SOME FACTORS IN THE AETIOLOGY OF MALADJUSTMENT IN CHILDREN:*

A Comparison of 100 Children "Ascertained" as in Need of Special Educational Treatment and 100 others referred to a Child Guidance Clinic.

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(Based on a thesis for the degree of M.D.Cantab.)

Introduction.

The Education Act of 1944 lays on the Local Education Authorities the duty of providing special educational treatment for certain categories of children distinguished as "handicapped." Included under this heading are maladjusted pupils. These are defined (by regulations) as "pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment to effect their personal, social or educational readjustment." This definition is, in the words of *The Times* (1950), "broadly based," and has indeed been a source of confusion. The first clause asserts a proposition which is very nearly circular, since "emotional instability" and "psychological disturbance" stand as much in need of definition as maladjustment. The second clause makes for even greater uncertainty. Is it intended to indicate that only *some* children showing evidence of psychological disturbance or emotional instability need "personal, social or educational readjustment"? The suggestion that this can be effected by special *educational* treatment has led to much bewilderment. Presumably what is intended is that these children have, in common with other handicapped children, a need for special educational treatment, and also a need for personal, social and educational readjustment. For no other class of handicapped pupils is it suggested that the handicap can be treated by *education*, however widely this term is conceived or however specialized to the particular needs of the handicapped child.

This definition given by the Ministry of Education has had the further unfortunate consequence of leading administrators to think that maladjustment has a precise significance, and that all maladjusted children can be treated in the same way.

A clearer concept would seem to be to designate as maladjusted all those children of the sort who would be judged by a psychiatrist (or the "team" of a child guidance clinic) to need treatment. (Maladjustment is a term whose connotation is of the same order as that of the term "sick," and, just as not all those who consult a doctor would be judged by him to be sick, and just as he

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would point to a number of sick people who fail to ask for medical aid, so can the psychiatrist say that under the heading "maladjusted" ought to be included some but not all of those referred to him and also some who fail to reach his notice.)

Of this large group, a further classification is permitted between those who are and those who are not "ascertained." Those who are ascertained are of a variety of types. The Ministry of Education does not attempt to define or describe any of these. Their only definite stipulation is that the recommendation for a child to be "ascertained" as maladjusted should be made by a psychiatrist approved by the Ministry for the purpose.

Once the child has been ascertained, the possibilities available for complying with the Act are:

1. Special boarding schools for maladjusted pupils.
2. Ordinary boarding schools (provided they are approved for the purpose by the Ministry of Education).
3. "Boarding homes" with attendance at ordinary county schools.
4. Foster homes with attendance at ordinary county schools.

It is clear that the essence of the "special educational treatment" is removal from home.

As the child may remain away from home, with or without holidays at home, for any period up to the remainder of his school life, the decision to send him away is an extremely serious one.

In practice, this decision is usually made in a child guidance clinic where the approved psychiatrist is assisted by a child guidance team and, frequently, by other social workers who have had occasion to concern themselves with the child's welfare. Children attending a child guidance clinic fall into two main groups:

1. A group suffering from some psychiatric disability of congenital or constitutional* type.
2. A group exhibiting the type of symptoms or signs which are held to be indicative of strain in meeting the demands of the environment.

While only a few can be said with certainty to be of the first type, the dividing line between the two groups is not clear cut. Both groups (in common with all children) are having difficulties of adaptation to their environment. The first group may be considered abnormal or potentially abnormal, the second group potentially normal or normal. Clearly there are many borderline cases, and some children who might properly be said to belong to both groups.

Although, in general, it is probably more difficult to cater for the first group in their own homes, the decision to send children away does not depend solely on the nature of their disability. What has to be considered in every case is the relationship between the child and his environment. Some homes may provide the shelter needed by seriously disabled children better than any

* The word "constitutional" has tended to become, in medical language, synonymous with "hereditary." The N.E.D. gives the definition "pertaining to man's physical nature as regards healthiness, etc." It should, therefore, include acquired conditions which permanently affect his physical nature, and is here used in this wide sense.

specialized institutions. At the other extreme, a particularly robust child may stand up to an environment which would, by all ordinary standards, be condemned. In the first case the fact that the child was abnormal would not necessitate his removal from home, nor would the badness of the home in the second.

For practical purposes the definition of maladjustment must take both symptoms and aetiological factors into account. A child cannot be considered in isolation from his home, and so while, for scientific purposes, the condition of the home may be found to be a cause of the maladjustment, for practical, therapeutic purposes it is part of the maladjustment. For this reason the group is not homogeneous. One of the purposes of this paper is to try to make a separation between these two closely interconnected elements of the problem.

Mental health workers—cf. Bowlby (1951)—are aware that material conditions are not an adequate index of the suitability of an environment for a child, and believe that, even for a child of school age, separation from his home can have adverse effects on his mental health, and is not, therefore to be advocated unless it is fairly certain that the advantages will outweigh the disadvantages. Good material conditions in his home may compensate (though not in any exact quantitative way) for bad parental attitudes; other things being equal, the worse the child's disability, the better the environment needs to be.

Criticism of Previous Work.

Surprisingly little attention seems to have been given either to the general problem of the aetiology of maladjusted behaviour in children or to comprehensive studies of the various aetiological factors operating in any given type of disorder. Recently a large number of authors in America and elsewhere have written on the origins of psychopathic behaviour disorders in children, e.g., Bender (1947), Goldfarb (1945, 1947, 1949), Menat (1943) and Spitz (1945, 1946 and 1952) have discussed the relationship between the type of behaviour manifested by the child and the (emotional) adequacy of the home background. These, and a large group of authors, have tried to give the criteria of an adequate background for normal mental development. All the literature between 1940–51 has been summarized by Bowlby (1951), who has specially stressed the importance of good parental attitudes to the child in his early years, and has sought to demonstrate the adverse effects of early separation of the child from its mother. Two recent writers on delinquency, Stott (1950) and Epps (1951), have made a detailed analysis of the home backgrounds of delinquents, and displayed the close connection between unsatisfactory homes and antisocial behaviour. Carey-Trefzer (1949) demonstrated the damage done to evacuated children by separation from their parents.

Material of the Present Survey.

At the present stage of psychiatric work a study of aetiological factors must necessarily remain incomplete. The data to be presented here are those that are available to workers in a child guidance clinic. This study is essentially "Clinical Research"—i.e., the information has been collected in the course

of work directed primarily to therapy While history-taking has been more protracted and more exhaustive than in a general medical clinic, it had not been planned with research in view and the data were not always recorded as fully as could be wished. The data come mainly from the observation of psychiatrist, psychologist and psychiatric social worker, and from the information volunteered by the child and his parent (or substitute)—usually the mother.*

The group studied consists of the first 100 children "ascertained" in 1949 and 1950 as in need of special educational treatment as maladjusted pupils. In what follows this will be referred to as the *ascertained* group.

It is thought that the significant features of the ascertained group can only be brought out by contrast with a control group.

For this purpose a group has been taken which is not a completely random selection, as it was decided that the age range should be that of the ascertained group, and therefore pre-school children (who are numerous in both clinics) were excluded and also children over 15. Other cases had to be excluded because of incompleteness of data; it seemed justifiable, therefore, to confine the control group to 100 cases which were selected three or four per month over a 15-month period and, subject to the limitations just described, constituted a random sample from the restricted group.

The comparisons that have been made have been subjected to simple statistical tests of significances, but space does not permit of giving the results in every case. Elaborate statistical procedures have been avoided, as it is not considered that the order of accuracy of the basic data is such as to justify complicated mathematical manipulation. In psychiatry, as in the social sciences in general, many assessments must be subjective, many desired facts are unobtainable and many significant phenomena are not susceptible of precise quantitative measurement.

One of the major difficulties for the social sciences has been encountered in the course of this investigation, viz., it is never possible to say that two classes of human beings which are regarded as similar contain individuals who are in fact similar, even in one relevant respect. For example, step-parents will be shown to have provoked an exceptional amount of aggression in the children studied. Yet in the large population that has no need for the services of a child guidance clinic, there are many step-parents who have the happiest relationships with their step-children. Hence the high degree of aggression displayed by the children in the care of substitute parents in the two groups under consideration is not sufficient to establish that substitute parents are themselves bad. Having a substitute parent is one, and one only, of a collection of experiences that the child has had. It is singled out because it is an indisputable and objective fact, but it is certainly not the only important fact in the child's life, and may not be the most important. Moreover, what is important for one individual member of a class may not be important for another. Any attempt to classify human beings must introduce these distortions and

* The word "parent" will be used to include persons exercising guardianship over the child, unless the context calls for an exact statement of the relationship, and "mother" is to be taken, similarly, to stand for female guardian.

sources of error. "There must be two ways of viewing the data: in classes, and as individual living biographies to be understood rather than schematized." Persons engaged in the practice of psychiatry in child guidance clinics are not likely to overlook the "individual living biographies." They are all too conscious of the imperfections of their classifications.

Another difficulty in psychiatric and sociological classification is that the attributes of the individuals classified are not independent of one another. Experiences such as acquiring a step-parent or losing a natural parent are connected with other experiences such as being neglected, being moved from home to home; these in turn with greater proneness to illness, a likelihood of poor attainment at school, a tendency to seek compensations that may militate against the development of character in socially acceptable ways. In social life one misfortune tends to predispose the victim to others.

Even the hostile, rejecting or cruel attitudes of adults to a child are not entirely independent of the child's previous experiences. If, for example, a child were not actuated by the need to "try out" his substitute parents, many of their unfavourable responses would never be elicited. It is not necessary to attribute absolute badness either to them or to the child. Situations arise in which each brings out the worst in the other. When social relations have become pathological, just as in organic disease, vicious circles can be set up and disaster can beget disaster. The "individual living biographies" of 200 cases cannot be given in full, but all contain intricate chains of circumstances from which a limited number of facts, artificially isolated, have been selected for study.

In addition "school failure" was mentioned in 20 cases and was the main complaint in 9, but it is difficult to know whether this frequency is reliable, as attainment tests were not performed as a routine.

Lying has also been excluded from the list, as when it is complained of it is often merely to give emphasis to the main complaint; at other times it may reduplicate a complaint already made. It is less reliably recorded than other symptoms

(1) because it can only refer to the lies that are exposed;
(2) the emphasis placed on it varies with the moral status of the informant.

The only other symptoms noted on referral were:

Stammering	1 case
Asthma	1 ,,
Thumbsucking	2 cases
Fears, anxiety or depression	4 ,,

CHAPTER I.

SYMPTOMATOLOGY.

Table I is the standard table of symptoms in use in child guidance clinics, and covers all the conditions for which children were referred to the two clinics in the period under review.

TABLE I.

1. *Nervous Disorders.*

Fears and anxiety.
Depression and lethargy.
Solitariness and unsociability.

2. *Habit Disorders.*

Enuresis.
Sleep disorders.
Habit spasms.
Feeding difficulties.
Hysterical symptoms—Aches and pains.
Vomiting.
Blindness.
Aphonia, etc.

3. *Behaviour Disorders.*

Delinquency (including stealing and lying).
Difficult to manage at home.
Difficult to manage at school.
Aggression.
Truancy and absconding.
Abnormal sexual behaviour.
Temper tantrums.

4. *Constitutional Disorders.*

Bizarre symptoms ? pre-psychotic.
Epilepsy.
Physical defects or disabilities.

The main symptoms of the ascertained group were as follows :

Aggressive behaviour	67
Stealing	28
Enuresis	22
Truanting	19
Encopresis	10
Destructiveness	9
Abnormal sex behaviour	7
Physical disabilities	5
Bizarre behaviour	3
Total	170

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The main symptoms given above were found among the control group as follows:

Aggressive behaviour	25
Stealing	16
Enuresis	28
Truanting	5
Encopresis	5
Destructiveness	4
Abnormal sex behaviour	2
Physical disabilities	3
Bizarre behaviour	1
Total	89

but at least 25 different symptoms have been listed (those of Table I).

The Significance of Symptoms.

Table I is the classification in use in child guidance clinics. It is a somewhat haphazard compilation, and is not satisfactory either from the logical or the nosological point of view. In the first place it seems important to make a sharp distinction between the symptoms of Group 4, which are symptoms of organic diseases, and those of the other groups which are symptoms of psychogenic disturbances.

The symptoms in the first three groups are of two sorts:

(1) those which *directly* express a disturbed state of mind, e.g., *aggression*, *temper tantrums*, etc., and

(2) those which are accepted as the *indirect* expression of a disturbed state of mind. It is now generally accepted that disturbed states of mind can be indicated by manifestations very similar to those which indicate disturbed states of body. It is, nevertheless, a little puzzling that mental disturbances are in some cases directly expressed, whereas in others the manifestations are so remote from the prime cause as to create a difficult problem of differential diagnosis.

A brief account must, therefore, be attempted of current views on this subject. What follows is very largely derived from Slavson, but his terminology, since it seems unnecessarily elaborate, has not been employed.

The states of mind which young children have to express in symptoms are few. The emotions of infancy are love, hate and fear.

These emotions are in one sense "primary," but they appear as a reaction to the emotions and attitudes of the parents. Even in the happiest home all three emotions will be brought into play, for no child can be brought up without sometimes being frightened, sometimes being made angry and resentful; but in the good home fear and hate do not occasion more than transient disturbances in the smooth passage from infancy to maturity.

If, however, the relationship between child and parent is disturbed, then

emotional disturbance in the child will follow and show itself in disturbed behaviour.

Bad parent-child relationships can be of any magnitude and can be temporary or permanent. The causes are many and complicated : some will be discussed in Chapter II, and the relationship of these causes to the symptoms shown by the Ascertained Group will be discussed in Chapter III, but it will only be possible in this paper to give a full account of the grosser examples.

One of the problems of relating symptoms to mental disturbances is the fact that there is not a simple one-to-one correspondance between *one* symptom and one state of mind. The symptom may express one primary emotion or more than one in combination. The emotion may be quite plainly expressed, or it may be disguised by the form taken by the symptom. The term " direct " will be used of those symptoms which are the normal bodily accompaniments of a strong emotion, the term " indirect " when the emotion is expressed in a more sophisticated way, and the term " compound " when two or more emotions are expressed simultaneously.

Direct Symptoms.

Of the primary emotions, fear might be regarded as the most primitive. Unmodified and uncomplicated manifestations of it are, however, rarely seen in psychiatric practice among children. The reason for this may be (1) that in a civilized community, when a child is giving unmistakable evidence of fear, other agencies intervene : (2) that children rarely get to a child guidance clinic in the acute stages and " in time we hate that which we often fear." Fear can be recognized as a component in some of the indirect and compound symptoms. It may be that when apparently hate is being directly expressed, fear is also being expressed. (Or, alternatively that fear has given way to hate.)

Just as physical health can be harmed by undernutrition as well as by a noxious diet, so can the child's mental health be affected by neglect and lack of affection as well as by ill-treatment (Spitz, 1952). And just as the reaction to undernutrition can be voracity, perversion of appetite or anorexia, so can the reaction to lack of affection be a craving for excessive stimulation, sexual perversion or apathy. The number of cases described as exhibiting " abnormal sexual behaviour " is small. When due allowance is made for the tendency to regard as abnormal *any* manifestation of sexual behaviour in a young child, the number becomes negligibly small. Some components of the compound symptoms can be seen to have sexual significance.

Consequently almost all the direct manifestations of primary emotion which bring a child to the psychiatrist are aggressive.

The function of psychogenic symptoms, whether direct, indirect or compound, is (1) to serve as evidence of the disturbed state of mind, (2) to gain some advantage, and (3) to have an effect on the feelings of others. It is obvious that aggressive symptoms fulfil the first and third functions. The effect that they wish to have on the parents may be regarded as " punishment " (i.e., to retaliate and, in an unformulated and rudimentary way, also to deter and reform.)

Indirect Symptoms.

Direct symptoms incur disapprobation. Their persistence in spite of measures taken against them is an indication of the strength of the underlying feelings. Painful consequences are, within wide limits, deterrent, and it is to be presumed that they will always have some effect It may not, however, be the desired effect. When the strength of the primitive impulse is very great, retributive action may only intensify it. If the impulse is slightly weaker, the effect may be to modify the symptom. A group of symptoms can be distinguished which would seem to common sense to be expressing a strong and aggresive feeling, but not with the same complete lack of organization as primitive aggression. These are to be described as "indirect." Direct and indirect symptoms between them make up Slavson's group of "primary behaviour disorders."

Compound Symptoms.

With increasing maturity the child develops a "conscience," i.e., a sense of guilt: When this has happened* the child will blame himself as well as others for his misfortunes and the symptoms will have the further function of *self-punishment.*

It is because of the number of ends being served simultaneously by compound symptoms and because the relation between the components is not necessarily one of simple summation that the symptom produced may seem at first sight so remote from the major mental disturbance.

This can be particularly well seen in adult neurotics: Freud, for instance (1917), takes the view that "melancholia" is the symptom produced when the patient combines grief for the loss of a loved object with the belief that he was responsible for the loss. He may punish himself to the point of self-destruction.

Even in this extremity he punishes others: the neurotic's "They'll be sorry when I'm dead" is all too true. None of us is quite free from self-reproach about our treatment of others and we are, therefore, vulnerable when they die.

As a further example, the hysterical symptom serves many purposes. The patient "gains through illness"; he finds his way to the centre of attention. At the same time he punishes others by the inconvenience he causes them. Nevertheless, their loss of normal pleasures and satisfactions is small compared with his. Still other purposes can be detected Some feature of his symptomatology will give a clue to the reason why he finds it necessary to go to such lengths to punish himself and others. These two examples have been given to show the complexity of symptom formation. They also demonstrate the presence of a powerful aggressive component even in behaviour which superficially shows no trace of it.

It seems possible, then, to arrange symptoms in an order of increasing complexity from aggression undisguised and unalloyed to manifestations in which aggression is one of many components and is nearly, if not completely, hidden

* It is not, of course, to be supposed that "conscience-formation" is a simple or instantaneous process. At any given time it may be imperfect in degree or extended only to certain of the person's activities.

from view, partly because it is overlaid by others, partly because it appears in such an unrecognizable form.

Symptom-Formation in Childhood.

The psychogenic symptoms of children represent all degrees of complexity between the extremes.

Certain symptoms other than primitive and unmodified aggressive behaviour (" primary aggression ") seem to be almost purely aggressive : ***destructiveness*** and ***stealing***, for example, seem to be very near to pure primitive aggression but can be seen to be, to some small extent, more " organized."

Truanting is held to have a large aggressive component—it is, in effect, an attack on authority—but often contains a component of fear, as well as of hostility.

In *encopresis* we come to a symptom where the offensive weapon is turned not only against others but to some extent against the patient himself. Even is (as commonly appears to be the case) he is not directly offended by it, he is indirectly injured by the social ostracism to which it leads.

These four symptoms can be regarded as indirect. They express, with a little disguise, the state of mind of the patient, and are directed very much more obviously against others than against the self.

A symptom that is difficult to place in the scale is *enuresis*. Physiological in the infant, aggressive in the young child (who gives offence by it but suffers little or no inconvenience himself), it comes to contain a large self-punishing element when, e.g., because of it, a child dare not sleep away from home, or an adult has to avoid a desired career or even renounce the idea of marriage.

The other " habit disorders " of Table I conform very closely to the neurotic symptoms of adults.

A possible regrouping of psychogenic symptoms would then be :

I. *Direct Symptoms.*
  Symptoms of primary emotions :
    (*a*) abnormal sexual behaviour.
    (*b*) " primary aggression."
II. *Indirect Symptoms.*
  " Secondary aggression," viz.:
    (*a*) Destructiveness.
    (*b*) Stealing.
    (*c*) Truanting.
    (*d*) Encopresis.
III. *Compound Symptoms*, viz.:
    (*a*) " Habit disorders."
    (*b*) Hysterical symptoms.
    (*c*) Depressive symptoms.
    (*d*) Anxiety symptoms.

This analyses without remainder the symptoms of the first three groups of Table I except for enuresis. This symptom, for the reasons already given,

cannot be assigned to any one class. Furthermore, it is quite frequently of organic origin, though this is often overlooked when it appears at the same time as symptoms that are psychogenic.

The objects of this long-drawn out-discussion are—

(1) *General*: to give a partial account of the nature of psychogenic symptoms and to display some, at least, of the ends they serve.

(2) *For the purposes of this paper*: to find some unity among diversity to make a basis for.

(*a*) an objective index of the "severity" of the disturbance of the child;

(*b*) a measure for comparing the ascertained and control groups;

(*c*) a criterion by which the significance of aetiological factors can be judged.

It has been pointed out that "belonging to the ascertained group" is not a simple character and, though it is of interest and importance to find that a certain factor appears with more frequency in the background of the ascertained than in that of the control group, it does not enable us to identify the feature of maladjustment with which the factor is associated. If it can be accepted that, in spite of its multiplicity of manifestations, aggression is a unitary character, then the problem becomes more interesting in that we need not confine our study to associating aetiological factors with ascertainment, but can explore the connections between external disturbances and expressions of aggression in the child (see Chapter III).

Difference in Symptoms manifested by Ascertained and Control Groups.

This simplified classification can now be used to bring out certain differences between the ascertained and control groups.

	Ascertained.	Control.
Direct symptoms		
Abnormal sexual behaviour	7	2
Primary aggression	67	25
Indirect aggression		
Secondary aggression	66	30
Compound symptoms	8	60
Enuresis	23	28

This comparison shows the predominance in the ascertained group of (1) direct symptoms and (2) symptoms of aggression.

There is little difference in the incidence of enuresis in the two groups, but there is the difference, not indicated above, that in the control group it was often the only symptom: in the ascertained group, never.

The 100 children of the ascertained group have between them a rather larger number of symptoms than the control group. The difference is not great, but it is at least possible that it should be bigger: The minor symptoms of the ascertained may seem unimportant by comparison with their major problem. On the other hand, there may be a tendency to make up in quantity for the lack

of severity of the symptoms of the control group to justify their claim for attention. Absolute accuracy cannot be attained, but the differences between the two groups are great enough to make quantitative comparisons worth while in spite of some margin of error.

Aggressive Symptoms.

The only source of inaccuracy about aggressive symptoms is the possibility that exasperated informants will exaggerate their severity. In most cases, however, information was available from school and other sources as well as from home and reports were consistent: moreover, confirmation from the subsequent history was available in almost every case.

Aggressive Temperament.

The number of aggressive children cannot be deduced from the number of aggressive symptoms.

There are two ways of arriving at the number of aggressive children: (1) to designate as "aggressive" each child showing one or more aggressive symptoms; (2) to obtain an independent assessment of "temperament" from observers. This assessment was made by the child guidance clinic staff on the basis of their own observations and the information provided by the schools.

Each child was rated as either—

1. Aggressive,
2. Dejected,*
3. Neither,

and the degree of aggression or dejection was also rated as severe, moderate or mild. While this has the usual defects of subjective estimates, it serves to draw attention to a group of children at the extreme end of the aggressive scale who can fairly be designated as violent.

These have been brought to our attention on account of damage to life or property, because schools refuse to keep them or relatives to house them. Children with aggressive temperaments were found in both ascertained and control groups but in very different proportions:

	Estimate of aggressive temperament.							Total.
	+++	++	.+	±	−	−−	−−−	
Ascertained . .	28	32	12	12	8	7	1	100
Control . .	3	14	11	42	17	10	3	100
Total . .	31	46	23	54	25	17	4	200

$x^2 = 22{\cdot}2$. $P > 0{\cdot}01$. (for $n = 4$)

Of the aggressives, those classed as "violent" number 28 in the ascertained group, three in the control group.

* The term "dejected" has been taken as the nearest opposite of aggressive. It is used to cover children described as "depressed," "timid," "withdrawn," etc. It is unfortunate that there is no exact antonym.

In neither ascertained nor control group was there any appreciable difference between boys and girls in the incidence of the aggressive temperament. In both groups there were more boys than girls who were violent (in all 22 boys, 9 girls) but the numbers are too small for this difference to be statistically significant.

Number of Children Manifesting Aggressive Symptoms.

The number of children manifesting aggressive symptoms is smaller than the number of symptoms, since some children manifest more than one aggressive symptom. It is not the same as the number manifesting primary aggressive symptoms, since it will include those who manifest *only* secondary aggressive symptoms.

It cannot be very different from the number judged to have the "aggressive temperament," since all those manifesting primary aggressive symptoms will be judged to have the aggressive temperament. So, however, will *some* of those manifesting secondary aggressive symptoms. A discrepancy arises (1) because not all those manifesting secondary aggressive symptoms will be judged to have an aggressive temperament; in spite of the symptom, some appear to the judges to be "dejected" and some "neither aggressive nor dejected"; and (2) because some are judged to have the aggressive temperament without a specific aggressive symptom being recorded (three in the control group).

	Ascertained.	Control.
Number manifesting primary aggressive symptoms	67	25
Number rated as aggressive	72	28
Number manifesting secondary aggressive symptoms (but not rated as aggressive)	11	16

On the assumption that dejection can be an indirect symptom-complex in which hostility is an important component, any child in this group who also shows other evidence of aggression should be placed in the aggressive group.

On this calculation the number of aggressive children in the ascertained group becomes 83, in the control group 44. The remainder manifested the type of symptoms referred to above as "compound."

In the ascertained group there was in every case some additional factor, such as organic disease or defect or some special circumstances in the home background, which weighed the scales heavily against the likelihood of profiting by treatment as an out-patient.

Severity of Aggression.

The assessment of temperament has already indicated that the aggression of the ascertained group is more severe than that of the control group. This can also be tested by an analysis of the number of children exhibiting one, two, three or four aggressive symptoms respectively (counting a rating of aggression as one symptom).

	Ascertained.		*Control.*	
Aggressive symptoms.	*Number.*	*Per cent.*	*Number.*	*Per cent,*
One symptom . . .	47	57	33	75
Two symptoms . . .	25	30	9	21
Three symptoms . . .	8	10	1	2
Four symptoms . . .	3	3	1	2
Total	83	100	44	100

The difference between the proportion exhibiting one symptom only and that exhibiting two or more in the two groups is statistically significant.

It may not always be legitimate to suppose that a person who shows several aggressive symptoms is more aggressive than another who shows only one but shows that very strongly. When individual patients are being dealt with, evidence accumulates from a variety of sources to show the "strength" of feeling in each case: but when groups are being dealt with, the additional qualitative information cannot be used. As a rough index it seems reasonable enough to assume that the group which shows the larger number of aggressive symptoms is, in fact, the more aggressive. This seems more than ever justified in view of the consistency of this result with that obtained from the assessment of temperament.

To sum up at this stage: The ascertained group differs from the control group by containing (1) significantly more children manifesting the "aggressive temperament," (2) a significantly greater number of aggressive symptoms, and (3) more aggressive symptoms per aggressive child, i.e., not only are there more aggressives in the ascertained group but on the average they are more severely aggressive than the control group. Although aggressiveness is not the only attribute distinguishing the members of the ascertained from the control group, it is more significant than any other.

Two not immediately self-evident propositions emerge from this discussion of symptoms:

(1) The differences between the ascertained and control groups, though great, are not absolute.

(2) The meaning of "severity" in psychiatric problems is complex; on the one hand the judgment is clinical, on the other social, i.e., when a child is ascertained as maladjusted and removed from his home, he may be ill or he may be a nuisance or both. The fact that a child is a nuisance plays perhaps the biggest part in reaching the decision that he needs "special educational treatment" away from home, but it cannot be the sole deciding factor, since there are a certain number of nuisances in the group not ascertained.

CHAPTER II

Aetiological Factors.

Data Suggesting a Constitutional Factor.

Hereditary Factors.

The data available do not permit of a detailed inquiry into genetic factors. Information about grandparents and collaterals is based on hearsay, and it is

to be expected that the information will be biased by the well known tendency to find positive traits more frequently among the collaterals of patients who themselves exhibit a positive trait.

Moreover, in spite of a high incidence of mental disorder in the parents of the children studied, there are comparatively few cases where the behaviour of the child, however anti-social, could not be regarded as the reaction of a normal child against intolerable circumstances.

There were in all twelve families in which a child exhibited symptoms of a recognized mental disorder.

Of these families with an affected child, five gave a positive family history (one or both parents affected): both parents were affected in two cases. The incidence is certainly higher than would be expected in a completely chance association. In view of the small size of the group, little more can be said. In view of the fact that the children were all below 15 years of age it is perhaps significant; i.e., that if gross mental disease is present in a child, it is likely that one or both parents suffer from a mental illness. Because of this limited age-range, no evidence to the contrary can be adduced from the cases where the parent was suffering from a recognized mental illness, but no comparable diagnosis could be made for the child.

TABLE II.

Diagnosis of child.	Number of children.	Diagnosis of— Father.	Mother.
Ascertained:			
Epilepsy	3	0	0
Schizophrenia	2	"Schizoid"	0
		0	"Schizoid"
Paranoia	1	"Psychopath"	Hysteric
Depression	1	Depressive	"Neurotic"
Mania	1	0	0
Total	8	3	3
Control:			
Epilepsy	2	0	0
Schizophrenia	1	Schizophrenia	0
Depression	1	0	0
Total	4	1	0

Sex and Age.

There were 64 boys and 36 girls in the ascertained group, 58 boys and 42 girls in the control group. The difference in sex composition of the two groups is not significant and no difference has been found to be related to sex. Consequently boys and girls have not been treated as separate groups.

Age.

In the ascertained group there were 58 cases under eleven, 42 over: these numbers are very closely in proportion to the school population (roughly 6/10 under eleven, 4/10 over eleven). The average age for boys was 11·8, for girls 10·0, for boys and girls together 11·1 years.

In spite of the fact that the age range of the control group was chosen to correspond with that of the ascertained group (5—15+), the average age was 9·7 (see Table III).

There is a significant excess of children from the infants' schools in the control group, a significant excess from the secondary schools in the ascertained group. In the ascertained group there are two peaks, one in the ninth year, one in the twelfth. The excess in these two years is significant.

Intelligence.

The children in both groups were given the Terman Revision of the Stanford-Binet Test and the distribution of I.Qs. is shown in Table IV. In the ascertained group the range is from 80–170. The I.Q. range does not go below 80, not because duller children are not maladjusted, but because schools will not accept them. The mean I.Q. of the ascertained group was 104, the median 100 and the mode 92.

There are 47 children with I.Qs. between 80 and 100, 32 between 100 and 119 and 21 have an I.Q. above 120.

In the control group the mean I.Q. is 105·7 with median and mode respectively 105 and 104. The range is from 67 to 150 and the distribution is symmetrical, i.e., the difference between the two groups is in the distribution rather than in the means.

TABLE III.—*Ascertained Group: Relationship between Age and I.Q.*

Age.	I.Q. Under 100.	100–119.	120 +.	Total.	Average I.Q.
Under 11	30	23	5	58	101·3
11	7	5	5	17	100·5
12	6	4	2	12	104·0
13	4	0	4	8	110·0
14	0	0	3	3	135·0
15	0	0	2	2	140·0
Total	47	32	21	100	104·0

TABLE IV.—*Control Group: Relationship between Age and I.Q.*

Age.	I.Q. Under 100.	100–119.	120 +.	Total.	Average I.Q.
Under 11	25	34	9	68	107·0
11	3	3	4	10	112·0
12	2	5	0	7	104·3
13	3	2	0	5	98·0
14	1	1	3	5	108·0
15	2	3	0	5	102·0
Total	36	48	16	100	105·7

36 of the control group had I.Qs. between 80 and 100, 48 between 100 and 120 and 16 above 120.

The high value of the mean in the ascertained group is accounted for by the excess of older children in the ascertained group. Since the school-leaving age is higher for grammer schools than for secondary modern schools, all those

in this group aged 14 and 15 come from grammer schools (which cater for children with I.Qs. above 120). This accounts for the fact that 16 of those over eleven have an I.Q. above 120 as compared with 5 of those under eleven.

A comparison has therefore been made of the distribution of I.Qs. among children of primary school ages (five to eleven) to give a better picture of the difference between the ascertained and control groups. In the ascertained group more than half of these had I.Qs. below 100 ; in the control group approximately one-third. The difference is significant.

It was noted that there was an exceptionally high incidence of ascertained children between the ages of eight and nine. It is of some interest that of the 18 ascertained children of this age no less than 14 were below average in intelligence and none had an I.Q. above 110. This is significantly different from the expected frequency (50 per cent. below 100, approximately 25 per cent. above 110). In the control group there were only 10 children of this age, but 7 had an I.Q. of 100 or more.

It might be inferred that duller children manifest the symptoms which lead to ascertainment at an earlier age than bright ones. It may be that the pressure of school work becomes serious for the first time in the ninth year with a selective effect on the behaviour of duller children.

Environmental Factors.

Social and economic.

The districts from which these samples are drawn are reasonably prosperous suburban and dormitory areas. An assessment of social class by the health visitor notifying births put the majority into the Registrar-General's Social Class III, but with considerably more in Classes I and II than in Classes IV and V. While our data do not permit great exactitude on this subject they suggest that the clinic population does not follow the pattern of the rest of the community from which it was drawn. Financial hardship and poor material circumstances are more frequent than would be expected and affect from one-third to one quarter of our patients. These assessments are subjective and not quantitative, but are reasonably reliable. The ascertained and control groups are not significantly different in these respects, and while economic and social differences may play some part in bringing children to the child guidance clinic, there is no evidence that they effect the likelihood of any particular child's being ascertained as in need of special educational treatment.

Size and position in family.

The calculation of size and position in family is not completely free from difficulties.

First of all, how should a family be classified where one or more sibling has died ? Goodenough and Leahy (1927) adopted the arbitrary rule of excluding from their calculations siblings who had died before their third birthday. This does not seem satisfactory from the psychological point of view : death does not remove the memory of a sibling from a child's mind ; it seems better, therefore, to exclude miscarriages (about which information is, in any case, extremely

inaccurate), but to count all other siblings, including the stillborn. In the present material there were extremely few deaths recorded; no serious error would be introduced whatever system were adopted.

A much greater difficulty is presented by the number of "composite" families arising from such circumstances as illegitimacy, adoption, remarriage and irregular unions.

The principle has been adopted of regarding as a sibling anyone whom the child would consider a sibling, i.e., if a child is adopted and subsequently a natural child is born, the adopted child is counted as the first of two. Similarly, if a widow with two children marries a widower with three and they subsequently have two of the marriage, the eldest is regarded as the eldest of seven. There is thus a slight tendency to weight the figures towards the larger families. The error introduced should affect both ascertained and control groups equally and, in view of the infrequency of large families, the amount of error must be small.

The one striking point brought out by this comparison is that "only" children are very much more frequent in the ascertained group than in the control group. The difference is highly significant. This has been found by others and accepted as evidence that only children are more prone to mental disturbance than members of large families.

The excess of only children in the ascertained group cannot, however, be taken as a sufficient indication that only children are specially prone to psychological disturbance. When family background is discussed, it will be seen that a high proportion of ascertained children come from "broken" homes, in which it might be expected that families would be smaller than in intact homes. A significant difference has been found between the proportion of only children in broken and in intact homes, If, as it is hoped to established later, the condition of the home is a major aetiological factor of maladjustment, then the greater proneness of only children to maladjustment may be no more than a reflection of the fact that a high proportion come from broken homes. In the 43 intact homes in the ascertained group there were 17 (42 per cent.) only children. This proportion is not significantly greater than the 28 per cent. in the control group. Moreover most of these families were "incomplete" families and, therefore, small numbers tend to predominate over large. However a sample of 220 cases taken from a children's hospital in which children were seen up to the age of 13, contained 10 per cent. of only children, 36 per cent. of families of two, 21 per cent. of families of three, 33 per cent. of families of four or more children. The differences between the maladjusted control group and the hospital group are significant as regards only children and as regards families of four and over.

This might be taken as evidence of the increased susceptibility of only children to mental disturbance, but it might equally well be interpreted as evidence of the proneness of members of larger families to organic illness. Whether members of large families are, in fact, less susceptible to mental disturbance is open to doubt. There are many reasons why members of large families are not brought to child guidance clinics. The figures presented here may suggest that their mental stability is greater, but this should not be accepted without further investigation.

Home Background.

Condition of the Family.

Ascertained Group.

1. *Civil status, etc.* (see Tables XI and XII).— Of the ascertained group, 71 were legitmate, 24 illegitimate and 5 doubtful. 43 were living with both parents. 19 were living with one parent only (17 with the mother). 38 had some person other than the natural parent in place of one or both parents; i.e., 43 homes were intact, 57 broken.

Of the broken homes 10 had become so through the death of one parent. The remaining 47 were due to separation or divorce or irregular union.

2. *Intact homes.*—Of those living with both parents, 13 only have a home in which, on the most lenient standards, the parental relationship could be described as satisfactory.

In the other 30 homes it was in the highest degree unsatisfactory.

3. *Broken homes.*—The 57 children in this group had the following backgrounds:

	Children.
One parent only	19
Step parents*	23
Adoptive parents	7
Foster parents*	4
"Homes"	4
	57

* It is impossible to give a precise account of every parental relationship. A household with an adult fulfilling the role of stepmother or stepfather is counted under this heading whether the adults are legally married or not. Aunts, grandparents, etc., who have undertaken the upbringing of their relatives' child are counted as foster parents.

Control Group.

Of 100 children 91 were legitimate, 8 illegitimate and 1 doubtful.

81 were living with both natural parents, and in 62 of these homes the parenral relationship could be regarded as satisfactory.

Twelve parental relationships were unsatisfactory by virtue of marked marital discord, 7 through severe mental illness in one or both parents.

Of the 19 children not living with both parents, 6 were with one parent only, 4 were with one step-parent, 4 were with adoptive parents, 2 in homes.

Table V—.*Condition of Family.*

	Both parents.	One parent only.	Substitute parents.	Home.	Total.
Ascertained	43	19	34	4	100
Control	81	6	11	2	100
Total	124	25	45	6	200

$\chi^2 = 94{\cdot}9$. $P < 0{\cdot}01$. Highly significant.

In six cases the "break" was due to the death of a parent. The differences just discussed between the ascertained and control groups are significant.

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TABLE VI.—*Comparison of Parental Relationships in Intact Homes in Ascertained and Control Groups.*

	Intact homes.				
	Satisfactory.		Unsatisfactory.		
	Number.	Per cent.	Number.	Per cent.	Total.
Ascertained	13	30	30	70	43
Control	62	77	19	23	81

TABLE VII.—*Comparison of Attitude to Child in Intact Homes.*

	Intact homes.				
	Satisfactory.		Unsatisfactory.		
	Number.	Per cent.	Number.	Per cent.	Total.
Ascertained	6	14	37	86	43
Control	52	64	29	36	81

TABLE VIII.—*Comparison of Attitude to Child in Broken Homes in Ascertained and Control Groups.*

	Broken homes.				
	Satisfactory.		Unsatisfactory.		
	Number.	Per cent.	Number.	Per cent.	Total.
Ascertained	6	12	47	88	53*
Control	8	47	9	53	17*

* Four children in " homes " in ascertained group and two in control group have been excluded from these totals.

Thus in the ascertained group, there were three times as many illegitimate* children as in the control group and there were only half as many " intact " homes as in the control group.

Other Factors in the Home Background.

So far the condition of the home has been discussed: i.e., whether it is *now* intact or broken. At least three other factors which play a big part in determining whether, from the child's point of view, the home can be regarded as satisfactory, can be singled out for discussion:

(1) the relationship between the parents,
(2) the attitude of one or both parents to the child,
(3) the child's experience of separation from one or both parents.

* It is of some interest to note that the illegitimacy rate per 100 live births in the districts under discussion rose from 4·5 before the war to a maximum of 9·35 in 1945. The number of illegitimate children to be expected in a group born between 1934 and 1944 would not be above 6 per cent. The number in the ascertained group is therefore very highly significant. The number in the control group is nearer to that of the population as a whole, particularly in view of the fact that more of the control group were born in years when the illegitimacy rate was higher. It might also be noted that the illegitimacy rate takes no account of two categories of children who may be much affected by the sexual irregularities of their parents, viz., (1) those legitimized after their birth by the marriage of the parents; (2) those technically legitimate, but not, in fact, the children of their mother's husband. No accurate figures are available of the numbers in these categories.

Relationship between Parents.

In the ascertained group, in only 13 of 43 intact homes were the relationships between the parents considered to be reasonably satisfactory.

> The qualifications "good" and "bad" are used of the parental relationships (and in the next section of attitudes to the child). These words are used, not in any absolute sense, but as convenient abbreviations. "Good" characterizes any home above a certain arbitrary and subjective level of tolerableness, "bad" anything below that level. In almost every case characterized as "bad" there is fairly strong evidence of the presence of what "any reasonable man" would regard as badness. When the epithet "good" is applied, it may mean no more than that nothing is known to the contrary.

In the remaining 30 the parents quarrelled violently with one another, were threatening to separate, or had in fact separated one or more times. Mental illness of one or both parents accounted for the bad relationship in 10 cases, the difficulties of the parents were aggravated by the antagonistic attitude of relatives in 4 cases. In the control group, the parents in 62 of the intact homes were judged to have a good or reasonably good relationship. The assessment is subjective and, to an exceptional extent, dependent on the truthfulness of information given by parents in interviews. The tendency of the informants is to conceal the worst of their difficulties until they have got to know and trust the workers interviewing them. Since, when the judgments were made, different parents were known for different periods of time, the assessments cannot all be of the same order of reliability They are, however, made by highly experienced workers; and often enough the parent's stories are amplified by those of the child. Such error as there is would be in the direction of over-estimating the number of "satisfactory" relationships, and this bias would be, if anything, greater in assessing the ascertained group than the control group since, on the whole, when the assessments were made the parents of the ascertained group were not quite so well known to the clinic workers as those of the control group.

For practical purposes there is only one case about which doubt is felt, but this may be due to too great self-confidence on the part of the interviewers!

There seems, however, every reason to accept the conclusion that relationships between the parents were very much more often unsatisfactory in the ascertained group than in the control group.

Attitude to Child.

Ascertained Group.

Only 12 of the families in the ascertained group were judged to have a good attitude to the child; in 32 homes the child experienced cruelty and in 55 others some other unsatisfactory attitude.

Unsatisfactory Attitudes.

Cruelty.

Corporal punishment is employed as a disciplinary measure in almost every familiy attending these child guidance clinics and few parents hesitate to hit

very hard on occasions. Something very much more than this is meant when the word cruelty is used : e.g., one father (a physical and psychiatric casualty from the war) actually said in the clinic," Sometimes I can't get at her with my hands, then I just kick her with my boots." The discriminations that step-parents can make between there own and their step-children might tax the credulity of those without first-hand experience. Only three children in the control group experienced cruelty and in all three cases there was some mitigating factor (see below).

Hostility, Rejection, Inconsistency, Neglect, etc.

A surprising number of parents and substitute parents openly expressed hostility towards their children. The neglectful or inconsistent behaviour of other parents is the subject of complaint by teachers and welfare workers and, often enough, corroborated by the stories told by the parents themselves.

By " rejection " is meant a basically hostile attitude overlaid by one which is superficially kind or affectionate. The detection of such an attitude is a matter of inference rather than of direct observation. Being a judgment, the assessment of parental attitudes may be wrong, and different observers might make different judgments. This applies with particular force to the judgment of " rejection." The sort of evidence on which it is based is (1) excessive protestations of devotion ; (2) undue protectiveness or anxiety for the child's health and safety ; (3) behaviour towards the child which seems distinctly less intelligent than that of the parent in other directions.

It will be observed that the " attitudes " of the control group have been put into four classes as against three in the ascertained group. The attitudes of the parents of the ascertained group can be simply classified as either " good " or " bad." In the control group there were 28 cases in which the parental attitude could not unreservedly be called good—it was characterized by anxiety, indecision, over-protectiveness, hypochondria, etc., yet seemed better and more likely to change than attitudes characterized as hostile, rejecting, inconsistent, etc. (It is just this group of parents with whom child guidance clinics have their greatest success ; experience shows that these midly neurotic attitudes can be modified with the help of a skilled psychiatric social worker. While not good, they may be regarded as potentially good.)

Control Group.

Cruelty.

It may be asked why not send away the children in this group who were victims of a bad parental attitude—or at least those subjected to cruelty?

Two children were old enough to withstand ill treatment and had a number of mitigating circumstances in their environment, one was five and may be sent away eventually. [N.B.—She was in 1952.]

Hostility, etc.

As to this group of cases, most homes were more tolerable than those of the ascertained group. A certain number of children are undoubtedly border-

line cases who, if young enough, may eventually be sent away. The fact, already referred to, that the school-leaving age is 15 for the majority of children is a reason for not interfering with some of the older children.

Separation of Child from Parents.

Bowlby (1951) and the authors he refers to have laid stress on separation of the child from his natural parents, particularly from the mother, as a major factor contributing to disturbance in the formation of character, and leading to anti-social and delinquent tendencies and, in particular to what is called the "affectionless character." Separations, whether permanent or temporary, are held by these authors to produce these adverse results and, in their opinion, the younger the child at the time of separation the more damaging the effects.

Separation for a shorter or longer period has been a frequent experience in the groups under discussion in this paper: 110 of the 200 children considered here had experienced some period of separation (longer than six months) from mother, father or both parents.

It is suggested that while all separation has bad consequences, the effects differ with differences in the type and length of separation.

Duration of Separation.

It seems necessary, therefore, to distinguish between separation which is permanent and that which is temporary (i.e., followed by reunion with the parent or parents). An occasional brief period of separation such as almost every child experiences cannot be taken into account, if only for the reason that it is not likely to have been accurately recorded. The sort of period that Bowlby has in mind is six months or longer. Those cases have therefore been recorded where either there was a continuous period of separation of six months or longer or there was a series of briefer separations amounting together to at least six months.

Parent from whom Child Separated.

It is also necessary to distinguish between separation from (1) the mother, (2) the father, (3) both parents.

Date of Separation.

It is also important to record whether the separation took place early in the child's life or later. Bowlby takes the age of four as the dividing line. Hence separation from parent or parents, if it has occurred before the fourth birthday, will be referred to as "early," if on or after the fourth birthday, as "late."

Those groups already distinguished under the heading "homes," "adoptive parents" and "foster parents" contain, by definition, children who have been permanently separated from both parents, but a further analysis can be made to show whether the separation was early or late. In the groups "one parent only" and "step-parents" it remains to be shown whether the permanent

separation was early or late and from which parent. In the "intact" group, periods of temporary separation can be classed as early or late. Of the 110 children who had experienced any period (longer than six months) of separation from one or both parents, 72 were in the ascertained group, 38 were in the control group. Taking period of separation, time of separation and parent or parents from whom separated into account would necessitate placing "separated children" in twelve classes. Each would then contain on the average nine or ten members—a number too small for useful statistical comparisons.

One amalgamation of classes that seems justifiable is of those who have been separated from the mother and those who had been separated from both parents. The amalgamation of these two classes is not entirely satisfactory, for it cannot be supposed that their experiences are exactly similar. Their members have, however, one significant experience in common, namely, that they have passed into the care of some woman other than their mother. (A substitute mother is almost invariably supplied for a motherless child, but not necessarily a substitute father for one who is fatherless.)

This still leaves two main classes each with four sub-groups, viz.:

1. *Separation from Mother or Both Parents.*
   - (1) Permanent.
     - *a*. Early.
     - *b*. Late.
   - (2) Temporary.
     - *a*. Early.
     - *b*. Late.

2. *Separation from Father.*
   - (1) Permanent.
     - *a*. Early.
     - *b*. Late.
   - (2) Temporary.
     - *a*. Early.
     - *b*. Late.

As the "separated children" in both ascertained and control groups can be divided into these eight classes, the number of comparisons that can be made is large. The data have been collected and shown in Tables IX and X.

TABLE X.—*Permanent Separation.*

	From mother or both.			From father.			Total permanent separation.
	Early.	Late.	Total.	Early.	Late.	Total.	
Ascertained	17	11	28	21	8	29	57
Control	8	2	10	3	6	9	19
Total	25	13	38	24	14	38	76

Temporary Separation.

As regards temporary separation there is no appreciable difference between the experience of the control and of the ascertained group, i.e., there is no evidence that the temporary separation either from father or from mother is associated with being "ascertained" (the numbers are small and the absence of a statistically significant association does not, of course, prove that there is none—it simply fails to provide evidence that there is).

TABLE IX.—*Separation from Parents.*

	From mother or both.						From father.						Total separation of any kind of more than six months.
	Permanent.			Temporary.			Permanent.			Temporary.			
	Early.	Late.	Total.	Early.	Late.	Total.	Total.	Early.	Late.	Total.	Total.		
Ascertained	17	11	28	8	1	9	37	21	8	29	5	1	6	35	72
Control	8	2	10	8	2	10	20	3	6	9	6	3	9	18	38
Total	25	13	38	16	3	19	57	24	14	38	11	4	15	53	110

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Permanent Separation.

Eliminating temporary separation of all sorts: 76 cases of permanent separation remain—57 in the ascertained group, 19 in the control—i.e. the ratio ascertained to control is 3 : 1. Permanent separation implies more than a change of environment from one or both natural parents to others. If the new environment is less good than the old, it may be its defects which are responsible for the manifestation in the child rather than the change as such.

However this may be, there is a marked association between permanent separation and being ascertained.

Parent from whom Separated.

Examination of the detailed figures shows that the differences between separation from the mother and the father are negligible, i.e., as far as they go, they provide no evidence for the view that separation from the mother produces worse effects than separation from the father.

Date of Separation from Mother.

There is no significant difference between early and late separation from the mother, but the numbers are too small to establish this conclusively.

Date of Separation from Father.

With the same size of group, however, the difference between early and late permanent separation from the father appears to be significant (the change of the observed difference being due to chance is less than one in 30).

A possible reason for this finding will be suggested later when the results are compared with those of previous workers.

These conclusions are not necessarily inconsistent with the findings of those who hold that early separation, particularly from the mother, causes an outstandingly adverse effect on the development of character. It may be that by taking ascertainment as the criterion, disturbances of character are not sufficiently isolated, since being ascertained depends on a multiplicity of factors, some in the child, some in the home. Factors in the home may account for some of the associations of "permanent separation" with "ascertainment."

Comparisons should therefore be made with regard to the aggressive characteristics previously distinguished, not simply contrasting the ascertained group with the control, but in both ascertained and control group comparing those who have experienced separation with those who have experienced no separation.

Discussion.

Certain factors in the home background have been picked out for study, viz., civil status, condition of the family (i.e., whether the home is intact or broken and, if the latter, then in what way), parental relationships, attitude to child, and finally separation of child from one or both parents for a longer or shorter period.

It is not suggested that these are the only significant factors: some factors that have been noted in a fair proportion of the cases studied, such as mental or physical illness of the parents, have not been analysed separately. The table that follows Table XI sets out twelve factors which singly or in combination play a part in making a home bad. It is not to be supposed that even this list is exhaustive; many other aggravating factors are known, such as bad relationship between the siblings, friction with relatives and neighbours. and, from time to time, though rarely in our experience, poverty and bad material conditions.

With the limited numbers of the present study, it seems as well to focus attention only on some of the grosser factors.

It will be obvious too, that many of these factors are not independent of one another and, even when it is shown that there is an association between a certain factor and a certain type of maladjusted behaviour, it cannot be supposed that the particular factor is in any precise sense the "cause" of the maladjusted behaviour.

TABLE XI.—*Bad Homes.*

I. *Broken Homes.*

(1) Never established—child illegitimate.
(2) Broken by death of one partner.
(3) Broken by illness—
  (*a*) Physical.
  (*b*) Mental.
(4) Broken by desertion, imprisonment, etc.

II. *Intact but Unsatisfactory Homes.*

(1) Bad marital relationship.
(2) Mental illness of one or both partners.
(3) Physical illness of one or both partners.
(4) Other adverse factors.

III. *Bad Attitude to Child.*

(1) Cruelty.
(2) Hostility or rejection.
(3) Inconsistency, "ambivalence," etc.

IV. *Bad Experiences Irrespective of the Nature of the Relationships in the Home.*

Temporary separation from—
  (*a*) Both parents.
  (*b*) Mother.
  (*c*) Father.

Unfavourable circumstances of different kinds are so frequently linked together: It can rarely be said that one adverse circumstance is responsible;

rather is it the chain of adverse circumstances which, on the one hand, gives rise to the final pattern of the family and, on the other, provokes in the child behaviour described as maladjusted.

CHAPTER III

Relationships between Aetiological Factors and Symptoms.

In Chapter II an attempt has been made to bring out differences in the home backgrounds of the ascertained and control groups and attention has been drawn to a number of significant differences between the two groups.

But since "ascertainment" does not depend on any one factor and may be recommended because of disturbances in the child, because of disturbances in the home background or (and most commonly) because of a combination of the two, it is an imperfect criterion for the comparison of aetiological factors in the environment.

For this reason an effort has been made to isolate aggression and give a definition according to which the term is to be used.

In this chapter, therefore, use is made of the criterion of aggressiveness in an attempt to assess the relative strength of various factors in the home background in relation to the disturbed behaviour of children.

Aggression as defined in Chapter I will be used for a comparison of sub-groups in the ascertained group with one another and for contrasting the sub-groups of the ascertained with the corresponding sub-groups in the control group.

I. *Intelligence, Age and Sex.*

It has already been noted that much the same proportion of boys as of girls was found to have the aggressive temperament. Neither is there any association between aggressiveness and age, or between aggressiveness and intelligence.

II. *Position in Family.*

Position in family has been shown to be related to the condition of the home and there is no significant relationship between position in family and aggression in either the ascertained or the control group.

Home Background and Aggression.

(1) *Legitimacy, etc., and Aggressive Symptoms.*

In the ascertained group there were 24 illegitimate children and five "doubtful" as against eight illegitimate and one doubtful in the control group. Of the 29 in the ascertained group, 26 showed one or more aggressive symptoms. This proportion is not, however, significantly different from that of the number showing aggressive symptoms among the 71 who were legitimate.

In the control group, on the other hand, the incidence of aggressiveness (i.e., of those showing one or more aggressive symptoms) is much more marked among the illegitimate than among the legitimate and is, in fact, very similar to that in the ascertained group.

(2) *Condition of Family and Aggressive Symptoms.*

It will be seen that in the ascertained group the "condition of the family" has no appreciable relationship to the number of children showing one or more aggressive symptoms.

The relationship between aggressive symptoms and the types of homes distinguished in Chapter II is shown in Table XII. This table displays the distribution of the symptoms aggression, stealing, truanting, destructiveness and encopresis (collectively defined as aggressive symptoms) among the various types of homes in (1) the ascertained and (2) the control group. Table XIII summarizes this material.

The number of aggressive symptoms shown by the ascertained group is more than twice the number shown by the control group, and the predominant characteristic of the ascertained group is aggressiveness of temperament as well as of symptoms. As is only to be expected, the temperament of the majority of the control group is "neither aggressive not dejected," and their symptoms are of a type which indicate psychological conflict, i.e., "compound" symptoms, to use the terminology of Chapter I. For the most part their behaviour is not anti-social. While it would be of interest to pay special attention to the minority of the control group who are severely aggressive (or anti-social or both), the primary concern of this paper is the ascertained group.

For this reason those adverse factors of the home background present in the control group, but *not* present among the ascertained will not be discussed.

Of the ascertained children from "intact" homes, 80 per cent. show one or more aggressive symptoms; of these with one parent only, 90 per cent. show aggressive symptoms; 84 per cent. of those with substitute parents. These slight differences might well have arisen by chance. Since three or four aggressive symptoms were manifested by only eleven children, it is obvious that the number of aggressive symptoms shown (i.e., severe aggressiveness) is not related to differences in the condition of the family.

TABLE XII.—*Condition of Family and Aggressive Symptoms.*

Ascertained Group.

Condition of family.	Aggressive symptoms. A.	S.	T.	D.	E.	Total.	Number in group.	Ratio.
Intact	29	12	3	2	3	49	43	1·14
One parent only	16	2	4	1	1	24	19	1·26
Substitutes	22	14	11	6	6	59	38	1·55
Total	67	28	18	9	10	132	100	1·33

Control Group.

Condition of family.	Aggressive symptoms. A.	S.	T.	D.	E.	Total.	Number in group.	Ratio.
Intact	20	10	4	1	3	38	81	0·47
One parent only	0	1	0	0	0	1	6	0·17
Substitutes	8	5	1	3	2	19	13	1·46
Total	28	16	5	4	5	58	100	0·58

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TABLE XIII.—*Condition of Family and Aggressive Symptoms.*

Ascertained Group.

Family.	Number of aggressive symptoms.	Number in group.	Total.
Intact	50	43	1·16
One parent only	24	19	1·26
Substitutes	59	38	1·55
Total	133	100	1·33

Control Group.

Family.	Number of aggressive symptoms.	Number in group.	Ratio.
Intact	38	81	0·47
One parent only	1	6	0·17
Substitutes	19	13	1·46
Total	58	100	0·58

In the control group, on the other hand, there was a marked difference between the children with substitute parents and those living with their own parents (whether one or both) in respect of the percentages showing aggressive symptoms. In this group, one third of children from intact homes show aggressive symptoms as against over two-thirds from homes with substitute parents.

Thus the main differences between the ascertained and control groups are found in children who are living with their own parents. While the control group children who were with substitute parents had a lower ratio of symptoms to numbers, the difference between this ratio and that found in the ascertained group is small.

This point can perhaps be put more clearly thus: In the ascertained group the ratio aggressive symptom per child is almost identical for children coming from intact and from broken homes. In the control group the ratio is three symptoms to four children from intact homes, five symptoms to four children from broken homes.

Relationship between the Parents.

In Table XIV the association is shown between aggressive symptoms and parental relationships.

Table XIV shows that in both ascertained and control groups there is a higher incidence of aggressive symptoms in intact homes where the parental relationship is bad than in those where it is good. In the ascertained this difference is significant but *not* in the control group.

Attitude to Child.

The same analysis has been made in respect of "attitude to child" and is summarized in Table XV. There is a significant association in both ascertained and control groups between unfavourable attitudes and aggressive symptoms, and in the ascertained group the most severely aggressive children are found among those who have experienced cruelty.

Separation.

In the ascertained group separation of any sort or duration was not experienced more frequently by those who showed aggressive symptoms than by those who showed none.

Among those showing aggressive symptoms, however, there was an association between permanent early separation from the father, mother or from both parents and the manifestation of *severe* aggression.

In the control group the one positive association found was between permanent early separation and aggressiveness, though there was no tendency to an association with severe aggression.

Since the numbers in the affected group are small, conclusions based on them cannot be regarded as more than tentative. As far as they go, they would appear to suggest that permanent early separation from either parent has worse effects than later or briefer separations. It must be borne in mind that permanent early separation is often but one link in a chain of disasters: and it cannot be concluded on the evidence available here that separation itself is the damaging factor.

Discussion and Comparison with Previous Work.

Bowlby's basic postulate is that "what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment." A state of affairs in which a child does not have this relationship is called maternal deprivation. The numerous studies which Bowlby reviews or makes himself are all directed to showing in one way or another the adverse effects on well-being and character that follow from this condition.

The present study, which had been begun before Bowlby's monograph appeared, can be regarded as another small piece in the mosaic supporting his general thesis. It has become evident in the course of preparing the present paper that the elucidation of the aetiology of maladjustment in children is a very complex undertaking to which no single investigation can make more than a small contribution. Nothing in the present paper is inconsistent with Bowlby's findings or with those of the authors whom he quotes. The analysis made in Chapter II ("Home Background") might be said to extend and amplify Bowlby's concept of "partial deprivation."

The only criticism of Bowlby's work which arises out of the present study is that he emphasizes a negative concept—deprivation—whereas what is revealed in the material reviewed here is the existence of many positive adverse factors in the background of the disturbed child. Hostility and ill-treatment from parents have been shown to have a more damaging effect than ambivalence. Furthermore, separation from parents—on which Bowlby and his colleages put much stress as an adverse influence on mental health—has been found to have significantly adverse effects only when it is early and permanent. Temporary separation, either before or after the age of four, was not found to be

associated with the manifestation of aggressive symptoms, nor was permanent separation which began in the fifth year of life or later.

What seems to emerge from the material studied here is that there is no one type of misfortune which, judged by the reactions of the child, is in itself significantly worse than another; what is damaging is a series of misfortunes. Many of the misfortunes are, however, of the sort that engender other misfortunes. Permanent separation from the parents is of this sort; temporary separation for the most part, is not. It is clear from the studies quoted by Bowlby that this is the case and that he would be far from denying it. His concept of "maternal deprivation" does not make this immediately apparent, and is, to that extent, an over-simplification.

A further point of apparent inconsistency between the results of this study and of Bowlby's is that permanent early separation from the father is here shown to be no less adverse in its results than permanent early separation from the mother. Bowlby stresses the importance of the mother-child relationship and relegates the father to a secondary role in relation to the child; his value is as the "economic and emotional support of the mother" which enables her to "maintain that harmonious contented mood in the aura of which the infant thrives." In view of this, the finding that separation from fathers is as disadvantageous as separation from mothers was unexpected. A possible reason, however, is that when a child is separated from his mother, some woman is soon found to care for him and often becomes a permanent substitute. A mother left with a young child will often try to care for him in spite of having to work long hours to maintain her family. She will resort to makeshift arrangements, and there may well be more change and more disturbance for the child than if a substitute mother had taken immediate charge.

It cannot be inferred from what has been said above that temporary separation is without adverse effects. Many children in the control group were suffering quite severely from mental ill-health, the treatment of which required much time and skill. It is maintained in this paper, however, that on the whole the control group were less seriously ill than the ascertained group, and that, although temporary separation produces some adverse effects, it is not among the factors producing the worst effects.

Neither Bowlby, nor any of the authors whom he quotes, discuss the positively adverse effects that appear in children with substitute parents, but Spitz (1952) has drawn attention to what he calls the "psychotoxic diseases of infancy" and suggested that they are no less important than those resulting from deprivation. The evidence collected in the present study is in accordance with this view, and seems to call for a much fuller analysis than has been made here. In this, as in so many other respects, the conclusions of this paper cannot be regarded as more than tentative.

Combination of Adverse Factors in the Home Background.

The analysis so far made has pointed to four aetiological factors which are significantly associated with the manifestation of aggressive behaviour in children—viz., transfer to the care of substitute parents, character of the rela-

tionship between parents, of their attitude to the child and separation of child from one or both parents.

TABLE XIV.—*Parental Relationships and Aggressive Symptoms.*

Relationship.	Aggressive symptoms. A.	S.	T.	D.	E.	Total.	Number in group.	Ratio.
Ascertained :								
Bad	21	10	3	2	2	38	30	1·27
Good	8	2	0	0	1	11	13	0·85
Total	29	12	3	2	3	49	43	1·14
Control :								
Bad	3	3	3	0	1	10	15	0·67
Good	6	3	1	0	2	12	40	0·30
Total	9	6	4	0	3	22	55	0·40

TABLE XV.—*Aggressive Symptoms and Attitude to Child.*

Ascertained (99 cases).

Attitude.	Number of aggressive symptoms.	Number in group.	Ratio.
"Good"	9	12	0·75
"Bad"	70	55	1·40
Cruel	51	32	1·60
Total	130	99	1·31

Control (70 cases).

Attitude.	Number of aggressive symptoms.	Number in group.	
"Good"	10	32	0·31
"Bad"	24	35	0·69
Cruel	0	3	0·00
Total	34	70	0·41

From the analyses that have been made it can be seen that, in the ascertained group, at least one of the adverse factors referred to in this chapter was affecting all but two of the children characterized as aggressive. Each of these two children was regarded as suffering from an endogenous maladjustment—the one a case of birth injury with multiple physical and mental disabilities, the other a psychotic child (whose parents. though united and devoted to him, were distinctly schizoid themselves).

In the control group there were four aggressive children who were not affected by one of these adverse factors. One was herself an epileptic and spastic child, but too old when seen to be provided with special educational treatment ; one was in the care of a mother who suffered from chronic physical and mental ill health ; the father of the third was a chronic invalid and thought likely to die ; the fourth had a pleasant Frenchwoman for a mother who was, however,

described by the psychiatric social workers as "a bit at sea with English standards" (in consequence of which the child was too).

Conclusions.

While it has not been possible to establish the relative importance of different aetiological factors in relation to aggressive behaviour, the following facts have emerged.:

There is a good deal of consistency between the results obtained by examining the control group and examining the ascertained group. As there are fewer aggressive children in the control group, it is only to be expected that there will be fewer in any limited section of it than in the corresponding section of the ascertained group. Given this expectation, the findings among the control group support those of the ascertained group as regards the association between the manifestation of aggression and—

(1) character of the parental relationship,
(2) attitude to child,
(3) permanent early separation of child from one or both parents,

and seem to put special emphasis on illegitimacy and transfer to the care of substitute parents.

These aetiological factors cannot be directly compared with one another because of the overlap between the classes. When analysing a series of 100 ascertained and 100 control cases the numbers diminish at each successive stage. Some of the desired analyses remain unmade because it would only be misleading to compare very small groups. Further comparisons are, therefore, desirable using groups of a size to permit of the isolation of each separate aetiological factor.

Nothing so far considered accounts completely for the differences between the control and ascertained groups. Throughout, the aggressive responses of the control group are less intense than those of the ascertained. One possible reason for this finding would be that different standards had been applied to the groups. This seems unlikely on grounds already referred to and it seems most improbable that a systematic error of this sort could be sustained throughout the numerous groups into which the two main groups have been classified.

Two other hypotheses remain: (1) That there is some additional environmental factor or factors in the background of the ascertained group that has not been observed; (2) that some or all of the individuals composing it have a particular tendency to re-act aggressively.

Both may be true.

In the environment there is an infinity of influences from which only a few of the most obtrusive have been selected for investigation, though it is hoped that no gross environmental factor has been overlooked.

It is tempting to postulate some inherent or constitutional predisposition to aggressive behaviour which is called forth in the susceptible by a smaller stimulus than in the majority of children. Clinical observation of some, at least, of the ascertained group lends colour to the belief, and evidence is accumu-

lating to establish the presence of cerebral dysrhythmias in many aggressive children.

It is impossible to work on material such as that reviewed here without becoming aware of many shortcomings and inadequacies. The most that can be said for a study of this sort is that it serves as a pilot survey ; that it draws attention to many complex issues in need of clarification, and shows the need for an extension of research on a larger scale into a number of more limited but better defined problems.

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