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The Altering of Family Attitudes Toward the Child with Prolonged Illness as a Causative Factor of Behavior Problems

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THE ALTERING OF FAMILY ATTITUDES TOWARD THE CHILD WITH PROLONGED ILLNESS AS A CAUSATIVE FACTOR OF BEHAVIOR PROBLEMS.

A study of fifty cases selected at the Institute for Child Guidance, New York City, from Child Guidance Clinic Records to weigh the importance as factors influencing behavior problems of prolonged illness on a child as compared to the effect of the illness in altering parental and sibling attitudes. Submitted in partial fulfillment of the requirements of the degree of Master of Social Service.

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Section I

Introduction

Illness has long been accepted as one of the main causes of inefficiency, unhappiness and inability to adjust to a situation. It must be born in mind, however, that illness is but one of the many causes for varying degrees of inefficiency and that all too frequently individuals may use illness as an excuse for retreating from a difficult situation. The retreat in this way from facing unpleasant situations may result from one or two factors, first and perhaps the most important, is the fear of facing a difficult and prolonged situation, and secondly, it may be a sense of inferiority which comes from an unsuccessful attempt to meet a simular situation in the past. (1) In both cases the individual's excuse for the fear of the failure may be found in poor health, because the physical problems seem so closely bound up with personality that the multiplication of disease states complicates a particular situation. It must, however, always be held in mind that,"the child exists as more than the sum of his disease processes." (2) The disease process, moreover, does not of itself make the child good or bad, as the same physical defect may produce either. The mechanism of restoration to goodness is complicated because of the close inter-weaving of the physical organism with other elements in the child's personality. Hence it is impossible to generalize as to the effect upon character of specific changes along physical lines.

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(1) Thom, Douglas Mental Health of the Child P.40
(2) Wile, Ira S. Challenge of Childhood P.19

The child who is ill has previously been considered just "one of the children", but when he is taken ill and rushed to the hospital the parents endow him with virtues they never before noticed. They feel the hospital is indifferent toward him and thus are unable to maintain a calm unemotional attitude and are anxious to bring him home to give him proper care and consideration to compensate for his sufferings. Often during convalescence the whole home revolves around the child and he enjoys a sense of power, as the other children are made to give in to him. (1)

The fact that the child has been ill makes the parents guard him carefully from strain and exposure; he cannot compete equally with others; his work is intermittent; his play restricted. There is frequently collapse just as he begins to play on an equal basis with others. Each failure increases the nervous tension and this increases the possibility of failure. (2) If illness forces a parent to be more indulgent, the child will use his reasoning power to create the condition which will necessitate the supplying of the forbidden want and feign illness, and, if the child does conquer through this weakness, it becomes unfortunate for both parent and child. The victory of weakness puts a premium on it, for through it the individual exerts a strong power over persons in his environment. He may then carry over into adult life that pattern which nervous invalids do, that of saying they, "would do anything to get well", but they really want health to come from the outside rather than from within themselves. (3)

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(1) Thom, Douglas. Everyday Problems of the Everyday Child. P. 207.
(2) Wickes, F. G. Inner World of Childhood. P. 63.
(3) Evans, Elida. Problems of the Nervous Child. P. 337.

The child does not want to lose this position which has been granted him as the center of all the family's consideration and may thus continue to tyrannize over them, though often this tyranny is unconscious. This desire to tyrannize seems to result from a regression of the libido to infantile patterns of reaction and because of this regression the mode of adaptation to life is infantile. The child wants the satisfaction of being the dominant person in the home and though he is weak he has become the center of power. This sudden accession to power makes a great impression on him and he is reluctant to lose it. (1)

Markey (2) has described two types of cripples who react in unfavorable ways to the same situation. The one becomes self-maximating through his realization first of gratitude for the help and sympathy he receives and later a sense of enjoyment in it and finally a demand for it as his due. He develops a habit of destructively criticizing the very person whose love, attention and support he demands as if it were his birthright. While capitalizing his weakness the second type of cripple, the self-minimizing one, withdraws because of it and becomes constructively modest even to the point of developing deep inferiority feelings. This one is either defeated by his handicap and lives silently and moodily alone or becomes motivated by it until it becomes the powerful reason for his ambition. Markey has also described a third favorable reaction by which the cripple may attain either consciously or unconsciously to the point at which he forgets that he is or has been crippled. He is not aware of being

(1) Evans, Elida. Opus Cit. P. 228
(2) Markey, Oscar. What It Means To Be Crippled, The Family, Vol. X, No. 4, June, 1929, Pp. 118, 119, 120.

different from those all around. Porgy, a character in DuBose Hayward's play of that name, carried on life in this way seeming not to expect anyone to do more for him because he was crippled.

Adler has written at length upon the subject of organ inferiority and the resulting compensation which the individual finds to conceal this so that the organ may become even stronger than others. "The inferiority may remain for a long period at an unchanged level and may also be confined only to the organ or part of it or else the requirements of life, domestication and culture, produce an over-compensation which, if sufficient, will make itself felt in the central nervous system. . . Nature forms from the inferior organ under the influence of compensation, apparatus of more variable function and morphology which show themselves in many cases to be quite capable functionally and even at times somewhat better adapted to external circumstances since they have derived their increase in strength in overcoming these external obstacles and have consequently stood the test. . . . The mastering of children's defects and all the difficulties which arise from the inferior organ point to compensatory activities in the superstructure and if hitherto childish defects were external tokens of organic inferiority it now appears that they really represent lines of direction from the life of the psyche and are signals which indicate amount of inferiority which as yet has not been sufficiently overcome." (1)

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(1) Adler, Alfred. Organ Inferiority and Its Psychic Compensations. P. 56.

Although this organ inferiority must influence the whole group of ill children studied to a certain extent, yet it is also as important to consider the handling which the child receives from the parents. Adler in "Individual Psychology" states that throughout the whole period of development the child possesses a feeling of inferiority in his relation to both parents and the world at large. "Because of the immaturity of his organs, his uncertainty and lack of independence, because of his need for dependence on a stronger nature and his frequent and painful feelings of subordination to others a sensation of inadequacy develops which betrays itself throughout life." (1) Thus it would seem that not only the child who possesses a special disability but all children to some degree or other possess this feeling of inferiority and inadequacy. The division of reaction patterns into those classified by Wickman (2) as the attacking and withdrawing types of behavior may be the result of this general feeling of inferiority working on two types of personality. The development of the type depending on the reactions within the family group.

This is a study of fifty cases selected from Child Guidance Clinic records to weigh the importance as factors influencing behavior problems of prolonged illness on a child compared to the effect of this illness in altering parental and sibling attitudes.

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(1) Adler, Alfred. Practice and Theory of Individual Psychology. P. 13.
(2) Wickman, E. K. Children's Behavior and Teachers' Attitudes. P. 139.

SECTION II

Description of the Cases

The group studied consists of fifty cases of problem children, 22 cases taken from the records of the Institute of Child Guidance of New York City, and 28 from the Demonstration Clinics of The Commonwealth Fund - 17 from the Philadelphia Child Guidance Clinic, 5 from the Cleveland Child Guidance Clinic, and 6 from the Minneapolis Child Guidance Clinic. The cases were selected at random on the basis of physical disability, each child having had a severe illness lasting over six weeks.

Included in this group are 32 boys and 18 girls, or 64% boys and 36% girls. This corresponds closely to the sex ratio, that of 67% boys and 33% girls found in the total number of children, 1745, referred to the Demonstration Clinics and the Institute for Child Guidance of New York City.

Comparison of Sex Ratio of Study Group and Clinic Group

Sex	Study Group		Clinic Group	
	No.	Percent	No.	Percent
Boys	32	64%	1175	67%
Girls	18	36%	570	33%

The ages of the children in the study group at time of referral range from 2 years, 9 months, to 19 years. In this group six percent of the children fall below 6 years as compared to 5% in the clinic group; 28% in the pre-adolescent period of 6 - 11 years as compared to 36% in the clinic group; and 66% in the adolescent years over eleven as compared to 59% in the clinic group. In the study group there are no girls below 6 years of age, although 9% of the boys fall in this group; 31% of the boys fall in the pre-adolescent group and 28% of the girls; 59% of the boys are in the adolescent

period and 72% of the girls. This weighting of the girls toward the adolescent age may be a factor of importance as the intelligence ratings for the girls studied are, in general, lower than those obtained by the boys. These are compared with the clinic group in the following table:

Comparison of Age Groupings in Study and Clinic Group

Age	Study Group			Clinic Group		
	Boys	Girls	Both	Boys	Girls	Both
Below 6 years	9%	0%	6%	4%	6%	5%
6 - 11 years	32%	28%	28%	37%	29%	36%
Above 11 years	59%	72%	66%	59%	65%	59%

In comparing the intelligence ratings of the study group as based on the Stanford revision of the Binet-Simon tests with those of 463 children referred to the Institute for Child Guidance in New York for the year ending June, 1928, it is found that the study group presents a lower intelligence rating; that is, the percentage of cases which fall in the groups of feeble-minded and borderline intelligence is larger than in the clinic group. The average intelligence quotient for this group is 94.5, as compared to 103.2 of the clinic group. There is an average IQ of 105.3 for the boys and 90.7 for the girls, as compared to 103.7 for the boys in the clinic group and 102.7 for the girls. Chart I shows a graphical comparison with Terman's group of normal distribution of unselected children as based on 905 cases.

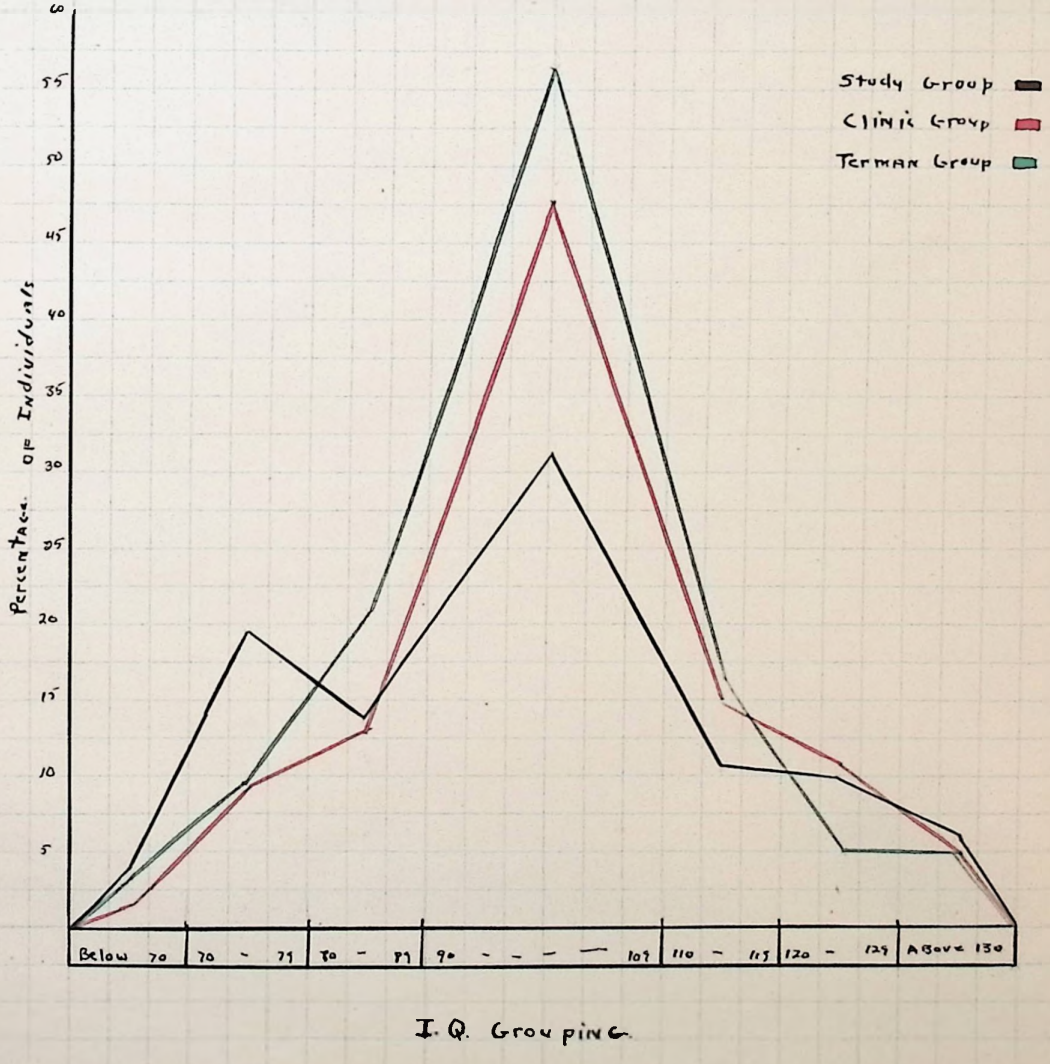
Although the factor of intelligence is of importance in determining the type of problems shown, the primary reason for its importance in this group is that the parents may expect too much of a child who develops feelings of difference from his more normal siblings or acquaintance because

of his inferior intelligence in addition to his inferior physique.

The child of lower intelligence who has had to be absent from school has a more difficult time in recovering the work which he has missed during his absence than the child of average or superior intelligence. Some of the problems may result from this feeling of inability to meet the exact scholastic attainments for when he is nearly equal to the others he may again become ill and lose more school work until failure becomes expected and he loses the desire to work.

CHART I

Graph showing comparison of range of intelligence ratings in study group and intelligence ratings of 463 children at the Institute for Child Guidance, with the normal distribution of intelligence as based on 905 unselected school children. (Terman)



SECTION III

Comparison of Illnesses

The list of illnesses in Table I has been studied according to the distinctions of disabling diseases and defects and minor ailments made by Moore. (1) He describes as disabling those illnesses which prevent a continuation of usual activities and occupations and, in the case of the school child, hazard the chance of his progress with his grade because of his need for long periods of bed care. By defects are considered congenital or developmental anomalies which may be of themselves handicapping or are of indirect importance because of the sense of difference which they produce. In minor ailments are included disease conditions which entirely disable a child for a shorter period of time or injure his full efficiency over a longer period, although he may not be considered very ill or kept in bed during the entire period. The final heading, that of operations, includes operations of varying degrees of importance which may or may not curtail the child's activities for a long period of time.

In a study of 24,000,000 children of school age in America by Dr. Thomas D. Wood (2) it was found that 75% of these suffered from some physical defect. These defects included 30-90% decayed teeth, 30-40% diseased adenoids and tonsils, and 7/8% with organic heart disease. In comparing the diseases of the study group no real basis for correlation can be found as the control group does not include the large bulk of the more serious disorders found in the study group.

(1) Moore, Harry. Public Health in United States. Pp.55-59.
(2) Wood, T. P. Health Education. P. 16.

As the percent of cases showing dental decay was not listed in the study group comparison can only be made with the percent of cases showing nose and throat disease, malnutrition, tuberculosis and organic heart disease.

Comparison of Illnesses in Study Group with Wood's Group of 24,000,000 School Children

	Study Group	Wood's Group
Tonsilitis	12%	30 - 40%
Malnutrition	22%	15 - 25%
Tuberculosis	14%	1%
Organic Heart Disease	7%	7/8%

It is then found that 12% are suffering from tonsilitis and 26% have had tonsils and adenoids removed. The Wood group show 30 and 40% with diseased tonsils and adenoids. Of the study group 22% are undernourished against 15-25% in the Wood group; 14% have tuberculosis compared with 1%, and 7% have organic heart disease compared with 7/8%.

Although this comparison shows a higher percentage of physical finding in the study group than in the larger group of school children, for purpose of a more detailed study the findings at initial examination of 2952 college freshmen entering the University of Kentucky have been considered. (1) The clinic group age range is from 2 years, 9 months, to 19 years with a mean age of 11 years, 9 months, whereas the college group has an average age of 19. Therefore the percentages of the clinic group which are lower than those of the college group are not necessarily significant whereas higher percentages, especially of diseases whose susceptibility and frequency reaches its highest percentage below the mean age of the study group, are of more significance.

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(1) Rush, J.C., Ross, D.S., Tate, M.B., Shakelford, J. Physical Defects of Entering College Students, Nation's Health. Vol. IX, No. 12, December, 1927, P. 27.

TABLE I

Table showing the percentages of illnesses of the study group as compared to 2952 students entering the University of Kentucky. Classified according to Moore.

	STUDY GROUP In percents	UNIV. GROUP In percents
I. DISABLING DISEASES.		
1. Communicable diseases		
Measles	50%	75.2%
Whooping cough	30%	59.7%
Scarlatina	20%	11.3%
Diptheria	20%	12.9%
Chicken pox	19%	47.9%
Mumps	6%	13.8%
Typhoid	2%	7.2%
2. Respiratory Infection		
Pneumonia	26%	8.6%
Influenza	10%	40.3%
Asthma	6%	0.95%
Bronchitis	6%	3.2%
Pleurisy	2%	1.9%
Empyema	2%	0.03%
Upper respiratory conditions		
Tonsilitis	12%	25.7%
3. Nutritional Disorders		
Appendicitis	6%	5.4%
Summer diarrhea	6%	0.0%
Intest. Grippe	2%	0.0%
Colitis	2%	0.0%
4. Heart Conditions		
Heart murmurs	6%	8.%
Endocarditis	4%	0%
5. Kidney Conditions		
Pyelitis	4%	0%
Nephritis	2%	0.03%
6. Tuberculosis		
Hip or knee	6%	0.39%
Respiratory	4%	0%
Cervical glands	4%	0.1%
7. Diseases of the Nervous System		
Chorea	12%	0.3%
Paralyses	8%	0.06%
Convulsions	8%	0%
Encephalitis	4%	0%
Meningitis	4%	0.06%
8. Rheumatis Fever	8%	4.4%
9. Accidents		
Fractures	4%	4.1%
II. DEFECTS		
1. Developmental		
Malnutrition	22%	29.9%
Rachitis	6%	0.03%

		STUDY GROUP In percents	UNIV. GROUP In percents
II.	DEFECTS (Cont'd)		
	2. Endocrine	6%	0.03%
	3. Special Senses		
	Eye conditions		
	Visual defects	12%	38%
	Strabismus	4%	0.1%
	Cataracts	2%	0.06%
	4. Special Senses		
	Ear conditions		
	Slight deafness . . .	6%	1.4%
III.	MINOR AILMENTS		
	1. Respiratory Infections		
	Frequent colds	8%	31.2%
	Chronic cough	2%	0%
	Chronic rhinitis	2%	0%
	Upper Respiratory Conditions		
	Otitis media	6%	10.3%
	Hay fever	2%	0%
	Nose bleeds	2%	0%
	Polyps in nose	2%	2.1%
	Vincents angina	2%	2.3%
	2. Nutritional Disorders		
	Chronic constipation . .	2%	10%
	Intest. parasite	2%	0%
	3. Heart Conditions		
	Disturbance in rhythm or rate	6%	4.8%
	4. Skin Conditions		
	Eczema	4%	0.03%
	Boils	4%	0%
	Ulcers	2%	0.03%
	Erysipelas	2%	0%
	Impetigo	2%	0.03%
	5. Nervous Disorders		
	Tremors	4%	0.9%
	Neuritis	2%	2.8%
	6. Minor Injuries	12%	30%
	7. Miscellaneous		
	Headaches	6%	22.7%
	Fainting	6%	0%
	Pustular conjunctivitis	2%	3.1%
	Vagainal discharge . . .	2%	0%
	Cocygeal sinus	2%	0%
IV.	OPERATIONS		
	1. Adenotonsilectomies	26%	33.3%
	2. Appendectomies	4%	3.5%
	3. Mastoid operation	8%	0.4%
	4. Herniotomy	6%	0.1%

In using a college group as a means of comparison it is realized that these students are a selected group both in intelligence and probably in physical stamina. The fact that the study group shows a comparable percentage of the less serious diseases and operations with a greater percentage of the more serious illnesses suggests that the disease experience of this study group varies from the college group only in the way of those serious physical disorders for which the cases were especially chosen.

The college group percantages are signigicantly# higher in measles, whooping cough, chicken pox and in influenza. As the maximum incidence for measles comes in the years from six to seven, it may be surmised that the percentage for the study group would remain fairly constant. Whooping cough reaches a maximum incidence in the fifth and six years which eliminates the future possibility of it for the majority of this group. The maximum incidence of chicken pox is also from five to six. Influenza has no special age incidence, therefore if a pandemic similar to that of 1918-1919 occurred again, it might be surmised that this group would be as likely as other children to have it later. (1)

The study group has, however, a higher incidence of the more serious communicable diseases as of diptheria 20% as compared to 12.9% in the college group. This should be an important factor in parental attitudes toward the ill child, because they consider it a serious disease. Parents

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The statistical formula used is: $\text{Sig.} = \sqrt{\frac{P_1 Y(100-P_1)}{N_1} + \frac{P_2 Y(100-P_2)}{N_2}}$
The difference is considered significant if it equals or exceeds 3 times the standard deviation.

(1) Terman and Allmach. Hygiene of the School Child. P. 141.

may tend to become more worried over this illness than over measles, which though of a higher mortality rate in school children, yet is so common as frequently to be considered of little importance. (1)

The percentage of children who have had pneumonia is significantly higher in the study group, 26% to 8.6% in the college group, which because of its high mortality might, as well as diptheria, be a more common cause for worry and fear about the child. (2)

Percentages of visual defects, frequent colds and minor injuries in the college group are significantly higher than those in the study group. A higher percentage of these conditions may be expected later in the study group. Minor injuries might reach a higher percentage through those frequent small accidents which occur everyday, and headaches which seem so frequent in adults. It is surprising that these children do not show as high a percentage of frequent colds as do the college group but perhaps the cause is a stricter definition of the term as given by the mothers in giving histories whereas the students in giving their own histories may emphasize these difficulties.

This latter point of difference in the source of histories whether given by mother or student is of importance in considering the higher percentages of rachitis and infants' intestinal disorders of which the student may have been ignorant.

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(1) Wood, T. D. Health Education. P. 17.
(2) Ibid. P. 17.

There is a consistent though slightly higher percentage of the more unusual diseases as asthma, pleurisy, empyema, pyelitis, nephritis and the nervous disorders. These would naturally be more of a cause of worry by the parents than those diseases with which they are more familiar.

Although there is a smaller percentage of adenotonsillectomies in the study group, 26%, than in the college group, 33.3%, it was recommended and carried out in 8% of the cases during treatment. The percentage of appendectomies is about the same, 4% and 3.5%, in both groups, yet this seems important as appendicitis is more frequently a disease of adolesence. (1) There are 8% mastoid operations in the study group in contrast to 0.4% in the college group. Because of its high mortality this should be important in considering the fear and worry reactions of the parents. The comparatively high incidence of herniotomies in this group (6% versus 0.1%) is important to both parent and child, because this operation involves special restrictions of the child's activities and the worry of a recurrent rupture and a second operation.

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(1) Jones, Allan A. "Appendicitis"
Nelson's Living Medicine Vol. 5 Ch.9 P.223

Section IV

Classification of Problems

Dr. Lowrey in his circular of information about the Institute for Child Guidance in New York City(1) when discussing the acceptable types of behavior problems in referring to children who present problems in behavior or personality states," Such children may conveniently be termed'maladjusted' in the sense that they show in their reactions to a group or to certain real situations which they are called on to meet(in home, school, or the community at large) that there is a lack of adaptation between the child and the realities of life. There is no satisfactory way to classify the possible reactions, but the following groupings may be suggestive:

1. Children who present problems because of their socially unacceptable behavior(whether legally delinquent or not) such as temper tantrums, fighting,. show-off behavior.. sex difficulties etc. whether shown at home, school or elsewhere.

2. Children who present problems manifested chiefly in personality reactions such as seclusiveness, timidity, sensitiveness, fears, nervousness, etc.

3. Children who present problems in habit formation such as sleeping or eating difficulties, speech disturbance.... thumb sucking, nail biting, masturbation, prolonged bed-wetting, etc.

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(1) Lowry, L. G."A Service for Problem Children" Booklet of Information about the Institute for Child Guidance, N. Y.C. 1928 P.5

TABLE II

DIVISION OF PROBLEMS ACCORDING TO DR. LOWREY'S CLASSIFICATION

Socially unacceptable behavior	26%
Socially unacceptable with personality problems	20%
Socially unacceptable with habit problems	4%
Personality problems	28%
Personality problems with habit problems	14%
Socially unacceptable, personality and habit problems	2%
Habit problems	6%

As is shown in above table II only 2% of the ill children fall into all three of the above groups; 26% show only socially unacceptable behavior and 28% only personality problems, and habit problems alone in 6% of the cases. In 20% of the cases socially unacceptable behavior is complicated by personality problems and in 4% by habit problems. Personality and habit problems are found in 14% of the cases.

This 6% of the cases showing habit problems only included those cases of: 1) a child who will not sleep without a bottle or her father slapping her to sleep, 2) a problem of speech defect in a child of low intelligence, 3) eneuresis and finger sucking due to a shift in discipline from over protection because of severe malnutrition to neglect.

The cases, 4% which combine socially unacceptable behavior with habit problems are: 1) eneuresis and temper tantrums as problems, and 2) eneuresis with lying, truanting and temper tantrums. Thus it is used as another form of socially unacceptable behavior rather than being purely an infantile mechanism.

In the cases 12% which show personality problems combined with habit problems there is one case of fears and regressive behavior in a young child, sleep disturbances with fears or nervousness in two cases, and food fads with nervousness, with cheating in school, and with use of illness as an escape in

three cases.

Of the cases showing only socially unacceptable behavior 20% of 26% of the 50 cases are over eleven years of age, 4% between six and eleven years, and 2% under six years-that a case of temper tantrums and swearing at his mother. Of this group 18% are boys, 8% girls. This group would probably include the type of child most frequently referred by schools because of the disturbance this child would create in the classroom. (1)

Of the personality problems 24% out of 28% fall in the adolescent age range and the other four percent in the group of those over six years. There is a slightly higher percentage of younger children than in the preceding group. 20% of these are boys and 8% are girls. Of the socially unacceptable problems as combined with personality problems there are 20% of the whole group of which 10% fall in the age range from six to eleven years and 10 after eleven years. Two percent were girls, and 8% boys.

Dr. Lowrey's classification is also used in table III with the problems listed separately, in order to compare them with the problems of a control group of 1745 cases from the Commonwealth Fund Demonstration Clinics and the Institute for Child Guidance, New York City.

The classification by which this control group is studied does not include some of the problems found in the study group and thus have been added, although no comparative study of these special difficulties can be made. These

(1) Wickman, E. K. Children's Behavior and Teacher's Attitudes P. 155

TABLE III

BEHAVIOR PROBLEMS

As shown by fifty children who have had prolonged illness compared in percents with 1745 cases referred to the Demonstration Clinics and Institute for Child Guidance in New York.

PROBLEMS	STUDY GROUP	CLINIC GROUP
Socially unacceptable behavior		
Lying	16%	30%
Stealing	16%	32%
Truancy	18%	22%
Bullying	14%	4%
Show-off	6%	4%
Negativism	34%	32%
Temper tantrums	30%	28%
Cruelty	2%	4%
Sex activity	4%	10%
Fighting	4%	#
Unpopularity with other children	14%	#
Personality problems		
Over-activity	4%	#
Crying	8%	#
Excess fantasy	16%	10%
Jealousy	24%	14%
Nervousness	26%	18%
Fears	14%	13%
Timidity	16%	8%
Sensitiveness	8%	15%
Inferiority complex	26%	26%
Neurotic illness	14%	#
Habit problems		
Refusal of foods	10%	3%
Thumb-sucking	12%	6%
Nail-biting	2%	#
Eneuresis	14%	21%
Sleep disturbances	12%	16%
Masturbation	8%	6%
Reading disability	2%	3%
School failure	36%	13%

include fighting, unpopularity with other children, over activity, nail biting and neurotic illness. By the last named is meant illness for which no physical basis is found and this illness is interpreted as a means by which the child unconsciously avoids unpleasant situations.

The latter problem is of interest because of the fairly high frequency, 14% of the cases. The child is usually unconscious of the cause of the illness, yet uses it when school failure threatens or perhaps when another child threatens to take its place as the center of attention. The knowledge which these children in the study group have acquired through past experience in the usefulness of the mechanism of illness to gain attention would make them turn to this as a useful weapon to continue or regain the indulgency of their parents.

School failure is classified apart from Dr. Lowrey's groupings as it is felt that, although it is sometimes due to a personality disturbance, it is not always so and is not socially unacceptable as, though it may cause some disturbance, the effect of it falls primarily on the child and not the social group in which the child finds himself. Although the difference in frequency of school failures between the study and clinic group is significant statistically yet the 36% of the ill children are frequently reported as doing poor work rather than absolutely failing their grade. Yet the fact that this group has necessarily missed school makes a difference obvious even when weighted for differences in criteria used.

Aside from school failure the two problems which show a significant statistical difference are lying and stealing. The study group shows 16% of the cases in each group of these two problems, while the control group shows 30% and 32% respectively. The difference may be due to the fact that the ill child has been granted special favors by the parent and does not have to steal as money is readily given him. The percentage of cases in which he does steal are caused, according to the psychiatrist's diagnosis of the case, in 10% as a means of getting attention at home or in the social group and in the other 6% the problems are present along with other socially unacceptable behavior, because of poor home discipline.

Three problems which show nearly the same percentage in the study and control groups are truancy 18% and 22%, negativism 34% and 32% and temper tantrums 30% and 28%. Thus, although the child who has been ill shows a higher percentage of these problems than of others in the socially unacceptable group, yet they are equalled to those found in the control group.

Bullying, as a problem, is higher in the study group, 14% versus 4% in the control group. This may be the result of the ill child's position of importance in his home and his subsequent attempt to carry this over into his outside activities. As Richardson (1) states, "There is a perilous situation when the parent mistakenly tries to compensate for the limitations of the handicapped child by making the rest of the family defer to him on all occasions. This not only

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Richardson, F. H. The Nervous Child and His Parents P. 54

cramps and harms other members of the family; it cripples still further the unfortunate youngster, since it makes of him the spoiled child." With this type of attention the child thinks he can boss other children as he does his siblings and thus comes into difficulties over his domineering attitude toward them. As Adler says, he may bully others also to compensate for his inferiority. A marked feeling of physical inferiority becomes inherent in this group and bullying may be the reaction of one type of personality to that feeling.

In the personality problems excess fantasy, which is 16% in the study group as compared to 10% in the control group, is a rather expected factor as an ill child, if of the withdrawing type, would, through his illness, be kept from social contacts and tend to flee further from reality.

Nervousness occurs more frequently in the study group, 26%, than in the control group, 18%. In a small proportion of the group this may be due to (1) a reaction to a nervous mother who projects her worries on the child, (2) to a physical basis, because the child has not regained complete health after an illness and may be emotionally unstable, and (3) to over-stimulation of the child by parents anxious to compensate to him for his enforced quiet and comparative solitude.

From the cases studied it is apparent that the child who has been ill is more timid than others, for timidity is recorded as a problem in 16% of the study group and in only 8% of the control group. This may be due to over-protection

on the part of the mother as her fears and worries have kept the child from his usual activities until he is now afraid to exert himself.

Fears are approximately the same in each group, 14% and 13% respectively.

Although it might be expected that the ill child would be more sensitive than others because of his handicap, he is not found so in this group.

Although it would be expected from the Adlerian theory that this group would show a marked increase in the problems of inferiority feelings, yet the 26% in which it appears is equalled by the 26% in which it appears in the control group. Although it is impossible to generalize from such a small number of cases, it may be wondered why the other 74% of the study cased who have probably had as severe physical handicaps do not show this as a personality problem. Of those who show this problem in 10% of the group this feeling was, according to the psychiatrist's diagnosis, directly attributable to feelings of difference in the group due to some physical defect, as very poor vision or a paralysed limb; in 10% of the cases it was due, according to the diagnosis, to too low an intelligence accompanied with too high parental expectations. This was complicated by the poor physique some of the children show. One case had a feeling which was definitely connected with a pre-schizophrenia. The other 4% have a feeling of inferiority in the group, because of absence from it for too long a period with the consequent difficulty of re-adjusting of it.

In the habit problem group there is found a smaller proportion of cases showing problems. Refusal of food ranks higher in the study group, 10%, than in the control group, 3%, probably due to differences in criteria used in selecting the problem as the study group included food fads, while the control group only absolute refusal of food.

Dr. Levy(1) has mentioned the frequency with which the children who are over-protected have food fads while those who have less attention take a longer time to become trained in bowel and bladder habits. The ill child who has been pampered while ill and given anything he wants to eat will want to continue this pattern of reaction rather than to lose his position of power.

There is a higher percentage of thumb-sucking in the study group, 12% versus 16%, although the study group has a slightly higher mean age, 11.9 as against 11.2 years in the control group. This is perhaps only part of an infantile pattern of reaction carried along because the parents feared to break an ill child of a pattern from which it got pleasure fearing his reaction might affect his convalescence.

Eneuresis is less important in the study group, 14% as against 21% in the control group because the ill child has been given a great deal of attention and as might be expected with this attention is easily trained and does not need to use this as an attention getting mechanism. Of the children who do show this problem 4% use it to gain attention as socially unacceptable behavior and 8% continue

(1) Levy, David M. Lecture on food fads and encuresis at Institution for Child Guidance, New York City Winter 1928-29

as an infantile pattern of reaction-the latter are the younger children.

SECTION V

Family Background

In considering the group as a whole in an attempt to isolate causal factors which, along with the illness, contribute to the problem, those arising from the familial situation are important. Flügel stresses this in saying, "The psychological atmosphere of the home life with the complex emotions and sentiments aroused by and dependant upon, the various family relationships must exercise a very considerable effect on human character and development." (1) The following factors were chosen to be considered in detail:

1. Economic status of the family
2. Amount of social contacts of the family
3. Marital status of the parents
4. Parental attitudes toward the problem child
5. Sibling position with the problems when a physically inferior child finds himself compared with physically superior children. Also the child who loses his temporary position of importance to again become just "one of the family".

1. ECONOMIC STATUS OF THE FAMILY

In determining the economic status of the family the following data is found:

CLASSIFICATION OF ECONOMIC STATUS

Dependant	Marginal	Adequate	Comfortable	Luxurious
14%	36%	26%	18%	6%

Thus it is considered that (1) 14% of the families are classifiable as dependant on some outside source for economic aid in maintaining the home; (2) that 36% fall in the marginal group of families who maintain themselves without outside

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(1) Flügel, J. C. Psychoanalytic Study of the Family P.4

support but who, if there is any severe additional strain on their finances are liable to need outside help to maintain the home; (3) that 26% have incomes just adequate to their needs; (4) that 18% are in comfortable circumstances, and (5) that 6% are in luxurious circumstances as they are able to afford things not within the range of the comfortable group.

The comparatively high percentage of dependant or marginal families may be important in that the sick child entails many expenditures in the way of hospitalization, operations, and general medical care. As a result the family are not able to take care of other immediate financial stresses, or the family has been unable to build up resources because of stresses in the past and face the present crisis unprepared. A case in point is that of Buddy aged nine, who was referred because of several nervous problems. He had a long history of illnesses from a severe attact of pneumonia at 18 months to measles, shingles, a severe cut in his thigh, and adenotonsillectomy all in the past year. Although part of the financial strain is relieved by clinics, yet the family has had to pay the clinic fee which, however slight, put a strain on the income which was barely sufficing to feed and clothe the family and pay off the large debts incurred in the past two years through three funerals. Buddy's reaction to the illness and the expense involved is shown in his wishes in the psychiatric examination which were that he might have plenty of money and have a big coffin when he died-certainly

an indication of the importance he has put upon the effects of illness in the home and the resulting expenses from death.

2. AMOUNT OF SOCIAL CONTACTS OF THE FAMILY

The child's adjustment to the social group must, to a certain extent, be dependant on the amount of social contacts the family has in order to give him a wider social background than his own school acquaintances afford. The restricted social contacts during illness give him a greater necessity for a means of again finding friends after convalescence. than a child who has been in constant touch with his school-mates. It is notable therefore that 44% of the families have restricted social contacts and are thus thrown on each other for emotional outlets. This tends to concentrate attention on the well being or deficiences of the members of the family group. The sick child therefore who is the center of attention and interest gets more spoiling than would be likely otherwise.

The families in this group who have a fair mumber of social contacts are 24%-that is those families have not lost touch with friends and have some outside interests.

There are 32% of the families who show good social contacts with a seemingly normal amount of friends and outside interests. The child from this type of home may be at an advantage because of the wider social background he will have or he may find himself at a disadvantage because the other members of the family through more continuous social contacts have more friends than he has.

4. MARITAL STATUS OF THE PARENTS

CHART SHOWING MARITAL STATUS OF PARENTS

Normal	60%
father ill	12%
mother ill	8%
others in home	16%
Deviations	30%
father dead	16%
mother remarried	8%
father away	2%
father deserted	10%
father in jail	2%
father insane	4%
mother dead	10%
father remarried	4%
mother deserted	2%
Institutions	4%
Foster Home	2%

Of the fifty cases in the study group 60% are living in normal homes, that is homes containing both father and mother. However, in these homes 16% have a grandparent, aunt, uncle, or boarder also. Of this group 12% of the mothers are ill, a factor which influences the patient, as illness is a matter of concern of all the members, perhaps much discussed by the entire family. The ill mother's discipline tends to be inconsistent and the strain of an ill child tells on her temper. These ill mothers are in the main described in the history as extremely nervous rather than suffering from some disease. The mother frequently projects her worries on the child who reacts in a nervous pattern-jumpy, hyper-sensitive. This may be due to the inconsistent handling given him or because the mother uses him as a source of her own nervousness not realizing that this may work two ways-the mother's nervousness increasing that of the child and vice-versa.

Of this normal group 8% of the fathers are ill. This means inconsistent discipline on his part. As an example, Michael's father had tuberculosis. This meant that, since he is in the home and because of his illness querulous, he objects to the noise Michael makes and severely disciplines him for any misbehavior. The father realizes Michael's physical inferiority and compares him to his more normally developed sister. Michael is delicate and it was questioned whether he too had tuberculosis. The treatment of Michael was made more difficult through the inability to reach the father because he was frequently too ill to be seen by the worker.

Of the homes in which one parent is away or re-married it is found that in 16% of the cases the father is dead and of these 8% of the mothers has re-married. The adjustment to the different ideas of discipline of the own and step-father seems to aggravate the behavior problems in some of the children, as in the case of George whose father died when he was four and now at nine years is referred to the Child Guidance Clinic for temper tantrums, lying, and thumb-sucking. The mother states that after the father's death she had a nervous breakdown and is still nervous and she considers George nervous too. The step-father treats him equally with his own children, but is a strict disciplinarian and makes the boy feel insecure because he realizes that he is not his own father.

The child whose father is dead and whose mother has not re-married may follow the pattern of Dorothy who was very much attached to her father at the time of his death

when she was ten(she is now twelve). She resembles him in many ways; her mother who over-protects her stresses this resemblance and Dorothy has carried this so far that the cause of her referral to the clinic was poor vision-"veils" descending before her eyes, a neurotic pattern copied from her father who had poor eyesight and stressed his difficulties. Her mother has sympathized with the pattern of reaction which has resulted in an increase in frequency of the "veils" and a change to a sight saving class with lighter school work. In treatment the veils stopped except when school failure threatened her. However, with the lessening of the mother's solicitude during these periods they cleared up completely.

Those fathers who have deserted or are away a great deal, 12%, are important mainly in the fact that the child may have conflicts about his absence and because of economic difficulties which tend to arise. One father is in jail and thus out of the family group. There are two insane fathers-one is rejected by the patient, as she thinks he is worthless; the other case is that of a father whose son has chronic empyema which furnished an added difficulty in a home already in strained circumstances through the loss of the working member of the family.

In those 10% of the cases in which the mother is dead, the child who has been ill and has in the past received a great deal of attention from the mother misses her tremendously and resents the presence of a housekeeper or step-motner in the home. Bob is very much in conflict over

his psychotic mother who has recently died. The father is elderly and finds the boy troublesome and disobedient. The boy could not adjust to a housekeeper but succeeded in adjusting when sent away to military school. He has always been "frail" but under school discipline this improved.

One of the mothers has deserted her daughter who is now in the home of the mother's sister. One other child who is in a foster home adjusted after a period, but still feels physically inferior to the own children in the home. Two of the children are in institutions, one because she cannot get along with her step-mother, as she compares her adversely to her own mother and the other was placed by the clinic in a foster home from an institution.

SECTION VI

Family Relationships

In family relationship the first factor, that of parental attitudes, seems of major importance in the emotional development of the child. They alone may be the cause of development of behavior symptoms. The attitudes of a parent toward the child are built up from the parent's background and present conditions, social and economic, and comprise the major factors influencing the child's personality development. An ill child is probably no more influenced by this factor than other children, except that his illness may contribute to difficulties in the home. These may upset the emotional balance of the home and be projected back onto himself. In comparing the attitudes of parents toward the children, they are classified into four groups, the over-protective parents, those normally interested in the child with no special worries shown to him, the parent who absents himself from the situation through either lack of interest in the child or absence from the home for various reasons, and last, the group of the parents who reject the child.

DISTRIBUTION OF PARENTAL ATTITUDES

Over-protective		Interested		Uninterested		Away		Rejecting	
Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath
50%	14%	8%	10%	6%	20%	8%	28%	28%	28%

Mothers over-protect the ill child in 50% of the cases and fathers in 14% of the cases. This is an expected attitude in that the sick child through his weakness and helplessness arouses in the parent a feeling of sympathy. Laura Hood(1) has expressed the feeling behind the attitude toward a crippled child, " To have a little child paralyzed or otherwise physically defective is an experience probably more devastating to mind and spirit than to suffer grave physical impairment oneself and the psychological adjustment may be more complex .....Because the social outlook for the crippled person has always been and still is, so uncertain that parents are filled with a feeling of helplessness about the future that finds expression toward the child in pity and pampering."

The importance of the mother of having an ill child is still further brought out by Myerson(2) who states that sometimes a wife's neurosis can be traced to the care and worry furnished by one child. He speaks especially of the truly delicate child who seems to be susceptible to disease. He has thus had to be more carefully guarded than other children and has required more care. Frequently, however, the mother carries this protection beyond the needed period and thus the child desires to continue the pleasant assumption of an important place in the mother's interest. Thus injudicious pampering and unwise handling during a period of convalescence may wreck in a few weeks the personality which has been carefully shaped to meet the demands of life. Thom mentions the child's imitation of the

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(1) Hood, Laura On Interviewing Parents of Crippled Children PP. 65-6

(2) Myerson, Abraham The Nervous Housewife P. 104

mother's attitude toward illness with its allowance for avoiding responsibility. (1) Carrying on this as an excuse for failure may lead to the developing of neurotic symptoms kept alive by the over-solicitous mother.

The above discussion applies to the ill child, but not all children who are over-protected are ill. A causal basis for over-protection suggested by Dr. Levy (2) is that the mother fears to lose the child as he represents the main emotional outlet for her. He may be either an only child or the only child of one sex in a family of siblings of the opposite sex. The mother being the dominant person in the home in some cases may reject her weak husband and turn to the child who, especially if he were ill, gains even a greater share of attention and affection than he would normally receive. If the mother has had a long anticipatory phase before the birth of this child, she tends to over-protect and worry unduly about that child, stressing every illness no matter how slight as of major-importance fearing she may lose the child. She will tend to do this even more if a previous child to whom she has been attached has died.

This matter of over-protection as it relates to ordinal position in the family is discussed under that section later.

In several cases the over-protection of the child is not caused by the illness, as the mother was prone to that attitude prior to it, but the illness greatly accentuated it, as in the case of John following.

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(1) Thom, Douglas. Everyday Problems of the Everyday Child. P. 208.

(2) Levy, David M. Etiology of Over-Protection. American Journal of Psychiatry. (Unpublished)

John, a fourteen year old boy, the oldest of three children is much over-protected by his mother. He has chronic empyema which has lasted for six years.

The father was committed to Ward's Island in January, 1924 with a diagnosis of catonic dementia praecox. following an episode of excitement in the home. He has been paroled for three short periods. but always has returned to the hospital in an excited condition. He was born in Ireland and on coming to America worked first as a footman and later as a bus-driver. He was recessive in nature, fond of the home life with few outside interests. He was fond of John, although Dick, the younger brother, was his favorite.

The mother has had a meagre education and feels inferior to the father. She married the father after coming to America, as she " was no longer young and he was a good man." She is a good housewife and manages well on the $56.00 from the Mother's Pension and $12 from Catholic Charities. She is now resigned to her husband's illness, although she was upset over it at the time because she was two months pregnant and John was seriously ill. She is worried over John's illness, but would not let an operation be performed fearing that it would not be any more successful than former ones. She considers John practical, not a day dreamer and enjoys his affection for her. She said that she hated to have him grow up as he was such a good baby.

The siblings are Dick and Jane. Dick is an active nine year old who is much interested in active games. He showed more affection for the father than John and cried when he went away. John is antagonistic to him, through his jealousy of the father's favoritism for him and his superior ability in physical activities. Jane, aged four, is an alert attractive child with whom John seldoms plays. Mother gives her a great deal of attention, but John shows no jealousy stating that he realizes she needs it, as she is the youngest.

John was a wanted child with normal birth and development. He had diptheria in 1917 and a cold soon after he had started school at six. This developed into influenza and then into pleurisy which left a discharging sinus which did not clear up with operations. In 1924 he had a rib resection operation for empyema and has since attended the out-patient department of P- Hospital. He has spent a period at a convalescent home following one operation when the wound was re-opened by a blow in his side at school. He is very resentful about his hospital experience, as he feels that it has done him no good and has made him lose a great deal of school work.

In the physical examination at the clinic he was found to be 9 pounds underweight with poor nourishment and development, poor chest, narrow and flat with a discharging sinus.

Tubular breathing was present and clubbing of the nails due to pulmonary pathology. Chronicity suggested tuberculosis, but there were no bacilli in the exudate.

His school history has been irregular due to his frequent absences for hospitalizations. He was in the 6th grade, one year retarded, and doing good work. His intelligence quotient fell in the average range, 104.

John was referred to the clinic because he was introspective and day dreamed a great deal, and a physician at the P.... Hospital considered that he showed early symptoms of schizophrenia. He shows marked emotional reactions paranoid in nature to the injustices of the Irish, a pattern copied from his father thru his indentification with him.

He had been carefully brought up and protected. His first chance to fight this over-protection came with his entrance into school, and because of his illness he had to return to the same infantalizing situation. It was surprising therefore that he had developed as much responsibility and reliability as he had. He seldom complained about his illness except as it had caused his school retardation. His love of reading and drawing seemed to have developed during his illness, the latter was mainly drawings of battle and sudden death. He used these two mechanisms as a satisfaction and compensation for his inability to be successful in physical activities . He desires to be a priest, a desire developed from the religious nature of his parents and his fear of illness and death, and his desire to go to heaven.

John was disturbed at the time of his father's committment as he could not understand the cause. He did not cry when he went away but seemed depressed for a long period afterwards and shows a fear of the father's insanity showing itself in him. He is very fond of his mother and helps her around the home.

In the psychiatric diagnosis it was questioned how much he would have withdrawn into the phantosy type of existence without the illness, but it was surmised that it would have developed to a certain extent because of the parental attitude. At present this retreat has been the easiest and most satisfying to him. His whole life seems to have been made up of deprivations except the satisfying destructive libidnal ones which tend to make him dependent. He has had no opportunity to build up an ego which would enable him to cope with reality in a manner satisfactory to himself.

The opinion of the psychiatrist is that there was no schizophrenia at the time of the staff conference, as there was adequate affect and spontaneous conversation and no quecrness as in early schizophrenia.

There is a possibility however, of future schizophrenia. His paranoid interests though taken from his father have a personal interest and intensity from which it was inferred that if he nurtured them they would develop to some extent.

Parents who are "normally" interested in their children comprise an unusually low percentage, 89 % of the mothers and 10 % of the fathers. The term normal interest has been used to mean those parents who show neither excessive fear or a worry over the child, yet do not ignore him in the home situation. The high percentage of fathers dead or away would necessarily involve a lesser percentage for study in this group.

Parental attitudes have been classified into a fourth type, that of those parents who either show no interest in the child or who are not in the home. This group comprises 14 % of the mothers of whom 8 % are dead or away, and 48 % of the fathers of whom 28 % are dead or away.

It is realized that the fact of absence of a parent is of importance, but this has been treated in marital situation as it concerns the home set up.

Of the 8 % of the mothers who pay little or no attention to the child one is emotionally unstable, one intellectually inferior and the other has no interest in the child as a child although she became more interested in him as he grew up.

Of the fathers who are not interested in the child 8 % are over strict with all the children. 6 % have too high expectations which this child has not met intellectually in the past, therefore the father is not interested in him.

One of the fathers is so infantile emotionally as to be interested in none of the children; one has outside interests and one prefers the brother to the sick child.

Another group of parental attitudes includes those parents who reject the child. By rejection is meant a dislike of the child, a lack of affection for him which is intense enough to cause him to feel insecure. This includes rejection caused by one of the following factors: rejection because the parent lacks emotional maturity to care for any added responsibility such as a child, and is especially of importance if the child is ill and causes more strain on his stability than a normal child; identification by the parent of the child with someone to whom the parent has been antagonistic in the paternal or maternal family set up; rejection by one or the other parent through jealousy of the attention the other parent gives to the child; rejection because the child cannot come up to the approved standard, mental or physical; this may also include rejection by a parent because the child shows a trait which the parent rejects in himself; rejection because of the expense involved in caring for a sick child. The latter includes necessarily other factors as the basal cause of the rejections, but this seems the main one.

The attitude of rejection was found in 28 % of the mothers and 28 % of the fathers. In 5 of these cases the child is rejected by both parents. In 2 of the cases the children are rejected because they can not attain the desired standard, one case because the child is inferior to his younger brother. The other because the childs' behavior is too much of a revolt against the parents' religious standards.

One girl was never wanted by the mother and rejected with her twin who was later accepted. The patient was not accepted because of inferior intelligence and a handicap of a paralysed leg. The father in this case rejects the girl as he feels that she is to blame for the death of his son, because she lived after the epidemic in which his favored son died. Two cases are rejected by the parents because of their emotional immaturity possibly complicated by low intelligence in one case. One father rejects the child because he feels that the child has kept him from being a sailor, as he was kept home because of his wife's pregnancy. One only child is rejected by the mother because of identification of this child with a brother-in-law whom she unconsciously admires, but professes consciously to dislike, and also, because the child was unwanted at birth. One girl is rejected by the father because he identifies her with an older half sister of his who is antagonistic to her. A boy is rejected because he fights against the pacifistic standards of his father and because he will not comply with the educational standards the father sets for him.

One mother is jealous of her husband's excessive interest in her daughter and thus rejects the daughter. Two boys are babied by the mother and the father resents this attention and rejects the children. One mother rejects her daughter because of the expense she has involved and also because she is too closely attached to the father to whom the mother feels superior. One boy is rejected by the father because of the excess attention the mother pays to him and the expense he has involved.

Two children are rejected one by the father, and one by the mother because of their low intelligence especially as it is evidenced as compared with siblings of higher intelligence. Two are rejected one by the mother, and one by the father on the basis that their behavior does not confirm to standards desired by the family. Two children are rejected one by the mother, and one by the father for their physical inferiority as compared with their siblings.

Ruth is an example case of a child rejected by both parents as evidenced in their desertion of her following their own separation.

Ruth's father shows an immature reaction to life through his drinking, his inability to adjust to marriage and his separation from his wife. He was the youngest of seven children and his mother's favorite. He has always been considered the black sheep of his family as his older brothers have made excellent business and home adjustments, while he has been a failure in everything. He is described as a man of unusually pleasing personality always liked but never trusted.

The wife's mother and step-father were both janitors and drank heavily. The home was poorly kept and the children neglected. Ruth's mother married apparently to avoid the home situation and did not want children. She had a difficult time with her first child who died as a result of a birth injury. Ruth was born with caesarian delivery and was cared for mainly by the father. Both parents drank before the separation and following it the mother has supported herself by prostitution.

Following the separation the mother kept Ruth with her for a period and later boarded her out with friends. While Ruth lived with her she frightened her with ghost stories to keep her quiet and often lost her temper at her. One time she would have killed her in a fit of temper but neighbors intervened.

Ruth, at present, is an attractive nine year old with blond curls. She gets excellent grades in school but worries and dreams over her retardation as she is behind a grade because of illness. She seems to live a great deal of her time in a world of fantasy. She has fears of ghosts which, at times, amount almost to hallucinations. She has few friends as they resent her superior attitude while she feels inferior to them because of their superior school progress.

Her play life lies mainly in playing school with her maternal cousins, aged two and four, with whom she lives. She gets along well with her aunt who is mother's younger sister and over-protects her through a guilt feeling over her sister's neglect. Her uncle frequently loses his temper at her when she is forgetful or disobedient. She cannot seem to rationalize as to why she cannot live with her parents although she admits she doesn't like her mother. She is much attached to her father and wants desperately to see him. She reacts intensively to her lonesomeness for her parents by flight from reality into day dreaming and excess fantasy.

Her developmental history is unknown. She was severely ill with scarlet fever at five and a half. She was then living with her mother who, however so neglected her during the illness that the mother's younger sister took pity on the child and spent long hours at her bedside. There were often people drunk in the room and the mother carried on her trade of prostituon.

At the present time Ruth is normal in height and weight has a palpable spleen and a decided tremor in the left hand.

On the psychological examination she rated an I.Q. of 110 but it was felt that this was not an adequate measure of her ability because of a great fear of failure and hesitancy in trying something new.

In the psychiatric diagnosis it was noted that she was remarkably deprived on the libidinal leval and has few compansations of the ego side, as her school which should be her main compensation gives her a feeling of failure. Her position in the present home as oldest child should give her a feeling of security, but her knowledge of her uncle's dislike of her has kept her from accepting this situation.

In considering the factors which operate in the development of behavior problems as they arise from the family situation, it is important to consider the second factor, that of ordinal position in the sibling group. Of this group the children fall in the following classes:

Oldest child	42%
Youngest child	28%
Middle child	24%
Only child	14%

This is especially important in relation to the first born as Alder states, " There exists a fundamental difference in the psychic development of the first born as contrasted with that of the second or last born.....He takes the element of

power always into consideration, comes to an understanding with it and exhibits a certain amount of sociability. He regards his superiority over his brothers as his inviolable position." (1) This would especially apply to the oldest ill child, for in addition to having the center of power through his ordinal position, he also gains the center of parental attention through his illness and has thus obtained even more attention, so that he achieves a position of tyranny over other members of the family. With the coming of younger children and, perhaps, his return to health he finds that his place is supplanted and that he has to fight for attention. He may then develop neurotic patterns as a means of regaining this important position, as in the case of John. John had been an only child for eleven years and on the birth of another baby developed symptoms of chorea as indicating his inability to stand the competition which ensued.

In the study group of which 42%, 21 cases, were oldest children 71%, 14 cases, show jealousy toward a younger sibling in the main interpreted at the clinic as a reaction to parental preference for another stronger child. Of those who show no jealousy one case the sibling is out of the home. 10%, 2 cases, show comparison without any jealousy being evident because of their emotional security in the other parent, the mother, who in both cases over-protects them. One child is worried over his sibling's school retardation, but does not dominate them. There are friendly relations between two patients and their siblings.

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(1) Adler, Alfred Practice and Theory of Individual Psychology P. 382

The following classification shows the relation of parental attitudes toward the oldest child:

	Over-protective		Interested		Uninterested		Away		Rejecting	
	moth.	fath.	moth.	fath.	moth.	fath.	moth.	fath.	moth	fath.
%	52%	5%	5%	5%	15%	15%	5%	37%	23%	37%
No.	11	1	1	1	3	4	1	8	5	7

Thus over-protective mothers seem to be in the majority, as do fathers who either reject the child or are away either through death, desertion, or jail sentence.

William is an example of the over-protected oldest child who has been rejected by the father and shows some jealousy of his younger sibling.

William, aged four, is the older of two boys of American born parents. There is an older cousin, Ruth, living in the home. William is an attractive blond boy now growing out of babyhood and frequently compared by strangers to his younger brother, Bobby, who is blond, curly haired and sturdier.

His father, whom William resembles, is a small, rather insignificant looking man. He is seldom in the home, as he works at night repairing typewriters through which he hopes to build up a business of his own. He plays poker Saturday nights as his only recreation and loses more than he can afford. When he is at home his interest is concentrated on Bobby who plays around near him while he is eating his supper. His preference for Bobby is very obvious, for he only turns to William when he seems to be waiting for his turn to be played with. Most of the time William pays little attention to his father's and Bobby's games, but plays by himself in the corner or helps his mother. The father resents his wife's over-attention to the children and would like more of her attention given to him, yet will not give up his poker game to go out with her. His family background of good German stock is superior to her's. The presence of his niece, Ruth, irritates him, as she frequently disobeys him and is careless.

The mother is an attractive, small woman who seems very repressed and has few outside interests and those few connected with her children. She married at the age of 18 to get away from a very unhappy home life. Her family have very low standards, both parents drink, the home is ill-kept and sloppy. Her older sister, the mother of Ruth, is a prostitute having separated from her husband, and her younger sister is in an epileptic colony. It seems remarkable that she has grown from this background to have as high standards as she has, for her home is well-kept and the children clean. She worries a great deal about the effect of heredity on herself and her children,

fearing she will pass on to William the drinking habit of her parents. Attempts to reassure her on this basis seem to have little effect. She seems to be hag-ridden by the idea that she must make up to the children by careful bringing up for the heredity that she brings them and has a guilt feeling because of this.

Her relations with her husband are not very happy, as he can see no reason for her over-attention to the children and she for his not being interested in them to the exclusion of everything else. They seem to have drifted apart and the mother has at times contemplated a divorce, but will not carry it through because of her inability to support the children. The sex relations are not satisfactory as she fears pregnancy and finds contraceptives unsatisfactory.

William was born the first year of marriage and developed normally. When the mother was to be confined the second time William was 22 months old. The mother feared leaving him with his grandmother because she knew the careless treatment he would receive would off set her careful training. She finally sent him to a day nursery, but when she went to get him after her confinement she found him seriously ill with intestinal grippe. He did not know her or the father and seemed afraid of everyone. His recovery was slow and it was about five months before he seemed normal again. During this period she paid little attention to Bobby while the father played with him as he never had with William.

When William was well again he continued infantile patterns of enuresis and thumbsucking although the former had stopped before going to the day nursery. The mother was worried over this and tried various means to stop these habits with no success. Bobby became a more attractive child fatter than William and more sturdy and self reliant. As the mother said in speaking of the two, "I can mould Billy's personality as I please but Bobby's is like steel". William shows a great deal of love for her (complimenting her on her appearance) and enjoys being fondled and kissed. She tries to be fair to Bobby and in her attempts frequently gives him more than his share.

William tries to protect Bobby from punishment but it is evident that he desires to be the baby. On his psychiatric examination he transposed their ages insisting that he was 2 and Bobby 4, and at another time told the psychiatrist how people in the reception room spoke of Bobby's prettiness and not of his own.

He day dreams a great deal and sucks his thumb at this time. He plays fairly well with Bobby although he plays the more infantile role by allowing Bobby to dominate him. He was referred to the Child Guidance Clinic through the Mother's Club of a settlement which the mother attended regularly.

In his examinations at the clinic he was found to be most cooperative and interested in everything but the physical examination.

When he was given a psychological test he rated as very superior in intelligence with a I.Q. of 132 with above average ability in the use of language. In his physical examination he was found to be above average in height and weight, fairly well developed and moderately pale. He has injected eardrums with hearing impaired slightly on the left side. There is an over-bite due to thumbsucking.

Since the examination he has had a long attack of grippe from which he recovered slowly.

The position of second or third child is somewhat different from that presented by the older child. He already has to compete with the older children for affection and thus has not the emotional security the oldest gains. Flügel states in relation to this problem, "As a rule the younger child resents the advantages and privileges of which it finds the older child already in possession ... Older children on their part are inclined to regard any new arrival in the family circle as an intruder upon their preserves and a competition for their own cherished rights privileges and possessions." (1)

The middle child who may fall as one of the in-between children in families of three, four, five and six compose 24 % of the group studied..Of this group 50 % are jealous of their siblings and 50 % are on friendly terms with them, that is protected by them or protect them.

The following classification shows the parental attitude as found toward the middle child:

	Over-protective		Interested		Uninterested		Away		Rejecting	
	moth.	fath.	moth.	fath.	moth.	fath.	moth.	fath.	moth.	fath
%	58%	33%	17%	0%	0%	33%	8%	17%	17%	17%
No.	7	4	2	o	o	4	1	2	2	2

(1) Flügel, J. C., Psychoanalytic Study of the Family, P. 20

Thus the percentage of over-protective mothers again forms a majority slightly larger than that found with the oldest child while the uninterested or rejecting mother is lower but that of the uninterested father is higher.

The younger yet middle child when ill becomes the center of attention which in some measure outweighs the insignificance of his position as an in-between child. He becomes the one to whom the older and younger child must give in and attains his desired position of power only again to lose it with the return to health, and the younger child comes along and usurps his place. It would not be surprising therefore to have him show problems in his desire to regain the attention he has formerly had by any means which he can use. He may however not lose his position of power and continue as the over-protected babied child who takes the place of the adored older one and the natural baby of the family. It would not be surprising therefore if the other siblings should become jealous of him because they are getting tired of always having to give in to "mother's pet", They may be seen striving for recognition outside the home group because of their inability to obtain it at home.

The youngest child also possesses a unique position for as Adler states, "People seem to have known for a long time that the youngest child is a peculiar type...For the parents he represents a particular child, and as the youngest child he experiences solicitous treatment. He is not only the youngest but also the smallest, and by consequence, the most in need of help...In a sense the youngest child is like the child who comes into the world with weak organs". (1)

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(1) Adler, Alfred Understanding Human Nature P. 149

The mother of an ill child would then tend to over-protect him more if he were the youngest, as he would also be the weak member of the family through his immaturity. His illness therefore should demand more attention which would be continued for a longer period of time because of his inferior age. As he has the preferred position in the family, except for the oldest child, he should not show as high a percentage of jealousy as those children who have another child usurping their place by rights of his youngness. In one case however jealousy occurrs in a younger child because of inferior ~~in~~ intelligence, as compared to the older siblings. This child is also rejected by the mother as his illness coincided with a period of financial stress. The child therefore resents the positions the older children have in the home through their ability to earn money and through their higher intelligence and health.

20 % of the children studied are the youngest in the family, of these 4 cases show jealousy of other siblings, because of parental comparison on the basis of physical inferiority shown by the ill child as compared to the more mornal and preferred sibling. 5 cases are on friendly relations with their siblings although of these, 3 are protected by the older sibling. One sibling is out of the home.

The following classification shows the relation of parental attitudes toward the youngest child:

	Over-protective		Interested		Uninterested		Away		Rejected	
	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.
%	50%	20%	10%	10%	0%	30%	20%	20%	20%	20%
No.	5	2	1	1	o	3	2	2	2	2

The proportionately high percentage of over-protective mothers follows along the line that Adler above, would have us believe is natural. (1) This however, compared with the percentages in the cases of oldest or middle children seems less significant as they too have half of the mothers over-protective. The two fathers who over-protect do so in one case because the mother is dead and the father finds his main emotional out-let in the boy, and the other boy's semi-invalid state due to tuberculosis makes him dependant on the father who is more interested in the boy than in the mother. The fathers' rejection of the child in the two cases is based on too much attention by the mother to the child and consequent jealousy of him. Rejection by the mother is apparently caused in one case by the patient's having a lowered intelligence than her siblings and the other because he is her step-son.

The only children comprise 14% of the total cases. These present an interesting difference from the pre-conceived ideas of only children, for a small percentage of them are over-protected, while the majority are rejected on one basis or another. The following classification points out the type of attitudes shown:

	Over-protective		Interested		Uninterested		Away		Rejected	
%	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.	Moth.	Fath.
No.	28%	0%	0%	45%	10%	28%	14%	14%	55%	28%
	2	0	0	3	0	1	1	1	4	2

Of these one child who is rejected has been deserted by both parents. The high percentage of maternal rejection is notable because it differs from the expected trend. For, as Adler

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(1) Adler, Alfred Understanding Human Nature P. 149

says, "Parents of 'only' children are frequently exceptionally cautious, people who have themselves experienced life as a great danger, and therefore approach their child with an inordinate solicitude." (1) The high percentage can be explained in these cases in that these parents have not wanted the child in two cases, in one of which he was illegitimate, in the other the mother had him because he was recommended for her neurosis. The other two do not come up to the expected pattern of behavior probably because this has been too high. The parents have only one child on whom to vent their whole emotions and find this child lacking in what they most desire, a perfectly behaved child. They do not realize that this child is not yet grown up enough to take responsibility as an adult which is what they desire.

The following case of an only rejected child has many other factors contributing to the problem, as he was not with the mother for five years. He was, however, the only child in the foster parent's home and in the home at present he is an only child.

Bob is nine years old, an illegitimate child with blond hair and long lashes. He has had a number of operations for a tubercular knee, so that it is now ankylosed. He lives with his mother and step-father.

His mother has spent most of her life in institutions as her father died when she was two and she was placed in orphan asylums. When she came home at fourteen, her mother had her committed through the Children's Court to the House of Mercy on a charge of incorrigibility. She disliked the latter place, because of the type of girls who were there and the prevalence of gonorrhea and syphilis among the inmates.

Soon after she was released she became pregnant with the patient, Bob. Bob's father has now married and though

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(1) Adler, Alfred Understanding Human Nature P. 155

she occasionally writes to him, he does not know of Bob's birth. She went to I----House for her confinement and nursed Bob for nine months. At this time she was asked to be a wet nurse and left, deserting the child. On her return to her mother she was prevailed upon to marry a man whom she disliked " to give the child a name." She was never happy with him, accused him of having sex relations with her sister-in-law. Later she had the marriage annulled.

Before the annulment she took up with the present step-father who supported her for four years before marrying her. She has paid Bob's board quite regularly and when she heard he was in the hospital, brought him home with her.

She has had syphilis and last spring was taken to the hospital in a comatose condition diagnosed as "meningo luetic condition in the tertiary stage of syphilis." At the hospital she was suspected of malingering. She no longer attends the clinics.

At present she is a rather common looking girl dressed in an extravagant fashion, a fact that her husband resents. She would like to divorce him because she thinks he is stingy and she resents him personal uncleanliness and general uncouthness. She spends all the money he gives her and asks for more.

She resents the step-father's punishing Bob saying, "let him alone-he's mine." Although she shows him some affection she nags him about his clothes, petty details of behavior and calls him "lamey" when he misbehaves. She realizes she has little control over him and that his misbehavior at school is the cause of much trouble there. She is at times cruelly indifferent towards him and at other times wants to give him everything others have. She seems to be compensating to him for his lameness, yet it irks her and she remarks on it frequently.

The step-father works at a news stand which he owns in partnership. He is inclined to exaggerate money expenditures and his own generosity. He has had lues in France, but has received treatment for it.

He feels that Bob has been spoiled by past handling but as he has known him for only a year and a half, does not want to be over-strict with him. He is continuously on the lookout for disobedience and feels rather seriously the patient's defects in school.

Bob was unwanted child who after his mother's desertion of him at nine months spent the next five years in foster homes and hospitals. At two years he fell from a high chair and as a result of tuberculous infection was in the hospital off and on for the next five years. He has been with his

mother for the past year and a half and has shown various behavior problems such as lying, stealing, cruelty to the boys, poking and pinching others in school, show-off behavior in the classroom, cheating, and temper tantrums.

He is fond of his mother and seems to want to be helpful about the home. He makes fun of the step-father and is jealous of his relation to the mother. He steals money lying around the house but mainly from his step-father's pocket. He has a few friends in school who seem to admire his ability to fight and tell stories. He uses his lameness as an excuse for getting out of tasks, yet fights if anyone calls him "lamey". He attempts to play on the teacher's attitude of sympathy because of it and trips children up in the aisle saying that he cannot help it, as occasionally is true. His show-off behavior is so extreme that he has been considered the "worst problem in the school."

His school work is poor, as he seldom hands in any written work. He reads showly, but there is no disability. He is within the average range of intelligence with an I. Q. of 100. He enjoys drawing and will remain quiet to do only this.

In his physical examination he was found to be well developed and nourished with the pathology of the left knee due to an old tubercular infection. There is a compensatory scoliosis of the spine with considerable atrophy of the muscles above the knee to the hip and some of the calf muscle. Refraction was needed and attented to during treatment. Wasserman and Von Pirquet are negative. He shows an ear perforation due to an old infection.

In the staff conference it was felt that he represented the problem of an only child with little security through the fact that his mother, owing to her lack of development beyond the narcissitic stage, has been able to give him little love. He has been given a great deal of attention in the past and has had a difficult time adjusting to school where he must become only a member of a group. His show-off behavior and stealing are an effort on his part to get that attention which he has had and misses. His fighting is a normal way of keeping his place in a group and a compensation for his lameness.

SECTION VII

Conclusions:

The factors found to influence the development of the behavior problems of the children with long continued illness can be considered applicable only to the cases studied. The general conclusions reached are stated below.

1. The illnesses found in this study group are comparable to the physical defects found in examination of public school children and entering college students plus a higher percentage of the more serious and the more unusual diseases. The nature of these diseases increases parental worry over the child and therefore increases the attention centered on the ill child.

2. The problems are comparable to a large clinic group except for school difficulties which are higher in the study group and lying and stealing which are lower in the study group. The problem of inferiority feelings, however, is equal to the clinic group.

3. The illness tends to induce over-protection by the mother, as it is found in 50% of the cases. There are cases in which there are more than one child in the family.

4. Fifty-seven percent of the mothers of only children in this group reject them. The reasons for rejection are varied, but do not seem to be related to the illness.

5. Illness tends to induce parental comparison with another stronger sibling with resultant jealousy. This is especially important in the oldest or middle children when compared to younger children by the parents.

6. Illness is a contributory factor in the development of the problem child heightened or accentuated by the parental handling of the situation.

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