILLNESS. Yahraes, H. Research of David Rosenthal and Elliot Gershon. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Research has shown that vulnerability to mental illness can be inherited, but the way in which genes can transmit this tendency is not yet clear. Rosenthal and Gershon are among the investigators who are trying to clarify the mechanisms of inheritance. Some investigators believe that one gene is responsible, while others believe that several genes together produce the vulnerability. The biochemical processes involved are also not clear. The level of one enzyme, monoamine oxidase (MAO), has been found to be lower in both schizophrenic and manic-depressive patients. Because it is also lower in the patients' relatives who are well, its usefulness as a biological marker of mental illness is diminished. Another enzyme, catechol-O-methyl transferase (COMT), has been shown to be higher in psychotically depressed patients than in their relatives, however. Researchers have also found that manic-depressive illness may be linked with color blindness, which suggests that the former as well as the latter disorder may be carried by the X sex chromosome.

POOR FAMILY COMMUNICATION AND SCHIZOPHRENIA. Yahres, H. Research of Lyman Wynne. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The influence of unusual styles of family communication on the development or prevention of schizophrenia is under study. Wynne's group is observing 150 families, each of which had a son who was 4, 7, or 10 years old when the family entered the study. In all families, one parent has been diagnosed as having schizophrenia or another psychiatric illness (psychotic depression, or a nonpsychotic mental disorder serious enough to require hospitalization). The families are being observed over long periods. Using a variety of tests, Wynne and his associates, notably Margaret T. Singer, study each family's relationships as evidenced by its members' communications. In past research, they have identified 32 categories of odd communication in Rorschach (inkblot) test responses of parents of schizophrenics. Underlying many of these oddities is the speaker's inability to maintain attention to the subject at hand or his or her attentional repetitions (such as not being able to drop a subject and move on). A relationship was also found between the level of vagueness and ambiguity in the parents' communications and the schizophrenic offspring's subsequent breakdowns. This finding suggests that deviant communication can contribute to *chronic* schizophrenia. Wynne and Singer believe that a family's deviance in communications styles *add* to a child's genetic vulnerability to schizophrenia rather than trigger the appearance of the disorder. In a 3-year followup of a third of the 150 families now being studied, children of parents with deviant communication styles were doing worse in school—academically and socially—than the other children.

LONG-RANGE STUDIES OF CHILDREN AT RISK FOR SCHIZOPHRENIA. Yahraes, H. Research of Sarnoff Mednick and Fini Schulsinger. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Two long-range studies of children thought to be at risk for developing adult schizophrenia have begun to produce results. Mednick's study of Danish children, begun in 1962, was one of the first to use the high-risk strategy for studying schizophrenia. He chose as the subjects at risk 100 children whose mothers had been diagnosed as schizophrenic and is comparing them to 100 children whose families had been free of psychiatric illness for three generations. In the second effort, Mednick's group is studying another 200 children on the island of Mauritius; on the basis of response to tests of the autonomic nervous system's response to stress, half of these children were chosen as high-risk subjects. In a 10-year followup of the Danish subjects (then

about 25 years old), Mednick found that 8 in the high-risk group had died, at least 4 by suicide, 13 had developed schizophrenia, and 71 showed evidence of related psychiatric disorder. Only one control subject had become schizophrenic. The response of the autonomic nervous system of those who became schizophrenic returned to normal much faster than those who had not. Mednick believes that heightened psychophysiological responsiveness and fast recovery characterize chronic, withdrawn schizophrenics. He and his associates are testing this hypothesis in the Mauritius sample.

DETECTION AND PREVENTION OF CHILDHOOD DEPRESSION.

Yahraes, H. Research of Leon Cytryn and Donald McKnew, Jr. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Three types of childhood depression were identified and described. *Masked depression*, the most common, masquerades as hyperactivity, school problems, delinquency, and psychosomatic disorders. Through psychiatric interviews and analysis of dreams and fantasies, depressive signs (sadness, despair, feelings of hopelessness or helplessness, lack of self-esteem) become apparent. *Acute depressive illness*, resulting from a real or perceived loss, is marked by a sad mood. It usually clears up in a short time. *Chronic depressive illness* occurs in children who have at least one chronically depressed parent, whose families have a history of affective illness, who have been repeatedly separated from persons on whom they were dependent, and who are apparently not reacting to a single precipitating incident. Cytryn and McKnew advise pediatricians and family physicians to watch for masked depression in children and recommend that therapists working with depressed parents should inquire about the children. They also suggest treatment approaches for children of different ages with different kinds of depression.

NEW LIGHT ON AUTISM AND OTHER PUZZLING DISORDERS OF CHILDHOOD.

Yahraes, H. Research of Donald Cohen. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Studies of brain activity and biochemical imbalances in children with severe psychiatric illnesses are now underway. Cohen's group is studying several aspects of autism. One is the apparent inability of the autistic child to generate rules for dealing with information received through the senses. Another is the body's faulty regulation of states of arousal and attention; autistic children seem involuntarily to reject sensory messages that lead to higher levels of arousal in other chil-

dren. Cohen and others believe this result may come about because autistic children are in a state of hypervigilance most of the time and so learn to withdraw and turn their attention inward. Cohen has found greater levels of the breakdown products of a neurotransmitter, dopamine, in the cerebrospinal fluid of severely autistic children, a finding that suggests that dopamine occurs in abnormally high proportions. Other studies are directed at learning the role of thyroid hormone and of abnormally high levels of lead in the blood of autistic children. Cohen's group is also studying: childhood aphasia, a failure to develop or use language and speech; atypical personality development (or early onset, nonautistic, childhood psychosis); psychosocial dwarfism, which is marked by both physical and behavioral immaturity; and Tourette's syndrome, a chronic disorder marked by multiple tics such as jerking and kicking and uncontrollable outbursts of vulgar and obscene language.

BASIC TRAINING FOR PARENTS OF PSYCHOTIC CHILDREN.

Runck, B. Research of Eric Schopler. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A North Carolina program for training parents as cotherapists with their own psychotic children was begun as an experiment in 1966. By 1972, it had proven so successful that the State legislature created Division TEACCH—the Division for Training and Education of Autistic, Psychotic and Related Communications Handicapped Children—as a statewide, largely State-supported program. Closely allied with the public school system, Division TEACCH now has five diagnostic and treatment centers and 25 classrooms scattered across North Carolina. It provides individualized treatment and education for psychotic children and others whose communication and behavioral disorders require similar therapeutic and educational techniques. In each case, both parents go through an extensive diagnostic procedure with their child. Once accepted, they attend a TEACCH center weekly, where they work with the child's therapist and a parent consultant. They learn techniques for teaching new skills and modifying the child's problematic behavior. Every day at home, they apply these techniques in special practice sessions, as well as in daily routines. They periodically demonstrate their progress to the TEACCH staff. Over the years, Schopler and his colleagues, notably Robert J. Reichler, have conducted research that has modified treatment methods and has tested the value of their Developmental Therapy. Perhaps the most important has been research showing that, although parents may be upset and confused by their psychotic children, they are not the cause of the child's disorder, as was once believed. Indeed, with guidance from the TEACCH staff, most parents become skillful therapists and teachers for their children. Initial findings of a recent survey indicate that 84 percent of parents found the

program especially helpful in improving behavior problems, language, and social skills.

IMPROVING PARENT SKILLS. Yahraes, H. Research of Ira Gordon. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

By training low-income mothers to stimulate the perceptual, motor, and verbal activities of their infants at home, Gordon hoped to decrease the need for intervention in later years. These mothers were trained by parent educators (PEs) who were paraprofessionals from the same social class as the families with whom they worked. The project began in 1966 with 150 low-income mothers and their 3-month old infants. Eighty percent of the families were black, the rest white. Parent educators were trained for 6 full weeks to demonstrate developmental tasks to the mothers. The project continued until the children were age 3. In followup studies, when the children were age 6, Gordon found that those who had participated in the home project tended to score significantly higher on IQ tests than controls. And, at 9 years of age, significantly fewer of the children in the program needed special schooling. Other findings indicated the importance of a caring, responsive parent in fostering a child's cognitive development. In addition, both mothers and PEs had improved self-concepts by the end of the program. Later projects introduced parents to the school system as active participants in their children's education. Prevention efforts should start in the prenatal phase and help parents recognize the emotional needs of their child.

TRAINING FOSTER PARENTS. Isenstein, V., and Krasner, W. Research of Patricia Ryan. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

A small program for training foster parents, begun in 1974, has expanded to serve most of the State of Michigan. Its success is suggested by the fact that wherever classes have been offered foster parents have usually turned out in numbers greater than expected. The parents express a need to learn techniques for raising foster children, and they also want to discuss their problems in dealing with social welfare agencies. Classes include such topics as (1) helping children cope with the trauma of separation; (2) the specific needs of retarded, disturbed, or otherwise handicapped children; and (3) techniques for handling school and behavioral problems. Foster parents can also take classes in child development and learn about dealing with the child's biological parents. Sharing their own experiences and expertise with other foster parents is an important part of the program. Ryan and her

associates have developed curriculum guides and teaching materials that are available to others who wish to establish similar foster-parent training programs.

DEVELOPING A SENSE OF COMPETENCE IN CHILDREN. Yahraes, H. Research of Burton White. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

An investigation was undertaken to determine how various experiences in the first 3 years of a child's life affected the development of competent behavior. After observing over 100 children, the investigator listed behaviors that characterized competent 6 year olds and the most competent 3 year olds. Thirty-nine families with more than one child under 3 were selected and divided into two groups based on the competency of the older child. As hypothesized, families with a competent older child reared their new child more successfully as assessed by measures of intelligence, compliance, and imitative behavior. Competence at the age of 3 was found to be associated with high scores in the activities during the preceding 12-15-month period: procuring a service, gaining attention, finding out information visually, and listening to live language. Effective parents who raised competent children provided maximum access to safe living areas, consulted with the child, and set firm limits in discipline. White hypothesizes that daily experiences occurring in the most critical period (between 6 and 24 months of age) shaped competent behavior related to language, curiosity, social interaction, and intelligence. Obstacles facing parents include ignorance of child development, stress due to the child's period of negativism, and lack of guidance. The latter, along with ongoing preventive efforts, are discussed in detail.

SOCIAL LEARNING TECHNIQUES FOR PARENTS OF DIFFICULT CHILDREN. Prestwich, S. Research of Gerald Patterson. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Using social learning techniques (a form of behavior modification), the researcher has developed a treatment program in which parents of children 15 years of age and younger are taught child-management skills in controlling maladaptive behaviors. The children are referred to the Center for engaging in severe antisocial behavioral disorders, such as setting fires, stealing, and being physically aggressive. Other aggressive acts for which they are referred include negativism, teasing, humiliating, noncompliance, and tantrums. Intervention techniques employed to shape desired behavior and reduce rates of deviant behavior include the use of rewards and punishments and "time-out,"

a method in which the child is temporarily isolated from ongoing social reinforcers. By improving parent-child relationships, Patterson and his staff also hope to prevent such children from developing later-life difficulties for which they are at high risk: mental illness, crime and delinquency, vocational difficulties, and social problems. Results thus far have been impressive: The program boasts of success in two out of three referrals, the average length of treatment being approximately 16 weeks.

GAMES THAT HELP SOLVE LIFE PROBLEMS. Corfman, E. Research of Elaine Blechman. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

The purpose of these studies was to evaluate the effectiveness of different training methods developed by Blechman and colleagues to increase skills in solving life problems, using behavior-modification techniques. A case study of treatment of a severely depressed woman was presented. A board game, somewhat like Monopoly, designed to be played by a parent and child, to learn and practice negotiating contracts in the resolution of conflicts they experience, was the object of evaluation of the main study presented. In the study, 47 single-parent families were randomly assigned to one of four groups: family-contract game training and playing, with praise for success from the trainer; the same treatment as the first group but with a small cash reward for success added; a control group measured like the first two, but not trained; a waiting-list control group, neither measured nor trained. Findings indicated that playing the game heightened commitment to change and solving life problems. Cash awards reduced the commitment. Contrary to a common belief that "talking things out" reduces conflict, repeated discussion of problems without structured guidance tends to *increase* family conflict. School age and adolescent children, despite inexperience and a power disparity compared to parents, can become partners in the problemsolving process, as can people with limited verbal skills. A considerable advantage of this and similar games developed by Blechman over other therapies and techniques requiring some verbal fluency is to allow participation and payoffs to very young children and to those with limited language skill.

FORTIFYING FAMILY TIES. Moore, C. Research of Bernard Guerny, Jr. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Described is an educational model designed to eliminate dysfunctional interpersonal interaction patterns and to teach participants skills that will enable them to deal more effectively and constructively

with each other. Four sets of behavior skills or "modes" are taught and systematically practiced—the Expresser mode, the Empathic Responder mode, Mode Switching, and the Facilitator mode. The technique, Relationship Enhancement (RE), derived in part from the theories of Carl Rogers, B.F. Skinner, Albert Bandura, and Timothy Leary, is seen as permitting the individual to make fundamental changes in important interpersonal systems and to influence positively his/her life and those of intimate associates, helping each person to learn and to elicit honesty and compassion. The development of RE therapies began in 1962 with Filial Therapy, in which parents learn to transfer into daily life the attitudes and skills gained during supervised therapeutic play sessions with their disturbed children. RE therapies include Conjugal Relationship Enhancement (CRE), Premarital Relationship Improvement by Maximizing Empathy and Self-Disclosure (PRIMES), and Parent-Adolescent Relationship Development (PARD) for father-son or mother-daughter couples. Special applications for retardates, substance abusers and their spouses, delinquents, school children, and business and industry personnel are suggested. There is a brief report on the Institute for the Development of Emotional and Life-Skills (IDEALS), a nonprofit institute for on-site training and/or continuing supervision. RE is viewed as an educational tool potentially replacing therapy in many instances of dysfunctional interaction between couples, family members, or other close associates.

FAMILIES AND PUBLIC POLICY. Blehar, M. In: Corfman, E., ed. *Families Today—A Research Sampler on Families and Children*. NIMH Science Monograph 1. DHEW Publication No. (ADM) 79-815. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979.

Various beliefs about the family and a new model of family-environment relations are discussed. The impact of institutions and particularly of Government on family lifestyles and decisions is delineated, and the new field of family-impact analysis is described. Different meanings of the term "family policy" are defined. An overview is given of some private-sector institutes active in family-policy and other family-related activities and of NIMH endeavors in the family area.

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