the etiology and treatment of childhood

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Childhood is a syndrome which has only recently begun to receive serious attention from clinicians. The syndrome itself, however, is not at all recent. As early as the 8th century, the Persian historian Kidnom made reference to "short, noisy creatures," who may well have been what we now call *children.* The treatment of children, however, was unknown until this century, when so-called "child psychologists" and "child psychiatrists" became common. Despite this history of clinical neglect, it has been estimated that well over half of all Americans alive today have experienced childhood directly (Suess, 1983). In fact, the actual numbers are probably much higher, since these data are based on self-reports which may be subject to social desirability biases and retrospective distortion.

The growing acceptance of childhood as a distinct phenomenon is reflected in the proposed inclusion of the syndrome in the upcoming Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, or DSM-IV, of the American Psychiatric Association (1985). Clinicians are still in disagreement about the significant clinical features of childhood, but the proposed DSM-IV will almost certainly include the following core features: 1. Congenital onset, 2. Dwarfism, 3. Emotional lability and immaturity, 4. Knowledge deficits, and 5. Legume anorexia.

CLINICAL FEATURES OF CHILDHOOD

Although the focus of this paper is on the efficacy of conventional treatment of childhood, the five clinical markers mentioned above merit further discussion for those unfamiliar with this patient population.

Congenital Onset

In one of the few existing literature reviews on childhood, Temple-Black (1982) has noted that childhood is almost always present at birth, although it may go undetected for years or even remain subclinical indefinitely. This

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observation has led some investigators to speculate on a biological contribution to childhood. As one psychologist has put it, "We may soon be in a position to distinguish organic childhood from functional childhood" (Rogers, 1979).

Dwarfism

This is certainly the most familiar clinical marker of childhood. It is widely known that children are physically short relative to the population at large. Indeed, common clinical wisdom suggests that the treatment of the so-called "small child" (or "tot") is particularly difficult. These children are known to exhibit infantile behavior and display a startling lack of insight (Tom & Jerry, 1967).

Emotional Lability and Immaturity

This aspect of childhood is often the only basis for a clinician's diagnosis. As a result, many otherwise normal adults are misdiagnosed as children and must suffer the unnecessary social stigma of being labeled a "child" by professionals and friends alike.

Knowledge Deficits

While many children have IQ's within or even above the norm, almost all will manifest knowledge deficits. Anyone who has known a real child has experienced the frustration of trying to discuss any topic that requires some general knowledge. Children seem to have little knowledge about the world they live in. Politics, art, and science—children are largely ignorant of these. Perhaps it is because of this ignorance, but the sad fact is that most children have few friends who are not, themselves, children.

Legume Anorexia

This last identifying feature is perhaps the most unexpected. Folk wisdom is supported by empirical observation—children will rarely eat their vegetables (see Popeye, 1957, for review).

CAUSES OF CHILDHOOD

Now that we know what it is, what can we say about the causes of childhood? Recent years have seen a flurry of theory and speculation from a number of perspectives. Some of the most prominent are reviewed below.

Sociological Model

Emile Durkind was perhaps the first to speculate about sociological causes of childhood. He points out two key observations about children: 1) the vast majority of children are unemployed, and 2) children represent one

of the least educated segments of our society. In fact, it has been estimated that less than 20% of children have had more than a fourth grade education.

Clearly, children are an "out-group." Because of their intellectual handicap, children are even denied the right to vote. From the sociologist's perspective, treatment should be aimed at helping assimilate children into mainstream society. Unfortunately, some victims are so incapacitated by their childhood that they are simply not competent to work. One promising rehabilitation program (Spanky & Alfalfa, 1978) has trained victims of severe childhood to sell lemonade.

Biological Model

The observation that childhood is usually present from birth has led some to speculate on a biological contribution. An early investigation by Flintstone and Jetson (1939) indicated that childhood runs in families. Their survey of over 8,000 American families revealed that over half contained more than one child. Further investigation revealed that even most non-child family members had experienced childhood at some point. Crosscultural studies (e.g., Mowgli & Din, 1950) indicate that familial childhood is even more prevalent in the Far East. For example, in Indian and Chinese families, as many as three out of four family members may have childhood.

Impressive evidence of a genetic component of childhood comes from a large scale twin study by Brady and Partridge (1972). These authors studied over 106 pairs of twins, looking at concordance rates for childhood. Among identical or monozygotic twins, concordance was unusually high (.92), i.e., when one twin was diagnosed with childhood, the other twin was almost always a child as well.

Psychological Models

A considerable number of psychologically-based theories of the development of childhood exist. They are too numerous to review here. Among the more familiar models are Seligman's "learned childishness" model. According to this model, individuals who are treated like children eventually give up and become children. As a counterpoint to such theories, some experts have claimed that childhood does not really exist. Szasz (1980) has called "childhood" an expedient label. In seeking conformity, we handicap those whom we find unruly or too short to deal with by labeling them "children."

TREATMENT OF CHILDHOOD

Efforts to treat childhood are as old as the syndrome itself. Only in modern times, however, have humane and systematic treatment protocols been applied. In part, this increased attention to the problem may be due to the sheer number of individuals suffering from childhood. Government statistics (DHHS) reveal that there are more children alive today than at any

time in our history. To paraphrase P.T. Barnum: "There's a child born every minute."

The overwhelming number of children has made government intervention inevitable. The nineteenth century saw the institution of what remains the largest single program for the treatment of childhood—so-called "public schools." Under this colossal program, individuals are placed into treatment groups based on the severity of their condition. For example, those most severely afflicted may be placed in a "kindergarten" program. Patients at this level are typically short, unruly, emotionally immature, and intellectually deficient. Given this type of individual, therapy is of necessity very basic. The strategy is essentially one of patient management and of helping the child master basic skills (e.g., finger-painting).

Unfortunately, the "school" system has been largely ineffective. Not only is the program a massive tax burden, but it has failed even to slow down the rising incidence of childhood. Faced with this failure and the growing epidemic of childhood, mental health professionals are devoting increasing attention to the treatment of childhood. Given a theoretical framework by Freud's landmark treatises on childhood, child psychiatrists and psychologists claimed great successes in their clinical interventions.

By the 1950s, however, the clinicians' optimism had waned. Even after years of costly analysis, many victims remained children. The following case (taken from Gumbie & Pokey, 1957) is typical.

> Billy J., age 8, was brought to treatment by his parents. Billy's affliction was painfully obvious. He stood only 4' 3" high and weighed a scant 70 pounds, despite the fact that he ate voraciously. Billy presented a variety of troubling symptoms. His voice was noticeably high for a man. He displayed legume anorexia and, according to his parents, often refused to bathe. His intellectual functioning was also below normal—he had little general knowledge and could barely write a structured sentence. Social skills were also deficient. He often spoke inappropriately and exhibited "whining behavior." His sexual experience was non-existent. Indeed, Billy considered women "icky."
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> His parents reported that his condition had been present from birth, improving gradually after he was placed in a school at age 5. The diagnosis was "primary childhood." After years of painstaking treatment, Billy improved gradually. At age 11, his height and weight have increased, his social skills are broader, and he is now functional enough to hold down a "paper route."

After years of this kind of frustration, startling new evidence has come to light which suggests that the prognosis in cases of childhood may not be all gloom. A critical review by Fudd (1972) noted that studies of the childhood syndrome tend to lack careful follow-up. Acting on this observation, Moe, Larrie, and Kirly (1974) began a large-scale longitudinal study. These investigators studied two groups. The first group comprised 34 children currently engaged in a long-term conventional treatment program. The second was a group of 42 children receiving no treatment. All subjects had been diagnosed as children at least 4 years previously, with a mean duration of childhood of 6.4 years.

At the end of one year, the results confirmed the clinical wisdom that childhood is a refractory disorder—virtually all symptoms persisted and the treatment group was only slightly better off than the controls. The

results, however, of a careful 10-year follow-up were startling. The investigators (Moe, Larrie, Kirly, & Shemp, 1984) assessed the original cohort on a variety of measures. General knowledge and emotional maturity were assessed with standard measures. Height was assessed by the "metric system" (see Ruler, 1923), and legume appetite by the Vegetable Appetite Test (VAT) designed by Popeye (1968). Moe et al. found that subjects improved uniformly on all measures. Indeed, in most cases, the subjects appeared to be symptom-free. Moe et al. reported a spontaneous remission rate of 95%, a finding which is certain to revolutionize the clinical approach to childhood.

These recent results suggest that the prognosis for victims of childhood may not be so bad as we have feared. We must not, however, become too complacent. Despite its apparently high spontaneous remission rate, childhood remains one of the most serious and rapidly growing disorders facing mental health professionals today. And, beyond the psychological pain it brings, childhood has recently been linked to a number of physical disorders. Twenty years ago, Howdi, Doody, and Beauzeau (1965) demonstrated a six-fold increased risk of chicken pox, measles, and mumps among children as compared with normal controls. Later, Barby and Kenn (1971) linked childhood to an elevated risk of accidents—compared with normal adults, victims of childhood were much more likely to scrape their knees, lose their teeth, and fall off their bikes. Clearly, much more research is needed before we can give any real hope to the millions of victims wracked by this insidious disorder.

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You grow up the day you have your first real laugh—at yourself.—*Ethel Barrymore*