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Kuhn, Andrew E., Ph.D.

City University of New York, 1993

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OBJECT RELATIONS REPRESENTATIONS ON THE RORSCHACH: PARENTAL AND FAMILY RELATIONSHIPS OF SCHOOL REFUSERS

by

ANDREW E. KUHN

A Dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1993

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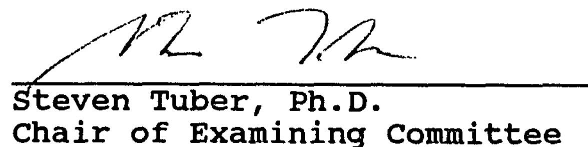

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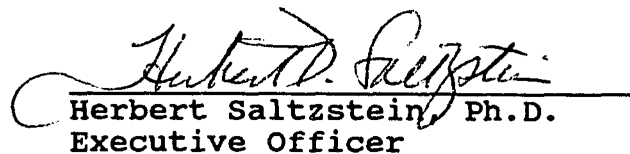

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Abstract

OBJECT RELATIONS REPRESENTATIONS ON THE RORSCHACH:
PARENTAL AND FAMILY RELATIONSHIPS
OF SCHOOL REFUSERS

by

Andrew E. Kuhn

Adviser: Professor Steven Tuber

Examined the object relations representations, family functioning, psychopathology, and parental relationships of 42 urban school refusers, ages 9 to 17. As predicted, subjects' Rorschachs, assessed with Urist's Mutuality of Autonomy Scale (MOAS), had more malevolent object representations than did a nonclinical sample. Unexpectedly, Blatt's Developmental Analysis of the Concept of the Object Scale (DACOS) did not differentiate older from younger school refusers. Of 18 hospital day-treatment subjects assessed with a semi-structured interview, 12 met criteria for Separation Anxiety Disorder, 7 for Major Depression. Two did not meet criteria for any diagnosis. By contrast, of 15 high school age subjects in a public school program for school refusers assessed with the Brief Symptom Inventory (BSI), only 5 met criteria for "caseness." On nine dimensions of the Family Environment Scale (FES), means of the school refuser sample did not differ by more than one

standard deviation from population norms; sample families were rated relatively high in moral-religious orientation and conflict, lower in expressiveness, active-recreational orientation, and independence. For the high school school refusing sample, on the Parental Bonding Instrument, maternal care and overprotection were negatively correlated ($r=-.75$, $p<.002$). Low maternal care ratings correlated significantly with poor form object representations ($r=-.56$, $p<.05$); thought disorder on the Rorschach ($r=.56$, $p<.05$); FES variables conflict ($r=.65$, $p<.02$) and organization ($r=-.55$, $p<.05$); and overall psychopathological distress on the BSI ($r=.71$, $p<.01$). There were no significant results for paternal PBI variables. Results are discussed in terms of attachment theory, reciprocal effects of relational, family, and psychopathological variables, and the development of object relations representations. A full Rorschach record is reproduced and clinically assessed from various object relational perspectives.

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To my wife, Rachel Asher, I owe a more indefinite yet still great debt of gratitude, one incurred and repaid daily, for me as light and necessary as air.

TABLE OF CONTENTS

Abstract. iv

Acknowledgments vi

Table of Contents vii

List of Tables x

Chapter
I. INTRODUCTION 1

Psychoanalytic Concepts and Statistical Research 1
Child assessment: Difficulties and benefits 3
Index group: School refusers 6

Chapter
II. LITERATURE REVIEW 8

Paradigm Shift for Psychoanalysis: Object relations theory 8
Assessment of object relations 12
Data sources, scales, and rationales . . 14

Object Representations and the Rorschach . . 17
Two Rorschach object relations scales: A review 20
DACOS 20
MOAS 22

School Phobia or School Refusal: A Review of the Literature 25
Background and significance 25
Prevalence 27
Prognosis 28
Early psychological conceptions of school age children 30
Identification of a school refusal syndrome 32
Studies contrasting school refusal and disorders of conduct 36
Comorbidity and familial psychopathology 39
Older versus younger, "acute" versus "chronic" school refusers 43
Etiologic formulations: A widening disagreement 45
The "overdependency" hypothesis 47
Family patterns 49

The separation anxiety hypothesis . . . 58
A shift in emphasis: Self-image and self-evaluation 61
Behaviorist perspectives and psychopharmacological studies 64
Summary 67

Main hypotheses 71
Other areas of inquiry 72

Chapter
III. METHOD 75

Subjects 75
Rorschach scales: MOAS and DACOS 80
Thought Disorder Index 83
Relationship measure: Parental Bonding Instrument 84
Brief Symptom Inventory (BSI) 88
Diagnostic Interview Schedule for Children (DISC) 89
Family Environment Scale (FES) 89
Data pattern 90
Clinical reading of a record 92
Data analysis 92

Chapter
IV. RESULTS 93

Demographics 93
Measures of psychopathology 94
Brief Symptom Inventory (BSI) 95
Findings 95
P.I. diagnostic information 95
Findings 96
Rorschach measures 99
Reliability 100
Rorschach: Mutuality of Autonomy Scale (MOAS) 101
Findings 102
Rorschach: Developmental Analysis of the Concept of the Object Scale (DACOS) 109
Rorschach: Thought Disorder 111
Findings 112
Self-report measures: Family Environment Scale (FES) 114
Findings 114
Intercorrelations among FES factors . . 115
Parental Bonding Instrument 121
Findings 121
Intercorrelations of Rorschach measures . . . 123
MOAS and DACOS 124
MOAS and Thought disorder 125

DACOS and Thought disorder 126
Rorschach measures with self-report measures 128
MOAS Mean and FES, BSI, PBI variables 128
MOAS and PBI 128
DACOS and BSI 129
DACOS and PBI 129
DACOS and FES 130
Thought disorder and BSI 131
Thought disorder and PBI 132
Thought disorder and FES 133
Self-report measures with each other 134
PBI and BSI 134
BSI and FES 135
PBI and FES 138

Chapter
V. DISCUSSION 139

A close reading from diverse perspectives . . 149
Rorschach record #1 151
Limitations of this study 179

Appendix: The PBI, attachment research, and
object relations theory 184

References 200

LIST OF TABLES

1. Data collected by site 91
2. Rorschach productivity by sex and site. 99
3. DACOS reliability 101
4. MOAS Productivity 103
5. Malevolent MOAS productivity 103
6. MOAS productivity by scale point: school refusers and normals 104
7. School refusers: MOAS 1 scores by gender . . . 105
8. Number of MOAS 1 and MOAS 2 responses by site . 107
9. Most benign MOAS score by sex and site 107
10. DACOS scoring by sex and site 111
11. Thought disorder responses, frequencies and percentages 113
12. Family Environment Scale factor scores 114
13. FES subscale correlations 116
14. Intercorrelations Among FES Factors: Normative Sample of 621 Adolescents 117
15. Correlations between Rorschach summary measures 123
16. Correlations between MOAS scale points and Rorschach summary measures 124
17. PBI mother care by MOAS scores 129
18. Mother Care and Thought Disorder 133
19. Correlations between BSI factor ratings and PBI variables 135
20. FES subscales by BSI-GSI. 136
21. Schematic view of data relationships, H.S. Sample 140

CHAPTER 1

INTRODUCTION

Psychoanalytic Concepts and Statistical Research

The problem of assessing the "truth value" of psychoanalytic conceptions of development and pathology has been a knotty one. It has been argued that psychoanalytic assertions are by their nature not disprovable, and therefore should not be admitted as scientific discourse (Turner, 1968; Wolpe and Rachman, 1960). Others have argued that psychoanalytic material is so complex that the analysis and synthesis of its elements may not be reduced to terms satisfactory to the demands of empirical behaviorists without a crucial loss of meaning (Rosenthal, 1966). While attempts to make psychoanalytic terms and concepts more rigorously defined and philosophically respectable have been pursued and resisted with some vigor (Schafer, 1976), psychoanalytic theory building has by and large proceeded in the fashion established by Freud, that is, by the method of making inferences and generalizations on the basis of clinical case studies, primarily of adult patients (Wachtel, 1987).

Whether clinical reports--condensed and selected according to prior theoretical commitments, in a fashion unobserved and probably by its nature

unobservable by others--may properly be considered credible evidence, was in the past hotly debated. More recently, the psychoanalytic and experimental traditions within psychology appeared to have agreed to disagree, or, perhaps rather conspired to more or less contemptuously ignore one another. This split has been reflected not only in academia and the professional journals but in clinical settings as well. Psychiatry has expunged nearly every trace of psychodynamic inference and theory from its behavioral diagnostic nosology, the Diagnostic and Statistical Manual (in its latest revised edition, the DSM-III-R). Similarly, for years psychiatric researchers have in the main appeared to take it for granted that psychoanalytic or psychodynamic observations and theories were bereft of reliability and validity, warranting no further investigation.

Yet there are indications that this cold war, too, may not prove interminable. With the advent of new currents in psychoanalytic theorizing (addressed below), specifically the development of an object relations paradigm, ingenious and promising efforts have been made to develop reliable and valid techniques for assessing clinically meaningful dimensions of experience and functioning, and subjecting the results to statistical analysis (Stricker and Healey, 1990).

Some have developed new instruments (Bellak and Goldsmith, 1984; Blatt et al., 1979), but many have made use of such familiar tools for clinical assessment as the Rorschach and the Thematic Apperception Test (TAT) (Urist 1977, Urist & Shill, 1982; Blatt & Berman, 1984; Thompson, 1986).

Child assessment: Difficulties and benefits

A considerable portion of this work has been done with children. Differences in developmental status across different ages inevitably complicate assessment, and there is considerable controversy over basic questions in child diagnosis, making the significance of findings about child clinical groups more difficult to assess (Klein and Last, 1989; Rutter et al., 1986). Yet continued attempts to apply the new techniques to children are essential for a number of reasons.

Since Freud, theories of psychopathology have stressed the importance of development, and all psychological theories of the modern era have felt called upon to give an account of development, even if only to deny any determinative impact of childhood experience on later functioning (Crain, 1985). The object relations school in particular has emphasized ways in which early experience shapes later development and the formation of character, and character

pathology. The experiences to which those theorists have pointed as crucially formative date from even earlier than the Oedipus complex, which Freud primarily stressed. Yet both the object relations and more traditional psychoanalytic accounts note that development is not consolidated for many years, and that children and adolescents in distress, less heavily defended and obscured by "character armor" (Reich, 1972) built up over many years than are their adult counterparts, may evince relatively plainly and directly the conflicts and developmental deficits that for them have proved pathogenic (Eisenberg, 1958b). The examination of child psychological development and psychopathology are thus of theoretical as well as clinical interest (Morris and Kratochwill, 1983).

Despite the difficulties noted above, working with children affords unique opportunities in addressing the question of validity of object relations concepts and instruments. To the extent that pathogenic early influences may still be extant and observable in the child's present family relationships, observing children suffering from psychopathology offers unique opportunities to examine the degree to which actual family relationships conform to current and/or expected object relations representations. Conversely, predictions that specific object relations

representations will be characteristic of particular patterns of psychopathology may either be confirmed or disconfirmed. Finally, groups that have been discriminated in the literature with respect to age or psychopathology or both may be examined with respect to their object relations representations, to see if predicted differences are in fact found.

The potential theoretical profit of pursuing these questions seems considerable. Perhaps more importantly, clinical benefits could be reaped as well. All the new techniques of assessment used in object relations research were developed by clinicians and are based on theoretically informed clinical observation. The instruments' concurrent, predictive, and content validity are being weighed in conjunction with their clinical utility (Stricker and Healey, 1990; Kwawer et al., 1980). Careful research that delineates what these scales can tell us about specific clinical populations has already helped to focus and lend new perspectives to data yielded by standard instruments of clinical assessment. But work in this area has just begun. While an impressive array of findings with respect to borderline and narcissistic disorders has been presented in a relatively short time--roughly, the decade of the Eighties (Wallace and Martin, 1988; Lerner, Albert, and Walsh, 1987; Edell, 1987; Spear and

Sugarman, 1984)--much remains to be done, especially in the area of research with children.

Index group: School refusers

It is with these broad aims in mind that this study was conceived. In the current study, for reasons to be addressed more fully below, the groups assessed are young (age 9 to 13.5) and adolescent (13.5 to 17) school refusers. Briefly, school refusers (or school phobics) have generally been distinguished from truants in that when not at school they stay at home (rather than roaming); they are anxious and/or depressed rather than delinquent, although they may be fiercely oppositional with respect to school attendance (Berg, 1980).

Although it has been one of the most heavily researched psychopathological problems of childhood, school refusal remains the subject of considerable controversy with respect to aetiology, dynamics, diagnostic significance, and prognosis (Atkinson et al., 1985; Ollendick and Mayer, 1984; Prince, 1968; Shapiro and Jegede, 1973). These issues will be addressed below. Here it is appropriate to note that one of the more robust research findings has been that older and younger school refusers differ significantly with respect to degree and nature of psychopathology

and prognosis.

CHAPTER 2

LITERATURE REVIEW

Paradigm shift for psychoanalysis: Object relations theory

The advent of object relations theory, as construed by Klein, Fairbairn, Guntrip, Bowlby, Winnicott, Mahler, Kohut, and Kernberg, has worked a profound shift in psychoanalytic conceptions of development and psychopathology, as well as metapsychology (Mitchell, 1988; Klein, 1948, 1975; Fairbairn, 1954; Guntrip, 1971; Bowlby, 1961, 1969, 1973, 1980; Winnicott, 1986; Mahler et al., 1975; Kohut, 1966, 1977; Kernberg, 1966, 1975). An intensified focus on the timing, mechanisms, affective coloration, and "structural" consequences of the internalization of early relationships has been in part occasioned by and has in part itself prompted a greater emphasis on preoedipal or pregenital development and pathology, with concomitant changes in theory and clinical practice (Greenberg and Mitchell, 1983).

Different theorists have taken different positions on the timing, sequence, phenomenology, structuralization, and drive characteristics of object relations development, as well as the relative contributions of innate and environmental factors. Broad agreement is emerging, however, that unconscious

representations of early relationships tend to be quite durable, and that they affect later functioning in important ways (Mayman, 1967). To the extent that internalized object relations constitute unconscious expectations of how affectively salient others will behave, they would be expected to mediate social behavior in a variety of contexts, leading to relatively stable behavioral dispositions, for good or ill.

In part, object relations theory was developed in order to attempt a more satisfactory explanation for what Freud termed "negative therapeutic reactions" or the repetition compulsion: the tendency to repeat maladaptive patterns, especially in relationships, without learning from experience (Greenberg and Mitchell, 1983). Much of the seminal work in object relations theory has been done by clinicians working with adult patients whose pathology they conceptualize as being characterological rather than primarily neurotic (Guntrip, 1971; Kohut, 1966, 1977; Kernberg, 1966, 1975). Other theorists with psychoanalytic training have directly observed infants in the process of pathological and normal development (Spitz, 1965; Bowlby, 1961; Mahler et al,. 1975), and their accounts have stressed the centrality of object relations to a wide range of phenomena, including affective tone and

expressive range, the ability to tolerate separation, the emergence of ego functions, sense of self, and even, in the extreme case, physical survival (Spitz, 1965).

To date, the most detailed scheme for preoedipal development has been worked out by Mahler (Mahler, Pine & Bergman, 1975). While aspects of this conceptualization have been strongly criticized (Peterfreund, 1978), it remains a useful and widely cited integration of observations and inferences about cognitive, social, and emotional development. At the same time, infant research from a biopsychosocial perspective has contributed insights into apparently innate object-seeking tendencies in very young children (Stern, 1985). Research anchored in the attachment theory paradigm of Bowlsby and Ainsworth--in some ways a more rigorously experimental heir of Mahler's observations in a nursery for normal children--has progressed from attempts at behavioral classification of infants along the dimension of security of attachment to explorations of the characteristic mental schemas and representations of attachment in older children and adults, bringing it within hailing distance of psychodynamic theory (Belsky and Nezworski, 1988). While attachment theorists have not by and large made explicit reference to the implications of their

work for object relations theory, it appears that in finding significant correspondences between representations of attachment figures and a variety of measures of social and emotional functioning, the attachment researchers have contributed further credence to the contention that object relations mediate a variety of adaptive and maladaptive behaviors and relationships.

There are indications that, at least for some, the schismatic tendencies and exclusionist rhetoric that have dominated the politics of psychoanalytic and psychodynamic theoretical development since Freud's time have begun to give way to attempts to integrate and find common ground, without falling into a complacent and atheoretical eclecticism (Mitchell, 1988). Pine, for example, borrowing from Anna Freud's conception of "developmental lines" (A. Freud, 1965), has tried to include overlapping and complementary perspectives from classical drive theory, ego psychology, and object relations in his conceptualization of development and the clinical process (Pine, 1985). And writers from the family systems perspective have looked to object relations theory as a "dynamic bridge" between individual and family perspectives (Slipp, 1984). Whatever the original "home base" theoretical position of the

revisionists, however, nearly all have reflected at least an implicit shift of emphasis toward the contribution of "the environment" to both normal and pathological object relations (Mitchell, 1988).

Assessment of object relations

As psychoanalytic developmental theory has itself developed, researchers have looked for new ways to assess individuals along the dimension of object relations, for both clinical and research purposes. By definition, object relations are unconscious (Stricker & Healey, 1990), which makes valid and reliable assessment a difficult matter. Moreover, object relations theory, and the observations on which it is based, cover an extraordinary range of phenomena. It would be astonishing if any single measure were to succeed in capturing all significant aspects of object relations. Nonetheless, a robust and burgeoning body of work has attacked the problem of assessing object relations from a number of different angles (Stricker & Healey, 1990).

Instruments are based on a variety of theoretical positions of varying degrees of explicitness and clarity regarding the significance, developmental sequence, and psychopathology of object relations. All of the instruments are in one sense or another

normative. Criteria are spelled out for distinguishing relatively healthy object relations representations responses from less healthy and plainly unhealthy ones. Similarly, scales are alleged to differentiate developmentally "higher" versus "lower" representations of objects.

Some have developed new instruments. Bellak, for instance, included object relations dimensions within a semi-structured interview that is itself rooted in the theory of ego psychology (Bellak & Goldsmith, 1984). Blatt and colleagues (1979) assessed cognitive-emotional dimensions of parental representations in written descriptions. While these relatively head-on approaches to the problem show promise, one may question whether they primarily capture aspects of actual interpersonal functioning and specific current relationships rather than representations of what theorists have generally meant by "object relations" (Stricker & Healey, 1990).

Certainly, to the extent that unconscious object relations mediate current functioning, one would expect some significant degree of congruence between the themes and expectations reflected in object relations representations, and other measures that tap more consciously available and/or readily observable phenomena. Indeed, the search for meaningful correlates

and correspondences between object relations measures and other conceptually related aspects of functioning has been a major theme in object relations research, and a buttress for its claims to validity. Some of these efforts will be reviewed below, in the context of an examination of the relative claims of various instruments to afford a representative sample of an individual's characteristic unconscious object relations. Practical considerations and limitations of the scales will also be addressed.

Data sources, scales, and rationales

Freud called dreams "the royal road to the unconscious" (1900/1953a) and psychoanalysis has traditionally stressed that dreams provide unique access to unconscious processes. Freud himself, however, tempered this assessment by noting that "the manifest dream" is itself the product of compromise and bears the imprint of defenses deployed to disguise the original wish around which it has been woven. Subsequent clinical writers, while generally following Freud's lead in how one goes about understanding dreams, have argued against assuming that dream reports are necessarily more privileged, as regards expression of primary process material or characteristic modes of object relations and defense, than any other material

presented by the patient. By this account, the interpretive heuristics applied to understanding a symptom, a quirk of speech or of self-presentation, or a selection of memories are much the same as those called upon to unravel the meanings of a dream.

Both aspects of the history of dream assessment are reflected in the uses that have been made of Mayman's Object Representation Scale for Dreams (ORSD), an 8-point ordinal scale that classifies individuals' perceptions of others as ranging from absent, fragmentary, alienated to alive, differentiated, and complete (Krohn and Mayman, 1974). To the extent that the scale taps object relations in a valid way, no compelling reason has been found not to apply it to sources of data other than dreams. Indeed, such efforts have provided another check on the measures' validity. If measurements of an individual's object relations yielded very different assessments, depending on the data source, serious doubt would be cast upon the assertion that what these measures are in fact tapping is a relatively stable, unconscious, affectively and behaviorally salient set of representations.

Krohn and Mayman (1974) reported high intercorrelations of the ORSD for data from dreams, the Rorschach, and a test of early memories. They found that partial correlations showed the relative

contribution of data from dreams and early memories to be relatively greater than the Rorschach data, which added little to the correlations. Spear, however, applied ORSD criteria to Rorschach data, and found that it was actually more successful in discriminating subtypes of borderline patients than was the ORSD applied to dreams (Spear, 1980). In reviewing studies that have used this instrument, Stricker and Healey (1990) speculate that as applied to the Rorschach, the ORSD yields some combination of level of object relations and of psychopathology.

Stricker and Healey note the ORSD's apparently acceptable reliability and validity in studies to date. In attempting to account for its having been used relatively infrequently, they allude to "the difficulty of reliably collecting dreams." While they do not elaborate on this, that difficulty is readily apparent. The conditions and context in which dream reports might be collected, for instance, could vary enormously, with potentially major impact on what is reported.

Some researchers have worked primarily with the TAT (Thematic Apperception Test). Westen's Object Relations and Social Cognition Scale (ORSCS) taps the complexity and differentiation of representations of people; affect and emotional involvement in relationships; moral standards; and comprehension of

social causality. Subscales have been found to predict social adjustment, clinician's ratings of pathology, and symptoms (Westen, 1989).

Object Representations and the Rorschach

The most thoroughly researched object relations scales, however, have been applied to Rorschach data. It is not immediately obvious why this should be the case, given that the Rorschach test predates the advent of object relations theory, and unlike the TAT, for instance, is not primarily made up of representations of human figures. But it may be argued that the lack of unambiguous figures or relationships on the Rorschach makes it more likely that the projective-perceptual mix in the individual's response will be more heavily weighted towards the projective than is the case for the TAT, for example. By this logic one would expect those percepts interpreted as human or humanlike to be more likely to betray the influence of unconscious object relations.

Such an assertion bears closer scrutiny. Rationales for the uses to which the Rorschach may be put must begin with an examination of the task it sets a subject. The Rorschach presents ambiguous stimuli which an individual is called upon to organize into a percept and articulate intelligibly. The rationale for

Rorschach testing, broadly speaking, is the hypothesis that this complex perceptual, cognitive, affective, defensive, and linguistic process affords a sample of the subject's functioning from which valid generalizations can be made (Klopfer et al,, 1954). It has long been noted that, in part because of the ambiguity of the stimuli it offers, the Rorschach tends to elicit material laden with what psychoanalysis designates as drive derivatives, as well as to prompt a regressive "drift" in the subject's productions, to a greater extent than does any other test in the standard battery (Holt, 1977). Indeed, for specific diagnostic groups, notably borderlines, a disturbed Rorschach with a relatively intact WAIS-R intelligence test have been found to be pathognomic (Gunderson and Singer, 1975; Wallace and Martin, 1988).

On the Rorschach, then, the balance between conventional social perception and creative, projective activity is of necessity tipped more toward the latter than is the case when the stimuli presented are less radically ambiguous. The TAT offers unmistakeably human figures in recognizable postures (although, of course, the meaning and context of the TAT figures' dispositions on the card are to a crucial extent open to interpretation). When a respondent reports seeing a human or humanlike figure in a Rorschach card, he or

she has "brought more" to the situation. If object relations are by definition unconscious, one may be a bit more confident that one is seeing an object relations representation in such a context.

Object relations investigators reason that the human and humanlike figures "seen" and reported by a subject--their degree of articulation, specificity, motivation, congruity of actions, and nature of interactions--reveal characteristic modes of perceiving self and others, and that these characteristic modes have significant effects on how the subject experiences and behaves toward others, and the responses he elicits from the environment. It is also posited that these modes have a developmental dimension.

Mayman's (1967) summation of the subject's experience of the Rorschach, the process of forming a response, and the rationale for assessing object relations with the test is particularly apt and evocative.

> When a person is asked to spend an hour immersing himself in a field of impressions where amorphousness prevails and where strange or even alien forms may appear, he will set in motion a reparative process the aim of which is to replace formlessness with reminders of the palpably real world. He primes himself to recall, recapture, reconsitute his world as he knows it, with people, animals and things which fit most naturally into the ingrained expectancies around which he has learned to structure his

> phenomenal world. . . [A] person's most readily accessible object-representations called up under such unstructured conditions tell much about his inner world of objects and about the quality of relationships with these inner objects toward which he is predisposed. [p. 17]

Two Rorschach object relations scales: A review

The two most heavily researched scales in use are Blatt's Developmental Analysis of the Concept of the Object Scale (DACOS) and Urist's Mutuality of Autonomy Scale (MOAS).

DACOS The DACOS derives from two theoretical strands, developmental psychology (Werner, 1948; Piaget, 1954, 1962) and psychoanalysis (e.g. Jacobsen, 1964, Mahler et al., 1975). Both structural and content aspects are assessed (Blatt & Lerner, 1983). While the earliest object relations representations are "vague, diffuse, variable, sensorimotor experiences of pleasure and unpleasure" (ibid., p. 8), the capacity gradually emerges to represent objects and the self in interaction with objects in more differentiated, consistent, and realistic ways. Early representations are concerned directly with need gratification; intermediate forms include specific perceptual features; mature or "higher" forms are more symbolic and conceptual (Blatt et al., 1976).

The DACOS assesses object representations of human or humanlike ("quasi-human") figures (Blatt et al.,

1976) with respect to differentiation, articulation, and integration. In each of six categories, responses are given weighted scores along a hypothesized developmental continuum (Blatt & Berman, 1984).

In a longitudinal study of normal development, Blatt et al. (1976) assessed object relations on the Rorschach in 37 subjects at ages 11-12, 13-14, 17-18, and 30. Over time, and as expected, this non-clinical sample showed an increase in well-differentiated and articulated human figures, behaving in meaningful, benign, reciprocal fashion. A sample of 48 adolescent and young adult inpatients, by contrast, produced human figure responses that were significantly more likely to be partial, distorted, and inaccurately perceived, and either inert or engaged in less-than-congruent activity. They also produced more representations of malevolent interactions. An unexpected finding was that for the patients previously and independently judged most disturbed on the basis of thought disorder responses on the Rorschach, accurately perceived human responses were articulated at developmentally lower levels than were inaccurately perceived responses. Blatt et al. discussed this finding in terms of the experience of psychotic patients, who appear more disorganized when attempting to integrate a presumably painful reality, and relatively better organized when

preoccupied with fantasy productions.

In a number of studies, the DACOS has been used to differentiate various diagnostic categories, including restricting and bulimic anorexics (Piran and Lerner, 1988), schizophrenics and borderlines (Spear, 1980; Spear and Sugarman, 1984), narcissists and borderlines (Farris, 1988), schizophrenics, inpatient borderlines, outpatient borderlines, and neurotics (Lerner & St. Peter, 1984a, 1984b), and nonpsychotic and psychotic patients (Ritzler et al., 1980). The DACOS could not, however, distinguish between two borderline "subtypes" designated hysterical and obsessive (Spear and Sugarman, 1984), although Urist's (1977) Mutuality of Autonomy Scale (MOAS) did differentiate these groups.

MOAS Urist's MOAS draws on theoretical contributions by Kernberg (1966, 1975) and Kohut (1966, 1977), focussing on the theme of separation-individuation. Figures in relation to one another, whether directly perceived and articulated or only implied, are scored on a seven point scale ranging from most benevolent and mature (intact figures interacting in a mutually autonomous and reciprocally aware fashion) to most malign (a figure is overwhelmed by forces completely beyond control). In contrast to the DACOS, content rather than formal characteristics of

the response is stressed.

In his original article, Urist (1977) reported significant correlations between the MOAS and autobiographical data and staff ratings of inpatients. With adolescent inpatients and outpatients Urist and Shill (1982) replicated the study using exclusively excerpted MOAS-scoreable data to make certain that MOAS ratings were based on MOAS responses alone, and not biased by other indications of psychopathology in the Rorschach protocol. They again achieved significant results.

An advantage of using the MOAS to assess children is that interactions between animals are also scored. Previous Rorschach research (Ames et al., 1974) with a longitudinal, developmental design found that younger children produced relatively few M or human responses, and that over time the number increased, while the number of animal responses decreased. In a nonclinical sample of children, Tuber found modal responses to be from the benign end of the scale (ones and twos), strengthening the claim to content validity (Tuber, 1989a).

The MOAS has also been used extensively in group comparisons of different clinical populations, to characterize boys with Separation Anxiety Disorder (Goddard & Tuber, 1989) and depressed female

adolescents (Goldberg, 1989). A modified 10-point version was used to differentiate restricting and bulimic anorexics from controls (Spear and Sugarman, 1984).

School Phobia or School Refusal: A Review of the Literature

Background and significance

Failure or extreme reluctance to attend school has been a management problem for parents and civil authorities since the beginning of mandatory schooling for children in the West over a century ago (Berg, 1980). It was wryly noted much earlier by Shakespeare, whose seven ages of man included "the whining school-boy . . . creeping like a snail unwillingly to school" (*As You Like It*, Act II). It has only been in the last fifty years or so that the problem has been investigated at all systematically from a variety of psychological viewpoints (Mitchell & Shepherd, 1980).

For administrative purposes no formal distinction was at first made between truancy that was part of a broadly delinquent pattern of behavior, and refusal to attend for reasons of depressive and/or anxious neurotic suffering (Weitzman, 1987). Between World Wars I and II, however, the increased involvement of child psychologists and psychoanalysts in treating school related problems brought into sharper focus the different psychological and familial contexts in which failure to attend school appears. For diagnostic and treatment purposes, a useful distinction was made

between those "truants" who remained at home during school hours (usually with the knowledge of a parent) and those who cut school to roam unsupervised (Broadwin, 1932; Eisenberg, 1958a; Hersov, 1960; Johnson et al., 1941; Kahn, 1962; Atkinson et al., 1985; Prince, 1968). The former have been identified in the literature as "school phobics" or "school refusers", while the latter have been said to show a "disorder of conduct", criteria for which were formalized in the DSM-III-R "conduct disorder" diagnosis.

While different authors have used the terms from different theoretical standpoints, and with different hypotheses in mind as to probable etiology and dynamics, no standard usage has emerged that would justify assigning to the term "school refusal", for instance, the meaning of a learned avoidance of a noxious situation (school), or firmly designating "school phobia" as a child's displacement onto the educational setting of fears and hostilities felt toward an ambivalently loved parent. While this has led to confusion about the precise range of meanings individual authors invest in their preferred terms, there is broad general agreement about the behavioral features of the clinical syndrome. Accordingly, the terms school phobia and school refusal will be used

interchangeably here to describe an extreme reluctance and at least periodic refusal to attend school; parental knowledge of this nonattendance; strong preference for staying at home when not at school (as opposed to avoiding school to escape all adult supervision); intense negative affect in response to attempts to force school attendance; and the absence of a conduct disorder. No etiologic formulation is implied in the nomenclature as used here.

Prevalence

Of all childhood phobias, school phobia has been called the most prevalent (Miller et ál., 1974). But estimates of prevalence vary widely, from .01 to 25 percent (Aldaz et al., 1984), or 2 to 8 percent of child and adolescent clinic admissions; a recent review put the figure at 5 percent (Hersov, 1985). A study in Virginia, using criteria similar to those outlined at the beginning of this review, found an incidence of only .4 percent in school-aged children (Ollendick & Mayer, 1984). It is probable that in most school systems many cases go unreported and unrecognized. When the Boston schools publicized a service for school refusers, 24 cases were referred in four months, suggesting a prevalence some ten times higher than studies based on clinic populations have estimated

(Eisenberg, 1958a).

Prevalences by sex show no clear pattern (Prince, 1968). Unlike with many other disorders of childhood, boys do not appear to be more at risk for school phobia than girls. Onset may be at any age from preschool to high school years; in a review, Leventhal and Sills (1964) report the highest frequency during ages ten to twelve. Interestingly, Hersov (1960) reported that 90 percent of his school phobic sample were either eldest or youngest children. Others, however, have reported no difference in birth order between school phobics and other clinical or normal control groups.

Early studies indicated that school refusers were more likely to be middle class and of above-average intelligence (Eisenberg, 1958a), but later studies cast doubt on these findings (Baker and Wills, 1978; Hampe et al., 1973). School refusers with average intelligence have been found to be underachieving academically on the basis of standardized tests; this finding is not startling in children who by definition have missed substantial amounts of school. They are not, however, more likely to be learning disabled (Ollendick & Mayer, 1984).

Prognosis

School phobics or school refusers have, as a

group, been found typically to be more dependent, anxious, immature, and depressed than normal age-mates and other clinical child populations (Trueman, 1984; Kolvin et al., 1984). The extent to which these problems persist and/or lead to other or more serious psychopathology has been investigated, and findings have been mixed (Piacentini, 1989). Of 67 school phobics assessed an average of six years after outpatient treatment, Baker and Wills (1979) found 85 percent either working or attending college. In another study, however, Coolidge et al. (1964) reported that nine years after treatment, 60 percent of 49 subjects continued to have "adjustment problems".

Hospitalized subjects have generally shown even more persistent and pervasive problems on follow-up. Three years after discharge, from one-half to 70 percent of subjects showed at least some continuing impairment (Berg et al., 1976); and 13 of 14 former chronic school phobics still had major emotional difficulties on follow-up after hospitalization. To a considerable degree, differences in findings may have to do with sample differences. However, studies have also linked school refusal with the development in adulthood of panic disorder and agoraphobia, among other anxiety disorders (Gittelman-Klein & Klein, 1973; Deltito et al., 1986), even in adults who received only

outpatient treatment for school refusal, or no treatment at all.

Early psychological conceptions of school age children

The roots of a psychodynamic understanding of educational difficulties can, not suprisingly, be traced back to Freud (Prince, 1968), who saw in the fear of examinations a displacement of anxiety from the sexual to the intellectual realm (Freud, 1913/1953b). Psychoanalytic authors have seen school as a crucial arena for growth of the ego and sublimation of instinctual energies; inability to cope with the psychological and social demands of school often precipitates the symptoms that cause children to be brought in for treatment (A. Freud, 1965).

Zealous and naive early attempts to apply psychoanalytic precepts in educational settings and childrearing gave way to second thoughts, given the dismaying (even "insufferable") results, which necessitated further intensive psychoanalytic repair (Sterba, 1945). Parental efforts to spare the child trauma and the ill effects of repression by, for instance, freely interpreting instinctual derivatives in everyday life and play, seemed to backfire, resulting in highly anxious and undersocialized children (Sterba, 1945). Reformulations followed,

reflecting theoretical shifts in emphasis from instinct theory to ego psychological and object relations paradigms (Fenichel, 1945; Hoffer, 1945).

Psychoanalytic revisionists have also made mention of educational applications. Adler (1930) stressed the relevance of his own theoretical reformulations to child training in and out of school. In 1924, Jung expatiated on his analytic psychology as it related to education (Jung, 1954). Melanie Klein's 1923 "The Role of the School in the Libidinal Development of the Child" (Klein, 1948) was perhaps the most comprehensive statement of the application of psychoanalytic thinking to the school setting. She noted that school challenges the child in a new way to sublimate drive energies and come to terms with a host of new objects; increasingly, appropriate and flexible activity must supplant a more passive, infantile attitude. With many clinical examples she showed how genital conflicts and inhibitions can interfere with sublimation in the academic setting, generalizing to undermine a variety of nascent ego functions. Her controversial techniques for analyzing such conflicts, including seemingly confrontational interpretations of "deep" id material as early as the first session, are most clearly and consistently displayed in her _Narrative of a Child Analysis_ (Klein, 1975), an account of ten months of

intensive work done with a ten-year-old boy during World War II. Prominent among his presenting symptoms was school refusal.

In a classic case study, Berta Bornstein (1949) recounted the analysis of an unusually young patient (5 1/2) referred for "severe school phobia". She stressed the dynamic complexity and over-determined nature of the symptom, and sounded a theme of cross-generational displacements and repetitions of difficult relations that has been remarked on by many writers since. Bornstein considered that a prime origin of the boy's difficulties, which included strong separation anxiety, was his mother's "primary rejection" of him as an unconscious revenge on her own much-favored older brother.

Identification of a school refusal syndrome

While psychoanalytic authors had written before about patients who refused school, Broadwin (1932) was the first to propose, on the basis of two cases, the existence of a syndrome of school refusal with anxiety. He saw the disorder as being due to the child's powerful regressive wish to re-establish ties with the all-providing mother of infancy (or of infantile fantasy). But Broadwin considered that this wish, and the child's overdependence, were in large part fostered

by the mother for a number of reasons, operating singly or in combinations: 1) the mother's insecurity about her competence as a mother; 2) the mother's unresolved dependency needs vis-a-vis her own mother; 3) a poor marriage; 4) the mother's lack of any interests outside the home.

The term "school phobia" was first used by Johnson et. al (1941) in a landmark article describing a syndrome of acute anxiety about attending school, culminating in refusal to attend. In an intensive clinical study of eight cases, they found 1) a history of considerable anxiety in the child patient's early years; 2) shortly prior to onset of school refusal, an increase in anxiety in the mother due to some "threat to her satisfactions" (economic, marital, or health); 3) a poorly resolved early dependency relation between the children and their mothers.

Johnson et al. distinguished clearly between the dynamics of the type of neurotic school refusal they described and those of "common truancy": "In school phobics the mother is . . . more affectionate, and therefore guilt is greater in the child, whereas in common truancy the child senses far less genuine love from the parent" (417). The child partially solves his neurotic (ambivalent) conflict by displacing the rage he feels toward his mother onto the teacher, a more

consistent disciplinarian on whom he is less dependent. Consistent with this view of etiology, Johnson et al. recommend a psychodynamically oriented treatment for both parent and child.

It is notable, however, that even in this early and quite firmly psychoanalytic discussion of the problem, the authors stress that characteristic patterns of relationships within the family--particularly between mother and child--serve to maintain and exacerbate the symptom, especially when therapeutic intervention "threatens" an improvement. For example, a woman whose own dependent needs had been frustrated by a mother bedridden with hysteric symptoms resented her nine-year-old son's independent strivings. When the boy suffered a bout of organic illness, increasing his dependency towards her, she reacted at first with indulgence, then with hostile envy, and a rather blatant attempt to "out-bid" him in illness. The child responded shortly afterward with school refusal. Johnson et al. saw this as reflecting the child's wish both to punish his mother for her begrudging of him, and to punish himself for his hostility towards her by falling behind in school. Remaining at home also served the purpose of reassuring him that his hostile fantasies directed towards his mother were not in fact coming true in his absence.

Both mother and son were treated independently in psychotherapy. In the son's treatment, major themes included his mother's resentment of moves toward independence on his part, and his consequent rage and guilt. The mother's birthday and Mother's Day fell just days apart, yet when he gave her a single expensive gift for both she responded with bitterness that here was proof that the boy didn't love her any more. It was not until the mother had worked through her own frustrated dependent needs in her own therapy, and was able to be less ambivalently giving to her son and husband, that the son's school refusal cleared up.

In other cases, Johnson et al. again stressed the role of the mothers' neurotic conflicts and, often, contemporaneously troubled relations with their own mothers as causative. "In countless subtle ways, these mothers create intense guilt in their children for their independence strivings." The sequence of independence strivings, guilt, resentment, hostile wishes, exaggerated gestures of restitution, and renewed independence strivings takes on the quality of a vicious cycle, and intervention with the mother as well as the child is often necessary to break the cycle.

Studies contrasting school refusal and disorders of conduct

While clinicians appeared to be in broad agreement about the outlines of the problem, the samples in early studies were small, and data collection was not systematic. The first planned study comparing truants and school refusers was done by Warren (1948). He observed that for adolescents and pre-adolescents, the upsurge in the drives pose a threat to the child's continued need for dependence, which may be unwelcome both to the child and the mother.

In a classic study, Hersov (1960) subjected to more rigorous testing the hypothesis that "children referred for persistent non-attendance at school fall into one or other of two groups: those whose behaviour is one facet of a psychoneurotic syndrome; and those whose attitude is one facet of a conduct disorder." He assessed three groups of 50 children: 1) school refusers who stayed at home when refusing school; 2) wandering truants; and 3) randomly selected controls. He made specific predictions of differences as to environment, parent-child relations, personality, and child's intellectual level, and assessed case records with a 124 item schedule covering child development, family environment, intellectual level, academic achievement, school progress, psychiatric symptoms and

diagnoses, and statistically assessed the frequencies for each item by group. Truants were found to be older, while the school refusers had significantly higher IQs, were better behaved, and tended to come from higher social classes. Truants were found to come from larger families than school refusers, and to have suffered more maternal rejection. Discipline in their homes was more inconsistent, and they were more likely to have experienced early maternal and later paternal absence.

Interestingly, school refusers had significantly less experience of both maternal and paternal absence during the first five years of life, and of maternal absence after age 5. Maternal overprotection strongly characterized the school refuser group, while maternal rejection occurred more frequently in the truancy group. The frequency of neurotic illness was highest among parents, parental siblings and grandparents of the school refusers. While a variety of personality types was represented in all groups, with half in all groups showing "no deviation toward extremes of personality type" (133), a greater proportion of the school refusers (about half) were found to be overly passive, dependent and inhibited, as compared to about a third of the children in the other two groups.

Diagnoses of a "psychoneurotic disorder" were made in a strikingly high proportion of cases in all groups,

although the distribution of diagnoses differed significantly across groups. Among the school refusers, 44 diagnoses were made of "psychoneurotic disorder", including "anxiety reaction", "depressive reaction", "hysterical reaction", "obsessional disorder", and something called "reactive behavior disorder with some neurotic features." It is not indicated whether this count represents individuals or diagnoses, more than one of which may have applied to a single child. If no child received more than one diagnosis, every single child in all groups received some diagnosis. That the threshold for psychopathology may have been set quite low is suggested by the finding that nearly a third of the control group (16) were found to have a conduct disorder; 22 presented a "reactive behavior disorder with some neurotic features," significantly more than in the other two groups. It is tempting, therefore, to conclude that this diagnostic category was the mildest, descriptively, but the article is not explicit on the point, and without any more than the diagnostic labels to go on, it is difficult to gauge the severity and significance of the psychopathology reported.

To the extent, though, that we may assume that the study was internally consistent in applying the same criteria across groups, it did show robust group differences. The school refusers as a group had a

higher incidence of anxiety reactions, and the truant group showed more conduct disorder, both at a .01 level of significance. There were no significant differences between groups with respect to "depressive reaction", though there was a trend for school refusers to suffer this more. While truants showed higher incidence of conduct disorder and enuresis, the school refusers had more eating disturbances, somatic symptoms, and anxiety.

Comorbidity and familial psychopathology

Before Hersov, researchers had not generally reported in detail whether school refusers presented with concurrent psychopathology ("comorbidity"), and if so what variety. Those who did reported some mix of anxiety and depression, with varying degrees of situational specificity or pervasiveness. In general, younger patients were reported to appear relatively healthy outside the sphere of conflict with their mothers around school; they functioned well intellectually, and had lively connections with friends. Adolescents, on the other hand, were found to be more likely to be withdrawn and depressed (Eisenberg, 1959).

With the adoption of a behavioral nosology in the DSM series, it became easier to compare findings by

different researchers. In a series of studies, Bernstein and colleagues have assessed comorbidity, parental psychopathology and family functioning of school phobics (Bernstein & Garfinkel, 1986, 1988; Bernstein, Garfinkel & Borchardt, 1990; Bernstein, Svingen & Garfinkel, 1990). One focus of their inquiry was to examine the degree of overlap between school refusal and DSM-III-R Separation Anxiety Disorder.

Separation anxiety has long been found to be associated with school refusal (Shapiro and Jegede, 1973; Waldron, 1975), with about three-fourths of patients being treated for school refusal also showing significant separation anxiety. Indeed, school refusal with anxiety is one of the criterion symptoms for Separation Anxiety Disorder in DSM-III-R, though an SAD diagnosis can be made without it. There is no DSM-III-R diagnosis for school refusal or school phobia alone.

Bernstein et al. (1986) found in their sample of 26 early adolescent, chronic school refusers that only three had no DSM-III-R diagnosis. It has been hypothesized (Hersov, 1985) that older school phobics are more prone to depression. Bernstein et al. note that symptoms of depression and anxiety are often hard to distinguish, especially in children. They found considerable diagnostic overlap, with 18 of their subjects showing an affective disorder, 16 an anxiety

disorder, and 13 (50 percent) presenting with both. Interestingly, six were also diagnosed with conduct disorder. On one authoritative and widely used set of criteria for the school refusal syndrome, children with conduct disorder would be eliminated from the sample (Berg et al., 1969).

The Bernstein sample was white, from a relatively low socioeconomic status; average age was 13.7, and over 80 percent of subjects had shown school phobic symptoms for over two years. As in earlier studies, sex was not found to covary significantly with symptom severity or diagnosis. Whereas other studies had reported a trend for older school refusers to present with more severe psychopathology, Bernstein reported no significant covariance of age with symptom severity or diagnosis. With an average age of 13.7 and a modal symptom duration of over two years, however, this sample was relatively older, and more "chronic" than "acute", so this negative finding may be due to restricted variability in the sample.

On the basis of self-rating and clinical scales, subjects were divided into low and high anxiety groups. All of the high anxiety group also carried a diagnosis of depression. Among relatives of the patients, there was an elevated incidence of alcoholism and depression. This was especially true of first degree relatives of

school phobics carrying both a depression and an anxiety diagnosis, as compared to those with major depression alone.

Last et al. (1987a) took a different tack in assessing the question of comorbidity, evaluating 73 consecutive admissions at an outpatient anxiety clinic for children and adolescents. Altogether 11 subjects of the 73 were school phobic. The most common DSM-III-R primary diagnoses were found to be Separation Anxiety Disorder (SAD) (33 percent), Overanxious Disorder (OAD) (15 percent), Major Depressive Disorder (MDD) (15 percent), and Social Phobia (15 percent). Interestingly, the latter were phobic specifically of school. While Last et al. do not say so explicitly, presumably there was no overlap between this group and the SAD group; it was not separating from mother or the home that was difficult for this group, apparently, but fear of some aspect of school itself that kept them away. What proportion of the SAD group presented with school phobic symptoms is not, unaccountably, reported.

Last et al. reported no clear pattern of comorbidity among school phobics. Two-thirds had one or more DSM-III-R diagnoses, as compared to all of the MDD group. School phobics tended to be older than the SAD and OAD patients. Interestingly, their families, like those of OAD patients, tended to be from a higher

socio-economic status than SAD families.

<u>Older versus younger, "acute" versus "chronic" school refusers</u>

Many researchers have distinguished between "chronic" and "acute" school phobics (Paccione-Dyzlewski & Contessa-Kislus, 1987; Baker & Wills, 1978; Syzrynski, 1976; Sperling, 1967; Eisenberg, 1958b). In describing similar subtypes, others have referred to "neurotic and characterological" (Coolidge et al., 1955), "Type I and Type II" (Kennedy, 1971) and "sudden and gradual" (Baker & Wills, 1978; Syzrynski, 1976; Tisher, 1983). Acute patients are said to show rapid onset of the problem with few and mild, if any, previous psychiatric symptoms. They present as stubborn, tense, clingy, and resistant to discipline; their social and intellectual functioning, however, is still basically intact. Chronics' school refusal appears to have had a more insidious, gradual onset, and to be accompanied by a more generally inhibited, depressed, and in some cases mistrustful presentation; school refusal is seen as part of a relatively pervasive and severe characterological disorder. Coolidge et al. (1955) found the mothers of both groups to be overprotective, having failed to resolve their dependencies with their own mothers, but the

characterologic group's mothers were both more overprotective and more dependent themselves. Coolidge et al. hypothesize that both chronic and acute school phobics both want and fear autonomy, and have displaced and externalized their conflicts onto the issue of school attendance.

Eisenberg (1958b) does not provide detailed information on the child patients' psychopathology aside from school refusal, but he also distinguishes between elementary school age and adolescent school refusers. In the younger children, intrinsic psychiatric disturbance was a far less prominent feature than their parents' neuroses. But "In the adolescents, intrafamilial pathology had been translated into intrapsychic" (p. 716). His sample included five adolescents.

Berg et al. (1969) likewise distinguished in their sample of 29 inpatient school phobics between acute and chronic patients. Acutes were defined as having enjoyed a minimum of three years of trouble-free school attendance before the onset of school phobia (N=18); chronics had not (N=10). On a questionnaire, chronics were found to have a higher dependency score. On weekend passes home, chronics spent more time with their mothers, and more time at home, and were considered relatively more attached to mother and

father than to their peer groups as compared to acutes. On the Eysenck Personality Inventory, both subgroups' mothers were found to be more neurotic than the general population, but did not significantly differ from one another. Chronic school refusers were found to be more neurotic on the Junior Eysenck, and more maladjusted on the Bristol Social Adjustment Guides.

School refusal has been found also with a subgroup of preadolescent "preschizophrenics" (Prince, 1968), adolescent psychotics (Kahn and Nursten, 1962), and "severe character disorders bordering on psychosis" (Coolidge et al., 1960).

Etiologic formulations: A widening disagreement

In keeping with the behavioral nosology of the DSM, the Bernstein and Last studies are agnostic on the etiology and dynamics of school refusal. The apparent early agreement among clinicians about the symptomatology, familial patterns, and intrapsychic conflicts characteristic of school phobics has given way to a sometimes contentious debate conducted in terms taken from paradigms so apparently irreconcilable that Shapiro and Jegede (1973) titled their review of three decades of the literature "School Phobia: A Babel of Tongues". They noted that such phrases as "school phobia," "school avoidance," "reluctance to go to

school", and "school refusal," while often used as if they were interchangeable, in fact mean different things to different people, and that the differing assumptions and data bases behind the terms reflect wider fissures in contemporary psychological theory and practice. While stopping short of claiming, as some writers have, that "School phobia is a symptom, not a diagnosis" (Davidson, 1960), Shapiro and Jegede stress that "School phobia is, in fact, a rather complicated psychiatric syndrome that is not uniform in etiology, structure, or therapy" (168).

Despite the increasing diversity of opinion, in reviewing 26 studies reported over three decades (1932-1962), Shapiro and Jegede discerned a trend toward formulations stressing separation anxiety, and "intrafamilial difficulties." Johnson (1957) has taken the strongest position on the former, claiming that school phobia is itself "a misnomer," and that the refusal to go to school in such cases is more properly considered "separation anxiety which occurs not only in early childhood but also in later years." Eisenberg (1958a, 1958b) likewise seconded this emphasis, while calling for firm interventions aimed at returning the child to school as quickly as possible.

The "overdependency" hypothesis

Helene Deutsch made a particularly strong early statement of the interpersonal and intrapsychic dynamics of overdependence (1948). While not addressed specifically to the problem of school refusal, it sounds themes later adumbrated, debated, and to some extent tested by research. Her emphasis on the importance of the mother's psychopathology is especially telling.

> The stronger the neurotic disposition, the more the mother's intolerance of her child's struggle for emancipation, and the greater her tendency to react with unhappiness and anxiety to his progressive separation from her. . . . The overindulgent mother who subjects herself completely to her children's tyranny and who exerts her overprotection in this more passive way is certainly a woman whose inner fear springs from masochistic, guilt-laden sources. The opposite type is represented in the domineering mother who drives the child into passivity and dependence by her own active attitude, and exerts her overprotection with the help of aggressions. All these means lead to the same end, that is, the dependence of the child. (p.267)

Coolidge et al. (1960) argue that overdependency can lead to school refusal. When prolonged into adolescence over-dependency can have especially pernicious effects, on this view, impairing ego strengths and leading to a severe characterological disorder. School refusal of insidious onset appearing in adolescence is seen as a symptom of a culmination of

a deteriorative process, not an acute crisis that may be swiftly resolved with firm handling.

More recently, Berg and his colleagues have attempted to assess the characteristics of school phobic children and their relationships with their mothers, in particular with respect to the degree of their dependency (Berg & McGuire, 1971; Berg et al. , 1969). Comparing 42 in-patient adolescent school refusers with groups of 12 conduct disordered and 12 anxious and/or depressed hospitalized adolescents, Berg and McGuire found all groups relatively more reliant on their mothers for activities and household tasks than their normal age mates. Both school refusers and non-school-refusing neurotics were relatively unsociable with age mates when away from their mothers, as compared to the conduct disordered group.

Berg has offered what has since become widely accepted as adequate behavioral criteria for inclusion in a school refusing group: 1) severe difficulty attending school; 2) emotional disturbance when school attendance is enforced; 3) remaining at home with the knowledge of the parents; 4) no significant antisocial behavior (this specifically excludes tantrums associated with attempts to enforce school attendance) (Berg et al., 1969).

Family patterns

Eisenberg (1958a, 1958b, 1959) has stressed the importance of family dynamics in the initiation and maintenance of the school refusal syndrome. "School phobia serves as a paradigm of neurotic disorders in children, for it illustrates with special clarity the relation between symptoms in the child and the psychologic structure of the family." (Eisenberg 1958a, p. 646). Following a precipitating stress to the family, such as a change in composition, hospitalization of the mother, a new baby, or marital turbulence, which may or may not coincide with a school-related stressor for the child, the symptom erupts. From the start, parents participate in maintaining the school refusal, with contradictory verbal and behavioral cues, for instance. Usually, Eisenberg reports, the mother is over-identified with her child, in what may approach a folie-a-deux. Inevitably there is a concomitant and probably pre-existing fault in the marital relationship; "the mother who is a partner in a mature and satisfying marriage is hardly likely to have such a symbiotic relationship with her child" (p. 655). Often the mother is enmeshed in an ongoing overdependent relationship with her own mother.

Eisenberg notes that working with school phobics

offers clinicians the unusual opportunity to observe symptoms in statu nascendi, affording greater confidence in etiologic and diagnostic formulations (1958b). Reporting on 26 cases, he describes intensely ambivalent relations between mother and child, most acutely evident at the moment of parting. His descriptions convey the clear sense that the mothers are "pulling" almost desperately for a separation anxious response from their children. "Another mother, after two farewells without responsive anguish in her daughter, turned to the teacher bitterly, 'How do you like that! She doesn't even seem to care!'" (p. 713). For these mothers, he remarks, "The umbilical cord evidently pulled at both ends" (p. 713).

The immediate antecedents to the mother's over-involvement with the child varied (Eisenberg 1959). In one case the child was born after multiple miscarriages, and shortly after the maternal grandmother's death. In two others, a boy kept a marriage going that otherwise would fail, but the emotional valence in each case differed significantly. In one, the boy was seduced into serving as a kind of erotic surrogate for the mother; his preconscious awareness of the erotic elements in their relations led to intense anxiety. In another, hostile feelings predominated; the mother, feeling trapped by the son in

a dead marriage, resented him, but denied it with suffocating overprotection, alternating with terrible outbursts at his demanding behavior. While the over-involved parent is usually the mother, fathers may also precipitate the syndrome. One father was over-identified with his son to the extent that when the son reported nausea on a school morning, the father actually vomited.

Despite some variation, however, commonalities in the family patterns among the 26 cases were striking (Eisenberg, 1958b). Of the mothers with school phobic children, "Each gave a history of a poor relationship with her own mother," which was usually described in terms of an ongoing struggle to escape from the "overprotective domination" of a critical mother and/or mother-in-law. Against this background of unresolved dependency, these mothers' own children's independence strivings "led to feelings of personal rejection and reactive hostility" (p. 715).

Elsewhere, however, Eisenberg sees the hostility as due primarily to the mother's "exasperation" at her helplessness to extricate herself from a web of unsatisfactory relationships (1958, p. 655). He emphasizes that the closeness with the child, while exaggerated, is not merely or in the first instance an overcompensation for hostile feelings. Rather, the

mother's own overprotective behavior, thwarting the child's needs for initiative and growth, elicits clingy, demanding behavior from the child which is burdensome, provocative, and eventually enraging to the mother. Typically she represses her own hostility, but has periodic outbursts of rage, for which she feels very guilty and to which she reacts with a new round of overprotection, continuing the cycle.

Eisenberg likens the appearance of the school refusal symptom to the sudden precipitation of a "supersaturated" solution (p. 716); the essential ingredients have been in place for a long time before the "reaction" takes place. Davidson's formulation (1960) is broadly in agreement. In her sample of 30 cases, over half (17) "clung to the maternal grandmother," living with or near her. In four cases, a move away from the maternal grandmother precipitated the school phobia. "To the mother, the child often represents the loved and hated grandmother, or the mother's own miserable, lonely childhood self in relation to the grandmother. Sometimes he stands for an ambivalently loved sibling" (p. 282). The fathers of the school phobic children were found to be passive and ineffectual, though not actually impotent; Davidson had the impression that the mothers were frigid and reproached their husbands for their sexual demands.

Despite the similarities, Davidson's findings are at variance from Eisenberg's in important respects. The quality of maternal ambivalence she reports in her sample of 30 cases appears to differ. "By ambivalence I do not mean the alternation of love and anger that all parents show, but a more primitive relationship, where the two emotions exist side by side. The mother gives with one hand and takes away with the other" (p. 276). Prior to onset of the symptom, this precarious relationship is upset by an upsurge in aggression and hostility, in a preadolescent context, or a lessened tolerance for hostility, because events such as a death in the family or the illness of the mother make the threat of an actual death seem real. (Davidson found that for 9 of her cases, the death of a close relative preceded the development of symptoms by a few months or less, while in 6 the mother had been seriously ill; in others, the mother's over-determined over-reaction to a child's illness made a relatively routine procedure, e.g. tonsilectomy, appear life-threatening). Missing here is the erotic aspect of the mother-child overinvolvement reported by Eisenberg. Davidson concluded somewhat apologetically, "I have concentrated mainly on the aggressive element in the ambivalent relationship and have said nothing about the libidinal aspect. It must of course be there but I have much less

evidence to offer" (p. 282).

It is possible that her sample may have differed significantly from Eisenberg's, though there is no way of knowing which sample was more "representative" of the population of school refusers. Seven of Davidson's child patients were unwanted children; nine were the result of difficult pregnancies and births; the gender of four was a disappointment to their mothers. Fear of childbirth and postpartum depression were reported to be unusually prevalent among the mothers. Eisenberg does not report information on these variables.

Hersov (1960) reports that of fifty cases, 25 mothers were over-indulgent and dominated by their children, while fourteen were considered demanding, severe and controlling. Over half the fathers, while adequate providers financially, appeared passive in the home, participating little or not at all in parenting tasks, and unable to cope with a child's rebelliousness. In the 14 families in which the father, by contrast, played a more active or even dominant part, and disciplined firmly, mothers were assessed as dependent, insecure, and over-indulgent with the child.

Like Hersov, Eisenberg (1958b), while offering many pungent clinical examples of mothers who do much to maintain school phobias, stresses that fathers may also contribute to pathogenic family patterns. In one

case, a year after the father left his wife for another woman, the wife was in an agitated depression and their 14 year old son was housebound, depressed, and enraged with his mother. The mother had a fixed idea that the husband would return, which he helped maintain by turning up periodically and unpredictably for a few hours at a time, then leaving.

In a reappraisal of school phobia, Skynner (1974) noted that most studies which have investigated the role of fathers have remarked on their weak performance in their paternal capacity; he characterized them as behaving more like anxious mothers, at times competing with their wives to play the maternal role. Skynner also cast doubt on the apparent exceptions, such as those reported by Hersov (1960), suggesting that "what at first appears like forceful management is often no more than a defensive rigidity in which other members of the family collude as part of a denial of the father's inadequacy" (p. 2). Skynner offers a case report of a family treatment as an illustration.

While his treatment method evidently focusses on family relationships, Skynner's model of school phobia takes account of developmental and intrapsychic dimensions: "[T]he essential problem in families producing seriously 'school phobic' children lay in the parents' failure to help their children relinquish

omnipotent demands for exclusive possession of the mother" (p.5). The birth of a child results in a temporary "primary maternal preoccupation" for the mother (Winnicott, 1956), which a mature husband and father will tolerate for as long as it is necessary and in the child's interest. When the child no longer requires the mother's exclusive attention, however, the father will normally move to reassert the primacy of the marital relation. In family systems terms--Minuchin's structural typology (1974), for instance--this appropriately re-establishes the boundaries of the "marital subsystem", heading off the potential hazards of "a cross-generational coalition" and/or "enmeshment", especially of mother and child. It is just this re-structuring, Skynner argues, that fathers in school phobic families fail to effect.

Skynner notes that from a developmental psychoanalytic perspective, this turning point comes during the child's oral phase. Failures or distortions dating from this pregenital period affect anal and oedipal struggles and resolutions." Thus the symptomatology is often complex, with derivatives from various levels simultaneously" (p. 6). As noted above, the comorbid symptomatology of school refusers covers a wide range of diagnoses and degrees of severity.

In an attempt to examine the functioning of

families of school phobic patients, Bernstein et al. (1988) compared six severe school phobics and five age-matched patients with affective and/or anxiety disorders. Of 12 parents in the school phobic group, only three had no affective or anxiety disorders; of 10 siblings evaluated, only 3 had no diagnosis. By contrast, three of ten control parents, and none of five siblings had a diagnosed disorder. Also, on the Family Assessment Measure (FAM), a long questionnaire about family relationships, school phobic families were found to be more dysfunctional in the areas of role performance, communication, affective expression, and control. That is, a lack of clarity in the family regarding roles resulted in high conflict; similarly, ambiguous messages led to a lack of mutual understanding. At the same time, an exaggerated inhibition of expressions of painful affect apparently added to tensions, and possibly to explosive outbursts and over-reactions.

The authors noted that the results of this preliminary investigation could only be tentative, given the small number of subjects and large number of variables. The findings were suggestive, however, so Bernstein et al. followed up with a much larger scale study of 76 families with at least one school phobic child (Bernstein, Svingen & Garfinkel, 1990). Again

using the FAM, they found ratings indicative of clinically significant dysfunction in parent-child relationships over the issues of role performance, values, and norms. Interestingly, there was no significant difference in the ratings on these items between single-parent and intact families.

Bernstein et al. (1990) further hypothesized that the child's diagnosis would predict the degree of family dysfunction. A sample of mean age 13.5 was divided into a depressed group (N=22), an anxious group (N=20), mixed anxiety and depression (N=20), and a no-diagnosis group (N=14). There were no significant differences with respect to the factors of task accomplishment, comnmunication, affective expression or involvement, or control.

The separation anxiety hypothesis

In their review of the literature from 1932 to 1962, Shapiro and Jegede are critical of what they see as a drift toward the "overgeneralized use of the term separation anxiety", one which confounds a behavioral description with a dynamic formulation. DSM-III-R tried to resolve this problem by specifying symptoms of a syndrome, Separation Anxiety Disorder, a certain minimum number of which must be present for a diagnosis to be made. As noted above, school refusal as

classically described is only one of the symptoms, and is not considered a syndrome in itself.

Still, it appears that school refusal is a distinctive enough clinical entity to continue to warrant investigation, even among researchers firmly committed to the DSM-III-R nosology. Two recent studies by Last and her colleagues (Last, Strauss & Francis, 1987; Last, Francis, et al., 1987; Last & Strauss, 1990) compare 48 SAD and 19 school phobic children. In this white sample, SAD children were younger, more likely to be female and prepubertal, and from relatively low SES families. The prevalence by sex differences were striking; 69 percent of the SAD sample was female, while 63 percent of the school phobics were male.

Interestingly, the mothers of SAD children were four times as likely to have an affective disorder (e.g. major depression or dysthymia). Both groups of mothers, however, had significantly elevated levels of psychopathology. The majority of both groups had a lifetime history of at least one anxiety disorder; 86 percent of SAD mothers and 64 percent of school phobic mothers had some lifetime psychiatric diagnosis.

While this study seems to suggest some differences between the Separation Anxiety Disorder group and school phobics, the results are undercut by the finding

that 73 percent of the SAD group showed some "school avoidance". Nor is it reported what was their (or probably more accurately, their parents') presenting complaint. In the absence of more explicit information on the type, frequency, severity, and associated affect and verbalization of this school avoidance, it is impossible to judge if this group would not, in earlier, pre-DSM-III-R studies, have been classified as school refusers with separation anxiety.

Last and Strauss (1990) have made a further attempt to distinguish school refusers who are separation anxious from those who appear to be more specifically or perhaps "genuinely" phobic about school itself. Looking at 63 outpatients presenting school refusal as one of their symptoms, they found considerable heterogeneity in DSM-III-R diagnosis, with 24 (38.1 percent) meeting criteria for SAD; 19 (30.2 percent) Social Phobic; 14 (22.2 percent) with a Simple Phobia; 4 (6.3 percent) with Panic Disorder; and 2 with Post-Traumatic Stress Disorder. Over a third had a lifetime history of Major Depression (N=22, 34.9 percent). Strikingly, over 57 percent of this sample had no history of previous psychiatric disorder. While this study does emphasize the diversity among school refusers, it is worth noting that all of them had an anxiety disorder.

A shift in emphasis: Self-image and self-evaluation

Leventhal and Sills (1964) directly challenged the notion that the "core fear" of the school phobic has to do with leaving the mother. They argue that if dependency and a fear of separation were the main problems, the frequency of school phobia would be highest among the youngest age groups. This is not the case, however. Also, they note, the separation anxiety model would seem to predict a difficulty for the child in separating from the mother in all contexts, not just in order to go to school. But this is not always the case, and school refusers over twelve rarely present with generalized difficulties in separating from the mother.

The alternative view put forth by Leventhal and Sills is that school phobics refuse school in a bid to protect a "preferred self-estimate". This estimate, they argue, is an over-estimate, highly cathected and insecurely held. At home, parents gratify their infantile demands, feeding a fantasy, never relinquished, of infantile omnipotence. School, with its relatively impersonal requirements and judgments of achievement, represents a distinct threat, in part because school refusers (unlike truants for example) care deeply about how they do in school, often to the point of perfectionism.

The cases summarized by Leventhal and Sills in support of their position present a wide range of severity, from a 15 year old "borderline psychotic" girl with long-standing fears of an inability to function in many spheres, to a bright, achieving, anxious 11 year old girl who refused to go to school for two days out of embarrassment over having passed gas while making a presentation in class. An eight-and-a-half year old youngest son who appears to fall between the other two in severity of psychopathology is presented in the context of an intensely ambivalent struggle of mutual submission and domination with a mother who complains of a cold husband for whom she has no respect; in the boy's psychotherapy, themes of power and powerlessness predominate. While the authors acknowledge that this case looks like a classic "separation problem", with an ambivalent attachment and avoidance of separation to ward off anxiety about hostile impulses, they argue that by this point, at least, the boy's need for closeness to the mother is secondary to his need to protect a grandiose self-image threatened by the school environment.

Others have noted the contrast between the wilful, sometimes imperious presentation of school refusers at home, particularly with their mothers, and their timid, retiring behavior in school, or elsewhere away from

parents (Nichols and Berg, 1970). In 18 cases with an unusually wide age span (4 to 17, with 15 males), Radin reports that school phobia developed as a response to anticipated failure in social or academic activities (1967). He described his sample as high achievers very afraid of the loss of love of their parents, and resentful of (real or presumed) demands for performance. He reported that the parents of such children have fostered the child's infantile omnipotence in such a way that the child mistakes his ego for his ego ideal. When the school's evaluation of the child's performance threatens this omnipotent self-image, the child refuses to return to school, re-establishing his strong, in fantasy magical position at home, with parental collusion. The soothing attentions of the parent, and the child's own rage displays, serve to re-inflate the child's ego to its preferred, distended proportions. Interestingly, Radin reports that similar dynamics may evolve with either perfectionist or overindulgent parents. In both cases, for children who develop school phobia, "the child's security and adequacy systems depend to an inordinate degree upon the quality of his own life performance" (122). Abandonment is the unconscious threat in situations where a child's comparatively poor performance seems a possibility.

The school phobic's self esteem is volatile and vulnerable; he is subject to rapid alternations and even the co-occurrence of pervasive anxiety and defiant rage. Radin conceives of the phobia as an attempt to contain and redirect overwhelming bouts of guilty fear and defiant rage. He notes that the child's guilt is intensified when he has lost or feared losing an ambivalently loved person to illness or death, which Radin found often to have been the case. For this imagined crime, the child blames himself, and fears yet guiltily seeks punishment from teacher or peers.

Behaviorist perspectives and psychopharmacological studies

Behavioral theorists have put forth no specific theory of school refusal (Burke and Silverman, 1987), but Ollendick and Mayer (1984) offer the generalization that while psychodynamically oriented clinicians have preferred the separation anxiety hypothesis, behaviorally oriented clinicians have supported a fear-of-school hypothesis. (The limits of this generalization are apparent in their main citation, however; Gittelman-Klein and Klein [1984], while favoring the separation anxiety hypothesis, could not accurately be described as psychodynamically oriented).

In behaviorist treatment studies the syndrome has

been considered a simple phobia of separation from the mother or of the school itself (O'Farrell et al., 1981; Prout & Harvey, 1978; Barabasz & Barabasz, 1977; Garvey & Hegrenes, 1966) or as a case of undesirable behaviors being elicited and/or maintained by parents and/or school personnel (Hersen, 1971; Lazarus et al., 1965; Welch & Carpenter, 1970). Operant, classical, and vicarious conditioning have all been invoked to explain the origin and maintenance of school phobia (Ollendick & Mayer, 1984).

Some behaviorist authors, while acknowledging separation anxiety as an important feature of school phobia, look at the phenomenon in terms of reinforcement schedules in effect between mother and child, and devote their efforts to changing those. Garvey and Hegrenes (1966), for instance, reported on a boy whose mother often warned him that she might soon die. The idea of "losing mother", which she introduced, became the unconditioned fear stimulus. When the mother paired this with "school", which had previously been neutral, school became the conditioned stimulus that called forth the conditioned fear response previously associated with "losing mother".

Divergences between theoretical perspectives on school phobia may reflect relatively subtle differences in focus (Atkinson et al., 1985) that are further

blurred in treatment. It should be noted that many psychodynamically oriented clinicians, despite their differing conceptualizations of the syndrome, advocate early active interventions to get the child back in school and "coaching" parents on how to handle their difficult children, well in advance of and even ultimately forgoing "insight" on the part of the parents (Eisenberg, 1959). This is justified on the grounds that continued absence from school is damaging to the child in a cumulative, ongoing way, and so constitutes a psychiatric emergency necessitating immediate action. Other psychoanalytic authors decry this practice, however, on the grounds that returning the child to school before his or her core conflicts are resolved will compound the trauma while sealing it over, guaranteeing severe problems later (Sperling, 1967).

Psychopharmacological researchers have found that treatment with a combination of the antidepressant imipramine and supportive efforts to return the child to school works more effectively than supportive efforts alone (Gittelman-Klein & Klein, 1973, 1984). This result, in conjunction with findings of an elevated prevalence of school refusal in the history of adult agoraphobics with panic disorder, has led Klein to look at school refusal as a childhood form of panic

disorder. This may be questioned, in that not all and probably not even the majority of panic patients were school refusers as children, and conversely, while school refusers may be at heightened risk for developing panic disorder with agoraphobia (and/or other anxiety disorders), follow-up studies have not shown that most school refusers actually develop panic disorder as adults.

Summary

School refusal has been conceptualized in different ways by different researchers. A major theme in findings by researchers from diverse theoretical backgrounds, however, is that school refusal is especially liable to reflect troubled family relationships, especially between mother and child. Terms like unresolved dependent tie (Broadwin, 1932), overdependency (Berg & McGuire, 1971), and ambivalent tie (Eisenberg, 1958a; Sperling, 1967; Radin, 1967), used in the literature by psychoanalytic and psychodynamic clinicians and researchers, point to a convergence about the broad outlines of etiology and dynamics, despite disagreements on specific causal mechanisms and differences in relative emphases.

In all but the earliest psychoanalytic case reports, which were not conceptualized in terms of a

school refusal syndrome per se and which emphasized intrapsychic dynamics to the virtual exclusion of accounts of family functioning (Bornstein, 1949; Klein, 1975), the literature is remarkably consistent in describing pathogenic family relationships which have led to and which continue to maintain intrapsychic, developmental, and psychosocial problems for the child. Findings of excess parental psychopathology in families of school refusers (Berg et al., 1974; Perugi et al., 1988; Gittelman and Klein, 1985) reinforce the impression that school refusal symptoms in the child reflect a significant "system-wide" disturbance. Despite quite different theoretical axioms and therapeutic techniques, even the behaviorists' account of school refusal, so far from challenging or contradicting the psychodynamic one, appears to complement and confirm it. Behaviorists note with admirable specificity the ways in which parents may induce a school phobia in a child by both classical and operant conditioning (Ollendick and Mayer, 1984), a phenomenon previously described in other terms by Eisenberg and others (Eisenberg, 1958b). (While behaviorists might make a claim for the greater parsimony of their own etiological account, it stops short of addressing why a parent would reinforce such plainly dysfunctional behavior in a child, and resist

interventions intended to change it, questions the psychodynamic accounts do address).

Despite this remarkable convergence from many sources, important questions and gaps remain. It would seem that, given the heavy emphasis on family relationships in the literature, considerable systematic research on school refusal from the family systems perspective would have been done, yet such is not the case. Bernstein and colleagues alone have assessed a sample of school refusers, with the Family Environment Scale (Bernstein & Garfinkel, 1986), but their study has yet to be replicated.

Moreover, despite its evident clinical and theoretical relevance to the problem of school refusal, and despite the availability of normed instruments used with other clinical populations for this purpose (e.g., the Parental Bonding Instrument), no systematic assessment of the preconscious representations of attachment figures has been done with school refusers. Such information could provide hard evidence to support or change clinical formulations, as well as providing a means of comparing school refusers with other psychopathological groups along relationship dimensions.

Perhaps most striking is that, after four decades during which variants of an object relations

perspective have increasingly gained ascendancy in psychoanalytic thinking, no study of school refusal has attempted to directly assess object relations representations among school refusers. The preponderance of findings reported in the literature about school refusers--as well as theoretical, developmental, and clinical writings from the object relations perspective--would lead one to infer that, in a context of disturbed familial and dyadic relationships, the object relations of school refusers would reflect that disturbance. Yet without systematic assessment, this must remain an unproven conjecture.

And if the object relations of school refusers are indeed disturbed, in what specific ways is that the case? Many writers have suggested that separation and individuation issues are particularly salient and difficult for school refusers and for their parents. Will this be reflected in the children's Rorschach responses?

If the object relations representations of school refusers are indeed disturbed, to what degree will this be found to be the case? The school refusal literature suggests that older school refusers are more psychopathologically disturbed, on average, than younger ones. Will this be reflected in object relations representations, and if so, how?

Another question, more difficult to answer, is the extent, if any, to which the severity of psychopathologal symptoms in school refusers may be predicted by a combination of measures designed to tap theoretically and clinically meaningful aspects of children's object representations and ways of seeing their parents and their family functioning. Any answer to such a complex question would necessarily be tentative. A systematic approach to it, however, could be both theoretically and clinically valuable. Elucidating the relative contribution of various factors to psychopathology would aid in the assessment process, and could guide clinical decisions. Is there a type of school refuser--or school refusing family--for whom family intervention is especially indicated, for example? A study like this cannot aspire to answer such questions, but could indicate fruitful directions for future research that would.

Main Hypotheses

1. School refusal is not a monolithic disorder; school refusers will show varying degrees of psychopathology as assessed both by the Rorschach and behavioral symptom measures (Brief Symptom Inventory and Diagnostic Interview Schedule for Children). Moreover,

psychopathology assessed on the BSI and DISC will vary meaningfully with Rorschach findings and responses on the Parental Bonding Instrument (PBI).

1b. More severely disturbed school refusers as measured by the BSI and DISC will have more severely disrupted object relations, as reflected by elevated scores on the Urist Mutuality of Autonomy Scale (MOAS), and a lower RORSCORE on the Developmental Analysis of the Concept of the Object (DACOS). (Recall that RORSCORE represents the arithmetic difference between good form DACOS and bad form DACOS responses). This group will also evidence more, and more severe, thought disorder, as measured by the Blatt scale, adapted by Tuber.

2. In the high school sample, more severely disturbed school refusers will be more likely to see their parents as affording "low care" and/or "high overprotection" (rated on the Parental Bonding Instrument) than less disturbed school refusers. The chances of any school refuser reporting that the mother or both parents treated the child with what the PBI terms "affectionless control" will be significantly elevated.

2a. Likewise, and more broadly, school refusers' assignments of parents to the two "high overprotection" cells will be significantly elevated. "Low care, low

protection" cell (neglectful parenting) will be underrepresented.

<u>Other areas of inquiry</u>

It is hypothesized that age will be a significant covariable in a number of ways:

a) In keeping with findings reported in the literature that older school refusers tend to be more disturbed, school refusers older than the median of the sample will show more malevolent object relations, as determined by mean Mutuality of Autonomy Scale score, than the younger school refusers. They will also show more severe symptoms on the Brief Symptom Inventory (BSI) than the younger P.I. sample will show on the Diagnostic Interview Schedule for Children (DISC).

b) As the DACOS is designed to assess the developmental level of object relations representations, DACOS scores for the older refusers will be higher than those for the younger refusers.

Also, school refusers in a thought disorder group, defined with respect to their Rorschach responses, will have lower DACOS scores on accurately perceived Rorschach percepts, and higher DACOS scores (more articulated and differentiated) on poor-form percepts with grandiose content. These subjects will also be rated as most disturbed on the BSI.

The findings will be compared to Tuber's normal sample. It is predicted that, taken as a whole, the school refusing sample will show more malevolent object relations (e.g., greater proportion of scores 5, 6 and 7). Also, as in the normal sample, girls' object relations will be found to be significantly more benign than those of boys. The school refusing girls' representations, however, will not be on average as benign as those found in Tuber's sample.

Also in contrast to the normal sample, because many sources in the literature report that school refusal is associated with a lack of full psychological differentiation of self from other, possibly in conjunction with narcissistic pathology, and/or incomplete achievement of psychological separation and individuation, there will be an excess of MOAS scores 4 ("reflection") and 3 ("dependency" or enmeshment) as compared with Tuber's normative sample.

CHAPTER THREE

METHOD

This study is intended to provide useful and distinctive information about aspects of school refusal, including children's psychopathology; children's preconscious representations of their parents; children's object relations; and family functioning. The primary aim in each case is descriptive and exploratory. Subsequent analyses will attempt to forge links between descriptive findings in such a way as to assess their potential for explanatory power, and to see which warrant more extensive investigation.

Subjects

School refusers will be defined as those being treated for school refusal at the New York State Psychiatric Child and Adolescent day treatment unit, and in two Life Skills Assessment programs for school refusers in the New York City public schools. No further exclusions will be made *a priori*. Forty-two protocols have been collected. Because the school refuser program has been phased out at the New York State Psychiatric Institute, no more than the 18 protocols already gathered will be collected at that

site.

The subjects from the Psychiatric Institute facility in Washington Heights are for the most part Hispanic and from working class or poor families. Subjects from the Life Skills Assessment program, which is based in Queens, are predominantly white and middle class. Moreover, there are differences in the age composition of the groups. The Psychiatric Institute group are between the ages of 9 and 13. The Life Skills junior high school group are between ages 10 and 13, while the Life Skills high school group are between ages 14 and 17.

The primary thrust of this study is to examine school refusers' representations of object relations on the Rorschach test. The purpose is twofold: to elucidate the nature and dynamics of an important clinical syndrome of childhood, and to investigate the properties of two object relations scales that are beginning to be widely used.

Two types of data will be utilized: Rorschach responses, analyzed a variety of ways, and answers by the school refusers on questionnaires with Likert-type scales. In addition, results of a more detailed diagnostic interview, the DISC, collected on the P.I. sample, will be included in the analysis. On the Rorschach, the child's object relations and thought

disorder will be assessed with the Urist MOAS, the Blatt DACOS, and Blatt's Thought Disorder Index (see below). The questionnaire measures include the Brief Symptom Index (BSI), a self-report instrument tapping nine dimensions of psychopathology; the Parental Bonding Instrument (PBI), assessing the subject's relationships with each parent; and the Family Environment Scale (FES), which assesses relationships among family members and the family's organizational characteristics. (Each instrument will not be administered to every subject in the study, for reasons detailed below. See chart, below, for summary of which set of data has been collected for each sample subset).

The PBI, a normed and widely used instrument, taps consciously available representations of family members and relationships. This will have a dual function. Descriptively, the PBI will yield information about patterns of parental relations in families with a school refuser. It will also provide a separate window on modes of relationship and representations of those modes that are conceptually related to those aspects of functioning the Rorschach scales are meant to tap. Information from this second source, it is hoped, will elucidate both the dynamics and etiology of the clinical syndrome of school refusal and the nature and dimensions of the information garnered by the Rorschach

object relations scales.

The PBI has been used extensively with adults and in several studies with adolescents. It has not, however, been used with preadolescents, or with populations for whom the language of the items might be difficult for subjects to comprehend. For these reasons, the PBI was not given to the predominantly younger, Hispanic Psychiatric Institute subjects, or the Junior High sample.

The literature on school refusal underlines that it is not a unitary syndrome with respect to type or intensity of the child's psychopathology. These will be assessed in the High School subset of the school refusing sample with the Brief Symptom Inventory (Derogatis, 1977). The BSI is a short-form version of the Symptom Checklist 90, Revised (SCL-90-R), which has been widely used with adults and adolescents and normed. The BSI has not, however, been widely used with preadolescent children, such as the Junior High sample, or with children whose reading skills in English may be weak, such as the P.I. sample. Accordingly, information on psychopathology for the P.I. sample has been gathered with the Diagnostic Interview Schedule for Children (DISC), a detailed semi-structured interview administered to thousands of children and on which there is a growing literature. The DISC, however, takes

two to four hours to administer and was not considered appropriate or manageable for use in the public schools. Accordingly, no psychopathology data have been collected for the Junior High sample.

Rorschachs are administered with the following instructions. "I'm going to show you some cards. I would like you to tell me what they look like, what they could be." The full set of ten are administered in order, then the subject's responses repeated, each time with the inquiry, "What makes it look like . . . ?" When a response implies an object relation the nature of which is as yet too ambiguous to score according to MOAS criteria, the prompt is offered, "As if?" (Tuber, 1989b). If a card is refused, on inquiry the subject is asked, "Is there anything it could be?"

In the exploratory, descriptive phase of analysis, results on the PBI and BSI will be compared with population norms to assess the degree to which, if any, High School school refusers differ from normal populations, and the extent and type of deviation. Findings on the Rorschach measures will be compared with the small normative samples reported by Blatt et al. (1976) and Tuber (1989).

The second phase of analysis will involve looking at the relationships between outcomes on the various measures taken on the sample of school refusers.

Correlations or where more appropriate a MANOVA and subsequent ANOVAs will be run to look at relationships between descriptive variables (age, sex, race) and Rorschach measures of reality testing (F+ percent, Thought Disorder), and Object Relations (M, MOAS, DACOS). If statistically significant relationships are found, additional analyses will be run including demographic variables as covariates when testing primary hypotheses.

Clustering of symptoms and/or diagnoses on the BSI and DISC will be assessed. To the extent that distinguishable groups emerge with respect to symptomology, analyses will be done to determine whether and in what respect the anxious subgroup of school refusers differs from depressed and/or behavior problem subgroups with respect to family functioning, characteristic parental relations, thought disorder, and object relations. Also, the P.I. and Senior High samples will be divided on the basis of a median split into groups of high or low overall symptomology and compared across instruments.

Rorschach Scales: MOAS and DACOS

Rorschach protocols will be scored using the Urist Mutuality of Autonomy Scale, or MOAS (Urist, 1977) as modified by Tuber for use with children (Tuber &

Coates, 1989); the Developmental Analysis of the Concept of the Object Scale, or DACOS (Blatt et al., 1976); and Blatt's Thought Disorder Index (Blatt & Ritzler, 1974). In addition, form level will be assessed according to Mayman's system.

DACOS For the DACOS, each response is categorized according to its differentiation (quasi-human detail, human detail, full quasi- human, full human); accuracy (F-, F+); articulation (either appropriate or inappropriate) with respect to perceptual (size, posture, structure, hair or clothing) and functional (sex, age, role, specific identify) aspects. The motivation of action is rated (no action, unmotivated, reactive, or intentional). Integration of object and action is assessed as either fused, incongruent, non-specific, or congruent. Content of action is rated as malevolent or benevolent. Interactions are scored as Active-Passive, Active-Reactive, or Active-Active. Weighted scores are assigned on the basis of a theoretically informed conception of a developmental continuum, with more mature and articulated responses receiving higher scores.

Reliabilities on the DACOS have ranged from 75 percent (perceptual articulation) to 96 percent (differentiation) (Stricker and Healey, 1990). Most

reported reliability scores are between the mid-eighties and low nineties, which is generally considered acceptable.

MOAS The MOAS assigns one of seven possible scores to both animate and inanimate movement responses. The points are summarized below:

1. A reciprocal, autonomous relationship between individuals is explicitly acknowledged. "Two girls dancing and sticking their tongues out at each other."

2. Individuals act in parallel fashion, with mutuality neither denied nor stressed. "Two dogs howling at the moon."

3. Figures are leaning or hanging on one another in such a way that one or both clearly need the other for support. "A little kid dangling from his father's hand."

4. One figure is a reflection or impression of another, and would not exist without the other. "Bigfoot's footprint." "A lion looking in the water, and he sees himself in it."

5. One figure exerts malevolent control over another, with a marked imbalance in the relationship. ("A witch casting a spell.")

6. The malevolence now extends to violence or the threat of violence that seriously compromises the

integrity of the other. ("A shark attacking a turtle.")

7. Figures are overwhelmed by forces entirely beyond control. ("A forest fire. All the animals are getting burnt.")

Reliability in recent research with the MOAS has ranged from .70 to .90 for exact agreement, and in all cases above .85 for 1-point discrepancies (Tuber, 1989b).

Thought Disorder Index Blatt and Ritzler (1974) distinguished three types of thought disorder on the Rorschach as indicating different degrees of disruption of psychological boundaries. "Contamination" responses, the most severely pathological, involve "a merging and fusing of independent percepts and concepts" (e.g., "Rabbit hand"). "Confabulation" responses, in which the subject loses the distinction between an external perception and his associations to it, betray difficulties in maintaining "a boundary between inside and outside" ("Two masked men, they're messengers of Death for me.") In "fabulized combination" responses, independent percepts maintain definition and separateness but are placed in some illogical combination only because they are spatially close to one another ("A rabbit being supported by two worms").

Blatt and Ritzler formed groups on the basis of differing degrees of thought disorder assessed on the Rorschach. They found consistent significant differences between groups on measures of cognitive impairment, reality testing, affect modulation, human representations on the Rorschach, and therapeutic outcome.

In an unpublished manuscript, Tuber has elaborated an eight-point synopsis of criteria for level of thought disorder, which takes into account the degree of critical distance taken by the subject to his own productions (the response examples cited above are taken from this synopsis). This scale is arranged hierarchically by degree of severity, and can be numerically weighted. This synopsis will be applied to all Rorschach responses.

Relationship Measure: Parental Bonding Instrument

PBI The Parental Bonding Instrument (PBI) assesses aspects of an individual's relationship with his or her parents. There are separate forms, otherwise identical, for describing relations with mother and father. The PBI consists of 25 statements about the parent which the subject rates on a four-point Likert-type scale ranging from "Very like" to "Very unlike".

Two major dimensions of the PBI have been

identified in factor analytic studies (Parker et al., 1979). Factor one is designated as a "care" dimension, factor two as "overprotection" (subsequently renamed and hereinafter "protection"). The poles of the care dimension are affection, empathy, and closeness, versus emotional coldness, indifference and neglect. The extremes on the protection scale are "control, overprotection, intrusion, excessive contact, infantilization and prevention of independent behaviour", versus "allowance of independence and autonomy" (ibid., p. 8).

A "very like" response on such items as "Spoke to me with a warm and friendly voice," "Appeared to understand my problems and worries," "Could make me feel better when I was upset" elevates the care dimension score, while a "very unlike" response to these statements drives that score down. Conversely, for the protection scale, a "very unlike" score on such items as "Let me decide things for myself" and "Let me do those things I liked doing" would elevate the protection score, and vice versa.

Combining the two factors yields a four-cell arrangement. High care with low protection is considered "optimal parenting" (Parker et al., 1979). Low care with low protection results in "absent or weak bonding" (subsequently relabelled "neglectful

parenting". High care with high overprotection is characterized as "affectionate constraint". High overprotection and low care yield "affectionless control".

The PBI has been used in over a hundred studies (Gordon Parker bibliography, unpublished, 1989; Psychlit abstracts, 1983-1990). In the original paper, split-half reliability was .88 for the care scale and .74 for the protection scale (Parker et al., 1979). Test-retest reliability over a three week interval was .76 for the care scale, .63 for protection. Higher correlations, from .87 to .92, were found with a clinical sample of depressed patients (Parker, 1981).

A recent epidemiological study with 369 subjects age 18 to 87 validated its two-factor structure and found the scales stable over time (Mackinnon et al., 1989). An even larger study assessed over 2,000 male and female adolescents, identifying the original PBI care factor and two protection factors, personal intrusiveness and perceived social control (Cubis et al., 1989). Subjects perceiving their mother as controlling and father as uncaring had the poorest psychosocial profiles as measured by self-image and health questionnaires and the Eysenck Personality Inventory.

Another study, of 12 depressed adolescents, 16

nondepressed psychiatric and 75 normal controls lent support to the view that the pattern of "affectionless control" (low parental care, high overprotection) may play an important but nonspecific role in adolescent psychopathology (Burbach et al., 1989). This confirms a conclusion reached earlier by Parker (1984), the originator of the PBI, in a review of studies to date, that implicated a parental style of affectionless control as a risk factor for neurotic disorder in offspring. In a case-control study, 62 percent of depressed outpatients characterized their parents as evincing affectionless control, as compared to 27 percent of controls. Conversely, only 32 percent of the depressed subjects reported optimal bonding, compared to 62 percent of nonpsychiatric controls.

Summarizing non-clinical studies, Parker (1989) reports a relatively consistent pattern of association between higher anxiety levels in respondents and reports of low parental care and, somewhat less strongly, parental overprotection. The high anxiety-low care finding is stronger for mothers than for fathers.

Of particular interest for purposes of this study, given the reported association between agoraphobia and a previous history of school phobia, are studies of agoraphobics' perceptions of their parents. A controlled study of 41 English agoraphobics found lower

maternal care scores, but no differences in protection (Parker, 1979). In that study, however, 40 social phobics did report both less care and greater protection from both parents. The odds ratio of a social phobic being exposed to "affectionless control" from a parent was 4.7 for mothers, 4.0 for fathers, and 9.0 for either one or the other or both. That is, social phobics were nine times more likely to report that at least one parent treated them with "affectionless control" as defined by the PBI. A replication study of Australian agoraphobics found lower care and higher protection PBI ratings of both mothers and fathers (Silove, 1986).

Brief Symptom Inventory (BSI)

The BSI is a 53-item Likert type self-rating scale derived from the widely used SCL-90-R (Derogatis & Melisaratos, 1983). For 565 outpatients, BSI correlations with the SCL-90-R were very high, from .92 to .99 for each of nine primary symptom constructs: somatization; obsessive compulsive; interpersonal sensitivity (inferiority feelings and self-deprecation with others); depression; anxiety; hostility; phobic anxiety (primarily of agoraphobic variety); paranoid ideation; psychoticism. The BSI also yields a General Severity Index which integrates symptom variety and

intensity.

Diagnostic Interview Schedule for Children (DISC)

The BSI has been used with adolescents but not preadolescents. It will be administered to the Senior High School sample. The Psychiatric Institute sample has been assessed with a much more detailed semi-structured interview, the Diagnostic Interview Scale for Children (DISC) based on DSM-III-R diagnostic criteria. The DISC takes an hour to two and a half hours to administer and could not be used in the public school setting. While these two instruments, the BSI and DISC, differ in their degree of detail and wording of questions, they both yield information about children's psychopathology that may be compared on a descriptive if not rigorously statistical basis. The extent to which, if any, particular configurations of Rorschach responses align with behavioral symptom clusters and/or diagnoses will also be assessed.

Family Environment Scale (FES)

The FES is a self-report instrument designed to elucidate relationships between family members, the values emphasized in the family, and the family's organizational and system-maintenance characteristics (Billings & Moos, 1982). Ten dimensions are assessed:

cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control. A normative data base composed of 1,125 families of various sizes, SES, ethnicities, and age combinations is available for the FES. Acceptable internal consistencies (Alpha from .61 to .79) and test-retest reliabilities (.68 to .86 for a two-month interval) have been found. Raw scores for each of the ten dimensions are converted to T-scores using data from the normative sample. Families of depressed parents were found to differ significantly on dimensions of cohesion, expressiveness, conflict, and independence from families of non-depressed parents (Billings & Moos, 1983).

Data pattern

Because not all instruments were appropriate or available to give to all subjects, the data pattern is somewhat complex. For clarity I have attached a chart. An "X" means data for this instrument was obtained with this population, an "O" means it was not.

TABLE 1

Data collected by site

	Public School Sr. High N=15	Jr. High N=9	P.I. N=18
BSI	X	O	O
DISC	O	O	X
FES	X	O	O
PBI	X	O	O
Rorschach	X	X	X

Thus, behavioral symptom data is available for only two of the three samples. The Junior High Public School sample (N=9) will not be helpful in assessing whether or not older school refusers are indeed more disturbed, as measured by the DISC and the BSI. Blatt's studies, however, have shown that the Thought Disorder scale as applied to the Rorschach itself offers one measure of severity of psychopathology. The age-severity association hypothesis will thus be assessed both ways, with the Rorschach data alone from all three groups, and the behavioral data (BSI and DISC) from the Senior High and P.I. groups.

Whether or not the BSI and the DISC will in fact yield compatible data is not certain. The DISC is tailored for DSM-III-R differential diagnosis, while the BSI is intended to assess clinically significant

levels of symptomatology. The degree of specificity and completeness of the DISC's assessment is far greater than that of the BSI, while the BSI may be more successful in identifying symptom clusters which are clinically signficant yet do not meet specific DSM-III-R criteria. Close analysis of the specific symptom data from each instrument will be needed to determine compatibilities, and findings will necessarily by preliminary and suggestive rather than definite.

Clinical reading of the records In addition to statistical analysis to address the hypotheses cited above, a close clinical reading of selected Rorschachs will be done to examine characteristic dynamics, defensive patterns, and ego functions. This post-hoc look at the data will be informed by but not limited to the narrower questions addressed in the statistical analysis. Both content and process aspects of responses will be addressed.

Data analysis

Correlations, t-tests, analysis of variance, multivariate analysis of variance, and analysis of covariance will be applied as appropriate to the above hypotheses, using the SPSS-X statistical programs.

RESULTS

In the first part of this section, demographic features of samples are first described. Findings for each of the instruments are then reported separately. In the next section, associations between variables tapped by different measures are reported.

Demographics Of 42 subjects, 25 or 59.5 percent were male. Twenty (47.6 percent) were white, 14 (33.3 percent) Hispanic and 8 (19 percent) were black. The subjects came from three sites; the New York State Psychiatric Institute day treatment program (hereinafter P.I.) and two New York City public schools special education programs, one for junior high (J.H.S.) and one for high school students (H.S.). Eighteen subjects (42.9 percent) came from P.I., nine (21.4 percent) came from J.H.S. and 15 (35.7 percent) came from H.S.

In this sample, sex and race varied independently of each other, as did sex and site. As expected, however, race and site did not vary independently; P.I. had a far higher proportion of nonwhites than the other two sites, including all 14 Hispanic subjects. The two public school sites combined had 6 blacks and 18

whites.

Measures of Psychopathology

Measures of psychopathology were collected at the P.I. and H.S. sites. (Limited access to J.H.S. subjects prevented collection of such data for that group). The P.I. sample was interviewed by hospital staff with the Diagnostic Interview Schedule for Children (DISC), a structured clinical interview designed to facilitate DSM-III-R differential diagnosis. The H.S. sample completed the Brief Symptom Inventory, a self-report Likert-type scale.

It was expected that these methods of rating psychopathology would reveal a variety of disorders, including, in the P.I. sample, a preponderance of Separation Anxiety Disorder. In general, and in keeping with the literature on school refusal, the expectation was that older school refusers would show more severe symptomology. Findings relevant to these predictions will be addressed immediately below.

It was also expected that severity of psychopathology would vary meaningfully with other measures. Those hypotheses will be addressed in later sections.

Brief Symptom Inventory (BSI)

BSI data was collected from 15 subjects, 8 male, 7 female, all from the high school site.

Findings Sample BSI scores were not significantly elevated compared to a normed population of non-patient adolescents. While differences were in the expected direction--means of both the overall distress scores and 7 of 9 of the BSI factor scales were higher for the sample than for the normed group--the differences did not approach significance, equalling one half a standard deviation or less.

The mean General Severity Index for all subjects was less than half a standard deviation above the adolescent non-patient norms, and slightly below the means for oupatient adults. Five subjects met BSI criteria for "caseness" (T-score of General Severity Index greater than or equal to 63, or T-scores of two BSI factors greater than or equal to 63). On the other hand, five subjects reported distress at levels at least one standard deviation below the non-patient adolescent norms.

P.I. Diagnostic Information

As part of the P.I. research protocol, patients

were administered a structured clinical interview (DISC--Diagnostic Interview Scale for Children) designed to elicit information necessary to make or rule out DSM-III-R diagnoses.

Findings In keeping with this study's hypotheses, 12 of 18 subjects met DSM-III-R criteria for Separation Anxiety Disorder (SAD), which was the most common diagnosis. Of those 12, 7 also met criteria for at least one other DSM-III-R diagnosis. The 18 P.I. subjects met criteria for a mean of 2.22 diagnoses each.

After SAD, Major Depression was the most common diagnosis (N=7), followed by Simple Phobia (4), Social Phobia (3), Conduct Disorder (3); Dysthymia, Overanxious Disorder, Avoidant Disorder of Childhood, and Attention Deficit Hyperactivity Disorder (2 each); and Agoraphobia, Obsessive Compulsive Disorder, Manic Episode (1 each).

In all, criteria for 25 diagnoses of an anxiety disorder were met, or 62.5 percent of all diagnoses made; 13 of 18 subjects met criteria for at least one anxiety disorder. Of the 5 who did not, 2 presented with major depression plus conduct disorder, one with a manic episode alone, and two did not meet criteria for any DSM-III-R diagnosis, on the basis of the self-

report DISC interview.

For the most part, the mix of diagnoses was similar to that of other school refusing samples (Bernstein and Garfinkel, 1986). The inclusion of three Conduct Disorder cases, however, makes this, by some definitions of school refusal, a less than "pure" sample; the single patient diagnosed with Manic Episode is also unusual. The two subjects who report no symptomology sufficient for DSM-III-R diagnoses--like the cases with low BSI distress ratings mentioned above--raise interesting questions about the limits of direct inquiry into symptomology, which will be taken up below.

The nature of the BSI instrument, and the results obtained with this particular sample (e.g., high intercorrelations among factors), make it impossible to conduct a rigorous comparison of the P.I. and High School samples with respect either to overall degree of psychopathology or specific diagnoses. At a glance, however, the results suggest, if anything, the opposite of what had been predicted, e.g., that the older subjects would show greater psychopathology. As noted above, all but two of the 18 P.I. subjects met criteria for a DSM-III-R diagnosis, while only 5 of 13 met the (arguably more lax) BSI criteria for "caseness". It is possible, however, that the difference in results has

more to do with the level of detail of the questioning; the BSI takes 5 to 10 minutes to fill out, while the DISC interview lasts at least an hour. For these reasons, unfortunately, the data on psychopathology from the two sites cannot be compared in a meaningful way.

Rorschach Measures

Rorschach responses of all types, on all protocols totalled 801, a mean of 19.07 (S.D.=7.08, range 8 to 35). Numbers of total Rorschach responses (TOTRESP) varied significantly by sex and site. Boys were significantly more productive in total Rorschach responses (male mean R=20.22, female mean R=15.84, p=.0527).

The P.I. and High School site subjects were more productive than the Junior High subjects (F=3.33, p=.047).

TABLE 2.

Rorschach productivity by sex and site

SEX	SITE	N	TOTRESP MEAN
MALE	P.I.	11	22.36
MALE	J.H.S.	6	14.83
MALE	H.S.	8	23.25
FEMALE	P.I.	7	17.43
FEMALE	J.H.S.	3	12.33
FEMALE	H.S.	7	17.29

This level of productivity was not far different from that of Tuber's sample (1989a), which had a mean of 22.7 responses for boys and 17.9 for girls. Why boys should be more productive on the Rorschach is not clear, but the replication of Tuber's unexpected finding in another sizable sample--this time a clinical one--suggests it represents a real difference rather

than a random variation. Later I will take up the question of its meaning in the context of other gender differences in Rorschach responses.

Why P.I. and H.S. subjects should have been more productive than J.H.S. students is even less clear. It may be relevant that while high school students were paid directly for their participation ($5 each), junior high school students were not, because of objections from the school administration.

Reliability All protocols were scored on the Mutuality of Autonomy Scale (MOAS); the Developmental Analysis of the Concept of the Object Scale (DACOS); and Blatt's thought disorder as adapted by Tuber. All 42 protocols were scored independently by the author and a rater, a post-internship graduate student in clinical psychology who was blind to the sample composition and the purpose of the study.

For the MOAS, exact agreement was achieved on 75 percent of all protocols. Agreement within one point was 83 percent.

For the DACOS, exact agreements for the different categories was as follows:

TABLE 3.

DACOS reliability

Scale	Reliability
Differentiation (e.g., quasi-human detail, human detail, full quasi-human, full human)	.83
Articulation (size/structure, clothing/hair, posture, sex, age, role, identity)	.71
Motivation (unmotivated, reactive, intentional)	.73
Object-Action Integration (fusion, incongruent, nonspecific, congruent)	.72
Interaction with Object (active-passive, active-reactive, active-active)	.73
Quality of interaction (malevolent-benevolent)	.76

Exact agreement for Thought Disorder ratings was 68 percent. Agreement within one point was 74 percent.

For all scales, all differences were conferenced. In most cases, after discussion, agreement was reached. In the handful of cases for which agreement could not be reached, the author's rating was allowed to stand.

Mutuality of Autonomy Scale (MOAS) This study hypothesized that:

1) School refusing samples would produce more object representations scored at the malevolent end of

the MOAS (scores 5, 6, and 7) as compared to Tuber's normal sample.

2) Gender differences in mean MOAS were expected, with school refusing girls producing more benign responses than boys from the same sites, but more malevolent responses than normal sample girls.

3) Older school refusers would produce more malevolent object relations responses than the younger ones.

4) In keeping with reports in the literature that school refusers have particular difficulties with dependency and fully differentiating self from other, possibly in conjunction with narcissistic pathology, there would be an excess of MOAS 3 (dependent) and MOAS 4 (reflection) responses.

These hypotheses will be addressed directly below. Other predictions about associations between the MOAS and other measures will be taken up in later sections.

Findings

School refusers' MOAS productivity was greater than that of the normal sample. The possible significance of this unexpected finding will be addressed in the Discussion section.

TABLE 4.

MOAS productivity: school refusers and normals

	School refusers	Normals
Mean N of MOAS Responses	7.6	4.8
MOAS R's as % of all R's	40%	24%

As predicted, school refusers' MOAS scores were more malevolent than those of a normal sample.

TABLE 5.

Malevolent MOAS productivity

	School refusers	Normals
Mean N of Malevolent R's (MOAS 5-6-7)	3.4	1.6
% of MOAS R's in Malevolent range (MOAS 5-6-7)	45%	32%
Percent of Malevolent R's that are MOAS 6-7	51%	22%

Percentages of MOAS Scale Points for boys only, girls only, and total sample groups are presented in the following table, comparing findings at the different sites and for Tuber's normal sample.

TABLE 6.

MOAS productivity by scale point: school refusers and normals

	MOAS Scale Points 1		2		3		4		5		6		7	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Tuber's Normative Sample														
Boys N=19	6	6	28	29	19	19	4	4	30	32	11	11	0	0
Girls N=21	16	17	46	48	12	13	0	0	18	19	3	3	0	0
Total N=40	22	11	74	38	31	16	4	2	48	25	14	7	0	0
P.I.														
Boys N=11	4	4	17	19	8	9	9	10	27	30	24	27	1	1
Girls N=7	1	4	9	38	4	20	2	8	3	13	5	21	0	0
J.H.S.														
Boys N=6	1	2	17	40	4	10	2	5	11	26	7	17	0	0
Girls N=3	2	7	9	33	4	15	0	0	8	30	4	15	0	0
H.S.														
Boys N=8	3	5	18	29	5	8	8	13	10	16	17	27	2	3
Girls N=7	10	14	12	16	14	19	14	19	11	15	12	16	0	0
Three Sites														
Boys	8	4	52	27	17	9	19	10	48	25	48	25	3	2
Girls	13	10	30	24	22	18	16	13	22	18	21	17	0	0
Total	21	7	82	26	39	12	35	11	70	22	69	22	3	1

The predicted gender differences in MOAS scores were partially borne out. While school refusing girls produced more high-level benign responses (MOAS 1) than school refusing boys, their MOAS records were more malevolent than those of girls from Tuber's normal sample.

TABLE 7.

School refusers: MOAS 1 scores by gender

	N	Mean MOAS 1 scores
Boys	25	.320
Girls	17	.767

Though boys also had a higher proportion of malevolent responses than girls (51 percent versus 34 percent) the difference was not statistically significant.

Interestingly, the proportion of benign responses by the boys in the normal and school refusing samples was quite similar. (Compare the combined proportions of MOAS 1 and MOAS 2 scores; 35 percent for normals, 31 percent for school refusing boys). Neither group produced many MOAS 1's (6 percent of all MOAS responses for normals, 4 percent for school refusers).

The differences in benign response productivity between normal and school refusing girls, on the other

hand, were more impressive. Nearly half of the normal girls' MOAS responses were scored MOAS 2, compared to not quite a quarter of the responses by school refusing girls. Also, a notably higher proportion of the normal girls' responses were scored MOAS 1 (17 percent versus 10 percent for school refusers).

At the malevolent end of the scale, a quarter of school refusing boys' responses were MOAS 6, in contrast to about one in ten of the normal sample boys. The divergence between the girls of the two samples on this dimension, however, was even greater. School refusing girls gave 21 responses scored MOAS 6, or 17 percent of their total; normal sample girls made only three MOAS 6 responses, or 3 percent of the total.

Taking both sexes together, the productivity of the school refusers at the malevolent end of the scale was striking. Though the samples were virtually the same size (normal N=40, study N=42), normals produced a total of 62 malevolent responses, while school refusers produced well over twice that number, 142. By contrast, productivity of the two groups at the benign end (MOAS 1 and MOAS 2) was virtually indistinguishable.

TABLE 8.

Number of MOAS 1 and MOAS 2 responses by site

	MOAS 1	MOAS 2
Normative Sample (N=40)	22	74
School refusers (N=42) (all sites combined)	21	82

Contrary to expectations--but in keeping with the findings for the BSI and DISC interview--older school refusers did not show greater psychopathology on the MOAS. Means on the MOAS did not vary significantly with age. The single most benign object relations response did vary significantly with age (F=5.37, p=.023) and site (F=3.59, p=.038), but in the opposite direction than the one expected; high school subjects had the most benign "best" object relation responses. When age, sex and sex-by-site were controlled for, along with total Rorschach responses, only the difference by site remained significant (F=4.88, p=.014).

TABLE 9.

Most benign MOAS score by sex and site

SEX	SITE	N	MOST BENIGN MOAS SCORE, MEAN
MALE	P.I.	11	2.45
MALE	J.H.S.	6	1.83
MALE	H.S.	8	1.75
FEMALE	P.I.	7	3.14
FEMALE	J.H.S.	3	1.67
FEMALE	H.S.	7	1.14

The prediction that there would be an excess of

MOAS 3 (dependency) responses was not borne out. Half of all subjects did not give a MOAS 3 response. Ten gave one MOAS 3, seven gave two, and three gave four MOAS 3 responses, for a total of 36 such responses (mean of .857 per subject).

Taken together, all sample sites produced proportionately fewer MOAS 3 responses than did normals (12 percent versus 16 percent). Even among the subgroup of P.I. patients diagnosed with Separation Anxiety Disorder (N=12), for whom one might expect issues of dependency to be particularly salient, the proportions were quite low, (only six MOAS 3 responses).

In contrast to the normal sample, however, girls were significantly more likely to offer a MOAS 3 response ($F=8.57$, $p=.006$). The number of MOAS 3 scores in a protocol did not vary significantly by age for either sex.

This unexpected finding of a gender difference in numbers of "dependency" responses suggests that the intrapsychic and/or familial dynamics of school refusal may differ for boys and girls. This will be further discussed below in the context of gender differences in findings on the Parental Bonding Instrument.

The hypothesis about greater MOAS 4 productivity was only partially confirmed. While two thirds of all subjects gave no MOAS 4 responses, four gave one, four

gave two, five gave three, and one gave four MOAS 4 responses, for a total of 31 such responses (mean of .738 per subject). This is nearly eight times as many as the normative sample produced (four), and 11 percent of all MOAS responses, as against 2 percent for the normative sample. Apparently the salience of reflection imagery differs markedly for individual school refusers; the higher prevalence of the MOAS 4 score needs to be interpreted in the context of complete Rorschach records. A case will be examined in detail in the discussion section to further assess the significance of this imagery for some school refusers.

Rorschach: Developmental Analysis of the Concept of the Object Scale (DACOS)

Three summary measures for the DACOS were used: ORPLUS, ORMINUS, and RORSCORE. ORPLUS represents the sum of weighted scores for the degree of differentiation, integration, and articulation of all human or humanlike Rorschach percepts which have good form; ORMINUS is the same for poor form percepts (Blatt, Brooks et al., 1976). RORSCORE combines the two into a single score by multiplying ORMINUS by negative one and adding it to ORPLUS (Fritsch and Holmstrom, 1990).

As expected, there was a wide range of DACOS

responses at all sites. The minimum total DACOS responses per record was 1, the maximum 14, with a mean of 6.38 (S.D.=3.18). RORSCORES ranged widely, from 0 to 117, with a mean of 46.74 (S.D.=31.95). ORPLUS scores ranged from 3 to 130, with a mean of 54.9 (S.D.=33.09). ORMINUS scores ranged from 0 to 46, with a mean of 8.17 (S.D.=11.21).

Unexpectedly, the developmental level of OR representations on the DACOS was not higher for older school refusers. RORSCORE, ORPLUS and ORMINUS did not vary significantly by age, sex, site, or sex by site, each controlling for the other variables. ORPLUS did vary significantly by total Rorschach productivity (F=4.25, p=.047). RORSCORE and ORMINUS did not.

TABLE 10.

DACOS scoring by sex and site

SEX	SITE	N	RORSCORE	ORPLUS	ORMINUS
MALE	P.I.	11	51.36	61.78	10.36
MALE	J.H.S.	6	35.67	48.00	12.33
MALE	H.S.	8	53.00	57.38	4.38
FEMALE	P.I.	7	28.86	34.86	6.00
FEMALE	J.H.S.	3	40.00	44.67	4.67
FEMALE	H.S.	7	62.57	71.71	9.14

Poor form object relations scores--ORMINUS--were relatively rare. Half the sample (21) had no ORMINUS score, and relatively few subjects accounted for most of the ORMINUS scores. Less than a quarter of the sample (10) accounted for 69 percent of the gross ORMINUS scoring.

Good form object relations responses (ORPLUS) were much more common than poor form (ORMINUS) responses. ORMINUS and ORPLUS varied independently of each other ($r=.24$, $p=.12$), as did ORMINUS and RORSCORE ($r=-.11$, $p=.47$).

Rorschach: Thought Disorder

Two summary measures of thought disorder were computed: TDTOTAL, the raw number of separate responses scoreable for thought disorder in a single record, and TDWEIGHTED, the sum of thought disorder scores weighted

with respect to the severity of the type of thought disorder of each response. As the two scores were highly correlated ($r=.992$, $p=.0001$), only TDTOTAL is reported in later sections.

Findings

In the total sample ($N=42$) there was wide individual variation in thought disorder scores (see table next page). Overall, thought disorder was not a prominent feature of the records of most subjects.

Number of thought disorder scores was significantly associated with total Rorschach responses ($F=2.64$, $p=.012$). So was weighted total thought disorder. Total thought disorder responses and total Rorschach responses correlated at 0.383 ($p=.0123$).

TABLE 11.

Thought disorder responses, frequencies and percentages

Frequency (percent)	0	1	2	3	4	5
Contamin.	34 (81%)	7 (16.7%)	1 (2.4%)			
Contam. tendency	40 (95.2%)	2 (4.8%)				
Fab.comb. serious	34 (81.0%)	6 (14.3%)	2 (4.8%)			
Fab.comb. ser.tend.	38 (90.5)	4 (9.5)				
Confab.	37 (88.1)	3 (7.1)	1 (2.4)	0 (0)	1 (2.4)	
Confab. tendency	40 (95.2)	2 (4.8)				
Fabulized confab.	19 (45.2)	9 (21.4)	3 (7.1)	4 (9.5)	4 (9.5)	3 (7.1)
Fab comb. regular	31 (73.8)	8 (19.0)	3 (7.1)			
Fab.comb. tendency	41 (97.6)	1 (2.4)				
Fluid	39 (92.9)	2 (4.8)	1 (2.4)			

Self-report measures

Family Environment Scale (FES)

FES data were collected only at P.I. and the High School site, due to limited availability of subjects at the Junior High School site. Data were collected from 30 subjects, 17 at P.I. and 13 at the High School site. No specific hypotheses were ventured about the outcome of FES data, except that it would vary meaningfully with other measures.

Findings On none of the FES's ten subscales did the school refusers' families differ by more than one standard deviation from the scores of a normative sample (Moos and Moos, 1986).

TABLE 12

Family Environment Scale factor scores

Factors	Mean T-Scores*
Moral-Religious Emphasis	59.87
Conflict	59.27
Control	58.24
Organization	54.04
Achievement Orientation	46.77
Intellectual/Cultural Orientation	45.17
Cohesion	43.86
Active-Recreational Orientation	41.84
Expressiveness	41.45
Independence	39.83

* T-score scale values derived from normed sample (N=627) of families with adolescents; mean=50, standard deviation=10.

Though differences between this and a normed sample do not achieve significance, the overall pattern of FES scores are of potential clinical interest as a rough sketch of the typical hierarchy of values in school refusers' families. Family members in the study rated their family life highest on scales measuring, in descending order, an emphasis on moral-religious concerns; conflict; control; and organization. Study participants rated their families higher on these dimensions than did a normed sample of families with adolescents. By contrast, subjects rated their families lower on scales designed to tap, in descending order, achievement orientation, intellectual-cultural orientation, cohesion, active-recreational orientation, expressiveness, and independence. On average in this sample, independence was rated lowest.

<u>Intercorrelations among FES factors</u> The top four rated FES factors showed a pattern of correlation with one another. Four of six correlations were statistically significant.

TABLE 13.

FES subscale correlations

	CONFLICT	CONTROL	ORGANIZ.
MORAL-RELIGIOUS (p=.XXX)	N.S.	.356 (.054)	.491 (.006)
CONFLICT		N.S.	-.325 (.0795)
CONTROL			.448 (.013)

In normative samples, too, significant intercorrelations among some FES factors have been found. These offer a basis for comparative description of the school refuser sample (see table next page).

Some of the correlations for the normed and the study samples are very close (e.g. Moral-Religious and Control; Conflict and Organization; Organization and Cohesion). Others differ somewhat, but trend in the same direction (e.g. Organization and Control; Moral-Religious and Organization; Intellectual-Cultural and Cohesion).

TABLE 14.

Intercorrelations Among FES Factors:
Normative Sample of 621 Adolescents

Subscales	COH	EXP	CON	IND	ACH	INT	ACT	MOR	ORG	CONTROL
COHESION	---	32	-53	30	11	38	28	22	38	-20
EXPRESSIVENESS		---	-07	32	-05	25	22	-01	-05	-42
CONFLICT			---	-13	07	-09	04	-07	-33	22
INDEPENDENCE				---	-01	27	34	-10	04	-36
ACHIEVEMENT ORIENTATION					---	05	12	31	31	40
INTELLECTUAL-CULTURAL ORIENTATION						---	40	10	14	-03
ACTIVE-RECREATIONAL ORIENTATION							---	04	12	-05
MORAL-RELIGIOUS EMPHASIS								---	27	35
ORGANIZATION									---	27

Intercorrelations Among FES Factors:
School Refusers Families

Subscales	COH	EXP	CON	IND	ACH	INT	ACT	MOR	ORG	CONTROL
COHESION	---	25	-15	21	27	56*	26	25	29	39*
EXPRESSIVENESS		---	-12	00	11	29	01	21	37*	29
CONFLICT			---	-17	-09	08	-24	-13	-33	-19
INDEPENDENCE				---	47*	-21	-12	-07	-15	-26
ACHIEVEMENT ORIENTATION					---	00	14	-17	-06	14
INTELLECTUAL-CULTURAL ORIENTATION						---	13	51*	45*	48*
ACTIVE-RECREATIONAL ORIENTATION							---	-05	00	03
MORAL-RELIGIOUS EMPHASIS								---	49*	36*
ORGANIZATION									---	45*

*Significant at $p<.05$

A few correlations, however, differ rather markedly, and may point up some differences between the normed sample and the school refuser families. In the normed sample, there was no correlation between Achievement and Independence (r=-.01), while the association between these factors for school refusing families was moderately high (r=.470, p=.0087). Of all FES factors, school refusers rated Independence lowest; in such a context, a tendency for a family also to put a low priority on achievement would create no countervailing pressure against maintenance of the symptom.

There was no association in the normed sample between Organization and Expressiveness (r=-.05), while in the study sample the association was moderate (r=.373, p=.042). Expressiveness is the second least characteristic factor for school refusing families; however, to the extent that Expressiveness is permitted in these families, it seems to be associated with a higher degree of Organization.

In the normed sample there was a strong negative correlation between Cohesion and Conflict (r=-.55), while in the study samples the correlation was weak and not significant (r=-.15, p=.44). For normal families, then, higher cohesion is associated with diminished conflict, while for school refusers' families this is much less reliably the case; perhaps because, for many

of these families, cohesion does not rise to the level that it would begin to mitigate conflict (recall that Conflict was the factor rated highest after Moral-Religious emphasis, and Cohesion was rated below the median for adolescent families).

For school refusers' families, Control is more strongly associated with both Organization and Cohesion than it is for normed sample families. The difference is most striking in the case of Cohesion, which for normed families is negatively correlated with Control ($r=-.20$), but for school refusers' families Control and Cohesion are positively and significantly correlated ($r=.39$). It is tempting to speculate that for school refusers' families, unlike for normal families, a relatively high degree of control is to an important extent "syntonic". This notion is buttressed by another reversal of pattern in the correlations. In the normative sample, there is a moderate positive association between Control and Conflict ($r=.22$); the higher the Control, the higher the Conflict. For school refusers, the pattern is reversed; the association remains moderate, but becomes negative ($r=-.19$). The higher the Control, the lower the Conflict. (That school refusers rated Conflict as their families' second most characteristic factor, however, suggests that increasing Control has limited effectiveness as a

way of diminishing Conflict).

Some differences in the strengths of correlations are difficult to interpret in the light of the concerns of this study. Correlations for the school refusing samples between Intellectual-Cultural Orientation and both Organization (r=.455) and Moral-Religious Emphasis (r=.513) were considerably stronger than in the normed sample (.14 and .10, respectively).

Parental Bonding Instrument

Because the PBI, a self-report instrument, has been extensively used only with subjects of adolescent age and older, data were collected from the High School sample only (N=15).

Findings It was hypothesized that low maternal care and high maternal overprotection would be the most populous cell in a four-cell forced assignment (care by overprotection: high-high, high-low, low-high, low-low), and this was confirmed. Ratings of low maternal care were strongly associated with high maternal overprotection. Maternal care and maternal overprotection showed a highly negative correlation ($r=-0.749$, $p=.0013$).

The mean maternal care score (23.6) was below the conventional cut-off for low-care, and the mean maternal overprotection score (15.07) was above the conventional cut-off for high overprotection. Statistical trends did not reach significance, however, given low N and high standard deviations (9.01 for maternal care, 6.44 for maternal overprotection).

Interestingly, males were significantly more likely to rate the level of their mother's care as low ($F=8.41$, $p<.02$), when age was controlled for. There were no significant sex differences in maternal

overprotection or paternal care or overprotection scores.

Age had no effect on maternal care scores for either sex of respondent. No relationship was found between maternal and paternal care (r=-0.12), maternal and paternal overprotection (r=-0.09), maternal overprotection and paternal care (r=.232, p=.41) or maternal care and paternal overprotection (r=-0.01).

Intercorrelations of Rorschach measures

The following table shows correlations between summary Rorschach measures and their significance levels, with Rorschach productivity controlled. Recall that Thought Disorder Total is the number of responses rated as thought disordered using Tuber's adaptation of Blatt's scoring system; ORPLUS is the weighted score of good form object relations responses scored with Blatt's DACOS; ORMINUS is poor form object relations responses; and RORSCORE is ORPLUS minus ORMINUS. P-values are reported only for those correlations which reach significance.

TABLE 15.

Correlations between Rorschach summary measures

	THOUGHT DISORDER TOTAL	RORSCORE	ORPLUS	ORMINUS
RORSCORE	-.25			
ORPLUS	.36 (<.05)	.93 (<.001)		
ORMINUS	.68 (<.001)	-.75 (<.001)	.24	
MOASMEAN	.19	-.45 (<.01)	-.36 (<.05)	-.12

The table below shows correlations between specific MOAS scale scores and Rorschach summary measures.

TABLE 16.

Correlations between MOAS scale points and Rorschach summary measures

Number of Responses	THOUGHT DISORDER TOTAL	RORSCORE	ORPLUS	ORMINUS
MOASONE	.00	.47 (<.01)	.42 (<.01)	.08
MOASTWO	.09	.39 (<.05)	.47 (<.01)	.23
MOASTHREE	.37 (<.05)	.37 (<.05)	.42 (<.01)	.16
MOASFOUR	.32 (<.05)	.30 (<.06)	.34 (<.05)	.13
MOASFIVE	.49 (<.01)	.36 (<.05)	.45 (<.01)	.27
MOASSIX	.58 (<.001)	.09	.04	.37 (<.05)
MOASSEVEN	.06	.13	.08	-.14

The combinations of Rorschach measures will be discussed separately in turn below.

MOAS and DACOS While conceptually distinct, both the Mutuality of Autonomy Scale (MOAS) and the Developmental Analysis of the Concept of the Object Scale (DACOS) were designed to assess aspects of internalized objects. For that reason, it was expected that findings on each would be meaningfully related,

and this was borne out.

As expected, more malevolent MOAS object relations responses (as measured by MOAS mean) were associated with lower values on DACOS summary scores of object representations, RORSCORE and ORPLUS. By contrast, there was no association between MOAS mean and poor form object relations representations (ORMINUS).

There were significant associations between ORPLUS and the number of MOAS responses at each of the MOAS score point levels at MOAS 1 to MOAS 5, but not at MOAS 6 or MOAS 7. By contrast, ORMINUS was significantly associated only with MOAS 6 scores. That is, good form object relations responses were more likely to be relatively benign, while poor form object relations responses tended to be more malevolent.

<u>MOAS and Thought disorder</u> In other studies of clinical populations, thought disorder on the Rorschach has been found to be associated with more malevolent MOAS responses. Unexpectedly, for the three samples of this study MOAS mean and total thought disorder were not significantly associated (see table above).

There were, however, interesting contrasts in the degree to which specific MOAS scores were associated with thought disorder. Thought disorder scores were not associated with the number of MOAS1 or MOAS2 scores.

Thought disorder was, however, significantly associated with the number of MOAS 3, 4, 5, and 6 scores, with the association trending upward with greater malevolence in the object relations response. The highest correlation was between total thought disorder responses and number of MOAS 6 scores ($r=.58$, $p<.001$).

Apparently the more malevolent object relations responses a child produces, the greater will be the number of thought disordered responses (and vice versa).

<u>DACOS and Thought disorder</u> Studies have found associations between object representations on the DACOS and degree of thought disorder, with more disrupted object representations correlating with higher thought disorder scores (Blatt et al., 1982). As expected, DACOS summary measures were significantly associated with total thought disorder responses (TDOTOTAL). In particular, ORMINUS was strongly associated with thought disorder (see table above).

To a lesser but still significant extent, however, ORPLUS, the measure of good form object responses, also correlated positively with TDOTOTAL. This surprising finding is difficult to interpret. Evidently an investment in objects which, at least on the level of form, are not notably distorted in their

representations, is not incompatible with thought disorder; on the contrary, the more object representations, the more evidence of thought disorder. It was noted earlier that the preponderance of thought disorder scores were of the milder varieties (e.g., fabulized combinations). It may be that characterizing such responses as "thought disorder" in the same sense as, for example, a contamination, may not be particularly illuminating, especially in the case of a sample of children.

Rorschach measures with self-report measures

MOAS Mean and FES, BSI, PBI variables It seemed reasonable to expect that individuals' mean object relations scores on the MOAS would vary in meaningful ways with respect to family functioning (Family Environment Scale), symptomology (Brief Symptom Inventory), and conscious parental representations (Parental Bonding Instrument). Contrary to expectations, there was no significant association between MOAS mean and any BSI factors. Nor was MOAS mean significantly correlated with any FES or PBI variable. There were, however, other associations between MOAS variables and numerous factors on self-report scales, discussed below.

MOAS and PBI Since both the MOAS and the PBI tap into aspects of the representation of other people, it was of interest to check degrees of divergence and convergence between the measures. Differences did not reach statistical significance, though they were in the direction expected.

TABLE 17.

PBI mother care by MOAS scores

MC	MOASMEAN	No. of MOAS5-7
Hi	3.63	1.99
Lo	3.73	4.34

All values are residualized to control for Rorschach productivity.

DACOS and BSI While no specific hypotheses about these two instruments were ventured, it was of interest to see if more symptomatic individuals had more disrupted object relations representations (and vice versa). For the most part, for the H.S. sample, the answer was no. Only one association between DACOS and BSI variables was found. Phobic anxiety correlated with residualized ORMINUS scores (r=.523, p=.046). Given the number of correlations (30, combining ten BSI with three DACOS variables), this isolated association could be a random occurrence.

DACOS and PBI It was expected that disturbed relationships with parents, as reflected by low care and high overprotection scores on the Parental Bonding Instrument, would be parallelled by more disrupted

Rorschach object representations. Again, this was confirmed for maternal representations on the PBI, not for paternal representations. Low Mother Care was associated with more poor-form object relations responses (ORMINUS), conceptualized as a measure of the degree of investment in unreal relationships. With productivity controlled, the negative correlation between Mother Care and ORMINUS was high and significant (r=-.562, p=.029). ORMINUS mean for the 6 "High care" subjects was 3.83; for the 9 "Low care" subjects the ORMINUS mean was 8.44 (F=3.49, r=.0838, after controlling for productivity).

There was no association between high care and ORPLUS or RORSCORE values.

The lack of any significant correlations between father care or overprotection and any DACOS variable seems to provide further support to the notion, suggested above, that relationships with mothers have greater impact on children's object relations representations than do relationships with fathers for this sample.

DACOS and FES Expectations that object representations as assessed by the DACOS would vary meaningfully with family variables were not strikingly confirmed. There were few significant associations between DACOS and FES

measures. Given the multiplicity of correlations run between these two instruments (30), and the lack of relevance of those few statistically significant correlations to the hypotheses of this study, they are not reported here.

Thought disorder and BSI It was expected that those with more thought disorder on their Rorschachs would show more symptoms on the BSI. This was not confirmed. Unexpectedly, no thought disorder summary variable was significantly associated with the BSI-GSI measure of symptom distress. Of BSI factor scales, only Phobic Anxiety correlated significantly with residualized TDTOTAL (r=.600, p=.018). As with the DACOS-BSI correlation noted above, this may be a random association, given ten correlations. Thought disorder and Psychoticism factor responses on the BSI were associated at the trend level (r=.406, p=.066).

Interestingly, the two subjects reporting the least overall distress on the BSI had the second and highest weighted thought disorder scores (35 and 23) at that site (N=15), and the third and sixth highest weighted TDO scores overall (N=42). The person reporting the greatest distress on the BSI, on the other hand, had no Rorschach thought disorder responses. This, like the dysjunction between the PBI

father scores and MOAS data cited above, suggests that differences in response styles and/or diagnosis may account for a significant degree of variability in results obtained on questionnaire type scales. Evidently the Rorschach does indeed yield information on defensive operations, and what is being defended against, that are not otherwise readily available. Conversely, a straightforward symptom inventory may identify some patients who, despite relatively "clean" Rorschachs (at least with respect to thought disorder) are in significant distress.

<u>Thought disorder and PBI</u> Again, no specific hypotheses were ventured about these two isntruments. But it was of interest to see if, for instance, representations of a mother as uncaring and/or overly controlling would be associated with more thought disorder on the Rorschach. To a surprising extent, this turned out to be the case. There was a significant association between higher thought disorder scores and lower ratings of mother care (residualized TDTOTAL and MCARE, $r=-0.562$, $p=.029$). The correlation was slightly less for TDOWEIGHTED, but still significant ($r=-0.530$, $p=.042$). Again, no significant associations with paternal PBI measures were found.

TABLE 18.

Mother Care and Thought Disorder

MC	TDOTOTAL	TDOWEIGHT
Hi	1.08	4.32
Lo	4.50	16.12

Thought disorder and FES No significant associations between thought disorder and FES variables were found.

Self-report measures with each other

PBI and BSI It was hypothesized that less optimal parental bonding as assessed by the PBI would be associated with other indicators of distress, and vice versa (high care would correlate with low distress). This was strikingly confirmed with another self-report questionnaire, the Brief Symptom Inventory. Higher maternal care scores were negatively correlated with BSI-GSI symptom distress ratings (r=-.707, p=.0032). Conversely, maternal overprotection was strongly associated with higher symptom ratings (MOVPROT with BSI-GSI, r=.799, p=.0004).

Lower MCARE scores were associated with higher Somatization, Interpersonal-Sensitivity (I-S) (r=-0.803, p=.0003), Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. High MOVPROT was also associated with high Somaticization, Interpersonal-Sensitivity (r=.773, p=.0007), Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism.

TABLE 19.

Correlations between BSI factor ratings and PBI variables

	MCARE r	p	MOVPROT r	p
BSI-GSI	-.637	.011	.796	.004
SOMATIZATION	-.636	.008	.789	.0003
INT-SENSITIVITY	-.798	.0002	.752	.0008
DEPRESSION	-.433	.094	.597	.015
ANXIETY	-.706	.002	.550	.027
HOSTILITY	-.540	.031	.649	.007
PHOBIC ANXIETY	-.682	.004	.700	.003
PARANOID IDEATION	-.572	.021	.785	.0003
PSYCHOTICISM	-.623	.010	.547	.028

Once again, no scores on father care or father overprotection yielded any significant correlations with BSI ratings of psychopathology or distress.

BSI and FES The clinical literature on family dynamics and treatment has long indicated that disturbed family functioning is associated with individual psychopathology; recently it has been stressed that the reverse is also true, that individual psychopathology may disrupt family functioning. Consistent with those findings, outcomes on family organization variables were associated at significant levels with measures of symptom distress. There were surprisingly strong associations between FES scores on several dimensions and outcomes on the BSI-GSI and BSI factor scales.

Conflict ratings were highly positively correlated with GSI (r=.783, p=.0016). In contrast, Expression showed a strong negative correlation with GSI (r=-0.671, p=.012).

TABLE 20.

FES subscales by BSI-GSI

FES Subscales	BSI-GSI
Cohesion	-.47
Expressiveness	-.67 (<.05)
Conflict	.78 (<.01)
Independence	.13
Achievement Orientation	.00
Intellectual-Cultural Orientation	-.46
Moral-Religious Emphasis	-.56 (<.05)
Organization	-.56 (<.05)
Control	-.22

This seems to support what might be characterized as a conventional psychodynamic position, to the effect that a family which allows a greater degree of emotional expressiveness will be less likely to foster symptomatic distress. At first glance, it would seem to counter the findings of studies of schizophrenics returning from hospitals to their families, to the effect that patients whose families were characterized by high "EE" ("expressed emotion") were likely to be rehospitalized significantly sooner. There is little reason to think, however, that familial emotional expressiveness and symptomatic distress interact in a

strict linear fashion across diagnoses. It should be noted that as a whole school refusal sample families were characterized by low levels of emotional expressiveness. Another way of stating the finding would be that to the (limited) extent that emotional expressiveness characterized the functioning of school refusers' families, it was associated with less severe symptomatic distress.

Also negatively associated with GSI ratings, all at the $p<.05$ level, were Active-Recreational Orientation ($r=.-569$), Moral-Religious emphasis ($r=-.558$), and Organization ($r=-.563$). This finding suggests that for school refusing as for normed sample families, these factors may indeed be usefully conceptualized as strengths.

It should be emphasized that these findings do not address the question of the direction of causality. Some family systems theorists have argued that a preoccupation with linear causality in assessing families is misguided analytically, and a clinical dead end, in that it tends to lead toward assessing degrees of blame for the problem (Hoffman, 1981). Instead, they argue, circular or mutually influencing feedback processes should be described. These matters will be addressed more fully in the discussion section.

PBI and FES To the extent that both the Parental Bonding Instrument and the Family Environment Scale assess interpersonal relationships, it was expected that there would be meaningful correspondences between the findings. This was borne out in interesting ways. High Conflict scores showed a strong negative correlation with MCARE ratings ($r=-.649$, $p=.016$), and a strong positive correlation with Mother Overprotection (Conflict and MOVPROT, $r=.694$, $p=.008$). The factor Organization followed the opposite pattern, correlating positively with MCARE and negatively with MOVPROT (Organization and MCARE, $r=.555$, $p=.049$; Organization and MOVPROT, $r=-0.642$, $p=.018$). At the trend level, Expression varied similarly with maternal PBI factors (EXP and MCARE, $r=.532$, $p=.061$; EXP and MOVPROT, $r=-.478$, $p=.099$).

Again, for none of these scales were associations with PBI father scale values significant.

DISCUSSION

This study set out: 1) to explore a relatively common, much researched, yet still perplexing psychological and behavioral disorder of childhood--school refusal, or school phobia; 2) with particular attention to unconscious object representations as assessed on the Rorschach; and 3) the degree of congruence of those representations with measures tapping preconscious views of various aspects of parental relationships, family functioning, and psychopathology. The purpose was to yield information about the disorder, its dynamics and etiology, and also about the instruments, and the ways and degrees to which they may illuminate (or raise questions about) one another's results.

It was to be expected that a study casting such a wide net would land at least a few interesting fish; the "take" was described in the Results section. In this section, we will discuss what the catch may reveal about the greater, uncaptured school from which it was taken, and the advantages and disadvantages of the net used here for making those sorts of inferences.

A schematic overall view of how the various pieces of data fit together may be helpful in integrating the multitude of data sources reported in the Results

section. (Every instrument was used with the High School sample only, so the diagram below applies only to that group). Given the high number of permutations and combinations possible, it would seem too much to ask for any one data source to connect with all the others. Surprisingly, however, one did.

TABLE 21.

Schematic view of data relationships, H.S. Sample

BSI DACOS

PBI MOAS

Maternal factors

FES TDO

The centrality of the child's relationship with the mother in school refusal, stressed in many clinical studies, is apparently confirmed. Scores on the maternal scales of care and overprotection were significantly linked with every other measure, something not true of any other measure. This was particularly striking given the limited statistical

power available with an N of only 15.

The pattern of significant intercorrelations between the PBI and other measures suggests the central importance of the mother-child relationship for 1) key aspects of family functioning; 2) the child's risk of developing significant psychopathological distress; and 3) the child's inner world, including unconscious object relations and even vulnerability to thought disorder.

While a study like this cannot prove the direction of the causality in the various correlations observed, the most parsimonious model (which also tallies with numerous empirical findings and theoretical developments) would place the mother-child relation at the center, from which radiate the various effects.

The finding of elevated maternal "overprotection" scores is in accord with many studies cited in the literature review. In a report of a failed psychoanalytic treatment of a 13 year old school refusing girl, Levinson (1984) noted the mother's intense fears and none-too-subtle cultivation of her daughter's nascent agoraphobia. On the basis of detailed clinical investigations over time, Hersov (1960) concluded that maternal overprotection strongly characterized school refusers. Deutsch (1948) wrote that school refusers' mothers may be either

overindulgent, or domineering and overprotective; for this sample, at least, the latter description appears to fit better. Eisenberg described ways that mothers of school refusers undermine their children's independence strivings, a style of interaction roughly captured by the PBI's "overprotection" dimension (1958a, b).

The finding of low maternal "care" scores also tallies with the reports of several authors. Bornstein (1949) described the "primary rejection" of a school refusing boy by his mother. Deutsch (1948) wrote that the domineering type of mother "exerts her overprotections with the help of aggressions". Eisenberg (1958a,b, 1959) pointed to disowned and imperfectly controlled hostility directed by the mother toward the child as key in many cases, though he also found erotic elements in the relationship etiologically important for some. Davidson (1960) failed to find evidence of a significant erotic theme, but in all of her 30 cases she noted the mother's hostile-ambivalent attitude toward the school refusing child; "Mother gives with one hand and takes away with the other."

Some studies have noted the importance of fathers to the development and maintenance of the school refuser syndrome (Hersov, 1960; Skynner, 1974). This study does not shed much light on those formulations; certainly it provides little support. Paternal care and

overprotection scores failed to correlate with other factors on other scales.

Apparently, for school refusers, their parents are anything but interchangeable psychologically. While the sample is small and differences did not reach statistical significance, it is curious that school refusers rated their fathers as more caring and less overprotective than their mothers. It may be that in response to disappointing experiences with their mothers, school refusers are idealizing their fathers; the incongruence between preconscious (paternal PBI) and unconscious (MOAS) object representations could be seen as lending support for such a possibility.

A case report of simultaneous psychoanalyses done with an 11 year old school refusing boy and his mother at the Hampstead Clinic in London bears on the question (Hellman, 1960). The mother, intrusive, seductive, and hostile, enacted her pathology with the son to an extraordinary degree (feeding him spoiled food, tongue-kissing and rubbing against him to the point of orgasm). The son, whose own symptomology and dynamics were complex,

> . . . brought his sane, active, and creative part into the treatment only when he transferred to the therapist the quiet, constructive aspects of his father. The need to keep this island of safety made him tenaciously maintain a one-sided positive image of the father; he denied that there existed a frightening aspect of the father as well as his own aggressive impulses against him, though his

> nightmares showed them clearly from the start" (p. 364).

The idealization-of-the-father hypothesis, then, may be part of the picture.

Yet other possibilities exist. Skynner (1974) reported that some school refusers' fathers "compete with the mothers" as to who will be more maternal (caring?) with the child. It may be that school refusers' fathers do indeed behave in a more affectionate way towards their children than the mothers do, but for some reason this fails to lead to more benign internal object relations for the children. Speculatively, the high conflict between the parents which may be a result of and/or a contributor to their dysjunctive parenting styles could "spoil" the effect of the father's more benign relations with the child.

The interaction of gender and object relations representations was not addressed in the hypotheses of this study. Some findings, however, raise interesting questions about this problem. As reported above, Tuber's findings for a normal sample that boys are more productive than girls on the Rorschach, and that their Rorschach object representations tend to be more malevolent than girls', were replicated with this clinical sample. Unexpectedly, and unlike normal boys, clinical sample boys were also significantly less likely than girls to offer a MOAS 3 or "dependency"

type of object representation on the Rorschach. Moreover, sample boys scored their mothers as less caring and more overprotective on the Parental Bonding Instrument.

While it is far from certain how all of this might fit together, it is tempting to speculate that boys from both normal and clinical samples must contend with various factors--endogenous and/or sociocultural--which tend toward the development of more malevolent object relations representations. Potential "buffers" in the environment which may mitigate these risk factors include the availability of a maternal figure perceived to be caring (loving) and not overprotective (non-intrusive). When such a figure is perceived as reliably present, as in normative development, boys are as capable as girls of internalizing representations of dependency relationships, and the tendency to conceive of the other as an antagonist in a hostile struggle is lessened to an important degree. Absent such a figure, however, boys may be especially prone to lose (or defensively repress?) their capacity to represent dependency relationships, and may become flooded (or counterphobically flood themselves?) with representations of aggressive, hostile, damaging encounters.

The data provided by this study allow only a

tentative, speculative approach to these issues. In any case, we are left with the more immediate challenge of elucidating conceptually the surprisingly strength and multiplicity of the Parental Bonding Instrument's maternal measures' empirical associations with other variables, which hold for both boys and girls.

To take just one set of associations, a strong claim would be that a mother-child relationship which the child experiences as characterized by low care and high overprotectiveness gives rise to a family style of interaction marked by low expressiveness and high conflict. A more "circular" description, with which family therapists might be more comfortable, would see the mother-child relationship as nested within or feeding back into a system characterized by low expressivenes and high conflict. (It is an interesting empirical question, beyond the scope of this study, whether such a system would pre-date the child, and assimilate the evolving mother-child interaction to it, or whether the system would grow up around the mother-child dyad).

Whatever its origins within each family's history, this apparently paradoxical family style--one might think that high conflict would necessitate high degrees of expressivity--suggests the cycle of suppression and explosiveness described in many studies of school

refusal and separation anxiety disorder. It may be that the family style of low expressiveness and high conflict in turn reinforces the child's sense of the mother as someone who is "not caring" yet periodically interfering in unwelcome ways ("overprotective").

The impact of these interactive patterns on individual children no doubt vary, but there are numerous indications that, even within a clinical sample, they account for significant amounts of the variance in distress and/or dysfunction, in the form of elevated psychopathological symptomology and/or an increased tendency to disordered thought. In addition, children who have experienced their mothers as especially uncaring and intrusive--an experience available to consciousness--are liable to harbor unconscious images of others that are unusually distorted and/or malevolent. Object relations and interpersonal theorists who disagree on much else might support a speculation that these unconscious object relations in turn feed back into the system, serving to sustain and reinforce the child's ongoing, present sense of the mother and others as uncaring and malevolently interfering.

To the extent, too, that the child sees mother as uncaring and intrusive, he or she is liable to become relatively more invested in distorted, fantasy

relationships (thought disorder). These patterns may in turn be exacerbated in the context of a family ethos favoring control over independence, and favoring moral-religious concerns over achievement, recreation, or other activities that can take place away from the family. One could surmise that the symptomatic child in such families has less than optimal opportunities for developing other real relationships which might challenge his expectations that the other will prove uncaring, intrusive, even bizarrely malevolvent.

The description above emphasizes the circular and mutually reinforcing aspects of the various factors (somewhat along the lines of Wachtel, e.g., 1977). But given that the mother-child relationship (as perceived by the child) is the only factor with a direct impact on all the others, it deserves to be considered more closely in its own right. What in particular about the mother-child relationship is being measured by the PBI? How might the empirically-derived constructs of "care" and "overprotection" link up with both clinical conceptions of object relations and recent research in child development?

Pursuing these questions will involve an examination of the theoretical underpinnings of the PBI, with particular attention to points of conjunction and contrast with attachment theory. It may be that a

version of attachment theory broadened to bring it into contact if not conformity with psychoanalytic object relations theories will provide the basis for a model of school refusal which accomodates this study's findings and points the way to potentially fruitful areas for further inquiry.

Such topics, while germaine, are complex and primarily theoretical, falling outside the frame of the dissertation study proper. They will be addressed in a theoretical essay in the Appendix.

Whether the generalizations and theoretical speculations ventured above will prove to have any clinical applicability remains to be seen. In the following section, an individual record will be reviewed with an eye to what sort of clinical pictures emerge when we are presented with this particular array of questionnaire and Rorschach data. Insofar as seems possible, inferences will be drawn about the diverse dynamics and personal and interpersonal histories which may lead to a common symptom.

A close reading from diverse perspectives

In this section, individual Rorschachs will be examined. The first is that of subject #1, a 16 year old male, whose Brief Symptom Inventory overall distress score was the highest among the high school

sample. He rated his mother low in care and high in overprotection, while rating his father the opposite. He rated his family on the FES as especially low in cohesion and in expression. His Rorschach record was unusual for boys in the sample in including only 13 responses. It is reproduced in full below.

This record is singled out in part because the subject rated himself highest in psychopathological distress, in part because the relative brevity of the record makes a fairly detailed analysis possible. The first approach will be to develop an overall clinical impression, beginning with elements in the record which bear on psychopathological distress *pér se*. Further on, the data will be examined from different theoretical perspectives, with particular attention to object relations representations.

Rorschach record #1 (ID22)

I. V ^ It don't look like anything....Actually--an animal--standing on a rock--and there's a reflection in the water. Nothing in particular, just a strange animal.

(?) Head, wings, legs, rock. (Standing as if? Looking out over the horizon.

Can I see a number of things? An insect of some sort--with pincers.

(As if?) Just for eating I guess. They're kind of short, can't do anything with them.

II. V There's gotta be something there, right? < V > ^ I don't see anything in this. (Laughs). An inkblot.

(Looking at it this time, is there anything else it could be?) < ^ (Shakes head no).

III. Looks like two people, leaning towards each other. V That's about it.

(Leaning towards each other as if?) Like they're holding onto something and it broke, and they're both falling back. (Falling back?) They're leaning forward, but their legs are backward at an angle--people don't usually stand that way, they've got to be falling. (Something broke?) What they're holding onto is in two halves. (Broke as if?) They were holding onto it for balance and it broke--so they're falling.

IV. \/ I don't know. < ^
Like the bottom half of something--bottom half of a dinosaur. Feet, and tail in the middle. (Anything else it could be?) Are these just random, they just put ink down? I don't see anything else.

(Bottom half?) Yeah, because there's no head or anything. (What makes it look like a dinosaur?) Really big tail. There's not too many things that stand on two feet and have a tail.
(Anything else?) This by itself looks like a head--two eyes and a nose down here. (Usual "tail"). (What kind of a head?) A reptile.

V. A bat.

(WMLL bat?) The head--wings are attached to the feet pretty much, there's not much space. I don't know if they're like that. (AE?) No.

VI. \/ This looks like an animal too. Four legs and a tail. Pincers again (top). (Pincers are part of the same animal?) Yeah. Sorry I'm boring I guess, I don't see too much.

(WMLL animal?) Sides, tail's at the bottom. The mouth (top, with figure turned upside down)--the pincers are up here--it's actually two sets, because there's another up here (smaller set lower on figure).

VII. \/ Rock formation. A doorway or something.

(?) Like that (traces). Three rocks, three on this way. (Doorway?) An arch.

I kind of see two faces--Indians, with feathers sticking out. (Covers lower half of figure). I don't know what the rest of it could be though. (Puts card on pile).

(?) Just heads. (As if?) I don't know, looking in the mirror. (Anything else it could be?) No.

VIII. --> A dog. Standing on rocks.

(?) Like the first one I saw, it had the same view. Like the first one I saw. (You mean a reflection?) Yeah, there's a reflection here.

\|/ Could be a skeleton.

IX. Looks like a dragon head (green). These are the eyes (space), the ears (orange). Its mouth is open--there's no bottom jaw.

(Mouth is open as if?) (No response.) (It has no jaw?) It just didn't fit in the picture.

X. ^ \/ Some birds. Birds sitting in trees, a nature scene.

(?) Birds, (yellow), sitting on a branch (brown). This is background--trees (pink). It looks like snails up here (green). Just a bunch of animals.

There is much in this record to suggest depression, aside from the low productivity, including one direct negative self-statement ("Sorry I'm boring I guess, I don't see too much"), and morbid and/or comfortless content in many responses (skeleton, half a dinosaur, dragon head with no bottom jaw, animals with pincers, two rock responses). The lack of specificity, and the desultory tone (Card I, "Nothing in particular, just a strange animal"; Card VI "an animal too") betray a lack of investment in the activity--which might have multiple meanings, including hostile ones--as well as a belittling attitude toward the subject's own productions. Even responses that on the face of it might seem to be affectively positive ("Birds sitting in trees") are undone in the inquiry. The birds are inert, and they don't appear much different from creatures which surely will never take flight ("It looks like snails up here. Just a bunch of animals.")

The depressive mood and content are associated in interesting ways with aggressive material that finds predominantly oral expression. The elaboration on the response "pincers" (Card I) denies the aggressive implications of the response, and appears to disparage the pincers as ineffectual ("Just for eating I guess. They're kind of short, can't do anything with them"). Yet on Card VI he returns to the theme, seeing a double

set of pincers on one animal; this time he appears to defend against the implications of the aggression by attacking himself ("Sorry I'm boring"). The dragon head has no bottom jaw; again, the potential for (oral) aggression is undone, and the percept is viewed as incomplete, perhaps damaged.

The most elaborate and perhaps most poignant response comes on Card III, notably in response to the MOAS inquiry devised by Tuber (repeat response, inquire "As if?"). It turns out that figures who had initially seemed to be leaning toward one another are actually in the act of falling away (falling apart?), because the thing they had each been holding onto for balance--the thing they held in common--has broken. Here the depressed mood and the theme of damage come together in the context of a devastating rupture of a mutual dependence, resulting in both parties' losing their balance.

This is the only response in the record in which human figures are interacting. The two Indian faces on Card VII turn out on inquiry to be one face looking in the mirror. Other creatures likewise are reflections (Card I, Card VIII).

How do these impressions compare with the data from the self-report instruments? The multiple dysphoric responses certainly lend support to the high

BSI overall distress score. An alternative hypothesis--that an overreactive response style accounts here for high distress scores, for example--does not seem supported by the Rorschach. Neither the interpersonal style (addressed in greater detail below) nor the perceptual style appear particularly histrionic. For example, the subject consistently minimizes or mutes his responses rather than dramatizing them; and while there are responses that use the whole card for determinants, the form level on these is adequate for the most part, and there are a number of detail responses.

The low maternal care/high maternal overprotection pattern on the PBI seems much more in accord with the overall emotional tenor of the record and with the few responses representing human figures than does the combination of high paternal care, low paternal overprotection. While this is in keeping with what most object relations theories and the attachment literature would aver--that relations with the mother, particularly early ones, have far more impact on psychological development than do relations with the father--other possibilities may need to be entertained. It should be noted, for example, that the gender of the figures in Card III are not specified; perhaps this response, which seems so tense with unfulfilled

yearning, describes a disruption in what had been (judging by the PBI profiles) the more valued and lively of the boy's parental relationships, the one with his father.

The subject's two extreme FES subscale scores--low cohesion and low expressiveness--evoke a family atmosphere broadly consonant with the tone of the record. Figures are isolated, turned in on themselves, or falling away from one another. No one is talking or expressing any affect directly; there is movement in only one percept (Card III). It is not hard to imagine, from the Rorschach responses, that for this teenage boy, life in the family sketched by the FES scores is a lonely one.

There appears to be, then, some convergence of the projective and questionnaire data, at least descriptively. This level of analysis stops well short, however, of the sort of formulation a clinician would find especially useful in developing a treatment plan. In clinical practice, most often such formulations keep the theoretical commitments that inform them in the background as much as possible, not only for the sake of clarity but to compel belief; reports are more persuasive when the conclusions appear to have arisen naturally from the data rather than been strained from it by the sieve of theory.

But in a study of object relations representations, the knotty problem of theoretical commitments may not be indefinitely avoided. So far we have taken for granted--and demonstrated, in a limited, empirical way--that such representations are significant for an individual's psychological functioning. But what, ultimately--and far less than ultimately, what clinically--do we make of this? How do we understand what these representations actually represent? Do they arise and do they function as archaic phantastic images, habitual action tendencies, deep-rooted psychic structures, historical vignettes, or current events newsreels? How much self-representation is implicit in the object-representations; in a projective context, can meaningful distinctions between representations of self and other even be made? And how do such representations fit in with everything else we know, surmise, infer, or have a hunch about a particular person?

Different theories have treated object relations and their representations in very different ways. Rather than explicate what has been so ably explicated elsewhere--the major theories themselves--the following section will attempt to apply each in turn to the Rorschach record of subject 1. The hope is that this will elucidate clinical choice points in understanding

projective data, and provide an applied as well as a theoretical basis for comparison.

In this brief record there appears to be ample material for a classical, an ego psychological, an object relations, an interpersonal, or a self psychological set of working hypotheses. The decision as to which material is seized upon as central, most illuminating, or "deepest" will of course be guided if not determined by the theoretic "hermeneutic" chosen at the outset (Spence, 1993). The recurrent oral aggressive imagery, for example, has already been alluded to; what are we to make of it? Needless to say, noticing the material as such--organizing the data in terms of the qualifiers "oral" and "aggressive" in conjunction--involves making certain decisions a priori about where and how meaning is likely to be found. It places the inquiry firmly within a psychoanalytic frame of reference, and seems to steer the discourse, at least initially, in the direction of a classical formulation.

Looking at subject 1's record, this viewpoint might postulate a fantasy of oral incorporation characterized by ambivalent wishes both to have and to destroy a frustrating or actually lost love object. The attacks on the ego which seem to follow closely on the breakthroughs of aggression in the record might be seen

as self-punishment reflecting the subject's remorse for his aggression, and/or his identification with the lost object with whom he is angry and who he would like to punish. Genetically, the preoccupation with oral aggressive themes in conjunction with recurrent imagery of damage and/or inadequacy (Card I: "They're kind of short, can't do anything with them"; IV: "there's no head or anything"; IX: "there's no bottom jaw") could be taken as evidence of a failure to negotiate the Oedipal crisis, perhaps due to especially intense castration anxiety and/or a strong oral fixation, with consequent regression to the point of (oral) fixation.

One might speculate further that this conflict, repressed unresolved in early childhood, has been exacerbated with the stirrings of the adolescent's sexual drives. On this reading, the inability either to possess or to relinquish the Oedipal love object has led to a developmental impasse characterized by a kind of resentful mourning, passive-aggressive modes of functioning, and a retreat to a narcissistic libidinal position, with failure to cathect new objects.

An ego psychologist, while not necessarily quarreling with the outlines of this formulation, might emphasize the ways in which certain ego functions appear for this subject to have become entangled in conflict, while pointing also to evidence of areas of

intact functioning. The refusal of Card II, for example, might be seen as an example of the ego deploying a relatively low-level and ineffective defense--denial--to counter the anxiety provoked by the breakthrough of aggressive material in the previous response. The inability throughout the record to effectively integrate color as a determinant of the responses might be taken as an indication of the ego's current incapacity to handle affect, probably especially angry affect. The paucity of responses, the recurring themes of lifelessness, and the tendency to convert images of living percepts into reflection responses might be seen as evidence that the ego is in crisis, depleted of energy (cathexis) and unable to effectively deploy those energies it does possess in the service of adaptation to the environment.

Yet the adaptive capacities of the ego have not been entirely overthrown by any means, as evidenced by the absence of thought disorder, the presence of some popular responses, and the two intact human figure responses with good form (Cards III and VII). The final response of (living) birds and snails, while hardly joyful, might be seen as reflecting the survival of the ego and its hopes for itself. These observations could be taken as evidence that the problem is not one of structural deficits but rather of conflict;

prognostically this would be considered encouraging.

An ego psychological perspective might accordingly venture to guess that the apparent current helplessness of the ego is in good part defensive. Evidently what had been, at least for a while, relatively autonomous ego functions have become embroiled in conflict. Specifically, the wish for mastery and healthy self-assertion seem to have become confounded with aggression and inhibited by guilt.

As noted previously, there is no single object relations theory; perspectives and emphases differ in significant respects (Greenberg & Mitchell, 1983). But most clinicians with a primary commitment to object relations theory as such--as opposed, for example, to those classical or ego psychologists who would see object relations as an ego function among others, albeit a very important one--would most likely approach this Rorschach record in a manner very different from those sketched above. Neither the instinctual derivatives, nor the drive-defense configurations, nor the adaptive or maladaptive functioning of the ego would be of primary interest, or perhaps even mentioned at all, at least in those terms. Rather, the focus would be on the person's representations of objects, and of self in interaction with objects, as reflecting both the developmental roots and the current crux of

his difficulties.

Whether the developmental typology of Margaret Mahler is best considered under the rubric of ego psychology (Blanck & Blanck, 1974) or as a transitional manifestation on-the-way-to-object relations theory (Greenberg & Mitchell, 1983) will not be addressed here. Despite fierce debate on some of her major contentions (e.g., Peterfreund, 1978) it is generally agreed that Mahler's observations of and theorizing about early mother-child interactions have had a wide-ranging impact on psychoanalytic theory and developmental research. Someone observing this Rorschach record through a Mahlerian lens would look for evidence bearing on how the subject had negotiated the passages from normal autism through symbiosis and the practicing phases to rapprochement and, finally, the stage of on-the-way-to-object constancy.

That the subject is plainly not psychotic would probably be taken as evidence that the transition from normal autism to symbiosis had been safely traversed. Nor are there any responses suggestive of a blissful symbiotic union with a nurturing other; from a 16 year old boy one would not expect there to be. By this age, certainly, the need for experiences of merger with a nurturing other should have been outgrown, and "(libidinal) object constancy" (and an individuated and

differentiated representation of the self) reasonably firmly established. Yet there are strong indications that for this subject they are not.

The "highest" response in terms of Mahler's scheme would be the one to Card III, previously described. Here there are two distinct figures, not merged, neither one apparently bigger nor stronger than the other. They stand in a posture vividly suggestive of struggle and ambivalence, leaning now toward, now away, clinging for balance to something held between them. This might be seen as capturing a particularly intense experience of the rapprochement phase, when the child has cognitively and affectively grasped the fact of his separateness from the mother, and is suddenly terrified by the threat of losing her. The world is no longer by any means his oyster, as it had appeared in the practicing phase; his omnipotence is abruptly punctured, and his need for the mother suddenly intensified. Yet he retains the aims of his fledgling ego to explore the world and achieve greater mastery in independent functioning--if only he may do it with the feeling of safety that comes from knowing the mother is available when needed.

In normative development, in Mahler's typology, this crisis is successfully negotiated if the mother can continue to provide the access the child requires,

without interfering with his ongoing explorations in a wider world (Mahler et al., 1975). Gradually (by the age of four or so) the child becomes better able to function independently of the mother, because he has internalized a representation of a gratifying, available object. (This takes longer to achieve than the more purely cognitive Piagetian stage of "object permanence", which is, however, a maturational precondition for the developmental achievement of object constancy).

This subject's Rorschach could be read as suggesting strongly that he and his mother enjoyed no such happy denouement. No possibility of comfort but instead a tense stalemate is represented. The outcome is a destructive rupture that makes both parties lose their balance and fall.

Mahler's clinically rich descriptions of the interaction of parental character and child development--which went far beyond her theoretical formulations in granting a crucial developmental influence to the child's individual experience with his specific caregivers--point the way to some hypotheses about this subject's experience of his particular mother. The relationship represented in Card III is symmetrical rather than complementary; the figures stand equally in need of each other for balance. In

that case breaking away could only feel like a destructive, hostile rupture, if it caused the other to fall. For some mothers, the lessening of the child's dependence on her is experienced as a loss that may occasion a significant depression (a "fall"). In such a case the child may lose confidence about investing himself in his own ego functions, or in exploring the world, for fear that it injures the mother, and because the mother no longer offers herself as a safe home base for "refueling". (Whether this particular mother is indeed at risk for depression cannot, of course, be answered by her child's Rorschach).

Mahler describes mothers who openly cultivate guilt in their toddlers over their fledgling attempts to separate (Mahler et al., 1975), in terms much like those Eisenberg uses to describe mothers and their older school refusers (1958, 1959). While Mahler does not put it in quite these terms, it appears that in such instances the toddler's natural behavioral and emotional ambitendency--the developmentally appropriate aims both to remain in contact with the mother and to grow away from her--are converted over time by an inadequate environment into an internally structuralized conflict. By the time the child reaches high school, on this view, the roots of the symptom of school refusal would be expected to run quite deep.

Such object relations theorists as Fairbairn (1954) and Guntrip (1971), and to a lesser extent Winnicott (1956) have, far more than classical or ego psychologists, tended to explicitly blame actual maternal failure as the determining influence in the development of psychopathology; by contrast, Melanie Klein (1975) did not (Greenberg & Mitchell, 1983). Similarly, these theorists differ considerably on how accurate they take their patients' representations of their parents to be. Obviously, whether one considered this subject's response on Card III to be a faithful representation of the essential qualities of his mother as she actually was; or an image determined primarily by projective distortions; or some compromise combination could make a crucial clinical difference.

No evidence from the record itself, however, could help settle the question one way or the other. And while it is tempting to do so, adducing the data from an instrument like the Parental Bonding Instrument is unlikely to settle the matter. Although it appears much more "reality based" in its form and language than the Rorschach, it still relies on subjective judgments about affectively loaded, very complex relationships. In any case a Kleinian view of mental functioning, for example, considers that conscious thought, such as that employed in answering a questionnaire, floats on an

ever-changing tide of unconscious phantasy; Kleinians could hardly be expected to privilege the truth value of questionnaires over projective data.

A Kleinian perspective on the record would most likely see the prevalence of incomplete, menacing percepts as evidence of the survival (or revival) of hostile introjected part-objects (bottom half of a dinosaur, pincers, dragon head) characteristic of the paranoid-schizoid position. The numerous manifestations of oral greed might be seen as a derivative of the aggressive drive, which not only fuels but also directs the child's envious wish to deplete the mother of all her internal goods, regardless of how gratifying or not she may have been in reality. The anxiety and guilt apparent in the responses would be conceived less in terms of forbidden Oedipal libidinal longings--though those would probably also be seen as operative--than as the subject's reaction to his own aggressive fantasies.

The co-occurrence of Oedipal and pre-oedipal material would pose no special problem genetically, as Klein contended that Oedipal fantasies were operative in the first year of life; the concept of regression would therefore not need to be invoked in a reading of this record. Similarly, the depressive anxiety in the record, noted above, and the apparent concern for the fate of whole objects (Card III), would not necessarily

point to a crisis as late as Mahler's rapprochement in the third or fourth year. For Klein, concern for the whole mother, who the child has in fantasy and reality attacked, dates from the second quarter of the first year.

Whether the subject had adequately attained the depressive position would be a consideration, though Klein's conception of "positions" has much less the implication of ordered developmental stages than do Freud's or Mahler's systems. In Card III, whole objects are disappointing, unreliable; contact cannot be maintained, and is not satisfying; intense joining with another leads to destruction of the thing that holds self and object together. A Kleinian would be likely to see these sombre representations less as an accurate portrayal of frustrating experiences with a real caregiver than as a reflection of the failure of the child's reparative efforts, perhaps in the face of an upsurge of destructive envy, and/or an apparent failure of the object to survive the infant's onslaughts (e.g., if the mother is or becomes depressed).

A clinician subscribing to a non-Kleinian object relations perspective (e.g., that of Fairbairn) might look for evidence in the record of splits in the ego corresponding to splits in the internal objects. What is the relative mix of representations of a rejecting,

withholding object, an exciting, enticing object, or an ideal, gratifying object? This would be considered to betray the state of the ego itself, divided among, respectively, the anti-libidinal ego (tied to the rejecting object), the libidinal ego (tied to the exciting object) and the central ego (tied to the ideal object).

In this record, it would appear that the central ego is the weakest of the three, given the paucity of pleasurable percepts or interactions. The libidinal ego survives, as evidenced most vividly by the initial reponse on Card III ("Looks like two people, leaning towards each other"). But the subject apparently harbors the expectation that the exciting object will ultimately prove disappointing (rejecting); for the most part, accordingly, the anti-libidinal ego, which is identified with the rejecting object, holds sway. The negativism in the subject's approach to the task, the harsh content, and especially the evocations of aggression and damage in so many of the percepts would all be considered hallmarks of the anti-libidinal ego's functioning, pointing unambiguously to a history of actual maternal deprivation. The hatred and destructiveness in the record would be seen as a consequence of frustration in the original need for contact, which is experienced in the first instance as

libidinal; the rage of the anti-libidinal ego is directed not only toward the exciting object, but toward the libidinal ego as well, for continuing to hope (Greenberg & Mitchell, pg. 166).

A Sullivanian interpersonalist's approach to this record--and indeed to the whole process of evaluation, including what sort of information was elicited, and how--would probably differ considerably from those sketched above. That there had been something significantly wrong with the care the subject actually received as a young child would be considered virtually self-evident, given the self-report of clinical levels of distress, as well as the evidence of depression in the record; neurotic misery must perforce have arisen in the context of miscarried relationships, in the first instance between infant and mother.

A baby's first experiences of distress are in response to the anxiety of "the mothering one" (Sullivan, 1953), picked up well before the era of speech through "empathic linkage". It is these experiences of disruptive, disintegrative anxiety which derail the smooth pursuit of physical and emotional satisfactions; the child's character develops around the urgent task of regulating the anxiety of the mother in interactions, and by extension minimizing his own distress. By age 16, this "self-system" and its

elaborate "security operations" would be well established, all in the service of avoiding experiences of anxiety and protecting and enhancing a (probably inflated) preferred self-appraisal.

The interpersonalist might note numerous bits of evidence that the subject's self-system is not effectively protecting him from anxiety, given the dysphoric quality of most of the responses. (Little if any distinction was made by Sullivan himself between anxiety and depression; in the index of The Interpersonal Theory of Psychiatry, 1953, there are no entries for depression). Developmentally, it would be of interest to note also the unusual proportion of reflection responses. From about ages one to four, Sullivan wrote, the main sort of relatedness sought by the child is for adults to provide an "audience." Might the reflection responses represent the child's effort to provide for himself a sense of being seen (if not particularly appreciated) which the parent had failed to provide?

While the representations of others on the Rorschach would be of some interest to the interpersonalist, we would expect him to focus particular attention on the subject's behavior in the testing session. This could provide clues to the subject's habitual "me-you" or "illusory 2-group

patterns", Sullivan's terms for the distorting evocations of others invoked by the self-system in anticipatory ways to ward off feared experiences of anxiety. This particular record would likely be seen as frustratingly sparse, since only verbal behaviors are recorded, without notations even with respect to pauses, tone of voice, pace and pronunciation of speech, and other relevant data; nor are facial expressions or postures recorded, or the tester's overall experience of interacting with the subject. Nonetheless, some observations could be made.

The subject cooperates rather minimally while disparaging the task, his own productions, and by implication the tester. ("It don't look like anything," "Nothing in particular." "There's gotta be something there, right? I don't see anything in this. (Laughs). An inkblot." "Are these just random, they just put ink down?" "Sorry I'm boring I guess I don't see too much"). He uses the word "just" for nearly half his responses (six), apparently as in, "that's all it is (and it's not very much)". This seems to convey a sense both of minimization and insufficiency, with undercurrents of both blame and self-blame. This might be summed up in the statement, "I'm disappointing but so are you." Probably, though, the thoroughgoing interpersonalist would not place great confidence in

projective data or brief snippets of behavior taken out of context; instead, the "me-you" model posited above could be used as a tentative hypothesis to be tested via a much more direct, detailed inquiry into the subject's past and especially current functioning.

A self-psychological approach to the record would focus initially neither on drive derivatives, nor evidence of modifications for good or ill in internal structure, nor representations of objects, nor clues to characteristic modes of interpersonal relatedness. Rather it would ask, what seems to be the state of the subject's self? Have his needs for a mirroring selfobject been adequately met? That is, is he developing, in health, in the direction of a relatively grandiose, exhibitionistic personality organization expressed through healthy ambition and assertiveness, or alternatively in an idealizing direction characterized by strongly held values? Or is there evidence instead that a history of early empathic failures has led to a breakdown in the relations between self and selfobjects, resulting in an experience of intense conflict and the release of "disintegration products" in the form of sexual and aggressive impulses?

Certainly there is little to suggest a healthy ambition or assertiveness in the record; the evidence

for low self-esteem and a diminished scope of activity have been amply outlined above. Nor is there much to indicate an idealizing trend; if anything, a rather cynical, desultory, defeatist tone prevails. And the "disintegration products" have been described above, under other names (e.g., in the classical model, drive derivatives).

On the other hand, Card III might be interpreted as evidence that at some point the self did experience itself as perceived and mirrored by a relatively undistorting and undistorted selfobject. Apparently this was disrupted--broken up--probably as a result of the narcissistic pathology of the parent. The reflection responses in the record might be seen as the injured self's attempts to mirror itself--act as a selfobject for itself--in the absence of other people who could act as selfobjects.

It is fair to ask what has been gained by this extended exercise in theoretical relativism. Have we slowly ascended to a more comprehensive vantage point, or merely built another tower of psychoBabel? Plainly from a practical standpoint the clinical utility of devoting 20-plus pages of inconclusive analysis to a two page Rorschach record is doubtful.

Yet this sort of clinical immersion in the data does provide perspectives and generate hypotheses that

tables of summary scores cannot. The MOAS statistics on this subject, cited above, were not particularly revealing; they did not provide much statistical basis for discriminating this subject from others in the clinical or even the normal sample. The MOAS criteria for scoring individual responses, however, were indeed helpful in consistently directing attention to representations of interactions along the key dimensions of malevolence versus benignity, and mutual autonomy between objects versus oppression or obliteration of one by another.

The data instruments, the MOAS and the DACOS, are far from divorced from theory; both are grounded in the supposition that various qualities of a person's representations of objects have far-reaching consequences for their functioning. Yet the key clinical and theoretical questions of how to understand the organization and dynamics of those representations --and how they achieve their effects--are left unanswered by the instruments themselves. Such questions are, or seem to be, another order of discourse from that of the statistical analysis of quantifiable data, and thus may, in such a context, be kept at bay.

The same may be said of the other, seemingly more objectively derived questionnaire instruments. The

Brief Symptom Inventory assesses psychopathology in one way, while the Diagnostic Interview Schedule for Children does so in quite another; the Parental Bonding Instrument assesses conscious representations of one's parents; the Family Environment Scale assesses perceptions of family functioning. Yet the key clinical and theoretical questions of how to understand the meaning of their results, and their ultimate significance for the subject's functioning, cannot be answered by the instruments themselves.

When data instruments are put to use in a clinical context such matters can no longer be so firmly set aside. For example, a subject's denial of psychopathological distress on direct inquiry--whether on a questionnaire like the BSI or in a clinical interview like the DISC--must be weighed against evidence of thought disorder and unusually malevolent object representations on the Rorschach.

The exercise of articulating as evenhandedly as possible the various priorities, commitments, and perceptual biases of the major theoretical positions vis-a-vis object relations, as these positions are brought to bear on a single Rorschach, has illumined, it is hoped, some choice points in the analysis of clinical data. But perhaps more clearly it has underscored the impossibility of denaturing theory from

data in this work. Theory adheres to the data; changing the theory changes the data.

A corrollary of this would seem to be that forswearing any given theory means forsaking potentially valuable information. It is tempting, then, to think that the best recipe for "cooking" the data would be the big-pot, jambalaya approach: toss in every scrap, theoretical roots and all, and simmer it all together until it seems about done.[1]

In retrospect, though, the jambalaya approach seems to more or less describe the plan of the current study. Data instruments originally rooted in widely divergent theoretical perspectives and adapted to very different sorts of psychological "terrain" were thrown together in the sample's broth. That this approach should have resulted in anything but an incoherent mess may legitimately be considered surprising. That it didn't suggests that there may be a degree of orderliness in development and psychological functioning--and a degree of convergence in our major ways of understanding them--heretofore not widely noticed.

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[1] There are plenty of reasons to question the soundness of this approach as a clinical matter, in that it provides virtually no guidance with respect to technique. This essential problem is beyond the scope of the current study.

Limitations of this study

The original plan for this study had been to take all subjects from the P.I. site; the untimely demise of the treatment program for school refusers there, after only 18 subjects had been through the protocol, made it necessary to search for members of this clinical group wherever they might be found. Drawing subjects from diverse neighborhoods, socioeconomic statuses, ethnicities, and ages compounded potential sources of variability in the data.

A major consequence of this increased variability was that it was not possible to address effectively one of the original questions posed about school refusal, debated throughout the literature: is it a a symptom whose significance varies tremendously across cases, or does it represent a genuine syndrome?

Other weaknesses of this study, many of which have been alluded to in previous sections, flow from the necessity of joining disparate samples. The most glaring one is the lack of statistical power generated by the small number of subjects for which full data sets could be generated. This is particularly unfortunate in that the instrument which appeared to occupy a pivotal position vis-a-vis other data sources --the Parental Bonding Instrument--was adequately normed only for adolescents and adults, and thus was

not administered at the P.I. and junior high school sites.

A related problem is the lack of uniformity of other data sources across sites. The DISC and the BSI, while both designed to assess dimensions of psychopathology, are all but incommensurable, making meaningful comparisons between subjects at P.I. and other two sites very difficult. The DISC, a semi-structured interview that takes a minimum of an hour, revealed far more evidence of psychopathology in P.I. subjects than the BSI, a short questionnaire, elicited from high school subjects. Whether this reflects real differences in the subjects or only in the instruments is impossible to tell for certain.

FES data was not collected from the Junior High School site, weakening the statistical power of those analyses as well. Moreover, the use of the short form rather than the longer form limited the degree of variability the instrument could pick up.

Despite the wide variety of instruments and types of information gathered for this study, some potentially important data was not collected. The history of each individual's symptoms, for example, was not inquired into. The screening mechanisms of each of the sites was relied upon to identify our school refusers; no independent assessment or criteria were

established. No distinction was made between individuals with longstanding and severe histories of school refusal, and others who may have avoided school briefly before being routed into a program. The extent to which school refusal remained an ongoing problem was not assessed. There is a certain irony in the fact that these school refusers were actually assessed at schools, or at a hospital with a fully accredited in-house classroom. This could well have had the effect of skewing the sample toward the milder end of the symptomatic continuum. No doubt there are school refusers whose symptoms are too severe (and/or whose families are too disturbed) to be accómodated even by these programs. In the public schools such children may receive home instruction; it is possible, however, that some entirely fall through the cracks of the system. In either case they would be unavailable to a study with the recruitment methods followed by this one.

Although some information about family functioning was elicited with the FES, the clinical relevance of that data to symptom formation remained a matter for speculation in the absence of the sort of information a more in-depth clinical assessment of individual families might garner. A true family systems approach to the issue would require an actual sample of interactive behavior among family members in order to

begin to generate hypotheses about the meanings and functions of the symptom of school refusal for any specific family. This could also provide information on if and how the symptom is maintained by family members. While it would be difficult to standardize such an assessment--not to mention obtain the necessary authorizations to conduct one--it could provide a depth of focus the various lenses used in this study could not achieve.

In addition, more information about actual family constellations--for example, whether the father was in the home, extent of contact, etc.--could have provided a useful context for the apparent disparity in perceptions of mothers and fathers as assessed by the Parental Bonding Instrument.

In order to better understand the developmental significance of the symptom in individual cases, it would have been helpful to know at what age school refusal developed. An inquiry into stressors on family members in the months preceding the outbreak of the symptom could have yielded information on its meaning for an individual and his family, as well as providing hints as to why the subject might have "chosen" school refusal as a symptom.

Finally, an important aspect of family functioning, and one potentially with particular

relevance to school refusal, is subtle or frank parental psychopathology. A comprehensive view of school refusal as a syndrome would probably require an independent measure of parental--and particularly maternal--psychological disturbance.

APPENDIX 1

The PBI, attachment, and object relations theories

The PBI was developed in 1979, when attachment theory was already well established. In the opening paragraph of the article introducing the PBI, the authors cite the originator of attachment theory, and appear parenthetically to take for granted one of the theory's major tenets (Parker, Tupling & Brown, 1979).

> The concept of a 'bond' between a parent and a child is generally accepted despite, as Bowlby (1969) and Rutter (1972) have indicated, the lack of a satisfactory definition of the concept. Theoretically, it might be proposed that parent-child bonds would be broadly influenced by characteristics of the child (e.g. individual differences in attachment behaviour), characteristics of the parent or care-taking system (e.g. psychological and cultural influences) and by characteristics of the reciprocal, dynamic and evolving relationship between the child and the parent (p.1).

While it contains a pair of perfunctory acknowledgments of attachment theory and theorists, on reflection this citation seems something of a back-handed compliment. It badly misconstrues a central point of attachment theory, that attachment behavior is not best understood as one of many "characteristics of the child" (which would seem to make it more nearly an aspect of temperament) but rather a dynamically emergent property of the relationship between caregiver and child (Sroufe, 1985). Parker et al.'s way of putting things appears to marginalize "attachment

behavior" to make way for a consideration of "the reciprocal, dynamic and evolving relationship between the child and the parent", a fair definition of what attachment researchers thought they were investigating. This body of literature is brushed aside in the next sentence.

> While that reciprocal interrelationship has resisted definition it is probably fair to suggest that most research has examined the influence of single variables instead of attempting to identify the principle dimensions of bonding.

While it may indeed have "resisted definition", attachment researchers have taken a fair crack at defining "that reciprocal interrelationship" between child and parent, and their findings merit more explicit mention in such a context. While Parker goes on to cite findings of Ainsworth, Bell and Stayton (1975) with respect to "dimensions of maternal behaviour which were reflected in the balance of attachment and exploratory behaviour" in children, he elucidates neither the theory in which their inquiry was embedded, their original and widely replicated empirical method, nor the system for classifying patterns of attachment which Ainsworth and colleagues developed.

Parker nowhere defines what he means by "bonding", but in places he appears to use the term interchangeably with "attachment".

> In reviewing the literature on parental qualities associated with normal development Rutter (1972) isolated characteristics said to be necessary for adequate mothering: a loving relationship, leading to an unbroken attachment to one specific person in the family who provides adequate stimulation. (p.1).

Yet the terms bonding and attachment are not interchangeable, as a contemporaneous, thoughtful article by Campbell and Taylor makes clear (1979). While bonding "is used most often to refer to a rapid process, occurring immediately after birth . . . . the term attachment has come to refer to a hypothetical construct reflecting the quality of the affectional tie between infant and parents, especially mother, that develops gradually during the first year of life." Moreover,

> Bonding is primarily unidirectional [parent to infant], rapid (within the first hours or days after birth), and facilitated or optimized by physical contact. Attachment, on the other hand, is reciprocal [mother to infant and infant to mother], develops gradually during the first year of life, and is influenced by psychological variables such as the quality, timing, and pacing of adult-child encounters (p.3).

Plainly Parker is not talking about bonding in the above, limited, conventional sense. His usage is broader, more congruent with what other theorists have meant by "attachment". Similarly, the time-frame he is investigating is quite a bit wider than the one most writers consider appropriate for a consideration of "bonding". In its original form, the PBI inquires into

"various attitudes and behaviours . . . . [a]s you remember your Mother/Father in your first 16 years." While attachment is considered to emerge within the first year, attachment status has been found to be psychologically relevant and remarkably stable through childhood, adolescence, and adulthood (Sroufe, 1987; Slade, 1987; Main & Goldwyn, 1984; Kobak & Sceery, 1988).

Having castigated Parker for the imprecision of his definitions, we need to be explicit about what is meant by "attachment". A full review of the literature would be out of place here, but salient points will be summarized.

Attachment theory, which owes much to ethological observations of and theory about nonhuman primates, posits attachment as a biologically based behavioral system that is primary rather than derived from associating mother with food or sensual gratifications (Bowlby 1969, 1973, Sroufe 1986). Though the originator of attachment theory, John Bowlby, was himself a psychoanalyst, attachment theorists and researchers have been at pains to distinguish their position from that of psychoanalytic developmental theory, which in their view errs in emphasizing the importance of drives and zonal pleasures in the development of the relationship between infant and caregiver. "Not . . .

oral gratification but overall quality of care (availability, responsiveness) is the central issue for the infant" (Sroufe 1986, p. 841). (Whether attachment theorists have fairly represented psychoanalytic developmental theory, especially in its later formulations, is debatable, but addressing it in full is beyond the scope of this study; selected aspects of the issue will be taken up below, however).

Researchers have categorized different patterns of attachment relationship. The most important distinction is between a secure and an insecure pattern. Securely attached infants (about two-thirds of most white, middle-class, two-parent samples) turn to their mothers when in distress and successfully derive comfort; insecurely attached infants do so less readily and/or less effectively. Insecure-avoidant infants tend to ignore or actually shun mother, on reunion following a separation for example; insecure-ambivalent infants do approach, but often with anger and tears, and are slower to be comforted.

Interestingly, having achieved the desired comfort, and secure in the expectation that the mother will be available should she be needed again, the securely attached child is then freed to resume adaptive, developmentally appropriate activities that do not directly involve the mother. Secure attachment,

in other words, is in important respects the opposite of a "clingy" relationship, and is associated with age-adequate independent functioning. Security of attachment, assessed at 12 months, has surprising stability, and correlates with measures of peer competence, persistence, and numerous other aspects of adaptive functioning.

Attachment researchers have focussed on what maternal behaviors tend to foster secure attachment. Sroufe's summary of their findings seems to articulate more fulsomely what Parker meant by "high care" and "low overprotection".

> Certain behavior patterns among caregivers appear to be linked with later secure attachment and competence among babies. At least half a dozen studies point to the same key characteristic, which is best described as responsiveness or sensitivity. Ainsworth's research has shown that highly sensitive mothers who are neither interfering nor rejecting consistently have infants who are secure in their attachment at 12 months.
>
> Good maternal care involves responding to the infant's signals promptly and effectively. When during face-to-face interaction the infant turns his head away, signaling that he needs less stimulation, the sensitive caregiver relaxes and waits. Not until the baby signals his readiness does she reengage him. When the infant cries, the sensitive caregiver responds warmly and affectionately . . . . She does not thrust interaction on an unreceptive infant. (Sroufe, 1978, p.96).

This passage makes clear the complementary relationship between (high) care (warmth, availability, affection) and (low) overprotection (non-interfering,

not thrusting interaction on an unreceptive infant). Bretherton (1987) sounds a slightly different emphasis, pointing up the distinctions between these two salient dimensions while uniting them under the rubric of "sensitivity".

> It is often overlooked that insensitivity as understood by Ainsworth is not necessarily indexed by unpleasant, rejecting, mean or nasty behavior. . . . It is insensitive to deny a distressed or fearful infant the solace of bodily contact (rejection), but it is equally insensitive behavior to insist on affectionate physical contact when the infant is deeply engrossed in some exploratory task (interference).

The qualities of interaction between mother and child which have been found to predict security of attachment appear, then, to be virtually homologous to the two factors tapped by Parker's Parental Bonding Instrument. This is noteworthy, in that it places the questionnaire findings in a larger context, and establishes the direct relevance to this study of a set of concepts and findings in the developmental and clinical literature which both illuminate and seek to challenge the conceptual frame that supports another main instrument of this study, the Rorschach object relations scales.

A few words of caution are in order. The PBI does not measure attachment directly, obviously. There is no way of knowing for certain from the questionnaire responses whether a specific individual should be

considered "secure" or "insecure" in his attachment. There are, however, good empirical and theoretical reasons to expect that a person who now considers his or her mother low in care and/or high in overprotection was insecurely attached as an infant, and continues to have problematic "internal working models" of attachment relations. (Just what may be meant by "internal working model", and how the concept compares with "object relations", will be discussed further below).

Having established, hopefully, the relevance of attachment theory to our findings, we would hope to find studies that are on point in the rich empirical literature on attachment. Thus far, however, attachment status has not figured as a variable in studies of adolescent clinical populations, for a number of reasons. Breaking away from the theoretical framework of psychoanalysis and its clinical data base, attachment researchers have for the most part looked at normative development. Until recently, the overwhelming majority of attachment studies focussed on middle-class infants of presumptively normal parents. The most widely used and reliable method for assessing attachment status, the Strange Situation, is valid only to the age of about 18 months. Recently, an "Adult Attachment Interview" has been used to assess the

"internal working models" adults have of attachment relationships, and in a very few studies this has been used with adolescents (Kobak & Sceery, 1988). Also, some authors have begun to explore some clinical implications of attachment theory (Belsky and Nezorski, 1988). No work has been published, however, investigating the impact of attachment status on an adolescent clinical population. By necessity our examination of these issues will remain exploratory.

While the relationship between attachment and psychopathology remains to be elucidated, a few things may be said about it. Plainly, if one-third of samples at low risk (e.g. middle-class, intact families) are insecurely attached, non-optimal attachment may not be equated with severe psychopathology, nor can it be considered to "cause" psychopathology, in and of itself. Many fewer children develop difficulties that would meet DSM-III-R symptomatic criteria, for example, or are referred for psychological treatment, than could be classified as insecurely attached. As longitudinal studies bear fruit, we may learn more about what sort of risk factor non-optimal attachment status may represent for the development of psychopathology, but to date no data are available.

We have argued that the Parental Bonding Instrument, in effect, provides a preconscious portrait

of the mother, specifically in her capacity as an attachment figure. Would it be fair to say that this also constitutes an object relations representation? If object relations are by definition unconscious, obviously not. But Greenberg and Mitchell (1983), in their survey of the field, provide a more inclusive definition. "In this book the term [object relations] refers to individuals' interactions with external and internal (real and imagined) other people, and to the relationship between their internal and external object worlds (p. 13)."

By these lights, it must be considered that attachment theory is beginning to develop a theory of object relations, though neither attachment researchers nor psychoanalysts would, for different reasons, be willing to call attachment theory an object relations theory. Until very recently, the tendency among psychoanalytic writers has been to respond to the enormous attachment literature with a yawn and the faintest of praise. In his 1985 book Developmental Theory and Clinical Process Fred Pine, second author of Margaret Mahler's seminal 1975 study, dismissed "systematic studies of development" as "aimed at discrete areas of function and lack[ing] the holistic view that I undertake here" (p.31). In their 408 page text on object relations theory, Greenberg and Mitchell

found room for three on Bowlby, characterizing him as having developed a model closely related to Fairbairn's work. While acknowledging that "Bowlby extends the concept of attachment to serve as the basis for a reconsideration of all basic areas within classical theory" (p. 185)--in no apparent order they mention anxiety, dependency, anger, the defenses, basic mood, and all significant relationships--and noting his efforts to ground his model in contemporary biology and ethology, they dismiss his theory as less than truly psychoanalytic, in a somewhat puzzling manner. "Because of these efforts to place psychoanalytic data within an extrapsychoanalytic framework, however, Bowlby's theory cannot stand as a distinctly and purely psychoanalytic model *per se*." (p.186).

More recently, some Freudian loyalists have adopted what Greenberg and Mitchell have dubbed the strategy of accommodation, trying to fit attachment research findings within the framework of classical theory while making putatively minor adjustments to the latter which, in fact, represent major and problematic innovations. Silverman (1991), for example, promotes attachment--idiosyncratically defined by her as "a positive, affective connection to caregivers, which leads eventually to an internalized object relations experience" (p.170)--to one of two apparently co-equal

"strands" in infant development (elsewhere she calls them "two separate instincts", p.171), the other being the more psychoanalytically conventional "drive-organized" strand. This is effected by packing both strands under a renovated and expanded wing of the concept of self-preservative instinct(s), never as fully developed as libido theory by Freud (Greenberg and Mitchell, 1983), and largely abandoned by him after Beyond the Pleasure Principle (1920). This move involves, however, detaching the establishment of object relations from experiences of drive satisfaction, that is, overturning a fundamental principle of Freudian theory. The resulting model seems neither fish nor fowl.

> Activation of the attachment system is a primary experience of the infant, and it gradually gets internalized as structure. . . Or, described in another way, it is a powerful psychobiological system that motivates behavior and leads to internalized mental representations of interactional object relational experiences. These representations can get distorted when they are caught up in drive-defense compromise formations and then the drives can color, invade, and deform internal object relational representations. Attachment behavior, too, can get expressed through drive gratification, and can also inhibit or distort drives and defenses.
>
> . . . . It should be borne in mind that typically, drive-defense and object relations patterns intertwine (184).

What is typical and normative, what is pathological? If "typically, drive-defense and object relations patterns intertwine", what does it mean to

say that "internalized representations of interactional object relational experiences . . . can get distorted when they are caught up in drive-defense compromise formations"?

With reference to Greenberg and Mitchell's dismissal of attachment theory cited above, it was not Bowlby's intention, and certainly not that of the researchers who have expanded on his work, to develop a distinctly and purely psychoanalytic model *per se*; they thought they were building on a much broader base. For their part, however, the attachment researchers have been almost equally grudging in acknowledging the efforts of object relations theorists who came before them to understand the phenomena attachment researchers have approached from a different angle. Ainsworth (1969) surveyed all of psychoanalytic object relations theory from Freud through ego psychology to the British School--offering one paragraph each on Klein, Balint, Winnicott, and Fairbairn--and concluded, "The main theoretical accounts of . . . development--psychoanalytic and learning theories--framed what now seem to be naive hypotheses as deductions from their larger theoretical framework without adequate preliminary naturalistic exploration" (1969).

Yet more recently, as they consider problems of development beyond infancy, the attachment theorists

seem to be rediscovering some of the concepts put forth most eloquently by psychoanalytic writers. After giving relatively short shrift to Fairbairn and Sullivan, Bretherton (1987) offers a more thoughtful appreciation of Mahler. While dismissing her concept of a normal autistic phase, she notes with approval that "Mahler's description of optimal maternal behavior during the symbiotic period (after 2 months and before locomotion) is strikingly congruent with attachment theory" (p.1075). Bretherton distinguishes, however, between Mahler's model of representation of the mother and that of attachment theory, criticizing the former as "static" and predominantly operative only when the mother is absent, in contrast to the latter, which posits "a working model that helps the child forecast mother's behavior whether she is present or absent." Later she reframes the psychoanalytic encounter in attachment terms, claiming that "What others have called empathy is really to enter into another's working models" (p. 1089).

Yet in the terms she uses, and in all that she leaves out of consideration, Bretherton does little to disconfirm Greenberg and Mitchell's critique of attachment theory as non-psychoanalytic. Her language--like that of Daniel Stern, whose research she cites approvingly--owes more to cognitive psychology than to

psychoanalysis; at times it becomes as de-natured, far from experience and "mechanistic" as the anything in psychoanalytic metapsychology ("Under certain circumstances, executive plans may be interrupted or disrupted by motivational systems that regulate survival-promoting behavior", p. 1093).

Moreover, "internal working models" may or may not be unconscious; the distinction does not appear to interest Bretherton much. The key question for her is how adaptive they are--and this brings attachment theory back around to points of contact with ego psychology. Yet here, too, the language becomes as experience-distant as a computer manual: "The executive or operating system (the _I_) processes inflow and outflow serially or sequentially by monitoring and controlling information from and to many lower-level processors that operate in parallel" (p. 1093). What is striking here is the apparent lack of awareness that a metaphoric language is being used. Is this implicit model of the brain/mind-as-computer so much more advanced, scientific, realistic, or humane than the vehemently discarded Freudian model of mind as a dynamic, closed, energy system?

As its research program leads it on toward later stages in child and adult development, attachment theory is having to accommodate a much wider data base

and more complex behavioral and mental phenomena than can be captured or conceptualized by, for example, the classifications of "Strange Situation" behavior. It remains to be seen whether the hegemonic thrust of the theory and theorists as they attempt to assimilate to their paradigm the clinical and theoretical contributions of those who went before will result in an enrichment or a flattening of the territory.

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