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DISORDERS OF EARLY CHILDHOOD

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Table of Contents

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Problems in the Establishment of Diagnosis

Child psychiatry is a comparatively new discipline. It is still struggling against the effort to apply to children the experiences and diagnostic categories that have been established for adult patients. At the same time, over the last decades, and in this field more than in any other in psychiatry, extraordinary progress has been made: A large number of discoveries have made child psychiatry a discipline in which research, and the development of new clinical techniques, have been increasingly gaining in significance. Moreover, the now general recognition of the existence of early childhood pathology, along with the difficulties encountered in the establishment of corrective measures later in life, have made services for the very young child a national priority.

During World War II, when large sections of the population were being drawn into military service, the nation became alerted to the great numbers of people who, for various health reasons, were unable to fulfill the requirements for induction; many were simply incapable of standing the stresses of army life and combat. This discovery contributed to a marked increase in mental health services. Similarly, the emerging national awareness of the fact that large portions of the population live at less than

minimal standards has also brought with it recognition of the great numbers of children who are living under conditions of deprivation, with consequent serious impact on their development. Legislation was introduced to cope with this problem, and for the first time programs were devised for services to children during the first years of life.

This thrust toward social action on behalf of sections of the population that had hitherto not been reached by traditional mental health services challenged the child psychiatrists and members of allied professions to extend their knowledge in many new directions. New disorders were described stemming from a confluence of economic, nutritional, maturational, and environmental dysfunction; new techniques of treatment had to be devised; and new forms of delivery of services became essential. This has made it even more important for a sound clinical base to be established, resting of necessity on the appropriate diagnostic assessment of young children.

The younger the child, the more often do we find that our existing diagnostic categories are not appropriate for the complex clinical picture. The more differentiated the mental and psychic apparatus, the greater the degree of independence that it has achieved from maturational and environmental influences, the more precisely are we able to define psychic and mental dysfunction. Conversely, any nutritional imbalance, or any biological disorder

in early life, has an immediate impact on psychic and mental development. Similarly, environmental influences on the child's emotional life will show direct effects in physiological functioning as well as having an impact on further development.

Thus, it is not surprising that the history of the establishment of early disorders reveals that some investigators, depending on their preferences, will stress either the neurophysiological or the biological components as the primary source of the disorder, whereas others will be far more impressed by the influence on the child of the specific environment, ascribing to it pathogenic powers as a way of explaining the most serious emotional disorders. Most clinicians and researchers have accepted the proposition that innate constitutional forces are in continuous interplay with the environment, and that very often the outcome is decided by both factors. But, as the search goes on for the primary etiological factor, a clearer distinction between causation and outcome has been found to be needed. That is to say, the prognosis in itself cannot make a sufficient explanatory contribution to the etiology.

The Developmental Factor

Infant observation, profile assessments, and research in early development have given us increasing information about ego formation and

its relationship to drive expressions and to the variety of maturational factors that are operative and enter in sequence into the process of psychic organization. The role played by ego equipment and by the emerging ego function is capable of being seen from the beginning in its interplay with the object.

Early interest focused on the evolution of the infantile neurosis—the drama and fate of the particular oedipal conflict, as well as the crystallizations resulting from the subsequent emergence of the superego. Interest also became directed toward preoedipal contributions, derived from earlier fixation points, and the effects these had on shaping the infantile neurosis, as well as character formation. These questions were explored mainly in terms of the conflict between instinctual drives and ego and superego forces, along with the resolutions arrived at in relation to that conflict. At the same time, S. Freud was always interested in constitutional contributions, those that were derived both from the varying strengths of inborn drives and from the innate endowment and proclivities of the ego, insofar as these might influence the course of later conflicts and also their resolution. Hartmann's concept of autonomous ego factors that exerted their own independent impact on developmental processes added to this a further dimension, in terms of the intertwining of these ego factors with the structures that were formed out of conflict.

During recent years, interest has increasingly turned toward the intricate details of the preoedipal organization of development, and in particular toward the processes of early ego formation. Two major contributions have been Erikson's mapping out of the epigenetic sequence of phase development and of developing ego modalities and Margaret Mahler's delineation of the processes of self-object differentiation through the vicissitudes of separation-individuation.

There has also been an efflorescence of infant studies, investigating the processes of the earliest evolution of psychic life, and particularly of incipient ego formation. Such studies too have focused on the effects of the infant's innate equipment (for example, activity type, tension-discharge patterns, or the particular infant's specific kind of perceptual sensitivity and discrimination) on the early evolution of ego organization. They have pointed to the highly complex way in which innate and maturing equipmental factors will relate to one another, as well as to the differing experiences offered by the environment. We are referring, of course, especially to the work in this field done by Kris, Escalona, Wolff, and Spitz. Crucial to this area of study is the monumental work done by Piaget in investigating the sequences of learning and of cognitive development, starting from earliest infancy.

The developmental point of view, that is, the observation of the processes of unfolding and of the interrelationship between maturation and

the repeated interchange with, hopefully, a relatively consistent environment, permits us to see how the primitive regulatory mechanisms are increasingly differentiated, ordered, and systematized.

As we have attempted to identify more clearly the apparent sequence of stages—the organization and reorganization of libidinal phases and the concomitant maturational and ego components—we have come to enlarge our view of the role of conflict in development. We are now able to observe the many individual variations, reflecting innate predispositions, and with them the quantitative and qualitative imbalances of the drives as well as of ego equipment and ego functions. While still taking note of the object's influence, we also recognize the infant's own selectivity as to what he will react to and how, by which he is in effect codetermining what is to become his significant environment. Early perceptual preferences, differences in levels of threshold and motor energy, and variations in drive endowment all make possible an early impression of the child's strength and vulnerabilities in his interactions with his specific environment.

Such studies lead into two directions: (1) They provide us with a greater awareness of the many factors that have to be taken into account, as we attempt to follow the organizing and structuring development processes; (2) such data make it less easy to reduce later psychic conflicts to some simple psychic mechanism of infancy, such as introjection, incorporation, projection.

The great degree of individual variability that is operative from infancy on has begun to help us to more fully understand the relationship of symptoms and character disorders within the context of individual consultations.

Anna Freud pointed to the psychosomatic matrix in terms of which the child's endowments and reactions can be understood. Annemarie Weil spoke of a basic core, which attempts to explain those particular clusterings of factors that are specific for any individual child; these can be assessed very early, their importance lying in the fact that they tend to be stable and to have a determining influence on future development. The child's pathology is thus capable of being viewed within the context of these constellations.

Within this broad view of the interplay between internal conflicts and structural variations we are able to include individual variations in the developmental process itself. In addition to either the precocious or delayed mode of development, we have been able to see children in whom there is not only an overlapping of phases but situations where early conflicts and structures continue to exist alongside later ones or become interwoven with them. While the progressive thrust continues, phase specificity does not take place; in other words, phallic primacy is not achieved. This, of course, affects the formation of the infantile neurosis, as well as the treatment of these children during prelatency.

Our awareness of multiple inter- and intra-structural interactions, and of the individual variability in this regard, has increased our ability to detect maturational and developmental deviations; faulty ego and equipment; atypical ego variations, resulting from either constitutional or congenital defects; deficient or inappropriate stimulation, or a combination of the two.

Any assessment of childhood disorders is, of necessity, in many ways bound to our notion of the normal developmental process. At present, our diagnostic categories are continuously in need of refinement, and very few of us are as yet satisfied with the usefulness or appropriateness of our present definitions. We need to study more intensively the sequences of developmental progression.

If we accept Anna Freud's proposition that one can use the primary task of childhood, namely, developmental progression, as a yardstick in order to decide on the health or pathology of a child, we thereby adopt a new way of arriving at an assessment of childhood disorders. Freud very early proposed the normal occurrence of the infantile neurosis, a proposition that implied that in our picture of normal development we must expect to include many problems, conflicts, symptoms, and even neurotic constellations. For as long as the child's development continues, various symptoms, rituals, compulsive manifestations, phobic phenomena, and so forth will be found to be part of those stresses that we can observe in young children and that are transitory

in nature. Any decision, therefore, as to whether they are to be regarded as within the range of normal expectations must rest on a determination of whether they are likely to last longer, without being resolved by succeeding stages and thus interfering with further development. Furthermore, even the developmental process itself may be pathological, and today we have a number of categories that address themselves to this condition.

Individual Variations in Development

An outline of normal development, or of developmental deviations would be incomplete without a consideration of individual variations in development such as takes cognizance of the variety of modalities of development as well as the variety of environments in which development takes place. These developmental variations have their source in factors of time and structure formation. Is development proceeding according to the expected timetable, or does it show signs of cautiousness or slowness? Furthermore, is the rate of development even in all areas of psychic development, or are certain faculties emerging with different speed?

Uneven development and maturation are very often observed, and within certain limits they belong among the individual variations. The structural aspect, which addresses itself to the formation of psychic function, is based on our assumption of stages of development. Instead, we very often

see overlapping of stages, in which earlier psychic organization is carried into the next succeeding stage without there being any signs of fixation, or in which, at a later stage, psychic functioning from earlier stages continues to exist alongside the stage-appropriate function.

Another way of looking at individual variation is based on a broader concept, which includes the developmental aspects mentioned previously but also takes into account a variety of personality characteristics. This concept has to do with the temperament of the child. Seven variables are regarded as being characteristic components in the definition of temperament, and the question of normality or abnormality in an individual case is tested against the constellation of these factors. Though we have thus made progress in our ability to define the individual condition, we have not proceeded with similar distinction toward a solution of how to assess the environment in which the child develops and to which he has to adapt. Family diagnoses and family dynamics have been in the foreground of our interest for a long time, but attempts to assess those variables that have a specific influence on the child at various stages have not yet brought about a profiling of the environment. Hopefully, in the future, this will be part of our overall assessment of the child.

In addition, we have become quite aware of the developmental differences between boys and girls, and thus we now know that a single

outline of development, designed to cover both, may distort our capacity for assessing a child appropriately. New discoveries as to the role of gender in development seem very promising.

Infantile Neurosis

The concept of infantile neurosis has played a major historical role in the establishment of childhood disorders. It was arrived at, during the earliest period of psychoanalysis, by way of reconstruction of the childhood of those adults who were coming into treatment. Freud therefore put forward the proposition that every adult neurosis can be traced to an infantile neurosis. This proposition implies, first, that no adult neurosis occurred later in life without first having existed in early childhood and, second, that the infantile neurosis is part of normal development. This gave significant weight to the understanding of early pathology and to a recognition of the need to investigate the development of children during the first years of life.

We define neurosis in terms of those conflicts that arise during the oedipal stage of development. This means (1) that superego, ego, and id derivatives are involved in the conflict; (2) that the child is unable to arrive at a resolution of the conflict; and (3) that specific symptoms emerge as part of the compromise formation between the internal and external struggle. In order for a neurosis to be formed, the conflict has to arise out of an

anticipation of punishment and guilt at a level of social evolution. The symptom picture that can be observed varies greatly; at times, the variability can be greater among children than among adults. Later psychic structuring and patterning of psychic life has the effect of stabilizing these symptoms and thereby reducing their variability. The younger the child, the more often do we find changes in symptomatology. Old symptoms may disappear and new ones emerge, as new compromise solutions are established. Various forms of phobic manifestations, obsessive compulsive phenomena, habit and conduct disorders may reach the neurotic level. The diagnosis of this disorder therefore rests on our ability to determine what characteristics we will assign to the neurosis.

The proposition that every adult neurosis is based on an infantile one does not imply that every infantile neurosis has to lead to an adult neurosis. The possibility of a spontaneous cure or of a change in this disorder during childhood to a regressive state of earlier pathology also has to be considered. Thus, during prelatency, diagnosis of an infantile neurosis does not imply a prognostic view that it will inevitably lead to an adult disorder, and this raises the question of whether and when treatment is indicated.

When Freud formulated this clinical picture in the cases of Little Hans and the Wolfman, he made a significant contribution to our understanding of early childhood pathology. Today we are able to add to his original clinical

formulation a clearer view of those developmental disorders that precede the infantile neurosis and that both influence its emergence and color the clinical picture of the neurotic pathology that is found between the ages of four and six. We now assume that, when an infantile neurosis occurs, pathology at earlier levels of development is a necessary precondition for its evolvement. Just as Freud traced the adult to the infantile neurosis, so we now trace the infantile neurosis to earlier pathological conditions. This widened view indicates the importance of earlier diagnostic evaluations. Such an evaluation will affect the decision as to the choice of treatment and reveals the need to outline treatment interventions that are able to assist the child during the earlier years of life.

Infantile Autism

During 1943 Kanner proposed the diagnosis of infantile autism for a group of children, as differentiated from the overall classification of childhood schizophrenia. This step was significant in that it initiated the classification of children with psychoses into subgroupings and thus opened up a new search for etiologies and differential treatment procedures. At the same time, a review of the literature will reveal the many questions that are still unsettled in our understanding of this and similar disorders. One can utilize Kanner's initial category in order to highlight the state in which we find ourselves at present, in terms of the manifold views that authors hold when they are

examining psychotic disorders of early childhood.

On a descriptive level, Kanner's outline was clear enough. He spoke about the affective disorder (most often the absence of affect); the ensuing difficulties in speech development and in the thinking processes; the hypersensitivity to various sensory modalities, or the absence of responses to normal sensory stimuli together with the obsessive need for the preservation of sameness; the attachment to inanimate objects; and the inability to use the mother for orienting and for organizing psychic structuring. Kanner related this condition to an inborn defect; but soon others were using this term in order to refer to less severe disorders. With the broadening of the knowledge of symptomatology, researchers have included such disorders as schizophrenia and many others that are simply labelled "atypical." Instead of maintaining the specific and somewhat circumscribed conditions of early infantile autism, we have extended them to other autistic mechanisms and thereby confused the diagnostic process.

Similarly, we now find a wide variety of opinions as to the etiology of this disorder. Kanner assumed an inborn defect, but he did add to it the possibility of parental refrigeration, that is, an environmental factor that contributes to the clinical picture. Some writers consider autism to be the result of a diffuse encephalopathy or of some form of brain damage encountered during pregnancy. Others have suggested that one may be able

to differentiate two forms of infantile autism: one based on a constitutional disorder; the other the result of severe environmental interference with the child's development. If one follows Kanner's original proposition, one has to be clear that the term "autism" does not refer there to a schizoid symptom, connoting withdrawal or detachment, but rather to a syndrome that permits the differentiation of infantile psychosis from infantile autism. Without recognition of these differences, one may lose the significance of this diagnosis. Insistence on maintaining this differential diagnosis will help to distinguish between those disorders based on interpersonal difficulties and those that stem from a different core, in this somatopsychological makeup of the child. It is clear that the outcome of a disorder will always depend on the interplay of the child's personality structure with the environment in which it is involved and that the prognostic possibilities also depend on the environment in which the child's problems are expressed. Yet this interplay of factors should not obscure the clarification that has been attained with regard to the primary etiology, nor should it minimize the role played by environmental conditions in determining the outcome.

A study of the epidemiology of infantile autism, carried out by assessing an entire state population under twelve, has shown how rare this condition actually is. Schizophrenia and infantile autism together gave a prevalence of 3.1 per 10,000 children. The 280 patients fell into three groups: infantile autism (25 per cent), psychosis of childhood (57 per cent), and psychosis

complicated by organicity (18 per cent). Infantile autism was thus very rare, with a prevalence of 0.7 per 10,000 children. This is particularly so if the meaning of this diagnostic category is maintained, rather than being changed by regarding infantile autism as a symptom rather than as a disease entity.

Developmental Deviations

Great progress has been made over the last decades in the classification of children's disorders through an understanding of those changes that are owing to deviations in the developmental process itself. The importance of being able to differentiate these disorders from ego disorders or from those that are based on conflicts, accompanied by symptom formations, lies in the fact that the prognostic implications as well as the choice of treatment will be affected by it.

When we address ourselves to the developmental process, we generally refer to its essential aspects, the time factor as well as psychic structure formation. Deviations can occur that involve either of these components or a combination of the two. For quite some time now it has been recognized that some children show a cautious or slow development, whereas others show unevenness as to the speed of development; that is to say, at different periods of development there may be a different rate of development, as the result either of acceleration or of the slowing down of progression.

The developmental factor may be connected with the maturational sequences, in which central nervous system maturation, along with its neuromuscular expressions, may follow various rates, within or outside the normal range. The pediatrician has long studied the physical growth patterns of children and established certain variations in that regard within and outside the norm. We know that puberty may exercise a significant influence, thus indicating the role that hormonal changes can play in maturation and, with it, in psychic development.

One can today outline quite early a timetable for development and thus what should be the individual rate of development during the first years of life. Psychic structuring is generally assumed to proceed according to phases or stages of development. Along with this concept goes the assumption that, with the establishment of new hierarchies in psychic organization, there is a discontinuation of earlier psychic structure. It has been recognized that we can often find an overlapping of phases within the normal range; but one can also find children in whom there is a total absence of phase distinction, so that early and later stages appear together for a long period of time. Furthermore, one can outline those developmental variations in which earlier developmental organization exists side by side with later ones.

Moreover, one can see variations expressed in the progression-regression balance of a child. There are those children who show a wide

swing in both the forward movement of development and regressive trends, whereas other children show a very narrow range of developmental mobility, in which the maintenance of function is closely held to and the psychic structure shows signs of rigidity. Thus, one could refer to this as the "elasticity factor" in development.

Ego Deviation

In addition to developmental variations, some writers have outlined ego deviations that have to do with unevenness in areas of psychic function. Thus, one can observe children with very low or very high thresholds in the sensory modalities, so that their reactions to sound, light, or touch are outside the norm. Such children may respond to normal stimuli with abnormal sensitivity, fright reactions, and anxieties or with gestures of avoidance of the stimulus. There are others in whom normal contact with the child has not reached a high enough degree of intensity to stimulate the child sufficiently into an appropriate interaction with his environment. If one extends this latter ego deviation, one then approaches categories that are close to infantile autism or other psychotic disorders. We are not referring here to a range of response, from the more normal to the more pathological, such as would encompass all forms of disorders and would indicate that, the same set of factors being always operative, the diagnosis is to be determined by the degree of intensity of the pathology. What we are maintaining is rather the

notion of a clear differentiation of diseases, based on etiology as well as on a clustering of symptoms, in spite of the fact that we are able to find similarities in clinical symptomatology.

Many decades ago, children were being categorized by reference to their *activity patterns.* In a group of children studied from infancy on or even during their uterine life, hyper-motility was found to be characteristic of the children's functioning, along with a tendency for that characteristic to maintain itself throughout childhood. Some of these have been referred to as congenital activity patterns, with modality of function that could be recognized early and that later on led to a great range of difficulties in social interaction and social behavior. Such forms of hyperactivity must be differentiated from those that are based on a recognizable organic pathology, in which the motility disorder emerges as a symptom of cerebral pathology. Follow-up studies of these children show that the majority show a modification of this abnormal deviation during adolescence, whereas those in whom it is the organic component that is significant continue to maintain impulse disorders and other discharge phenomena in the motor area for a more protracted period of time.

Similarly, one can outline developmental deviations in the area of the affective life of the children. Pleasure-displeasure responses, the early smile, and the degree of stranger reaction indicate variations in the affective

modality of psychic life. The threshold component discussed earlier in connection with sensory stimuli seems here to be significant as well in the affective area. There are affect-placid children and there are those with a wide range of affective responses. At times, it is difficult to be certain whether one is dealing primarily with a developmental deviation in the emotional area or whether this is in itself a response to deviations in the area of sensory modalities (it could even be a mixture of both). Such deviations will have a strong effect on the degree of interrelationship with the mother, with its varied forms of object interaction. Whereas some children maintain a strong interplay cathexis with the mother, others seem to have a wider scanning or interplay with the environment and are thus less bound to the mother as the sole source of gratification.

At the extreme, we find the case of an individual whose variations are described by Mahler as the "symbiotic child." The deviations of the "symbiotic child" are rooted in the separation-individuation process. There are children in whom the smile appears either very early or quite late and children in whom the intensity of pleasure or displeasure is quite great, so that the stranger reaction can lead to panic and clinging. In these children, the necessary separation from the mother, during their toddler phase, cannot be negotiated, in that the child shows extreme fear of the loss of the object. These deviations will have an effect on imitation and identification with the object, so that anticipation of events and sequences will not lead to providing

regularity and continuity in psychic function. These clusterings of symptoms in connection with the mother can of course be reinforced by the mother's attitude; in severe cases, they may even be the effect of her pathology. We are addressing ourselves here to variations that seem to stem primarily from the child's innate equipment and psychic apparatus, though they manifest themselves in the interplay with the environment in its specific forms. Annemarie Weil suggested which groups of children fall within these categories of deviational development.

The Atypical Child

This category refers to those disorders that can be observed in infancy as affecting some specific ego function. These children show a variety of symptoms in the areas of the development of thinking, language development, motility controls, reality testing, social judgment, and defensive psychic organization. They are similar to children who have been affected by various forms of psychosis in childhood; but once again it is important to differentiate these groups and to establish specific categories for them.

The absence of a psychotic process, and the prognosis of these conditions, as well as the early beginning, permit such a differentiation. At times, what we see is a clustering that points to a deviation in maturation; one example of this is late language development. When it does finally take place,

the child's thinking indicates an undue influence on the part of primary-process qualities. There seem to be difficulties in differentiating those stimuli that have arisen in the internal psychic life from those that come from the outside, and thus reality testing is very often affected. What the child sees as real, and what he wishes or feels, emerge only very slowly. Fears reach a severe level of intensity, to the extent that one part of the clinical picture is early phobic manifestations, with avoidance of situations and undue clinging to the mother. At times, one can observe in the child an inability to move from the concrete to the more abstract, and thus to reliable concept formation. One gets the impression that it may be the integrative or synthesizing function of the ego that has been primarily impaired.

Similarly, psychic control over impulses and motility may be involved. What is observed as restlessness may be the sign of a continuous high level of anxiety. At times, infants with this disorder can be comforted only in the arms of the caretaker; at other times, they show very strong resistance to any tactile closeness, as if the influence of the mother had already gone beyond the limits of their tolerance. Bowel control may be delayed, and one may find an erratic symptomatology. Among those functions that have suffered may be the process of differentiating internal and external life, developing logical sequences and concepts, establishment of the sense of time and sex differentiation. Frequently, these atypical children show hypersensitivity in certain areas, for example, to sound or to light; they may respond with panic

to silence, to the sounds of the vacuum cleaner, or to the flushing of the toilet. They may be finicky in their food selection, and show an early development of food fads. Enumeration of these clinical manifestations may remind us how closely they resemble those symptom formations that we associate with schizophrenia in childhood. Yet these symptoms, as part of atypical development, may at times be quite mild; they may go hand in hand with many strengths in the child, and they may not impair progression in development, at least with regard to stage sequences, nor be connected with strong regressive phenomena or fixations. Basically, it is insufficiency or inability in areas of ego function that is characteristic. The child may slowly evolve his own corrective measures, which, as other aspects of the psychic equipment become strengthened, may in turn lead to the development of appropriate compensatory measures.

Personality Disorders

The category of personality disorders has great significance for that part of childhood when psychic organization and function have been sufficiently established. Still, it would be a mistake not to use it and to make its diagnosis, since it is possible very early to determine significant character and personality traits that are already deviant from the normal. Today we assume that these personality disorders stem from the specific makeup of the child, the child's preferred employment of defense mechanisms, and the

transmission of conflicts from parent to child.

Within this disorder there are many subcategories. At times, it is possible to determine these clearly (for instance, the obsessive-compulsive personality type or the over-dependent or overly independent child); but most often we find the various disorders commingled, with the result that hysterical and anxiety reactions, together with some compulsive features, occur concomitantly. We can find, at about the age of three, a specific core constellation, which is determined by both the healthy and the abnormal psychic functioning of the child, in which symptoms, character traits and specific ego functions together determine the direction of further development. Stability of function is a prerequisite for the ascription of personality disorders, since in this category we assume that the disorder has become part of the defense system and the adaptive process. Since we are indeed able to discover these conditions quite early, it is important to make such an assessment and to initiate the appropriate treatment. We have learned about the existence of a continual change of symptom pictures in young children, that is, that while the personality disorder can be described, the symptom pictures within it can shift.

At times, these personality malfunctions interfere with further development, so that the stage of oedipal organization or of latency cannot take place in appropriate sequence. At other times, these disorders are

modified by later stages; or the child does engage in further psychic organization, but brings to it the earlier deviations.

The successful assessment of large numbers of children shows how frequently one is able to make these diagnoses. In the past, the diagnosis was formulated in relation to those manifestations that were a direct outcome of conflicts in oral, anal, phallic, or oedipal constellations. One therefore used the diagnosis of oral-anal-phallic character disorders. Outlines and descriptions were made early of incorporative greediness or oral aggressivity; compulsiveness in connection with either cleanliness-orderliness or its opposite as the result of anal conflicts.

Primary Behavior Disorders

In addition, we have a diagnosis of primary behavior disorders in which the internalization of the process has not yet been established. Psychic organization from the higher oedipal conflict has yet not added to those psychic functions that deal with guilt and social consciousness.

Originally, the category of primary behavior disorder was divided into two parts: (1) habit disorders and (2) conduct disorders. The category of habit disorders refers to those difficulties related primarily to body function, such as thumb sucking, nail biting, sleep disorders, and excessive masturbation, whereas that of conduct disorders refers to the behavior of the

child in relation to his environment, for example, the biting child, the aggressive child, and the over-dependent child. These forms of behavior have been regarded as being the consequence of the child's experience and, in particular, inappropriate care by the parents. Since these symptoms tended to be part of the child's functioning for a long period of time (at times, over a number of years) they had to be separated from the category of reactive disorders.

Reactive Disorders

Under the category of reactive disorders, we observe that the child is showing a strong and abnormal response to a specific event, but we assume that that response is transient in nature. The transitory aspect of the disorder can be related to the fact that the environmental condition may change to normal, or that the child may be able, after a comparatively short period of time, to find a more normal adaptive response. Reactive responses may be expressed in a number of different ways: We may find a depression in early childhood, in which the affect is dulled, there is a deceleration of the function of the child, the thriving developmental pull is retarded, or the somatic vegetative function of the child is slowed down. It may be important to recognize the possibility of a state of depression in young children and not to neglect its significance, since very often the quiet state of the child to which one would otherwise refer may actually conceal an underlying depression.

The reactive response of some children may constitute a regression to earlier modes of function, for instance, at a time when a sibling is born; other children may respond to that same situation with aggressivity, irritability, or increased dependency. It is clear that, in all areas of psychic function, we may find symptom formation to be dependent on the age of the child, as well as on his psychic development up to that time.

Thus we have learned to pay particular attention to those events in the life of the young child that may have a strong, or even decisive, influence on further development. This may be, for example, the death or absence of a parent, particularly the mother, that is, the loss of the caretaking person. It may be connected with particular handicapping illnesses on the part of the child himself. The emotional condition of the mother—her own illness, which may handicap her in her functioning with the child; her depression or other forms of mental illnesses—may also have a crucial effect on the early years of the child. There are a host of circumstances that have direct relevance to the child's early development; in dealing with these, early intervention on a primary or secondary level will be essential, and the resources and mechanisms for it should be part of the community facilities.

Reactive disorders are very often discussed today under the headings of *crisis conditions* and *interventions.* One assumes here that the cause of the interference in parent-child relationship has occurred suddenly and that

therefore there are no advance preparations available for the care of the child. Yet such by no means uncommon events as the death of a parent or acute hospitalization may create a serious upheaval in the child's life, particularly among children in those families for whom the prevailing economic and social conditions do not permit easy solutions or substitute measures.

There are a good many studies dealing with these conditions, ranging from Spitz's anaclitic depression and hospitalism to interferences during the first few years of life as the result of various depriving conditions. The experienced observer will be able to discover and study these various forms of interference with normal development, one good example being the findings that have been made in connection with the separation of the young child from the mother.

Principles of Treatment

It may be advisable to discuss the modes of psychiatric intervention under one single heading, instead of in relation to each psychiatric disorder. This will avoid needless repetition, and it will also make for an understanding of the therapeutic approach, which may be similar in relation to a number of different symptom formations. Moreover, there is often a similar treatment for disorders that share basic dynamic constellations.

1. The younger the child, the more the treatment approach will be based on the need for supporting the environment that has direct responsibility for the care of the child. Thus, one will help the mother to provide the appropriate conditions for modifying or correcting the child's disorder. If the mother proves to be unable to use such assistance, or is unavailable, one would then have to consider that other caretakers need to be brought in in order to provide such function. It is clear, therefore, that our ability to help will greatly depend on the parent's ability to cooperate and to participate in the intervention that is required for the child.

2. It is necessary, when we outline the treatment program, for us to assess the parents' capacity for collaborating with the program, in addition to making an assessment of the pathology of the child.

In addition to relying on the participation of parents in our efforts to carry out an appropriate treatment program, we have become more aware that we have to involve community participation. In our present social climate, the outlining of needs for services by the community, the feasibility of the programs, and the mobilization of resources for these programs have all become essential factors when one is planning services designed to reach large groups of those children who are at present outside of the orbit of appropriate care. Again, this becomes particularly significant with regard to services for children during their first years of life. Collaboration with well-

baby clinics, outpatient departments of hospitals, community clinics, prenursery and nursery facilities, day-care centers and so forth is an essential condition for success in these efforts. It is necessary if we are to detect those children who are in need of such services and to build in a clinical arm for those children whose pathology warrants specialized programming.

3. To the degree that the child has reached a more stable psychic organization and that the child's difficulties have become internalized, that is, have influenced defensive patterning and have resulted in symptom formations based on intrapsychic conflict, one is able to address oneself directly to the child's psychic life.

4. It is in the American tradition of child guidance that the individual therapeutic approach to the child is coordinated with the guidance or treatment of the parents and is carried out in collaboration with the essential persons in the child's life. Often enough, a number of different combinations are made in which a teacher or a nurse provides appropriate developmental stimulation for the child, oriented toward the correction of ego function, while individual therapy may at the same time attempt to alter the internal psychic conditions. These combinations may vary in accordance with the therapeutic needs of the child and with the availability of the resources needed to fulfill such a program. We have only begun to make available adequate professional assistance for the correction of early psychiatric

disorders; there is a great need to rapidly increase the training of people from various professions for effective participation in treatment programs for the very young child. There is also a need for adequate care-taking programs for children, as is now established in the Department of Welfare, for those children who do not have available a family condition that can be guaranteed to provide for the minimal care of the child. If these programs are appropriate, they may be of great help; but they cannot take the place of the special skill that is necessary to help those children who already show signs of special psychiatric conditions.

One essential prerequisite for carrying out these functions in early childhood is a knowledge of child development. One must be able to provide assistance to the developmental progression of the child by buttressing the thriving components, and to do this effectively one has to be acquainted with the milestones in developmental progression. The ability of the child during the first year of life to achieve an attachment to the mother, along with the emergence of the smile or the stranger reaction, becomes one of the significant criteria by which one observes and measures development.

5. One could outline treatment procedures in accordance with the degree to which the child's disorder either is based on innate or congenital conditions or is the result of reaction to environmental influences. There is convincing evidence that, even if one has to deal with constitutional disorders

or with diagnostic categories whose etiologies are unknown, one nevertheless does not have to, for that reason, feel helpless with regard to the possibilities for treatment; one can rely on the child's responsiveness to his environmental conditions, which may make the margin of difference for his further development. Even in the event of the most serious early pathology, one has the right to expect that some maturation, and with it some form of development, will take place. Without a full assessment of this capacity of the child, therefore, a capacity that will reveal itself only over a period of time, it would be inappropriate to adopt a nihilistic treatment approach.

We have already described above the serious disabilities of the child with infantile autism (see page 55); the general lack of responsiveness; the turn toward inanimate objects for stimulation; and the insistence on sameness and repetitiveness. Experience with these children is likely to make the establishment of any treatment program seem extraordinarily difficult: Since the etiology of the illness is unknown, we are unable, it would appear, to construct an appropriate treatment program. Yet, one can recommend that, precisely in recognition of these behavioral problems, one can utilize these very functions to provide stimulation at the level of the present psychic organization. The manipulation of inanimate objects by an adult, for example, may slowly gain in significance; over a period of time, a shift may occur in the child from activities engaged in solely with the inanimate world to include as well the person who will then have the opportunity to bring the social

influences to bear on the child. A caretaker who is specially skilled in these functions can be introduced into the child's environment from infancy on.

It is important that the child not be stimulated in directions that are, in fact, beyond his capacities and that stimuli not be introduced in such a way as to create displeasure and discomfort, for that will surely counteract their usefulness. The reason why the normal environment is very often inappropriate for these children is that it exposes them to a world that does not fit their actual condition and that will therefore increase, instead of diminish, the gaps between psychic organization and environmental conditions. It is very often impossible to create such a special environment in the home, since it would have too great an effect on the living milieu of all the family members involved.

This principle of therapy is applicable not only to infantile autism but also to the symbiotic condition, as well as to deficiency syndromes, maturational unevennesses, and developmental deviations, except that, when the child's condition is less serious, one is very often able to provide the appropriate therapeutic milieu within the home. Special treatment techniques have been developed and applied to children who are suffering from developmental fixations and who therefore require a special form of intervention by a trained person, who will spend many hours with him in order to provide the appropriate stimulation. Dr. Alpert's corrective object

relations program provided just such a technique, based on the following treatment processes: both adults and peers, becomes one part of the practicing activities of the child. The teacher supports this activity by verbal reinforcement of the child's search and by the very fact of the dependability of the therapeutic relationship. The child is then able to progress from the initial one-to-one relationship to an increasingly expanding environment, and to experience for the first time certain steps in the separation-individuation process.

1. A special form of object relationship occurs. While the child permits the therapist to provide need satisfaction, he also recovers the wish for the mother, the hitherto distant and unavailable adult. In this relationship with the therapist, the child re-experiences the loss, the frustration, and the disappointments. It is the task of the special teacher to satisfy the child's need and, at the same time, to make possible not only the testing of the availability of the original primary object but also the emergence of longing for her. During this period, the special teacher has to be readily available, when and as she is needed.

2. Separation and differentiation processes become involved in the relationship to the therapist, as well as to the environment. In this step, orientation toward the outside world, both spatially and in terms of relations to both adults and peers, becomes one part of the practicing activities of the

child. The teacher supports this activity by verbal reinforcement of the child's search and by the very fact of the dependability of the therapeutic relationship. The child is then able to progress from the initial one-to-one relationship to an increasingly expanding environment, and to experience for the first time certain steps in the separation-individuation process.

3. A change appears in the fantasy-reality balance. The child moves from the more autistic, self-contained fantasy world to one that not only includes the teacher but one in which the child expresses his fantasy, verbally or through direct action toward and with her. This step can now include reality testing, during the course of which the fantasies expressed by the child can be explored in terms of the capacity of the environment to fulfill them. At times, this reality testing will lead to an eruption of the child's frustration, resistance, and anger. As in normal development, such angry turning against the teacher may further the developmental progression of turning to other persons in the environment.

4. The capacity to form relationships with peers emerges on the strength of these hitherto unexperienced progressive developments. In these new relationships, too, the child expresses all the primitive mechanisms that we know from our work with younger children. There is imitation, incorporative identification, and the trying on of other children's functions, as evidence of newly found identity. Slowly, a more complex orchestration of

relationships can be observed, which then leads to a more realistic interaction with other children and adults.

Dr. Alpert's form of therapeutic intervention is based on two factors. One factor carefully follows the child's own modalities of behavior when a one-to-one relationship is being established. No technique is imposed on the child, nor is any specific area selected for improvement. In the past, enrichment treatment was often either based on the problem of nutritional supplies or addressed itself to the cognitive or motor control areas. If Dr. Alpert's suggested therapy is followed carefully, we find that all these areas—the affective, the cognitive, and that of body skill functions—are included within the context of the social experience.

The second factor involves the fact that the therapist must be aware of the detailed steps of the developmental process. Since so much in this method is conditional on the effective return to a point of fixation, and then from there to the exercise of those developmental steps that had never before been taken by the child, it is essential that the appropriateness of the developmental experience be understood. Otherwise, various aspects of the child's behavior, which may be quite appropriate when they are seen as fulfilling the necessary task of developmental progression, may be regarded as pathological simply because they appear to be age-inappropriate. Moreover, those aspects of the child's activity that follow a line of

developmental organization must be differentiated from those that are pathological in nature, being based on conflicts and experiences that may add to the child's differentiation syndrome. Nor can one assume, whatever the degree of developmental inhibition, that the possibilities of other emotional pathology are excluded.

This detailed description of a technique has been presented in order to highlight the fact that therapeutic intervention, to be effective, must be based on a clear knowledge of the developmental processes, as well as on carefully outlined technical maneuvers, and thus on trained personnel. The treatment of the atypical child with ego deviations and of those children in whom the developmental sequences deviate from the norm, will be based primarily on a clear profiling of the child's overall function and development. With these guarantees, detection of the specific area of disorder, whether it be motility, language development, thought process problems affecting judgment, or reality testing, can lead to the appropriate therapeutic maneuver.

Development of a treatment plan for developmental disorders requires that one observe the child's growth for a long period of time, in order to determine the specific forms of developmental deviation. At different periods, different modalities of intervention may have to be employed; retesting and reassessing will help to determine the degree of progress the child may be expected to make or the degree of the fixation and unevenness from which he

is suffering. It is clear that such programs will have to draw on the skills of specialists in language correction or training, or of those who deal with perceptual problems in the visual area (problems that very often contribute to dyslexia), or of hearing specialists. Often enough children who suffer from these conditions have also developed conflicts at various levels of psychic organization, with pre-neurotic or neurotic symptoms and other personality disorders based on inappropriate conflict solutions. Therefore, one has to keep in mind the necessity for individual psychotherapy.

The criteria for effective therapy are by now well established: (1) The child must have developed the capacity to form a specific relationship with the therapist, and there must also be adequate capacity for verbal expression and for self-observation; (2) A certain degree of individuation and differentiation must have occurred; (3) A degree of internalization of conflicts is necessary.

Frequently, the child needs preparatory help by a teacher, a nurse, or some other specially trained person, in order to arrive at the evolvement of the conditions mentioned. It is clear that one can establish indications for the psychoanalysis of prelatency children. Neurotic conflicts, sometimes the infantile neurosis, which has already reached an intensity beyond the norm and is intervening with further development; obsessive-compulsive character disorders; the early appearance of sexual confusion; perversions; and a host

of other symptoms have all been proven to yield to psychoanalytic treatment.

In the largest number of cases, it is only the intensive and careful exploration of the child's inner life—his fantasies, along with his defensive organization and its relationship to his external reality—that makes possible a clear diagnostic assessment of the child's condition.

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