# THE AUTISTIC CHILD

Lecture by Dr. Lauretta Bender

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The concept of autism in children was put into the literature by Leo Kanner, Professor of Psychiatry at Johns Hopkins. His first publication was in 1943 when he spoke of the primary autistic affective disorder in children. Dr. Kanner and I worked together at Johns Hopkins in 1929 and 1930. Then I was at Bellevue Hospital from 1930 until the last four years, when I have been working for the New York State Department of Mental Hygiene. In 1940, Dr. Helen Yarnell and I presented a paper at the American Psychiatric Association on 250 children under the age of six from our observation nursery at Bellevue Hospital. In this series we reported a few children with regressive phenomena which we could not account for. Some of these young children were cases of atypical post-encephalitis, but there were two other groups which we did not know how to classify. One group we called Heller's Disease, because they seemed to develop normally to three or three and one-half years of age and then regressed without any known reason, such as an illness, or any neurological signs. The other group did not develop beyond the two-year level and even seemed to lose some development normally acquired by the two-year-old child, namely saying a few words and beginning toilet training and some social contact. This attracted Dr. Kanner's attention and he corresponded with me about it and said, "How did I ever find such children"; that he had read about them in the German literature with which he was well acquainted, but he had never had any of these children referred to him. Dr. Kanner was in a less favorable situation at Johns Hopkins, where he was consultant on

the pediatric staff and would have to have children referred to him, than I was at Bellevue Hospital, New York City's reception hospital where a large number and range of child patients came under my care. I explained to him that if he would just not accept other peoples' opinions about retarded and defective young children, he would probably soon be able to see some of these children. He did have a ward set aside at Johns Hopkins for such children, so he only saw children referred to him privately, largely by people of the higher professional class; his associates as Professor at Johns Hopkins. He soon began to see some of these children and developed his concept of primary affective autism. As he defined it, there are three characteristics; namely, extreme aloneness, a desire for the preservation of sameness, and an inadequate language development. Then he also observed that these children were brought to him by intellectual parents who made their life adjustment intellectually, and so he referred to them as icebox parents. He had a series of about 30 children,whom he studied for a while on a ward at Phipps Clinic and followed through many years. He has expressed the desire to have this concept recognized as an entity, which, I think, is correct. However, in his later writings, he has stated autism in the young child may have different etiologies. He believes that cold, unresponsive parents are partly responsible for the withdrawal in the child. Still,he stated in the last edition of his textbook, and last spring when he was receiving the award from the National Association for Mentally Ill Children for his outstanding contribution to this particular area, that he felt that the majority of these children were schizophrenic, although some of them may have had encephalitis or other types of brain damage.

My own feeling about autism is that it is a defense mechanism which young children will present under a variety of different conditions. Perhaps the majority of young children (under the age of six) that I have considered autistic were schizophrenic or I considered them schizophrenic. It is certainly true that a child who has had an early brain damage - by early I mean prenatally, paranatally or early postnatally - may present exactly the same type of defense reaction. On the other hand, a child potentially schizophrenic who has brain damage which may precipitate a breakdown in defenses, is very likely to react with an autistic pattern of behavior in the early years of his life. And certainly it is also true that a child who has suffered very serious deprivation in the way of being institutionalized in an impersonal institution which does not give the child much individual attention, is likely to react with the same type of behavior and be considered an autistic child. There would still remain the problem, however, as to whether such a child might not also be schizophrenic because children left in such institutions without anyone taking any interest in them are more likely to be the offsprings of atypical parents, schizophrenic or defective or what not. So the fact that one does find an autistic child in an institution for babies, or who has been grossly neglected, may really be schizophrenic.

Now the concept of autism has called forth considerable controversial discussions in this country and also in England and in some of the western European countries. We have the opposite picture more or less, which has been discussed by Margaret Mahler, of symbiosis in which instead of the child withdrawing from the parent or from reality, he becomes over-dependent and anxiously and obsessively clinging to such an extent that the parent and the child become involved in a

relationship in which they both become extremely disturbed. The issue here is whether it is the parent who initiates the relationship or the child, or whether or not they are both involved for reasons of familial patterning. Of course, I am very much aware that in the State of California, Dr. Szurek's point of view is dominant and should be. Dr. Szurek is the professor of psychiatry in charge of the children's unit up at Langley Porter Hospital, University of California, and has been there since 1946. Dr. Szurek was trained by Adelaide Johnson in Chicago at the Institute of Juvenile Research and before that by Dr. Harry Stack Sullivan, so he is a Sullivan analyst; and he and Adelaide Johnson have done considerable work together. I won't take the responsibility of explaining Dr. Szurek's concept of dynamics. I spent a week up at his unit at the Langley Porter Clinic, so that we would have a chance to exchange opinions. So we exchanged points of view for a full week, and I will say of Dr. Szurek that his integrity and his capacities and his dedication are of the highest level, and he has trained a group of people who are equally dedicated to the problem of trying to prove something of this type of dynamics: the mother or the father, or both, have a neurotic problem in which their own childhood conflicts have not been resolved and in which they have made an inadequate or unsatisfactory compromise in their life adjustments. They somehow unconsciously project this conflict into the child so that he is not able to develop and the child remains fixated in an autistic state or what we call a schizophrenic pattern of behavior. They have hoped that the child can be gotten out of this state by the parents being psychoanalyzed and receiving therapy to the point where they can go back and unravel the problem and then react to their child

in a new situation. During this time the child also receives therapy and the three of them can then hopefully unravel the conflict and resolve their neuroses.

I am sure I have not given an adequate descripton of Dr. Szurek's contribution, since it is not my theory and I am not dedicated to it. In fact, I have some questions about this view. It does not explain why one child in the family becomes autistic or disturbed, while siblings do not. After my experience in child psychiatry, seeing so many very seriously disturbed children, I have become overwhelmed with the impression that children have a tremendous capacity for normal development and that they will overcome almost any kind of handicap and succumb only to some combination of problems or a very gross and overt disturbance. This does not deny that our personalities are made up by the interplay of personalities of the individuals with whom we have been associated; as children with their own parents. But it has been my experience that one cannot readily account for gross disturbances by the unraveling of this kind of unconscious dynamics. Although Dr. Szurek and his group have devoted themselves to this program for all these years, he himself in his last statement, has said that they are still looking forward to getting results if they can only devote themselves more thoroughly and for a longer time. I myself am very grateful to Dr. Szurek and his group for doing this work because I think it should be done. I don't believe in it but I think it should be done and I wouldn't want to do it. We need to know whether it is or is not true.

Now, on the other hand, Kanner's concept is that the parents were cold and unresponsive to the children and therefore that they were raised

in a "cold family climate." This followed the ideas of Dr. Adolf Meyer that psychosis or other emotional disturbances or behavior problems are reactive patterns, determined by the background of the constitution, (whatever that is) as reactive patterns to life experiences. Adolf Meyer's idea of schizophrenia was a discrepancy between the high goals or aims or drives or expectations for an individual, and his capacity to fulfill those goals. Leo Kanner accepted these ideas. He conscientiously followed this group of 30 children although he felt that they had been irretrievably damaged by the cold environment of their parents in which they had been raised.

He saw these parents as cold and what he called non-defrosting refrigerator parents. In the first place, it requires, in my opinion, a professor or psychiatrist or someone of considerable academic or medical sophistication to find Dr. Kanner at Johns Hopkins University, to know about his work, and to arrange a consultation with Dr. Kanner, and so it was a selected group that he saw. He is also a chain smoker of cigars. My opinion is that no parent and no child - I don't care what his nature is - can very well warm up to a chain smoker of cigars. Dr. Kanner claimed that these people, since none of them had ever been in a state hospital, were not schizophrenic and had no family history of mental illness. It was my feeling that many of these parents were ambulatory schizophrenics who had made good adjustments intellectually and academically. Incidentally, I had good reason for thinking this, because many of these parents shopped around. Dr. Kanner told them there was little hope for their child; the only thing they could do was to give it to a married couple, simple folk who are warm and with very little intellectual pretentions, out in the country somewhere, and to try and forget it. This was the advice he gave them in early years.

Of course, this advice was seldom followed and consequently they shopped around. I saw some of the parents with these children, and in getting their history, they gave me a picture of paranoid, schizoid, brilliant, gifted people. And they certainly "defrosted" in my office. One story has been told frequently and is in the literature. It concerns a man who could not recognize his own son on the street. In my opinion, such a man is not over intellectualized but a schizoid individual.

Dr. Kanner and his associate, Leo Eisenberg, did follow these children into adolescence, and found that the bad prognosis which they gave was not entirely justified. Of those children who were not talking before the age of five, only one made some kind of incomplete social adjustment subsequently, and of those children who were talking before the age of five, which was about half of the group, several of them made excellent adjustments, having come out of this autism, attended school, and developed satisfactorily. Dr. Kanner quite fairly said this was without his recommending any kind of therapeutics. However, one cannot say that it was entirely spontaneous because some got treatment elsewhere. Some of them received electric shock at my hands, as a matter of fact, but not necessarily with good results. One of the group has been quoted frequently as deteriorating because I treated him with electric shock. The child did not respond to electric shock but continued to look just like all of the children who do not respond to any treatment or who have not had any treatment and who remain autistic and look much worse when they are older. It is pretty hard to prove deterioration in an autistic child. They often start at about as low a level as possible.

Now there are other ways of looking at autistic children and, as I say, my feeling is that autism is a defense. It is a defense in a child who is so disorganized, so overwrought with anxiety, so over-stimulated by the impinging environment from which he cannot select the proper stimuli and organize them properly, that he withdraws into the autistic state. Unfortunately, of all the defenses, autism is the worst, short of actual suicide, and it is undoubtedly true that our institutions for the mentally retarded and our state institutions for the mentally ill, have an increasing number of individuals who were autistic children to begin with and who have not been able to respond to treatment. In my opinion, this is one of the most challenging problems in psychiatry. I will not say that our care of our elderly citizens, senior citizens, as they need special care, is not a very challenging social problem, but I would say that aside from that, our next most challenging problem is these autistic children. This is because, unless they do come out of their autism within the first few years, they are lost souls. They have lost their childhood and it has been very seldom that a number of children who have remained autistic for longer than five years have been able to respond as normal children. However, it is not unknown.

I know of one child who came from a family of many schizophrenic individuals and people who usually reacted with neurotic defenses, compulsiveness, etc. and highly gifted individuals, journalists, and some people who have made quite a stir in the world. This child shortly after he was born at first showed every evidence of being a gifted baby but startlingly obsessive-compulsive, trying to throw his foot out of the slats of his crib and going into temper tantrums because he

could not succeed, and later on reacting to anything else that was slat-like in the same fashion; frequently waking up in the middle of the night and rolling out of his crib and rolling all over the floor, injuring himself, denying recognition of his mother and not allowing anyone else to console him. Then later on he began to show tremendous compulsive capacities in block building, word formation, etc., when he was literally a baby. At about the age of 15 months he regressed, lost his language, lost whatever habit training he had and became a truly regressed, autistic child, showing all the characteristics that Kanner mentioned, wanting everything in his daily routine to be the same and getting very disturbed when something different happened. He had no speech and no contact with people except negative contact, screaming in terror at anyone new, withdrawing into a corner, injuring himself, chewing his knuckles until they bled, masturbating, walking around on tiptoes. A course of electric shock treatment did reduce the anxiety, the extreme distress, his compulsive and self-damaging behavior. He went to a children's unit in a state hospital and slowly quieted down but did not speak until he was about seven or eight years of age. Then he gradually came out of his autistic state and his I.Q. raised gradually, and within a year he was reading and writing. In a couple of years he became a superior child and was released from the hospital, went into the public schools and then into high school. The last I heard was when the father wrote and asked for help in finding a therapist for him because he was presenting problems in adolescence. When I tried to see the boy, the family objected, so I do not know what has happened since. But sooner or later I will hear from him or find him in one of the state facilities. However, the fact remains that he recovered spontaneously as late as seven or eight years and lived a normal life from that time until he

was in his middle adolescence at least, and maybe is in college. Other boys similar to him have gone through college.

Recovery from an autistic state can happen spontaneously. But it is usually our aim to try to stimulate some kind of development before they have gotten out of their pre-school period and in order to get them ready for school of some sort by the time they are in their fifth, sixth, or seventh year. By and large, this is what I urge upon parents and what I urge upon psychiatrists whom I train. I believe that one is not justified in postponing energetic treatment in a severely autistic or disturbed child unless milder treatment works very fast. Also I recommend that such a child should be removed from the home for a period of treatment, because the family are so dreadfully involved and because certain behavior patterns have become set in both the sick child and his family. It frequently happens that removing the child from the home and putting him in a new environment with new adults and with other children, even though they are sick children, and establishing new patterns of behavior, will start a change. In the majority of cases there will be a change in behavior under these circumstances. During this period the child should be observed and an effort made by several ~~hospital~~ members of hospital staff and personnel to involve him in a relationship and start him in activities that will interest him. Also immediately start with drugs; drugs will help the child and will not harm him. He is put into a nursery or kindergarten class where he gets habit training and socialization with other children. Response to this is very fast in the majority of such children. Then if this program is not adequate, that the child starts to speak and to play with other children in a few weeks, then

I am in favor of using electric shock therapy to shorten the time of progress. I have found that electric shock is, in my experience, the best way of initiating maturation in such children and that it is not harmful. You can feel the child's muscle tone pick up. His intestinal functions become more regulated; his eating and sleeping habits are better and he looks healthier.

It is my belief that childhood schizophrenia is a lifelong phenomenon. I am not sure that it is a disease. The clinical disturbances that we observe, autism for example, are defense phenomena against the anxiety and disorganizing effects that occur in some schizophrenics. Schizophrenia is hereditary or gene determined. I follow the work of Franz Kerman and believe in what his research demonstrates as far as the genetic factor is concerned. I have in my experience, one group of autistic children whom I sent to Letchworth Village, a state school for the defective in New York, of whom 40 per cent had a sibling who was schizophrenic and whom I had personally treated. The incidence of schizophrenic parents of our young schizophrenic children is overwhelming. So I feel very strongly that there is a gene factor. I also feel that no child or adult can become schizophrenic without the gene. However, not everyone who has the gene has a psychosis. Schizophrenia, I also believe, is a more common phenomena in human beings than is generally realized. I find it hardest to get professionals to accept this fact. The lay population will almost accept it sooner than the professionals. It has been estimated as being in the neighborhood of one percent. I think the incidence is several times that number. Many schizophrenic individuals are never sufficiently disturbed to require psychiatric help. Many are particularly brilliant and gifted. I also

feel that as we become better acquainted with the diagnostic criteria for children we will find that we will be able to make the diagnosis just as commonly in childhood as in adulthood. The breakdown in defenses causing a mental or emotional disorder is caused by some other physical or organic disorder in the individual. In children this may occur at birth or it may happen before birth. It may happen in that very critical period of the first trimester of development in which dramatic things happen. It may happen in any of the other developmental epics during the lifetime - puberty, childbirth, menopause, senility.

The basic characteristic of schizophrenia in childhood, as I see it, is an embryonic plasticity in all patterns of behavior. It will not only be in behavior as such, but in thought processes and in perceptual experiences, and also in the tone of the muscles and the tone of all the internal organs, the G.I. system, the heart, the respiratory system, etc. The individual who has this difficulty, has the problem to create patterns and to maturate patterns that are appropriate to other human beings in the world in which we live. If this is too big a problem, so that they are not able to create these patterns and identify themselves with others, they are likely to demonstrate in the first place an unpatterned, plastic, regressed, immature type of behavior; and in the second place, anxiety. These dysplastic phenomena are extremely anxiety-producing because the individual cannot integrate himself with the environment. Following the anxiety, there is always some kind of a reaction or defense. Perhaps the easiest and most obvious defense is withdrawal. In infants this may lead to apathy and miasmas. This does account for some of our unexplained infantile deaths. A

better defense, of course, would be a neurotic reaction, and it is my belief that neurotic phenomena in childhood are defenses against either schizophrenia or organic patterning, at least when neurotic defenses are of a degree which require professional help or create problems for a child. Of course, all of us have neurotic mechanisms in our personality makeup and none of us is perfect. None of us has perfect brains either. We all have a bit of cellular loss, brain damage, deviations here or there. This is something that is hard for people to accept. Somehow parents get offended or awfully upset if you say their child had brain damage. All of us have brain damage; it is a question of degree and how we handle the problems that arise. We all accept the fact we don't have perfect teeth, etc. Why not accept the fact that we do not have a perfect brain.

The best way that I have come to understand schizophrenic children or babies is by reading Arnold Gesell's book on "The Embryology of Behavior", in which he describes fetal infants as young as he could observe them when they were born prematurely. His description resembles so closely what we see in schizophrenic infants and children, that this led me to speculate that schizophrenia in early childhood is basically a disturbance in maturation of behavior patterns at the embryonic level. (Question by staff member, not audible -(How recognize schizophrenia?) In the first place, it is very important to follow schizophrenia through the life course of a large number of individuals in order to understand the early stages. One finds, for instance, that the infant who ultimately is schizophrenic, is always immature in appearance. He is toneless and he has poor patterns of physiological functioning in respiration, gastro-intestinal, and sleeping; and he is either hypersensitive to external stimuli or he shuts them out entirely and does

not react to them at all. So that for all purposes, the infant has to react with what he has, namely his organic and psychosomatic responses. He may become autistic or he will react with neurotic mechanisms in the toddling stage, which is not uncommon. Children who are driven with obsessive-compulsive behavior often appear highly gifted, with tremendous verbal capacities. At this age we find a difference between girls and boys. As a matter of fact, the relative incidence in young children between boys and girls is such that there are about three times as many boys under the age of six as girls. Along about the age of six it is more often a girl who will show a frank and dramatic psychosis, which may last for some months and then often remit into good behavior during the latency period in girls. It is true we expect girls to be charming and shy and studious and a bit obsessive. This makes for a perfect little girl, so a little bit of schizophrenia may add to the charms of the girl and she may be able to get away with it and be a better girl for it if she is not too schizophrenic.

Between the ages of six and about ten and a half, there are up to ten times as many boys as there are girls who come for professional help, and out of a family of schizophrenic children, we will get the boys and will not get the girls. If they are twins, not identical, a girl and a boy, we will get the boy and not the girl, but if you examine the girl you will find that the problems are there. The boy is babyish, immature; he does not fight back - we get that complaint frequently; doesn't know how to fight; not only that, but he invites abuse and is considered a sissy; completely disorganized; cannot achieve in school; cannot achieve in playgrounds; cannot achieve on the streets; and he is a terrific disappointment to his family. They just don't know what to do with him and he is a blubbering baby. With all

this, he is anxious and he may, if he has more capacity to adjust, become obsessive and then very soon he begins to talk about things inside of him that make him do things. The more articulate ones will talk about elaborate fantasies about body image distortions and introjected devils. Then along about the age of 10 or 11, they may have serious problems involving social adjustment. The most serious symptom is firesetting. Then, interestingly, the boy who is so disturbed in childhood, suddenly begins to clear up about the age of 11 and he more or less changes into a normal child. I have sent these children off to state hospitals, when I was at Bellevue, and after they had been there a couple of years, the hospital says my diagnosis is all wrong. The children say I told them to say they heard the devil inside of them. They don't remember saying such things. It was only that I asked them all those questions. They thought the only way to get out of the hospital was to admit to them, etc., and I began to think I really was pretty crazy, until I got hold of some of these children myself and I was really amazed to find that these children were either completely free of symptoms, or almost. This is one time when your Rorschach is of value. Your Rorschach will still show spatial disorganization, body image distortions, identification with animals, poor human responses; color shock. In fact he even seems to have no anxiety. Furthermore he can do his school work and can get along at home and at school as a normal child. They will go through a period of remission in puberty. This was a great and pleasant surprise to me, because I had warned parents that a withdrawn or disturbed little boy would be worse in puberty and adolescence. Instead, they may be normal children. On the other hand, along about middle adolescence they begin to have impulse disorders without really understanding what they are doing, and yet

feel they have to act out and even feel righteous about it. If they are very intellectual, they identify with the Hitlerians, Nazis, or other negative ideologies - at present it would be the Russians or Communists, etc. In other words, they begin what Anna Freud says, they identify with the negative. Then they begin to feel they are justified in almost any kind of act and if there is an unfortunate combination of a gang that needs a leader, there may be a serious problem. Most of the adolescent-individual kind of serious crimes have been committed by schizophrenic boys who were known to be schizophrenic in boyhood, appeared better in puberty, and got into trouble in adolescence. I have written a paper on children who have been responsible for a death before the age of 16. The boys in the 12 to 16 year age group, where the death has been a compulsive act, have either been schizophrenic, epileptic, or both. They get involved occasionally in gang episodes merely out of boredom and being dragged along by the gang. But those who have actually done the deed have usually been known to be schizophrenic and in many instances the families, the communities, and the schools have been warned that these children were dangerous. Now I also have to admit that there have been a lot of other children that we considered dangerous and nothing has happened. It requires more than a schizophrenic child to commit a murder. There has to be also a combination of events and opportunities, weapon and victim, and no one around to interfere. It is not a case of locking up every kid we think is schizophrenic in childhood to prevent crimes, but rather that we supervise the children and keep track of those whom we know have problems.

(Slides were shown and discussed by Dr. Bender).

Discussion was held following the showing of the slides.

My theory about the origin of object relationships in children is quite different from the psychoanalytic one and is based on the concepts of the actual development and evolution of children. The first of all sensory experiences in the human being is the vestibular system and the sense of gravity. The first sensory systems to develop are the vestibular organs and the central cerebral system. Infants in utero are able to right themselves even when there is very little connection between the vestibular apparatus and the motor system as a whole. The righting reaction to gravity and vestibular responses produce the first of the patterned reflexes; namely, the startle reflex or the Moro reflex. If whatever support the child is lying on falls from under it, it shows a total tonic response of all the muscles in order to keep from falling. The first reaction in which one can see a child aware of its own mother, besides the gleam in its eye, let us say, is when the mother approaches the baby and there is a tensing of muscles in anticipation of being picked up. One can see very early in the child who is developing normally if you reach for him, his tone becomes firm as you pick him up, this tone adjusts itself to being lifted so that the first sensory awareness of the outer world, the world of reality, is in terms of gravity and in terms of the child responding with changes in tones; and the tone change will be reflected into the face and throughout the body. On the other hand, if the child rejects the person who is coming to him, either because it is a stranger or an unpleasant association, he will not do this or he will even pull back and turn away. The autistic child will not change its tone and this is one of the earliest complaints that the mothers have to make. One of the complaints the mother expresses as being one of her first problems is that when she picks the baby up she is afraid she will drop it. It is like jelly in her hands

and the baby does not seem to respond. When one gets these schizophrenic children early, from the age of two or three up to 12 years, you can observe this. You take them onto your lap and these schizophrenic children melt into your body and you really have the feeling that they might be able to melt into you. You try to take a normal seven year old boy on your lap and he will look the situation over and try to figure out what goes here. He will look at you with surprise, not want to offend you but will soon be able to edge off and stand up and get away from you. But a 7, 8, 9, 10, or 15 year old schizophrenic boy will willingly cuddle in your arms and be a baby in your arms and just give up to you completely. You can feel the same thing if you touch their hands or body and they become cohesive to your skin; it is as though their boundaries really melted into the boundaries of other people. These things are phenomena that one can really feel and one can also be aware that anyone that has such phenomena must feel very insecure and very unclear about their own identity and own capacity to function in the world. Then we get the history of constantly running noses, constantly running diarrheas, so that one realizes that all the inner organs have this same kind of a continuing dysfunction.

This is my concept of what the schizophrenic baby who reacts with autism is like. A treatment program should include a stimulus to which the child must respond. This stimulus should be physiological and psychological which will help the child to become better integrated and to start maturating patterns appropriate to their age and to the world in which they live.

Now we have done some psychotherapy with some of these children which has been quite successful. Dr. Saul Gurevitz (Ph.D.) had both Freudian and Adlerian analyses; he worked with me in treating schizophrenic

children very successfully for quite a while. We reported on a group of six of these autistic children. One boy, for example, had both parents in mental hospitals since his birth. He had been left in a pediatric hospital ward until placed in a foster home at two years. He couldn't do anything and came to us as a totally unorganized child of three years, three months of age. We went to work trying to do everything for this child. We fondled him and talked to him. The child was constantly in someone's arms, being talked to and played with, and then Dr. Gurevitz started him on the kind of treatment which we feel is appropriate for such children. He begins with a real body contact with the child. These autistic children accept body contact, usually very readily. He would hold and rock the child in his arms, repeating the child's name over and over and saying, "I am Dr. Saul and you are Lennie and I am Dr. Saul." The child would be inclined to take his own finger in his mouth and suck it or Dr. Gurevitz' finger. He did not seem to care or even know whose finger it was and he might bite it too hard. Then Dr. Gurevitz would say, "This is Lennie's finger; this is Dr. Saul's finger. Lennie bit Dr. Saul's finger; now Dr. Saul is going to bite Lennie's finger." Then he would take him into the kitchen and say, "This is bread. This is what we bite and eat." He kept this and similar activities up for an hour a day. At the same time we were giving the child drugs. The drug we gave at that time to these children was benadryl. This was before the tranquilizers. Benadryl, an antihistamine, was used for allergic phenomena and to help pattern the allergic defenses and the autonomic function as a whole. These children had very bad physiological functioning and allergic responses such as upper respiratory infections, quick pneumonia, diarrhea, skin reactions, erratic temperature, pulse rate, etc. So we gave benadryl with very good results. Usually children

became very well organised under the benadryl. I even think we have made a mistake in giving it up in part, since the other drugs came along. Benadryl is still an excellent drug and it should be used in combination with other drugs. We gave benadryl to Lonnie and a little later we added benzedrine to make him a little more vigorous and active, and we gave electric shock also. We didn't wait. This was a very sick child. We had no right to wait to see if psychotherapy would be effective. As a result of this combination he improved rapidly, attended the hospital nursery school, played with other children; had habit training with the other children, and ate with them. After six months of this treatment, we then got a foster home for him that was prepared to care for his special needs. This child has since developed into a precocious school child with obsessive-compulsive patterning. He easily becomes anxious and upset; every now and then he has to have help again from the clinic; but he is developing into a normal child. Whether or not he will become psychotic eventually, I do not know. His parents obviously remained in the community long enough to get married and have a child. We hope this child will do better than that. We hope that he can get help whenever he needs it and function as a normal individual in the community. Anyway there are so many schizophrenics in our society who are functioning well that I sometimes almost wonder if the schizophrenic phenomena with its plasticity and its lack of a ceiling on capacity to progress as well as regress may not be our next threakthrough into some kind of higher form of human evolution. Our psychotics, of course, are a major medical and social problem but even those we are learning to live with more, and I think it is one of our problems to learn to live with our own schizophrenia if we have it. Our treatment program should be in that direction - to help people form the kinds of defenses that are useful

to them and to society and to learn to live with their schizophrenic experiences in the community. From time to time they may have to go to a hospital but this should not be too bad; or maybe they have to live in hospitals, but even then they should learn to live with their schizophrenia as effectively as possible.

In the schizophrenic children whom I have followed I have been able, in most cases, to confirm the diagnosis. The greatest problem in confirming diagnosis is with the young autistic children. I followed a group of children whom I sent out to Letchworth Village while I was at Bellevue Hospital. Now I am a consultant there and see the children I used to know. About half of the group of 100 remained low grade, autistic and withdrawn even in adolescence. In the other half, many developed language but became quite serious management problems in late adolescence. It must be realized, however, that children who were sent to the institution for the retarded from Bellevue Hospital at the time I was there, represented children whom we had tried to treat and had failed. Therefore, they did represent a "hard core" group. On the other hand, the follow-up of children under the age of six, who had been diagnosed as schizophrenic while they were still young, indicated that about 40% of them were making some kind of social adjustment when they were followed into their childhood or adolescent period. The earlier we make the diagnosis and the more closely we follow the child and work with the family and child and try to do the kind of treatment just described, and the more we stick to our diagnosis if we believe in it, the better the prognosis is getting.

Last spring I made a study of 50 children with both schizophrenia and convulsions. There has been the belief that epilepsy and schizophrenia do not get along together. Therefore Meduna rationalized his

convulsive treatment for schizophrenia. In the group that were autistic, there were a number of these children where I feel the diagnosis was erroneous. It is quite difficult, of course, in young children to be sure whether they are schizophrenic or brain damaged. It is very important that we make this differential diagnosis. One child came from a family in which there was no history of schizophrenia. The child did not talk and was anxious and disturbed. The family moved to Boston to put him into the Mary Putnam Nursery School for children with atypical development until he was six years old. The mother was also in therapy. When they could not keep him there any longer, they moved to Brooklyn and put him in the League School for Emotionally Disturbed Children, where he stayed until he was 12. Then he had to go into the Middletown State Hospital. This child had stereotyped behavior in which he would masturbate and then rush up to the nearest boy and put his hands on the boy's face. Needless to say, he got beaten up for this. He was very hard to handle because he was overactive, but never responded to any therapeutic efforts. I saw him there at this age of 12. I thought we should try drugs and shock treatment, but first do an electroencephalogram on him. Strange to say, he had a convulsion in the room just before the electroencephalogram was run which showed paroxysmal electroencephalogram. Since then he has been having increasing/progressive convulsions. Now this boy is without question an organic deviate but the parents spent eight years of their lives and everything they had in the way of money. We should make diagnoses earlier and correctly and we should not subject families to this amount of dislocation in time, place and money. The parents are still dedicated to the agencies that care for emotionally disturbed children, which is all right. They have finally,

however, given up hope for this child, which they should, and he is now in an institution for the retarded which cares for epileptics also. He is one of the lost souls of the world, of which there are a small, and we hope, diminishing number.

To return to Dr. Gurevitz' study. He treated six children, of whom five responded. One did not. Regardless of what we did with this little girl, she would not respond. The family were very co-operative. They also had no schizophrenia in their family and I am now quite convinced that this girl, who is now 14, looks like an aberrant defective child that we would have previously accepted as a defective child. In our institutions for defectives we undoubtedly have a lot of autistic schizophrenic children, and maybe some of them could have been saved if they had been treated earlier with stimulating treatment and had not been isolated in an institution. As it is, they will spend their lives in an institution. Also amongst those we are treating as autistic children, there are organic brain damaged children who cannot be treated. I remember one lately that was heartbreaking to me. The child was sent to me apparently with the idea that I should tell the parents what was wrong, but it didn't do a bit of good. The child had been a premature baby who had been exposed to too much oxygen and had retrolental fibroplasia and was completely blind. She was also defective but she was a strong, sturdy little girl. She was about eight years of age and her motor development had been normal and it had been figured that as long as this child's motor development was normal and she was blind, that chances were her intelligence was normal. She had no habit training. She would wear her father out by piggy-back riding, swinging her up in the air, and the kind of play that small babies like. Three times a week the father

and mother took her to a neighboring state,at great cost, for one hour of psychotherapy. I told the parents, "Of course, your child has brain damage." They said, "What do you mean? No one ever told us she had brain damage." I said, "Any child with retrolental fibroplasia has brain damage. The eyes after all are only a projection of the brain." They replied, "Well, no one ever told us this. We don't believe it. Why didn't someone ever tell us this before?" In the case file was a copy of a letter written to them stating this opinion which surprised them very much. I urged them not to go around shopping any more and to try an institution for defective children, to lead their own lives and take care of their other children. Later I got a request from another clinic where they had gone asking for another examination and opinion. So they were still shopping, because someone said the child's lack of language was due to psychological factors she had because she was blind and therefore has been deprived of normal seeing experiences. There is too much of this in my opinion. We should be able to evaluate a child and give a reasonable period of treatment. A child who can respond will show some evidence of it. If he cannot respond, we should not expect the impossible from the child. It is not fair to the children themselves. They have a right to live their lives in peace without harassment, and certainly the families have that right.

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