PSYCHOGENIC FACTORS IN THE ALLERGIES OF CHILDREN:


by

MARGARET ISLES PURDIE

Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of MASTER OF SOCIAL WORK in the Department of Social Work

1950

The University of British Columbia
ABSTRACT

The purpose of this study is to examine the psychogenic factors involved in the allergies of children, and to determine the area in which the social worker can contribute to the treatment of allergic children. It is intended to define (a) the limitations of this area of function as well as the limitations of the doctor's function; (b) the ways in which the doctor and the social worker can work together in the interests of these children; and (c) some of the types and methods of treatment that the social worker can use in treating allergic children.

Literature on the subject has been consulted; but the essential material of the study is derived from an analysis of cases. The study group is made up of seventy clinical cases, who have been receiving medical services over periods of from one month to two years. Eighteen of these cases have received, in addition, casework services for approximately the same period. Where there is more than one record concerning the same patient, all available material has been used. For all those cases referred to social workers, an adequate social history of the child's personality and family background is available, and for the remainder of the seventy cases use is made as far as possible of the limited information on the child's background. The age limits of the group are from birth to sixteen years of age.

This study has resulted in four major conclusions. (1) Psychogenic elements in the allergies of children appear to be particularly evident. (2) Allergic disorders create additional family tensions, thereby hampering adequate treatment, as well as the general adjustment of the child concerned. (3) The present resources for the diagnosis and treatment of allergic children in Vancouver lack adequate means of dealing with the psychogenic elements in these illnesses. (4) The social worker is equipped to deal with the psychogenic elements in illness, and she can, therefore, play an important role in assisting with diagnosis and treatment.

This study of the psychogenic factors of allergies in children helps to clarify the role that social work must play in an adequate treatment programme, and it indicates the need for further research into this particular area of allergic disorders both as regards prevention and treatment.
ACKNOWLEDGEMENTS

I wish to express my sincere thanks to the following persons for their invaluable assistance in the preparation of this thesis:

Dr. L.C. Marsh for many helpful comments and suggestions, and for constructive criticisms.

Miss Margaret Johnson for stimulation and guidance throughout the period of writing.

Miss Olive Cotsworth and Miss Eleanor Bradley of the Social Service Department of Vancouver General Hospital, for their cooperation in the selection of cases and organization of the study group.

Mrs. Janet A. Mill and Mrs. Dorothy Purdie, for their criticisms of the text, from a lay-man's point of view, and for proof-reading each revision.

I am also indebted to the many friends who have reviewed various sections and given the moral support which has rendered this thesis possible.

June, 1950

Margaret I. Purdie.
# Table of Contents

Chapter I. Part 1. The Problem of Allergies in Children

Allergies and Allergens: medical aspects; emotional aspects. Various views on the causes of allergy. No one factor contributes to cause.

Part 2. The Focus and Method of the Study

Focus of the present study. Clinic setting of study group. Methods used. Preliminary survey of the field. Reasons for final choice of group. Objectives of the study.

Chapter II. The Significance of Allergies to Children


Chapter III. Personality Patterns of Allergic Children

The need to understand personality make-up. The abnormally withdrawn child. The abnormally aggressive child. The "normal" child. The part social work can play.

Chapter IV. Parental Relationship and Attitudes

The patient belongs to a family. Lack of family equilibrium. Parental emotional problems. Traumatic experiences. Symptoms which indicate maladjustment. The need for family study by the social worker.

Chapter V. Diagnostic and Therapeutic Facilities for Children with Allergies


Appendices:

A. Classification of Common Allergies.
B. Bibliography.
PSYCHOCGENIC FACTORS IN THE ALLERGIES OF CHILDREN:


Margaret Purdie
Chapter I


The group of ailments commonly known as allergies are only recently being understood and examined from both the medical and emotional points of view. The word "allergy" was first coined in 1906, and means literally "altered force". It may be defined as an abnormal reaction or hypersensitivity to some substance or substances. The reaction may manifest itself in a variety of symptoms with a common pathology, which has as its principal characteristic an oedema of tissue or mucous membrane, and the stimulus may be any of a number of substances which have no apparent effect on the majority of people. The stimulus is commonly called an allergen.

Allergic reactions are usually of two distinct kinds, those of the respiratory system, for example asthma, hay fever, and vasomotor rhinitis, and those of the skin, such as eczema and urticaria. Headaches, diarrhea, enuresis and even appendicitis have been included in the allergic group of diseases by some authorities. Allergic conditions have much in common and they may occur singly, together, or in sequence. A common sequence is eczema, prurigo, and asthma. They are usually characterized by periodicity in attacks with a sudden onset and often an equally sudden cessation. Allergic changes take the form of a local oedema of the affected tissues, tissue infiltration with cells, and a tendency to smooth muscle spasm.

Allergic conditions may be so mild that they are no real problem to the persons suffering from them, on the other hand, they may be so severe that they make life a misery both for the sufferers and their
families. Allergies do not belong to the group of "great killers" like tuberculosis and cancer and since they are not infectious they are not a menace to public health in the usual sense. However, most allergic children are hampered in some way by their disorder. Children with severe allergies may be unable to play games and join in the social activities of their contemporaries. They miss a great deal of school because of the necessity of attending clinic regularly for an indefinite period, and many are continuously in and out of hospital, or have to remain at home. Those children with milder allergic disorders also have to attend clinic and may be required to give up their pets or discard former hobbies at home if the substances to which they are allergic are involved.

Medical diagnosis depends upon a carefully taken history, and the use of skin tests and elimination diets as an aid to finding the offending allergens. The only medical treatment that can then be offered at present is palliative. This may consist of eliminating the offenders where possible, or desensitizing the patient by giving him injections of small quantities of the material to which he is sensitive.

In some instances the allergens are substances outside of the body, such as the pollen of a variety of plants, the dander of animals, common house dust or some food substance, in which case, the disorder is termed "extrinsic". In other instances, the allergens are within the body itself, in which case, the disorder is termed "intrinsic". The latter may be due to bacterial infection, disturbances of the endocrine system, disturbances of the emotional system or faulty metabolism according to numerous authorities. Until recently it was generally thought that allergens were protein in nature, but tests have now proved that persons may become sensitized to such substances as plastic, glue, and rubber.

For some time, it has been believed generally that when an
allergen comes in contact with the sensitive body cells of an allergic person, a substance, known as histamine, is released spontaneously. This substance causes the symptoms of allergy. Since 1943, drugs have been developed to prevent the action of the histamine; such drugs are generally known as anti-histaminics. However, it must be pointed out that they are only palliative, as are all other drugs used for the medical treatment of allergy.

Why some people are allergic to one substance, others to something else, and the rest have no allergy at all, has not been determined, although, there have been many attempts to explain the mystery. Again, why one person reacts with asthma and another with skin rash to the same allergen, is another question which remains unanswered.

Hypocrates first recognized the significance of emotions in asthma. These emotions are now recognized in other allergic disorders and it is now known, to some extent, how they work and what can be done about them. Unfortunately, in recent years, the ability to identify specific allergens through the use of skin tests has resulted in a trend of highlighting this area and subordinating the emotional factors. Some doctors have been of the opinion that, if, persons knew what substances they were allergic to, all they would need to do would be to keep away from them. In reality this is feasible in some cases, but in other cases it would not be practical. For example, if one were allergic to ten different foods, the pollen of elm, oak, grass and ragweed, in addition to wool, housedust, flaxseed, and tobacco, it would be extremely difficult to avoid these substances in daily life. In any event, it has been noted that, in certain cases of allergy, patients may have an attack, as a result of an emotional stress, without actually contacting those substances to which they are sensitive. Others may find they can be exposed to their
allergens without suffering an attack at times when they are relieved of emotional conflict. Also, it has been found that certain allergic persons, who can tolerate a specific amount of their allergens before reacting to them, have this "threshold of tolerance" increased or decreased by the state of their emotions.

"Perhaps the psychosomatic relationship is never so obvious as in the work that has been done in recent years on hay fever and asthma. Dr. Leon Saul states the case when he offers the thesis that "the emotional state leads to physiological changes which either 1) imitate the allergic symptoms or 2) render the tissues more sensitive to allergies or 3) do both." Thus the choking brought on by a pollen may be intensified or relieved by the emotional state, and the choking originating in the state of the emotions may become worse because of the pollen."¹

Today, most authorities on the subject of allergies recognize that there are emotional aspects involved in allergic disorders which are of particular significance in determining the "threshold" of the allergic individual's sensitivity. Since these emotional aspects seem more obvious in allergies than in most illnesses, they are also not too difficult for a large number of lay people to accept, at least superficially. However, the social worker is trained to recognize the emotional factors involved in illness, and has the skills to deal with them. Because of the emotional aspect of allergic disorders, and the fact, that most doctors have neither the time nor the interest to examine this area, it would seem, then, that the social worker can be most helpful in assisting with the diagnosis and treatment of these disorders.

¹ Dunbar, Dr. Flanders, Mind and Body: Psychosomatic Medicine, Random House, New York, 1947, p.177.
It should be recognized that since the focus of this study is specifically upon children with allergies, a special problem exists, in considering the emotional aspects of their disorders. Children are very much more concerned with themselves and their relationships with their immediate families than are the average adults, whose emotional lives are directed towards the outside world. Also, it must be remembered that the emotional lives of children are different at almost every age level, from birth to sixteen years (the age limitations of the study group in this thesis).

The emotional development of allergic children can easily be upset by the feeling of "specialness" they will no doubt develop as a result of all the medical attention they receive and the necessary special arrangements that must be made for them at home. Such children may also tend to use the disease for their own advantage, for example, in getting out of duties they dislike, or in seeking the attention of others.

All allergies are of a particularly uncomfortable nature, and they result in tensions which only add to the vicious circle of causes. For instance, asthma causes considerable fear in some children who have severe attacks. The helpless choking sensation tends to make such children more dependent upon the mother than are other members of the family, which aggravates the situation again. Asthma and hay fever result in irreversible changes in body structure after a certain period of time thereby hampering children for life.

Numerous medical and psychological studies have been made in a search for the basic causes of allergy, but as yet there is very little factual material on the subject. The theories vary, but at present, the majority of those who have made medical studies, feel that hereditary predisposition is a strong factor. Studies have shown that one-half to
two-thirds of the cases have a history of allergy in the family. It has been suggested that transmission from parent to child may occur through either the germ plasm or the placenta. It is thought however, that though the allergic tendency may be prenatal in origin, the actual manifestations of allergy and the offending allergens generally depend upon post-natal factors. One medical authority states that "The site and type of reaction is frequently consequent upon some local strain or injury, and the selectivity of the allergy generally follows repeated or continuous contact with some factor of diet or environment."1.

There is a large body of professional opinion to the effect that psychogenic factors play a major part in the causes of allergy. It is suggested that in the many cases where there is a marked family history of allergy, a form of pseudo-heredity may be in operation.

"...namely, the manner in which a child can absorb the behavior pattern of some member of the household to whom it is intimately attached and then...imitate the illness of that particular person. Because the person is a blood relative we often think of this relationship as an hereditary one when it is in truth an environmental problem dating back to the earliest days of infancy."2

However, the view is still tenable that the predisposition to allergic disorders is acquired by means of true heredity.

Many psychological and psychoanalytical studies have been made of the relationship between emotions and allergic disorders, and neurotic trends have been recognized in a large proportion of the cases studied.

2. Weiss, Dr. Edward, and English, Dr.O. Spurgeon, Psychosomatic Medicine, W.B. Saunders Company, Philadelphia, 1943, p.495.
However, until recently, any neuroses in allergic persons have been generally thought to be due to the disorder, rather than causally related to it, as is now held, to be the case by the psychoanalysts. Such results as the following are offered by this group as partial proof of their theory.

In a recent study of forty asthmatic patients by Drs. Ethan Allan Brown and Lionel Goitein at the New England Medical Center in Boston it was found that only 57% of the patients possessed what might be regarded as normal personalities. Curiously, 39% of the patients were left-handed and 12% were ambidextrous.¹

The many psychoanalytical studies of allergy have indicated that certain specific emotions seem to be linked to the different forms of allergic reaction. For example, in asthma and hay fever, it has been noted that there is a conflict about longing for mother love. It is suggested that, given a predisposition to allergic disorders, children who suffer from abnormal mother-child relationships could conceivably develop the illness. It has been suggested also, that since asthmatic children seem to cry less than others of their age, asthma may be a substitute for suppressed weeping. Such children are said to be very dependent and have a strong fear of losing the mother, or of losing her affections in favour of younger siblings.² They also seem to fear her anger at times when they express a sexual curiosity.

It is often stressed by the psychoanalytic group that the results of psychotherapy are strong evidence of the importance of psychic factors in allergy. Psychotherapy has been used with success in many cases of asthma and it has been found that in some instances it reduces the number and severity of attacks, while in other instances, this type of treatment has resulted in a total elimination of symptoms.

². Brothers and sisters.
Skin allergies have been described by this group as a conflict between desire for affection and a fear of being hurt in seeking this affection. The skin is highly responsive to emotional feeling as can be illustrated in pallor, blushing and perspiration. It is suggested that skin allergies are also linked to specific emotions. Eczema and its related allergies generally appear in young children, and have usually been connected with the earliest mother-child relationship. However, not such an intensive study has been made in this area as in the case of asthma.

A summary statement by Dr. Leon Saul, which has been quoted elsewhere,\(^1\) runs as follows:

"On the basis of studies now available on the role of emotions in allergic symptoms, the working hypothesis is presented that states of repressed, intense frustrated longing are of central importance. This was found in studies of certain cases of common cold, asthma, hay fever, and urticaria. The choice of sites for the symptoms seems to be determined by more specific factors. But whatever the factors in the choice of site for the symptom the repressed longing, basically for the mother, frustrated or threatened with frustration, plays a central role. The longing is only one factor in the production of the symptoms. It operates in some cases independently of, and in other places together with, specific allergic sensitivities. It is related to allergic sensitivity perhaps through increasing this sensitivity in the individual. It also operates apart from the allergens by producing similar symptoms. It is a biological factor which apparently influences and complements allergic sensitivity at least in certain cases."

It is as yet, the most favoured opinion, that the psychological element should not necessarily be thought of as the cause of these illnesses, but rather as a means of increasing the likelihood of allergic manifestations in an otherwise predisposed individual. No one factor

\(^{1}\) Weiss, Dr. Edward, and English, Dr. O. Spurgeon, *Psychosomatic Medicine*. The clinical application of Psychopathology to general Medical Problems. W.B. Saunders Company, Philadelphia, p. 501
contributes to the cause of an illness, and this fact applies to allergies as it does to any other illness. It would seem that a combination of hereditary predisposition, constitution, emotional factors and environmental factors are involved in the causes and manifestations of allergies.
Part 2. The Focus and Method of the Study.

The focus of this study is concerned with the area in which the social worker can function in treating cases of allergy in children. It is intended to define the limitations of this area of function as well as the limitations of the doctor's function, and to show the ways in which the doctor and the social worker can work together in the interest of the patient. The types and methods of treatment the social worker can use, in working with allergic children, will also be discussed.

In every case, the patients, whose records have been used for the purposes of this study, have been attending the Allergy Clinic of the Health Centre for Children at the Vancouver General Hospital, and have an established diagnosis of allergy. The word "case" is employed to designate one child who has received or is currently receiving treatment. In some instances there may be more than one record concerning the same patient, and where this occurs all available information is used. The study group is made up of seventy cases who have been receiving medical services over a period of from one month to two years. Eighteen of these cases have been referred to the Social Service Department and have been receiving casework services for approximately the same period. Cases referred to the Social Service Department are submitted by the doctors because of their perception of a problem which should be handled by a social worker. Both this act and the case referred are usually named "a referral".

The Health Centre for Children is an outpatient clinic serving children from those newly born up to the age of sixteen. Financial eligibility is confined to those families whose income is below $110 per month for a man, wife and one child, rising by $20 for each child thereafter. This is over and above family allowances. Borderline cases are given special consideration by the social worker, who admits all patients
and eligibility may be altered temporarily on account of debt, illness and other personal difficulties. All facilities in the Health Centre are entirely free to eligible patients. This service is available only to residents of British Columbia. The cases used in the study group are of all ages within the limits specified and there is some slight variation in their financial status.

In addition to a paediatric clinic, varied specialized clinics are held at the Health Centre and of the cases used in this study, many have been attending other clinics in addition to the Allergy Clinic. The Allergy Clinic is held one afternoon per week and is in the charge of two paediatric allergists (physicians specializing in allergy), who have, at their disposal, the best modern methods of medical diagnosis and treatment. Referrals can be made by these physicians to the Social Service Department of the Hospital.

The method used for this study has been that of case study, on an individual basis. Three of the cases referred to the Social Service Department were carried by the writer, and six of these cases were carried by social workers who were interviewed by the writer at various periods. The survey method of study has also been used for the total group. Two methods were open for using the material obtained. (a) to select significant data from the group referred to the Social Service Department, and either to substantiate it or to repudiate it from the observations of the larger survey; (b) to illustrate significant data selected from the whole group, through the use of case examples from the referred group. The latter was decided to be of the greatest value for thesis purposes because it was more comprehensive in scope.

Before the group selected for study was finally decided upon, numerous other groups of cases were considered, from a variety of social agencies, which serve allergic children in one capacity or another.
The Children's Aid Society of Vancouver had no cases available at present for study purposes, and the Vancouver Preventorium had no social work records available, their cases generally being dealt with by T.B. Social Service or other social agencies. The cases at the Child Guidance Clinic varied considerably in financial background, since there are no financial eligibility limits at this agency and the cases at the Children's Hospital were not a homogenous group for the same reason.

There are a number of reasons for which the group attending the Allergy Clinic at the Health Centre for Children has been finally selected. These are: (a) it is a controlled group with defined financial and age limits; (b) it is the most adequate clinic of its kind in Vancouver from both the medical and social work points of view; (c) it is the only clinic which specializes in allergies in the city; (d) the same doctors and usually the same nurses attend the children; (e) it now has the services of its own social worker.

No attempt is made in this study to explain the causes of allergy. Rather, it is intended to ascertain the emotional and social problems that are related to allergic illnesses in children by means of case analysis and the examination of written data from the previous studies. Thus, those persons who are interested in treating children with allergies may have a greater understanding of the problems involved, and the area in which the social worker can be of most assistance can be outlined. This will involve (1) a knowledge of the significance, or meaningfulness, which an allergic illness may have for the child, (2) a knowledge of the personality of the child and (3) some familiarity with the nature of his family relationships and environment. It is in this order that it seems best to approach the study and in each of the following three chapters, one of the above factors is discussed.
Chapter II

The Significance of Allergies to the Child.

The reasons for which allergic children commonly come to the social worker are because they are making abnormal uses of their allergies and not simply because they have an allergy. These children have basic personality problems, which may or may not have been originally caused by their allergic states, and they are using their attacks as a means of expressing their personalities. The particular uses that they make of their disorders depend, to a large extent, upon the significance that those disorders have for them. It would, therefore, seem necessary that some person with special insight for the purpose should make a study of significance, personality development and family relationships in every case to be treated. The medical social worker is equipped to deal with these tasks.

The social worker in the generalized social agency usually first sees the client in his family background with all the personal interrelationships and problems which may be involved. On the other hand, the social worker in the medical setting first sees the patient with an illness, which has some particular significance for him, then she considers personality make-up and family relationships. Therefore, in a study of the ways in which a social worker can be of most assistance in the treatment of the allergic child, it seems best to examine the subject in this order.

In analysing the significance of allergies to the child, it has been found in this study that there is an underlying similarity in the attitudes of allergic children toward their disorders, but to each one of these children the allergy has a different and special significance. The significance of the allergy to the child depends upon his particular

1. "His" refers to both sexes throughout the thesis except where specific cases are being discussed.
personality pattern, the severity and type of his allergy, his environment and the meaning his illness may have for those persons who are closest to him. A child who has a weak ego structure, or personality pattern, may use his allergy to a large extent as a defence against his weakness, or as an excuse for failure in other areas. His allergy may or may not have originally contributed to his weak personality pattern, but it will certainly continue to play into any weakness which may be there; or it may in itself, be an expression of an already weak personality.

To the child with a "normal" personality pattern, a mild case of vasomotor rhinitis or seasonal hay fever will be little more than a nuisance. On the other hand, a severe case of asthma will probably instil considerable fear in the same child as well as in other members of his family. The child with an "abnormal" personality pattern, for example, one with either an abnormally withdrawn or an abnormally aggressive nature, will be hindered to an even greater degree, and the allergy will probably be of considerable significance to him. If the attacks have any degree of severity they will mean something in particular to the child as a person, and consequently, they are certain to have some effect upon his functioning and personality. On the other hand, the reasons for his using these allergic attacks rather than some other means of expressing his feelings may be found in his basic personality formation.

The personalities and attitudes of the child's parents are of considerable importance, since it is in his relationships with them that he will either exploit or relinquish the hostile uses he may make of his disorder. If the parents have unconscious feelings of guilt because of their rejection of an allergic child, or because of their concern over the extent to which they are responsible for his condition, the child may play into this weakness through using his illness in a hostile manner. For
example, he may increase their guilt by his own suffering and the severity of his attacks, or he may seek an unnecessary amount of care and attention from parents who feel they must satisfy his desires as a compensation for their own hostile attitudes. Parents who are too wrought up in their own problems may sacrifice the interests of their healthier children for the sake of keeping peace with an allergic child.

The very nature of most allergies and their symptoms engender sympathy; such as the miserable discomfort and unsightly appearance of eczema, the acute aching of a migraine headache, and the fearful suffocation of an asthmatic attack.

The allergic child is often aware of the inconvenience of his illness to his parents. He may use this awareness to his advantage in many ways, and the parents can also use it as a compensation for their feelings of guilt, if they have rejected the child, or conversely as a means of satisfaction to them, if they enjoy the child's dependency. The parents may not have wanted the child in the first place, and the disorder with which he reacts to this situation only makes more work for them. For example, in the elimination of substances to which he is sensitive the parents must watch the food he eats, strip their home of such comforts as rugs, feather pillows and cushions, and keep house dust down to a minimum. These factors are likely to cause a strain in any home, and are disturbing to both parent and child.

It is obvious that the factors which have been discussed only make a vicious circle. The child's ailment is disturbing to the family. This, in turn, causes the family to use measures which intensify the development of personality difficulties in the child, consequently aggravating his physical symptoms.

In the interest of a good treatment plan, it is therefore, important to determine the meaning that a child's allergy may have for him.
Knowledge of its significance will aid the social worker in her plan for helping the child and his parents to overcome their problems, and it may assist in revealing those factors which precipitated the illness and the causes of its persistence. The child may use his allergy as (a) an attention-getting device, for example, on the arrival of a new sibling; or (b) he may use it as a means of avoiding tasks he dislikes. Other uses he may make of it are: (c) setting himself up as "different" from other members of his family; (d) as an excuse for his difference; (e) as a covering up of other weaknesses; (f) as an excuse for failure; (g) as a weapon; and (h) as a method of obtaining sympathy.

With her training in personality development and her understanding of the motivations of behaviour, the social worker can detect the uses a child may be making of his allergy and understand the causal factors. By means of discussion, over a reasonable period of time, she can then help the parents to understand the motivations of their child's behaviour and modify their own attitudes toward him. She may also work directly with the child and build up his ego strengths by taking a real interest in him as a person. Once he attains some feeling of his own personal worth, he should then be able to relinquish some of the hostile or aggressive uses he is making of his allergy. It is understandable that a child will only make hostile uses of his disorder so long as he is forced to do so through his own feelings of insecurity.

Among the eighteen cases referred to social workers, from the group under study, there are a multiplicity of uses made of a variety of allergic disorders. Eleven of these cases show strong evidence of their use of allergies as some form of attention-getting device. All children seek attention at some time, but these particular children appear to develop allergic attacks to serve this specific purpose. Children of varied personalities play up their disorders to a marked degree in their
search for attention both at home and at school. For illustrative purposes, three children with totally different personality patterns have been chosen. These are the abnormally aggressive child, the abnormally withdrawn child, and the "normal" child.

The first case is that of Warren F., who displays a certain amount of hostile aggression in his general personality pattern, as well as making use of his allergy for attention-getting purposes. Warren is an asthmatic boy of eleven years of age, the second of four children. His father, who is in poor health, is a truck-driver working irregular hours on a rather inadequate income, for a person buying a new house and keeping a large family. His mother is small and sickly and has little control over her children. She resents having to "keep down the dust" (meaning ordinary house cleaning), and make other special efforts for Warren. This attitude and lack of understanding only seems to aggravate the situation.

Warren is backward in comparison with most children. He has no constructive means of proving himself, such as in good school grades, or success at games; furthermore, he has not been encouraged by his parents to develop outside interests. As a result the boy uses his asthmatic attacks in order to obtain the attention he otherwise does not get from his parents at every opportunity. While away in a sanatorium four years ago, his asthmatic attacks were at a minimum. However, since his return from the sanatorium, and the arrival of a fourth child, his asthma has been worse, in spite of medications. When he has an attack his mother either ignores him or is strict with him, because "he babies himself" she says. It is as though he has never experienced the normal "babying" which is the need and right of every child, but rather, he has had to create this for himself and make pitiful attempts at obtaining it from his mother. It is small wonder that he uses his asthma and an aggressive manner as the only

1. These names are fictitious.
means by which he can get any kind of notice from the family.

In this case a social worker is taking an interest in Warren's activities through visits to his home and talks with him at clinic, and she is encouraging him to feel confident in himself through praising any little things he may do well, and in taking a personal interest in him. The cooperation of the parents is also being enlisted where possible, though this has been difficult in this particular case due to personality problems of long standing. This case can be considered partially improved because the child's symptoms have lessened; however, there is still much room for improvement in his general adjustment.

A slightly different example of attention-getting through the use of her allergy is evident in the case of Cathy G., who has a withdrawn personality pattern. Cathy is the eldest of four children and is now fourteen years of age. She suffers from asthma. Since she is four years older than the next child in the family, and they have suffered from years of illness and financial worry, Cathy has been left to care for herself a great deal. Her father is a chronic invalid and her mother has a physical condition which prevents her from working. Any interest in family affairs which Cathy may show is discouraged by her mother, who thinks she is "too young to understand", and at such times of tension her asthma increases in its severity.

Under the circumstances, the use Cathy makes of her allergy is only to be expected. She is pathetically eager to please anyone who shows the slightest interest in her, and when she is given consideration and responsibility, her attacks diminish in intensity. She was quite healthy and "normal" for a period when her mother was sick and the rest of the family had to depend on her for their care.

In this case a social worker is taking an interest in the child at clinic only, because the mother is unable to accept home visiting at
this time. Since the social assistance worker calls at the home, the mother connects this service with "charity". This is a new referral to the social worker at the clinic, but already Cathy is responding to the attention she is receiving. The worker is taking a personal interest in her hobbies and constructive pursuits, and is giving her every opportunity to discuss any problems she may have. An attempt is also being made to help the mother to overcome her own feelings of inadequacy and to understand those of her daughter. This is being done by commendation of the many positive contributions she has made toward the upbringing of her family, in spite of many difficulties. In addition she is being given the opportunity to discuss family problems in a setting which is acceptable to her.

The third case in this group is that of Sylvia A., a sixteen-year-old, who appears to have a "normal" outgoing personality. Her adjustment is good in all areas, except for the fact that she suffers from severe periodic attacks of asthma. She does not respond to ordinary medical treatment. Frequently, she is brought into hospital with a severe attack, and in a day she has no asthmatic manifestations whatsoever.

Sylvia's mother left her father soon after marriage and the child remained very close to her mother for a number of years. Her first asthmatic attack occurred at eight years of age, at the time her mother re-married, and the second attack two years later on the mother's third marriage to her present husband. Since this time Sylvia has had severe attacks on the arrival of new siblings and at times of family emotional tension. It seems obvious that her asthma is at its worst when her special position in her relationship with her mother is threatened and she is competing with others, especially with her step-father and siblings, for attention.

The reasons for Sylvia's need to use her illness in this way
are to be found in her basic relationship with her mother, which has been
established since birth. In some instances, the difficulty can be "worked
through" by a process of giving the patient insight into the reasons for his
difficulty. This process requires the establishment of complete confidence
in the worker by the patient, and an intensive study of the patient's
emotional and physical development since birth. For adequate results, it
is necessary that a social worker, who is skilled in the use of this process
of "insight therapy", handle the case. In addition, a considerable period
of time must be allowed. However, in this particular case, "environmental
therapy" was used with success. That is, Sylvia was placed in a foster
home and her asthmatic attacks ceased altogether. It should be pointed
out that, though the latter type of treatment is often preferable where
the difficulties are too deep-seated for removal without psychiatric help,
this treatment does not remove the basic causes of the symptoms and, there­
fore, recurrences may take place.

It has been stated that "Social Work concerns itself with human
beings where there is anything that hinders or thwarts their growth, their
expanding consciousness, their increasing cooperation."¹ There is a special
place for such a service in the medical setting where growth and cooperation
are essential to successful treatment and the readjustment of the patient
to a healthy and "normal" life. The service is usually called medical
social work when it is offered in the hospital or clinic setting. However,
the medical social worker uses the same method as does the social worker in
the family and children's agency. This is the "casework" method, which
seeks "to assist families and individuals in developing both the capacity
and the opportunity to lead personally satisfying and socially useful
lives."²

¹. Reynolds, Bertha C., "Social Case Work: What is it? What is its
Place in the World Today?" pp. 136-147 in Readings in Social Case Work,
1939, as quoted in: Social Work Year Book 1941, Ed. Russell H. Kurtz,
². Swift, Linton B., "The Purpose and Program of a Family Case Work
Agency", The Family, March, 1939, p. 3.
The only real attention that many allergic children ever receive is from the doctors, nurses, and social workers at the clinic. These children thoroughly enjoy their visits to the Health Centre for Children and make the most of them. Many compete with the other children for notice, and after a period of time, some even feel that they have established rights so far as the clinic is concerned. Since these children have to attend regularly for indefinite periods they are much better acquainted with the Centre than are children who attend the other clinics, and the staff are more familiar with them in turn.

This situation should offer an excellent opportunity for the social worker to help in this area. For example, she can make a thorough study of each situation and help the parents to supply at home the needs which their children are seeking at clinic. Good results obviously require time and the establishment of a good relationship between the social worker and the families concerned. Emotional factors will be involved in every case and in some there may be deep seated problems which will have to be dealt with on a casework basis before the people concerned are free to give their children the needs they require. For example, a mother who is overly dependent upon her own parents as a result of early over-protection from them, can hardly be expected to give her own children the security and affection they need for normal development.

Between one third and one half of the children in the group of cases who were referred to social workers obviously use their allergies either to cover up their feelings of inadequacy or as an excuse for weakness in other areas. These children often feel sorry for themselves and rationalize their situation by thinking that they would be able to do the things other children do if only they were well.

Bobby W., for instance, feels that his whole family, including
himself, is inadequate in comparison with those of other children. Bobby is a twelve-year-old asthmatic who lives in two rented rooms with his mother and great aunt. He is an only child. His mother left her own unhappy home at thirteen to work, and she has always been nervous and fears insanity. She married at twenty-six and soon after Bobby's birth, while she was ill in hospital, she learned that her husband still had another wife whom he had married a number of years before meeting her. She left him with the child and moved to this city. To this day she has not attempted to contact Bobby's father because of her intense pride, and she maintains herself and her son by doing day work. She is an extremely attractive woman who is accomplished in art; however, she now lives almost entirely in the past.

Bobby seems very much aware of his poor family situation and feels better if he has an acceptable excuse for it, which he seems to find in his asthma. With the help of his mother he has built up the story that they are only living here because of his allergy; that if it were not for this they would be living with his father. Out of her pathetic need and pride a defence for Bobby's weaknesses, has been contributed to, and the boy, realizing the sophistry of their story is unduly defensive of it. Bobby has a rather glorified picture of his father, who is an artist of considerable note, and he identifies with him in many ways, even though he has never seen him. He is unable to play games or attend camp because of his asthma, and he explains that he will be unable to enter a profession for the same reason. He has strong feelings about his home, his mother's work, and his lack of a father, and attempts to explain it all away with his allergy. He is even preparing for the lack of his desires in the future by explaining why he cannot have these things now. He talks as a much older person would of how he must avoid certain exerting occupations
and care for himself in various ways. Bobby's need to be always explaining things certainly points up his feelings that there are many ways in which he is deprived in comparison with other boys and girls of his age.

Bobby's mother has been receiving casework services from a social worker for some time, and considerable improvement is evident in her own social adjustment. She has been given support for her feelings of inadequacy through the worker's confidence in her ability to handle her own problems and to develop her own personality. By means of discussion, she has been helped to work through difficulties of long standing to a point where she can talk them over realistically with her son. In addition, she has been encouraged to take part in outside interests whenever possible. This mother is now taking an interest in people and the many activities going on around her, rather than dwelling entirely in the past. Her feelings of guilt have been lessened considerably, and she has a much greater understanding of her son's needs.

In cases, such as the one just outlined, where the causes of the problem lie mainly in the personality maladjustments of one or both parents, it is necessary to treat the parents as well as the child on a casework basis. Indirectly, the casework treatment of Bobby's mother relieves Bobby himself of a considerable amount of tension. However, his own problems are such that he requires direct casework treatment himself. A great deal more can be done in this case if the pattern of defence is not too deeply ingrained. Both mother and child should be helped to achieve the satisfaction of "normal" living and the status to which they are entitled.

Another boy with somewhat similar feelings to those of Bobby is Teddy M. Teddy is a fourteen-year-old, and the youngest of three children. He suffers from asthma, vasomotor rhinitis, and hay fever, and he had
eczema as an infant. His parents were never happy together and his father is now a patient in a mental institution. His mother is working as a waitress, and the family is living in two rented rooms.

Teddy is above average in intelligence, and has strong feelings about his inadequate home situation. He seems to be compensating for this to a certain extent in his illness. An intelligent boy, in a family situation such as he finds himself, must feel extremely hampered and hostile towards his parents, and he has every reason to use his illness as an escape. The clinic is his only outlet at present.

Teddy is always seeking acceptance from people, and he shows more self-assurance at clinic than anywhere else. It is here that a social worker should take the opportunity to develop in him some outside interests and a feeling of self-confidence. He will most likely relate quite well to her, and her acceptance of him alone should be of considerable therapeutic value since acceptance is one of his greatest needs. She can also help him to overcome some of his hostility toward his family through discussion of their problems. Also, if possible, the mother should be given some support in her rather difficult situation, and some help in the understanding of her child and his motivations.

It is noted that some allergic children tend to set themselves aside as being "different" from other children of their age or from their siblings. These children usually have some other interest which sets them apart, in addition to their allergy. For example, a child may be fascinated with art or music in a family where there are no other persons with such interests. He will withdraw from others and indulge in his special interest and his allergic symptoms. Cathy G., whose case was outlined earlier in this chapter, is very interested in art and prefers this occupation to playing with other children, or to profiting from other occupations. Bobby W., whose case was also recorded earlier in this chapter,
is so obsessed with his interest in art that he spends most of his time in school, drawing all over his books.

Allergic children, whose siblings and parents do not suffer from allergies, have been observed to use their illnesses alone to set themselves apart from others. This can be illustrated by the case of Ralph B., another asthma victim. Ralph, aged twelve, has a brother of thirteen, and a sister nine years of age. The family live in slum conditions, the father usually obtaining his living by irregular work out of town. He has deserted the family on several occasions. The mother suffers from anxiety and nervous tension and has recently attempted suicide. Both parents are mentally slow.

Ralph has sized up the family situation and remains independent of it so far as possible. He has little reason to be interested in his family, and they in turn seem too wound up in their own problems to be interested in him. He is above average in intelligence and recognizes his superiority to his parents and siblings in this area. For example, he does not associate with his brother's gang, but competes with his brother at school where he is able to display his superiority. It would seem that his asthma and attendance at clinic are probably the only outlets for his natural drives at present. The development of healthier outlets for intellectual drives would give him more personal satisfaction and relieve his family of some of the strain of his negativistic attitudes. This could be dealt with by a social worker with the aid of community resources. At the same time the basic reasons for his feelings of inadequacy should be analysed and dealt with.

A child who needs to use his allergic disorder in order to set himself apart from others must feel basically insecure and, therefore, needs the help of someone who is understanding of his feelings and able
to help him to make a better adjustment. The social worker must be able to offer to such a child adequate treatment, in addition to being able to diagnose his emotional problems.

A large number of the cases studied have been found to use their disorders at one time or another in order to get out of activities they dislike, or to avoid unpleasant tasks. There are some, for example Alice R., who make this a regular habit. Alice, age fifteen, is the second eldest in a family of four girls. She has suffered from a variety of illnesses, and has been admitted to hospital a number of times throughout her life. Recently she developed rhinorrhea and asthma with no organic findings. Her father, who was twenty-three years older than her mother, died at the time she developed these latter symptoms, and the mother thinks that this child has inherited a "weakness" from her father which makes her "different" from the rest of the family. The mother had an unhappy marriage, and she still resents her husband. The other children in this family appear to be normal and happy, but Alice is a very withdrawn child and is rather "homely" in appearance in comparison with her sisters.

This mother's certainty that her child can never do anything well, gives the child little opportunity for normal development. It is small wonder that she will not, and cannot, do anything for her mother; the only defence she has is her illness and she uses this to the limit. It would appear that she has always used sickness for this purpose, but on the loss of her father she has added asthma to her afflictions. The mother is unable to get Alice to help her in any way in the house, and when the mother becomes upset about it Alice develops an asthmatic attack. The mother complains that if she ever does get Alice to do anything, she is always clumsy about it. She cannot lift a plate without breaking it, then she either weeps or has an attack when she is upset.
In this case a social worker has been working with the mother in an attempt to help her to modify her attitudes toward her child. This has naturally involved some analysis of the mother's own personality, and an evaluation of her own needs, followed by some insight into the causes of her problems along with continued support. She appears to be carrying over those feelings she had toward her husband into her attitudes toward this child. This is possibly because Alice was particularly close to her father, and the mother's relationship with him was never good.

Casework has also been used with Alice in helping her to develop feelings of security through personal interest, and considerable improvement has been noted both in her symptoms and in her general adjustment. However, a great deal more work has yet to be done before she will be strong enough to discard the use of her allergy for getting out of tasks she dislikes.

Another common use that children make of their allergies is to obtain sympathy. This is sometimes tied in with a desire on their part to produce feelings of guilt in their parents or other people close to them. Each one of these children are saying: "if I am ill, you will be sorry you treated me the way you did." The desire for actual care and attention from the mother, in addition to sympathy, is naturally strongest in the child who is rejected or unwanted. For example, in the case of Mary I., a fourteen-year-old girl who suffers from hives and allergic dermatitis. She has two brothers over twenty who are away working, and her father is dead; so Mary and her mother live alone. They are supported by social assistance. The mother is an extremely tense person who seems convinced that she should never have had this last child because she was "too old". Now she feels, in addition, that the child is a burden to her.

This mother not only did not want her child in the first place,
but she is now saying: "see how much trouble you are to me," and is thereby making an even greater burden for herself. She makes a great deal of fuss over Mary's skin condition, and gets extremely upset when the child is given injections. She is either unable or unwilling to help Mary in other areas, for example, in music with which she is very interested, but she is able to spend hours nursing her skin. Mary naturally enjoys this care because it is the only way by which she can get it from her mother, and she most likely also gets some satisfaction out of the mother's concern for her. However, she is no doubt vaguely aware of her mother's compensating rather than sincere interest in her and is reacting to this also.

In speaking specifically of skin disease Dr. Flanders Dunbar says:

"The outstanding feature of the typical sufferer from skin disease is a deep-seated emotional conflict between desire for affection and a fear of being hurt if they seek it....Many of them are lonely people, even though they are surrounded by relatives and acquaintances....Despite the general leniency of the home environment, the skin sufferers have been hurt in childhood at the same time that they developed their strong craving for affection....Often they derive an exaggerated compensation from their illness, which makes it difficult for them to fight the disease. Their exhibitionism is soothed by the obvious signs of their ailment. Their desire for care is partly satisfied by the application of ointment and the hope of sympathy."¹

Because of the dependency needs of the allergic child and the strong ties to the mother, it is to be expected that the child will require more than the usual amount of love and affection in order that any sense of security may be gained or proof of adequacy acquired.

It is noted from the records that children also use their allergy as a weapon at times. There are many ways in which it can be used for this purpose. In the case of Jackie L. it has reached the point

¹ Dunbar, Flanders, M.D., Mind and Body: Psychosomatic Medicine, New York, Random House, 1947, p. 192.
where the child is playing for favourites between his own parents and the foster parents with whom he stays while he is in town receiving treatments from the clinic. Jackie L., aged twelve, is an asthmatic and the only child of two elderly parents. The father is a crippled and unhappy person who has withdrawn from society since his unemployment. The mother is an old-fashioned and kindly person who does day work in order to keep the family. The boy has been described as their "whole life". The family live in the country, and since Jackie must come to town for medical attention, he has been staying frequently with family friends. The boy is fond of these people, and they have been sympathetic of his ailment. Recently he has been declaring at home that these friends take better care of him and have more consideration for his illness than his parents, and he threatens to remain with the friends. The parents answer this by giving him gifts beyond their means. This pattern will continue unless the parents are helped to understand what Jackie is doing and why he must do this. In addition, they should be given some insight into their own feelings and motivations. It is possible that these parents have some feelings of guilt with regard to their own part in this child's illness, and if this is the case they should certainly be helped to handle such feelings by someone who understands their development and knows how to deal with them.

It will be noted from the examples given in this chapter that many of the uses made by children of their allergic disorders are somewhat alike basically; for example, all of them are seeking for love and attention. But each child, with his different personality and background, uses slightly varied methods of expressing his need; and, when thwarted, his hostility is aroused. Some allergic children use more than one of the methods mentioned, or even all of them at one time or another, and to
varying degrees of intensity. It can be assumed that all use one method or another at least to a slight degree at some time in their lives.

It is important that, whatever use the child makes of his disorder, it should be recognized and the pattern understood, and that both parents and child should be helped to deal with it realistically, lest it continue to weaken the child's development and hinder the prognosis of his illness. This, of course, requires considerable insight and a good understanding of the total situation, otherwise one may only tamper with defences rather than replace the supports one has removed. It is this type of work that requires the skill of a well trained social worker.

In addition to showing examples of the uses children make of their allergic disorders, the case records of this chapter show some of the effects of parental attitudes, environment, and the basic personality of the child upon the illness. It is a matter in which family tensions aggravate the illness, while the severe symptoms of the illness aggravate family tensions. A wide range of social problems are involved, leaving a large area for the specialized treatment of the social worker in the care of allergies in children.
Chapter III

Personality Patterns of Allergic Children.

The social worker who assists in the treatment of allergic children must necessarily have some knowledge of their personality patterns if successful treatment is anticipated. A knowledge of personality is invaluable to an understanding of the various meanings allergies have for those children who suffer from them (the subject of the last chapter), and to obtaining a more comprehensive picture of the problem to be dealt with. With this in view, an attempt has been made in this study to find out whether or not allergic children, as a group, show any similarities in their personalities. What kind of children develop allergies? Do they display any predominating types of personality?

A variety of theories have been put forth about the type of children who are allergic. For example, it is said that they are usually of superior intelligence because of their hypersensitivity. They are also said to be "nervous" and fussy children with overanxious parents. Some authorities have even pointed out that the thin and active child with fair hair is more prone to these disorders than others. Whether or not there is any truth in these theories however, has yet to be proved.

Because of the brief methods of recording, only twenty-eight records of the cases under study give a reasonable indication of the child's personality, and almost every one of these cases display individual variations. Nevertheless, the underlying trends are very similar. For purposes of simplicity the cases may be described in terms of the three predominating patterns; these are the abnormally withdrawn child, the abnormally aggressive child and the child who shows "normal" personality patterns.

In general, the abnormally withdrawn child can be defined as one
who draws attention to himself by his quietness, his unwillingness to play with other children of his own age, his lack of interest in normal pursuits or his interest in pursuits which make him different from others. Eighteen cases out of the twenty-eight in the present sample come into this category. This predominance of withdrawn personality types in allergic children is borne out by numerous other studies, and it ties in with the general pattern of dependency upon the mother which is constantly observed in the child suffering from allergy. By their very nature, of course, allergies are in a sense a disorder of withdrawing rather than aggressive character.

The abnormally aggressive child can be described as one who draws attention to himself by fighting continuously with other children, causing unnecessary discomfort to his family through his continued defiance of authority, restlessness, temper tantrums and bad disposition, and causing trouble at clinic by bossing other children and showing off. Seven out of the twenty-eight, or one quarter of the cases, display this pattern, or considerable elements of it. The three remaining cases appear to display "normal" aggression in their personality makeup, and appear to be generally well adjusted with the exception of their allergic symptoms.

The personality pattern of a child is the product of his environment and constitutional inheritance; which includes the attitudes of his parents, his position among siblings, his physical surroundings, and his developmental history. The allergy itself is a part of the child's total personality pattern and the attacks are capable of interpretation as an expression of that personality. Actually, both the abnormally withdrawing and the abnormally aggressive children are using methods of reaction to their environments which are basically hostile; and both are trying to achieve the same ends, but in totally different ways. The difference seems to be caused by other specific factors in the environmental situation,
including parental personalities and attitudes. There are several examples of these which can be observed in the case records of this study.

The most common characteristics of allergic children seem to be their feelings of anxiety, insecurity, and dependency; and the majority appear to have abnormally strong ties to the mother. It is almost certain that the allergic attacks in themselves will create feelings of fear and anxiety, but since these feelings seem to characterize the personalities of many of these children even before any manifestations of allergy, it is suggested that these particular personality types, in combination with other factors, may be predisposed to allergic attacks rather than some other form of expression. Also it has been noted that where the parents are overprotective of their children: this was usually the case before the onset of the allergy, though the disorder itself could be expected to give rise to overprotection. It would seem that the overprotective attitude is caused by deeper motivations: these may be as different as fear of losing an only child, or overcompensation for not wanting a child.

In their discussion of allergies Drs. Weiss and English say:

"It is generally admitted that there is a high incidence of neurosis among allergic individuals, so high indeed, that we must pay particular attention to the personality of allergic patients to see whether we cannot find psychic factors that are fundamentally important in the background of the illness and also important from the standpoint of precipitating attacks."  

The Abnormally Withdrawn Child

Children in this study who are described as being abnormally withdrawn are not all of one personality type, but each one has his own personality which is different from all the others. However, the tendency

to withdraw, to a greater or lesser degree, from association with other children or adults, is a predominating feature of the personalities of children in this group. The first case example is that of Gladys N., who exhibits such symptoms as nocturnal enuresis and fainting spells in addition to her asthma. These symptoms seem to be an expression of her withdrawn personality. Gladys is a ten-year-old. She has a brother, aged nine, who is also asthmatic, and a sister, aged three, who has cerebral palsy.

Both the parents of these children are allergic, and the mother has been diagnosed as having anxiety neurosis. The mother's ties to her own mother are so strong that she seems unable to function as a mature adult. She was brought up in a family where duty without complaint were demanded of her. Now she has a strict and punishing conscience and a rather weak ego; she fears criticism, is unsure of her own decisions and feels generally inadequate.

The three-year-old child in this family has been sick since birth and gets all the attention in the home; as a result, she is very spoiled. The boy is poorly adjusted, like Gladys, but he has an aggressive rather than a withdrawn personality. Gladys is an unhappy child who feels generally inadequate. Her adjustment has been self-effacing and she is priggish toward other "naughty" children. She is the quietest child at home and has been described by her mother as being "like a mouse". She is fearful of some of her teachers, and does not mix well with other children.

If Gladys's personality is estimated on the basis of the definition for withdrawn children, stated earlier in this chapter, her personality is certainly withdrawn to an abnormal extent. Her mild attacks of asthma are one sector of her total personality and a means of its expression. She has obviously developed this personality as a direct result of her unwholesome environment. Both parents have personality difficulties themselves and seem too immature emotionally to be able to bring up a family successfully. Mrs. N. differs strongly with her husband on the disciplining of their children, and she feels that she has sacrificed her-
self for them and that all family responsibility is on her shoulders. Mr. N. is a rather ineffectual person who feels that women are domineering and that his wife controls their home. He seems fond of his children, not expecting too much of them, and tends to be passive and unworried in his manner.

Mrs. N. would have liked a clever and somewhat precocious child whom she could feel was a "credit" to her, so she pushes Gladys into the preconceived pattern she has set for her. She wants a child she can show off to her friends and neighbours, and for this purpose she makes Gladys take music, skating and lessons in other skills though the child has no interest in them whatsoever. Unable to win out against her mother, Gladys uses her only method of defence, that of complete withdrawal and the development of asthmatic symptoms. This can be seen as a hostile act since obviously by this means, Gladys is certainly no credit to her mother, but rather the reverse; she has become a sickly child, has receded into the background, and become more of a discredit from her mother's point of view. The mother further aggravates the situation by belittling the child and setting herself up as a self-sacrificing parent.

It is particularly interesting to note that Dick, Gladys's younger brother, is outwardly aggressive in his personality, quite the opposite to his sister. He belongs clearly to an aggressive personality group, and is referred to under this head later.

In treating Gladys's case the social worker has stressed helping the mother to build up her own ego strengths. Through discussion and continued interest, the worker has encouraged her to feel that she is a worthwhile person and able to live a life of her own. She has given her some insight into the causes of her family's problems, and has given her ample opportunity to discuss her own difficulties. Because of the deep-seated
nature of this mother's maladjustment, this is taking considerable time; but some improvement has been noted in that she has been able, to a large extent, to allow Gladys to develop her own personality and independence. For example, she no longer forces lessons upon her, and she lets the child attend clinic for remedial reading by herself. Gladys thoroughly enjoys these lessons. Also, she is now encouraging, rather than belittling the child in any efforts she makes on her own account.

Social casework should also be done with the child, in order that she can be helped to build up her feelings of security and independence and seek healthier outlets for her natural drives. However, considerable improvement is evident in her general adjustment since the mother has been helped; her enuresis is considerably improved, and she is much more mature in her manner. She is receiving remedial reading lessons from the psychologist at the clinic in quite a permissive atmosphere, and the attention alone seems to have helped the child considerably.

The next case is that of David O., who has been faced with tensions of one kind or another since his birth. His extremely withdrawn personality may be a reaction to this situation.

David, aged thirteen, is an only child who has suffered from asthma since two years of age. At present it is quite severe and has daily attacks. He had eczema prior to this which began at nine weeks of age. David was an eight month baby, his birth was difficult and he remained in hospital until six weeks old. This was followed by further hospital care, for varying periods, until he was almost two. He had feeding difficulties and numerous other problems at this time. He has always had poor health and is now only the height and weight of an eight-year-old.

This child's father is a chronic alcoholic with an ill temper, and he is generally irresponsible so far as the care of his family is concerned. The mother is afraid of him and seems to be a rather timid person. She, also, is allergic and suffers from hives.

This cannot be considered a comfortable home situation for any
child, since it offers neither emotional nor financial security. David's asthmatic attacks seem to be one of the many symptoms he has used throughout his life as his particular method of reacting to his environment.

David does not know his true age and thinks he is really younger than he is. It seems obvious that his mother has little pride in him if she has so much feeling about his size and appearance that she cannot even tell him his true age. He is now abnormally withdrawn in that he is unwilling to play with other children. He is actually afraid of those his own age, and is rejected by them. He has none of the normal interests of a thirteen-year-old. For example, he has no interest in games or in joining clubs.

Even from these short extracts, the reasons for David's withdrawn personality show up clearly in the personalities of his parents and the attitudes they have adopted toward him. His parents are both weak, anxious and insecure, and he is reflecting these attitudes himself. As a result of his rejection, he has developed a pattern of anxiety and dependency, which has been intensified by his continuous illness which entails dependency upon the mother. His asthma is actually only one facet of this pattern.

Another example of the withdrawing child can be seen in the case of Billy P., aged seven. He has had asthma for the past two years. The onset of this disorder took place at the time his mother was hospitalized with a degenerating neurological disorder and anxiety state. Billy is the youngest of two children, having a sister of ten (Virginia P.). He is a weak and unhealthy child who has suffered from numerous disorders throughout his life. He is very nervous and picks at his skin and fingernails, and is almost always tired. He sleeps poorly and has nightmares, is afraid to play in case he hurts himself, and spends most of his time sitting
in the house reading. Billy's mother is convinced that he is suffering from the same disorder that she has. She is an unhappy woman who feels that she is a burden to her husband and children, and their kindness to her appears to add to her feelings of guilt. There was a considerable amount of emotional maladjustment in her own family, and her father committed suicide. Billy's father is a serious hardworking man who seems concerned about the care of his family, but has had little success in his work. He had an extremely unhappy childhood; his parents were elderly, and one was psychotic. He is somewhat withdrawn and has trouble mixing with people. Mr. and Mrs. P. have never really been happy together and it has been noted that Billy's attacks are much worse at home than when he is in hospital, and he always has a violent attack when his parents are fighting.

Again, the asthmatic attacks in this child's case are part of a total personality pattern reacting to a harsh environment. This child had a withdrawn personality long before the advent of his allergic disorder, but his mother's illness and hospitalization precipitated this new means of expressing his unhappiness and insecurity. Both parents come from deprived homes and are emotionally unbalanced themselves. The mother seems to have guilt feelings about having passed on her illness to her child. She is also unhappy in her marriage, and her discomfort when her husband and children are kind to her seems to indicate her unconscious rejection of them.

Social casework has already helped the parents of this child to understand some of the tensions with which he has to contend. Considerable support has been given to the mother by helping her to make plans in connection with her illness, including hospitalization and the care of her children. Also, she has been helped to work through some of her feelings of inadequacy through the discussion of possible causes. She has gradually
attained the ability to see her situation more realistically, and seems able to understand some of the feelings of her children. In a family situation, such as this, where the problems are of long standing and are deep-seated, the social worker can offer supportive therapy to the parents in order to relieve the children of tensions; she can also help the children to develop independently, with some measure of security in themselves, in order that a repetition of their own family situation can be prevented if possible.

A different case is that of Harry D., who wants to be like other children, but feels so inadequate and inferior to them that he has withdrawn completely from the companionship of others both at home and at school. He is eight years old, and has had asthma since he was three. His only sibling, a brother, is one year younger, and appears to be "normal" in every respect. Harry cannot hold his own in competition with other children and he is extremely jealous of his brother. He is generally unhappy and is always seeking adult approval. His mother states that Harry is inferior to his brother in most respects and that "he is embarrassing to her". She fears criticism and feels that this child is a disgrace to her.

It is obvious that the brother is the "wanted" child in this family and the parents appear to have played one child against the other. Nothing that Harry could do would be right in the eyes of his mother. It is no wonder that he has no feeling of personal worth and is a failure in social activities.

Another child, Cathy G., is entirely withdrawn from her family and from other children, and she indulges only in drawing and sewing quietly by herself. Her siblings are aware of her "difference" and seem unwilling to play with her. Cathy is the eldest of four children and is now fourteen years of age. Since she is four years older than her nearest
sibling and the family has had years of illness and financial problems, she has been left to care for herself a great deal. Cathy's father is a chronic invalid and her mother has a physical condition which prevents her from working. The family is cared for by social assistance. Cathy is pathetically eager to please anyone who shows the slightest interest in her; when she is given consideration and responsibility, her attacks diminish. She was quite healthy and "normal" for a period when her mother was sick and the rest of the family had to depend upon her.

This child is responding well to one of the social workers at the clinic, and it is thought that once a good relationship is established she can be helped to develop friendships and indulge in other social activities. She no doubt feels the inadequacy of her family, and in her own insecurity she is apologising for it. Any interest in family affairs which Cathy may show are discouraged by her mother who feels she is "too young to understand". At such times of tension her asthma increases in its severity. She does not get along well with her sisters and brothers, who generally play together, and she spends most of her time at drawing or needlework. Her mother should be helped to realize that Cathy is growing up and can accept some responsibilities, and that she is able to understand family problems if they are discussed with her.

This group of withdrawn children consists of eight girls and ten boys. Since this is a larger proportion of girls than exists in the total group (33% girls and 67% boys), and the aggressive children are all boys with one exception, it would seem that girls suffering from allergies are more likely to manifest the symptoms of the withdrawn personality than boys.

In the records of these withdrawn children not so far cited, there is a considerable incidence of other emotional disorders such as
enuresis, functional deafness, stuttering, nervousness and generally unhealthy appearance, all of which are characteristic of the insecure and anxious personality patterns displayed by these children. They also show evidence of poor environmental situations which in most cases have been the major causative factor of the maladjusted personality. For example, the father of one child is on gaol, another has a father who is alcoholic. The mothers are decidedly neurotic in two cases, and one child is illegitimate.

The Abnormally Aggressive Child

In this study, children classed as abnormally aggressive are those who are anti-social in their behaviour for the greater part of the time. A certain amount of aggression is generally considered to be "normal" and conducive to growth in children, but beyond certain limits it is thought to be indicative of disturbances in personality development. For example, these children may be reacting to an inadequate environment, poor parental relationships, the tensions of physical illness or to other traumatic experiences.

The first case example of the abnormally aggressive child is that of Dick N., who is the younger brother of Gladys N. (previously referred to in this chapter). He is an interesting contrast to his sister in personality structure in that he is outwardly aggressive in all his general activities.

Dick, aged nine, suffers from asthma. He also has severe nightmares and some enuresis. He is an enthusiastic boy who likes to be at the head of everything. He bosses all the boys around his home, even those much older than himself, and is often the instigator of a fight. He seems to have developed a poor name for himself in the neighbourhood because of his manner. At school he feels that "he must get good grades". At home, Dick is usually cranky and bad tempered and is the only member of the family who is
always being punished because he is in trouble so much. Mrs. N. says that Dick acts as though he felt "unwanted around the house", and he is always taking "revenge" upon other members of the family if he feels they have "done him out of" something.

The mother did not form a preconceived pattern for this boy as she did for her daughter, but rather she has rejected him. She has even consciously considered this, but places it on the boy's feeling rather than on her own attitude where it really belongs. Mrs. N. says that she "just does not understand boys". She fears he may become delinquent, and fears particularly the criticism this boy brings to her. The suggestion that "she does not understand boys" is rather a weak explanation for her inability to handle him. Dick reacts to his rejection with his strongest weapon, that of displaying the aggression and "badness" his mother fears so much.

The hostility in this method of reaction is more obvious than in the case of his sister, Gladys, but it can be seen that both children are achieving the same ends through shaming their mother in the way she most fears. Dick's asthma is again an expression of personality, and his attacks probably result from the conflicting situation in which he finds himself; that is, his underlying desire for love and affection from his mother and his need to repress these feelings.

Social casework done with the mother in this case has improved the situation somewhat, as it has for Gladys, but a great deal more time needs to be taken with the whole family. Modification of attitudes in both parents and children and encouragement for independent development would seem most helpful.

It is interesting to note that Dick's personality pattern is somewhat similar to that of his mother, and Gladys's personality corresponds more with that of her father. It is possible that there is also
some identification with the parent of the opposite sex which is the residue of an unresolved Oedipus Conflict.

Another example of an allergic child who is outwardly aggressive in his basic personality pattern is that of Jimmie K., aged seven, who is the eldest of three children. He also suffers from asthma. Jimmie is a high spirited and overactive boy, who is often the cause of trouble among the other children at clinic. He usually plays with children younger than himself, being somewhat childish in his ways, and he appears to cause trouble in order to get attention. Jimmie's father is a labourer, of whom little is known. His mother is shy and apathetic and seems to have little control over her child.

Jimmie's weaknesses are somewhat the same as those of the withdrawing child, but a mild form of aggression seems to serve his purpose better. He plays with younger children, feels his inadequacy, and is aware of parental apathy; but he makes his attempt at aggression in a bid to prove himself, and most likely to "prod" his mother into giving him attention.

Warren F. (whose case is further discussed in a succeeding chapter), is another asthmatic child with aggressive tendencies. He is eleven years of age and the second of four children. Warren mimics his rather weak mother, fights continuously with the other children at school, and is generally careless and disinterested in his attitude.

The children in this aggressive group are of varied ages, but they are all boys except one. The one girl is a four-year-old suffering from allergic rhinitis. She is a poor eater, and is considered cranky by her family. It is probable that this child is merely displaying an exaggerated form of infantile negativism as a reaction to her poor environmental situation.
Of the remaining three boys in this category, two are wards of the Children's Aid Society and come from very deprived homes; the other is living with an unhealthy mother on social assistance, his father, a chronic invalid, being in hospital. All three suffer from other emotional disorders in addition to their allergies, and there is ample evidence that their total personalities are maladjusted.

The "Normal" Child

Children have been described as "normal" if they appear to be generally well adjusted, although they have allergic attacks. The number, probably significantly, is small: only three children can be placed in this category. The reason for this small number is probably that well adjusted children are not commonly referred to a social worker. It is, therefore, difficult to estimate the number of children who suffer from allergies and, at the same time, develop well-balanced personalities, because, as pointed out in the last chapter, children are referred to a social worker because of the uses they make of their allergies and not simply because they have an allergy.

The first case in this category is that of Sylvia A., aged sixteen, who has a history of severe periodic asthmatic attacks, which she uses as an attention-getting device. She is otherwise a happy and fairly clever girl with an outgoing personality and numerous friends. She is very attractive, and for the most part seems to be able to use acceptable methods for the channeling of her aggressions. Virginia P., the older sister of Billy P., is a ten-year-old asthmatic who seems to have found enough outside interests to satisfy her needs. Like Sylvia, she is attractive and is an extrovert with plenty of friends; she also belongs to numerous clubs. Her father is very fond of her, which is a compensating factor. It is probable that both these girls are compensating for their
inadequate homes and family situations by filling their lives with social activities, and making the most use of their own attractiveness for this purpose.

Peter S., a third child in this group, had a withdrawn personality until he was four years of age, but recently, he has made an excellent adjustment and his allergic symptoms have almost disappeared. Peter is a six-year-old boy who was born in England during the war. He has two younger brothers. He developed asthma at a time when he and his mother were living alone and the mother was very nervous of the bombing. Since coming to this country the family has been through considerable financial difficulty, but during the past year, their situation has improved immensely. Peter had only one attack last winter, and he now seems to be an energetic, bright and normally adjusted child in every way. It is probable that this improvement is, at least partly, the result of less tension in the home, and the fact that his parents are now able to live together with their children.

This case is an example of one in which the attacks seem to be an expression of the child's discomfort while under tension. Since he is no longer under tension he has no further use for his asthmatic attacks. Because he is young, this readjustment is made easier; in an older child a habit pattern may have been formed which would be difficult to get rid of, even if the tensions which originally caused the disorder were removed. In some cases secondary and irreversible changes may have taken place, for example, the development of "pigeon chest".

The child who receives the normal satisfactions of life has no need to seek for them through the abnormal development of his personality. There is unlimited scope for social casework in the area of prevention in
allergies, since allergic children seem prone to use their allergic attacks as an expression of their personalities, and the social worker is trained in the understanding of personality development and its abnormal manifestations. In the interests of helping cases, such as those discussed in this thesis, and preventing abnormal developments in others, further research into the psychogenic aspects of allergies is essential.
Chapter IV

Parental Relationships and Attitudes.

"Patients have families"\(^1\) says Henry B. Richardson in his book of the same name, and he continues:

"...the individual is a part of the family, in illness as well as in health. It is no longer easy to conceive of asthma or ulcer or obesity as a characteristic only of the individual. The idea of disease as an entity which is limited to one person, and can be transmitted or spread from one individual to another, fades into the background, and disease becomes an integral part of the continuous process of living. The family is the unit of illness, because it is the unit of living."\(^2\)

Richardson's statement is made generally, but from the cases studied it is made abundantly clear that it applies with particular force to allergic disorders. With this fact in view, it is obvious that any adequate study of the social effects of allergies in children should certainly include some analysis of family backgrounds. Each individual is profoundly affected by every other member of his family and by the family as a whole.

"...the family maintains an equilibrium within itself and toward the environment which is comparable with homeostasis, the mechanism by which the individual organism maintains itself in a state of balance. The members of the family may be compared to the organs of the body, in spite of obvious differences. Although the intra-family relationships are not often essential to life, each individual is profoundly affected by the others, and by the family as a whole. This influence is shown in the phenomena of identification, dominance, interplay of factions, and the like...."\(^3\)

---

2. ibid. p. 76.
3. ibid. p. 95.
Lack of family equilibrium is marked in the seventy cases under study. In searching for the causes of this lack of family balance, which may be aggravating the allergic state of the child, or may be even the origin of it, it is found that the families of each case fall into three general groups with some overlapping. These are:

(1) Cases in which one or both parents have emotional problems or display signs of such problems.

(2) Cases in which children have suffered severely from family problems which are not necessarily emotionally based.

(3) Cases which show other indications that the family situation is inadequate, besides that of the abnormal use of allergic attacks.

Each of the total group of seventy cases have been placed under one or another of these three headings. Group (1) is by far the largest, with thirty-eight out of the seventy cases showing such evidence of parental emotional maladjustment as separation and divorce, marital incompatibility, alcoholism, sexual delinquency, or illness which has a decided emotional component. Because of the summary method of recording there is little material on this subject in the group as a whole; however, we can assume that a number of the remaining thirty-two cases also have such problems. Evidence to this effect will be discussed under heading (3): cases which show other indications that the family situation is inadequate besides that of allergy.

At least half of the cases in the first group could also be included under heading (2), which covers problems that are not necessarily emotionally based; for example, such problems as early hospitalization of the child, sick parents, inadequate income, and inadequate housing. However, it is felt that where the parents have decided emotional problems,
these factors are more likely to cause or aggravate the child's allergy than are other traumatic events, though the latter no doubt intensify the seriousness of the situation.

It is interesting to note that all the cases which were referred by the doctor to a social worker, are included in this first group. This may indicate some realization, on the part of some members of the medical profession, that there is a definite need to work with parental problems in addition to those of the child.

Case Examples from Group 1.

The first case example in which parental emotional problems are evident, and the children seem to be reacting to them with disorders of an emotional nature, is that of Eileen C., who is fifteen months of age and the youngest of three children. She suffers from asthma, and one sibling is nervous and anemic, while the other is enuretic.

The father of these children is at present in hospital with a bone disease. He is inadequate so far as supporting his family is concerned and tends to feel that the "world owes him a living." They are on social assistance at present and live in a one-room shack without heating, or sanitary facilities. The mother is a talkative and nervous person who seems very dependent upon her husband. She feels unsettled, and unhappy and blames the children's illnesses on her "state of mind". Social Service Index has this family listed with five different agencies.

Both these parents are emotionally upset, and all three of their children are reacting to it in their own particular ways. At least the mother is aware of some relationship between her own attitudes and the condition of her children, in spite of her own immaturity. There is little doubt that this family suffers from economic problems which are beyond their control, but their attitudes, unsettled living conditions,
and social agency records suggest deeper-seated problems.

In this case the doctor saw that treatment of the child's allergy was useless unless the parents were helped in making a better adjustment for themselves and their family, so he referred the case to a social worker. Material help was given, through assisting the family to seek a better home and provide the children with healthier surroundings, but little was offered in the form of casework services. There is now a marked improvement in Eileen's symptoms, and the family has moved to much better living quarters in the country. This case has now been closed. In this instance, casework services from a social worker at the clinic, or referral of the family to another social agency, may have been of more lasting value.

Nevertheless, when the need for such services is not seen by the patient and his family, it is useless to continue. When families move to a new environment, there is often a feeling that "all is now well", and, as a result, casework treatment of the patient and family ceases.

Another case, in which the lack of emotional adjustment in the parents seems to be aggravating the physical condition of the child, can be illustrated by the case of Gordon G. Gordon is a fifteen-year-old asthmatic, and the eldest of three children. He has been severely hampered by his asthma since he was an infant, except for two years when he was away from home. During this period he had no attacks. When away from home his asthma is relieved, but apparently when he is at home the tensions are too great for him. His parents are separated and the children are living with their mother. They are on social assistance and have a small basement apartment. The family emotional maladjustment, of which the separation gives us evidence, seems to be causing tensions in the home which are aggravating the boy's condition.

The consequences of the emotional maladjustments of a family
upon its children are very obvious in the more extreme case of Ruth Y. Ruth is an eight-year-old asthmatic with one younger sibling. She is strongly attached to her mother but resents her father. Both Ruth and her sister have been behaviour problems for some time.

The mother of this family suffers from epilepsy and is considered incapable of caring for her children adequately. The father, who is ten years older than his wife, operates a flophouse and bootlegging establishment. He is more often drunk than not, and has been known to have sexual advances toward his daughter, Ruth.

This is an extremely deprived home, with which little can be done from a social point of view, the mother and father seeming to be totally inadequate as parents. This case is now being carried by the Children's Aid Society, and the children are being taken into care. This is probably the best answer, but Ruth will need considerable help in building up her independence and adjusting herself to a foster home, before any positive results will be attained in the treatment of her asthma.

An example of a case in which the emotional difficulties of a family are seen to go back at least two generations is that of Tommy S., who is a four-year-old asthmatic, and the eldest of two children. The younger child is also allergic. Both children are nervous and are usually unhappy, according to the mother. The father is alcoholic, and returned from war service "a completely changed man" in his wife's estimation, and she is contemplating separation. She is a highly emotional woman who had a "nervous breakdown" prior to her marriage "because of the way her own parents treated her". There is a long history of allergy on both sides of the family. One would hardly expect the children to be well adjusted under these circumstances. If they were not allergic there would most likely be some other problem manifesting itself.

Children whose parents are anti-social in their behaviour are
are certainly handicapped in their emotional growth, as can be seen in the case of Anne Q., whose step-father is at present in the penitentiary. This child is an asthmatic of five years of age, and the eldest of three children who are also allergic. Her development is hindered by numerous other difficulties, in addition to that already cited. She is her mother's child by a former marriage. The present home situation has been described as "poor and complicated", and there are apparently numerous relatives living with the family. Anne is a highly strung child whose attacks seem much worse at home than when she is in hospital. This child likely suffers from the effects of social criticism in addition to the tensions of her home environment, and there would seem little hope for much improvement.

Another child who is poorly adjusted as a result of emotional problems of his mother is Bruce H.

Bruce, aged six, is illegitimate, and an only child living with his mother and grandfather. He has eczema and mild asthma, and is a quiet, shy child. His mother, who works in a restaurant part-time, is diabetic and "nervous". She is a dependent person with a strong tie to her father; she has few friends and feels she is inferior in general, though she is actually quite intelligent.

Though considerable damage may have already been done in this case, this mother could probably benefit by some social casework assistance, and the child would certainly profit by it indirectly. She could be given considerable support with the many difficulties she must be facing, and, in addition, some ego-building in order to give her a feeling of worthwhileness. Also, she may still need to work through some of her feelings in connection with being an unmarried mother. This should all be handled in regular interviews with a social worker. Some interest should also be taken in the child, and he should be encouraged to develop independence.

Jackie L. is the only child of two elderly parents, both of

1. This case record is outlined in Chapter II.
whom show evidence of emotional problems. His father is crippled and withdrawn from society, and his mother is neurotic. They are abnormally protective of their child and lack any real understanding of him on account of their own difficulties. Casework with this boy, which has stressed building up his own independence, has brought excellent results. There is a decided improvement in his physical condition and he is making a more "normal" life adjustment.

The marital unhappiness of his mother, and the lack of a father has certainly caused considerable emotional tension for Bobby W. Also, the home of Ralph B. can hardly be considered conducive to normal personality development, since the father deserts for long periods at a time, and the mother has attempted suicide. Again, Sylvia A. may have had less need to compete for her mother's attention if she had been given greater security in her developmental years, instead of having had to move from one home to another, and having two step-fathers.

In addition to the examples cited above, eight other cases in this group have parents who are either separated or divorced. Three other cases are now wards of the Children's Aid Society because of extremely deprived home conditions. In three cases, one parent is hospitalized on a long term basis, one being in a mental institution; and, there are numerous instances of nervous disorders in the family histories of the group as a whole.

Case Examples from Group 2.

Eleven out of the seventy cases in this study can be classified under the second group; that is, those cases in which children have suffered severely from family problems which are not necessarily emotionally based.

1. This case record and the following two are outlined in Chapter II.
These include such situations as the death of one parent, inadequate housing, inadequate income, birth injuries, accidents and illness, and parents of different races. It is clear that all these factors have the capacity for causing undue tension, and they are bound to upset family equilibrium for at least a certain period, thereby effecting the health and well-being of each one of its members.

The first case example in this group is Johnny V. Johnny, an asthmatic, is four years of age and the youngest of five children. Their parents are each thirty years of age. This family has suffered a series of mishaps for a number of years in the way of accidents, illness and unemployment. Recently they have been burned out of their home, and the father was severely injured. They are at present living with relatives.

Family situations such as this are bound to upset the lives of all its members to some extent, and a child of four years most likely will suffer from the reactions of his parents to their misfortunes, in addition to his immediate discomfort from the actual events. The youth of the parents, the number of children and the fact that they are living with relatives makes the situation even worse. The general atmosphere is unhealthy and is bound to aggravate the condition of an allergic child.

A child hampered by a physical deformity, in addition to an allergy, is illustrated by the case of Carl U. Carl, aged fifteen, suffers from eczema and asthma, and he has a disfiguring birth injury on his face. His appearance, no doubt, makes him feel very different from other children, and possibly even inferior to them. In addition, he is seriously handicapped by his allergy and is often hospitalized for asthmatic attacks. His father died suddenly when the child was five years of age; at this time he was sent to live with relatives. Both the death of his father, and the fact that he was sent away from home at this tragic time, must
have been damaging to his emotional growth and physical health. Later the mother re-married, and he returned to live with his mother and step-father. Carl soon became a severe behaviour problem and has continually become worse. Recently, the parents have declared that they can no longer handle him, and foster home placement has been contemplated.

If Carl's behaviour is as poor as the record suggests, it would seem that there are other parental or family problems not mentioned in the record. If he had received a normal amount of affection and security before his father's death, and since that time, loving care from his mother, these problems of serious behaviour and sickness would, very likely, never have occurred. However, there is no doubt there would be some reaction to the misfortunes of his young life.

Two similar, but as yet, less serious cases, are those of Donald J. and Wayne T. Donald is another asthmatic, aged four, and the youngest of three children. He has a hair lip. His father is a T.B. patient who has been hospitalized for over a year, and the mother has very poor health. The family is living on a marginal income. This child is growing up in a home where illness is making a happy and well adjusted living impossible. He is without his father at a time when he needs him most, and his mother is too ill and too concerned with her husband's condition to give her children any of the security and support they so urgently need. Wayne T. is a twelve-year-old who suffers from eczema; he is the second child in a family of four. His father is dead, and the mother and two of her children, including Wayne, live in one room on social assistance. Again, this boy's condition is aggravated by the lack of a father and the lack of an adequate home. The family must have intense feelings with regard to their unfortunate situation and Wayne is over-reacting to this with his attacks of eczema. Certainly, both these
mothers need some help with planning for their families, and, from a preventive point of view, casework services should prove to be beneficial.

A case example of a child born of two different races is that of Charles E. Charles is a six-year-old asthmatic, and the oldest of two children. His mother is Chinese and his father is German. It is most likely that this family suffers from a considerable amount of external pressure as a result of the different races of the parents, and the children will be unable to avoid the tensions that this is certain to cause in the home. The family lives behind a store in a very poor district. The father is unemployed and the whole family is malnourished. An inadequate home and unemployment only add to an already poor situation, and a malnourished child can hardly be expected to undergo this strain without some reaction. In this case, the asthmatic attacks seem to be either caused, or intensified, by the environmental situation.

The records available on the eleven cases in this group suggest that the children come from homes which have suffered considerable tension, though there is no definite indication that the causes of the tension may be based in the personalities of any of the family members. In treating cases of allergy where misfortunes, such as those outlined in this chapter, are apparent in the family histories, it is important for the social worker to know what meaning the event has for the various members of the family, how they react to it and why, in order that she may help them to relieve the allergic child of tensions, and help the child to develop independently, in spite of family misfortunes.

Case Examples from Group 3.

Group (3) is made up of twenty-one cases which show other indications that the family situation is inadequate, besides that of the abnormal use of allergic attacks. The records for at least half of these
cases, which make up the remainder of the total group, are rather insufficient for our purposes; however, some of the material does indicate the existence of individual or family maladjustment through its very nature. For example, in eight cases there are emotional problems such as stuttering, headaches, enuresis, vomiting, cranky disposition, and severe temper tantrums. Fourteen cases have a family history of allergy which is quite marked. In two cases the parents are more than ten years apart in age, and in another case the mother is only seventeen years of age, and her husband is eighteen years of age. In two cases the onset of the allergy occurs at weaning, and in another the allergy is not apparent while the child is away from home.

The first case illustration in this group is Brian C., who stutters badly with no apparent organic cause. He has had asthma since he was two years of age, and he is now six years old. There has been some improvement in this condition since he began medical treatment one year ago, but he still has attacks at times of emotional stress, and his stuttering remains unchanged. Symptoms of an emotional nature, such as these, certainly indicate the presence of tensions in the home which are hindering the child's development. The psychogenic factors involved in this case should be dealt with by a social worker, who is equipped to do this work; in addition, the doctor should deal with the medical aspects of the case.

Another child, Paul V., aged six, suffers from headaches of an emotional nature and allergic rhinitis. As suggested in the case of Brian C., Paul's family background should be studied by a person who is competent to do this work, in order that those factors which are disturbing his emotional development can be detected and dealt with. The case of William B. should be treated in a similar manner. William, aged eight, has eczema and asthma; in addition, he suffers from a type of "nervous"
vomiting.

A case in which the onset of an allergy occurs at the time of weaning can be illustrated by Paddy L. Paddy, aged two, was a perfectly healthy infant at birth and during the time he was being breast-fed. However, when he was suddenly weaned at the age of two months, he immediately developed eczema and at eight months he developed asthma. Why he was weaned at this time is not known, but it had a decided effect on the child's health. Since there has been no improvement as yet, in his allergic attacks, it would be interesting to study the case from a psychogenic point of view.

It is interesting to note that in the case of Gerald A., the child's allergy only manifests itself while he is at home, and there, it is always severe in spite of medical treatment.

Gerald is a seven-year-old asthmatic, who has a sister of three years. His attacks have been very severe since five weeks of age, and he has had eczema and pneumonia also. While in hospital he has no manifestations of his allergy whatsoever, and while he was in a sanitorium for a year he was completely free of attacks. He has not responded well to medical treatment.

A social study of Gerald's home would enlighten us on the causes of his problem, and would be an invaluable aid to treatment. It is such evidence as can be seen in this excerpt from the record that should be a signal for further investigation into the child's background.

Finally, the case of Jane R. illustrates the emotional reactions of a child who is poorly adjusted to her home and family environment. Jane is a four-year-old who suffers from allergic rhinitis: the oldest of three children, the child has also had eczema periodically since birth and she has always been a poor eater. She is a cranky child with an aggressive negativistic attitude. Since this child shows numerous other
symptoms of distress besides her allergy, it can be assumed that there is some problem in her relationship with her parents. Her allergy, poor eating, and her undesirable disposition all suggest inadequate adjustment. The father works irregularly and the family income is poor. A difference of twelve years in the ages of the parents, and the father's work problems should be kept in mind in any social study of this family.

Environment and experience becomes a part of the personality of the individual, and, to a large extent, governs his mode of reaction to life situations. The case illustrations in this chapter make it sufficiently clear that a knowledge of family background and relationship is absolutely necessary to the adequate understanding of the allergic child. The diagnosis and treatment of the psychogenic factors involved in allergies is useless without this understanding, regardless of the quality of service offered. It is essential, then, that a study of each child's family and his place in the family setting be made a part of the treatment programme; all such studies should be made by a social worker, who is equipped to deal with this type of work.
Chapter V

Diagnostic and Therapeutic Facilities for Children with Allergies.

In the light of what has been discussed, it can be seen that children with allergies require certain specific facilities for diagnosis and treatment if they are to make the best possible readjustment in their total life situations. Therefore, out-patient clinic facilities are needed for allergic children who are living in either their own, or in foster homes and physical facilities, available in hospitals or sanitoriums, are required in the care and treatment of emergency cases. The professional services required may include: (a) the services of physicians and nurses for medical diagnosis and treatment; (b) the services of medical social workers for the casework treatment of psychogenic factors; (c) the services of dieticians for helping parents with eliminations and general health-building diets; and (d) the services of physiotherapists for body-building and breathing exercises.

The services required by allergic children in the group under study must necessarily be provided by the community. The cost of specialist care, over a considerable period of time, in addition to the cost of the many drugs, treatments and other necessities for the alleviation of symptoms, is extremely high, and is therefore prohibitive to this group. Boarding care away from home, used in the treatment of some cases, would likewise be an impossible financial burden. Although they are still quite inadequate, Vancouver has a nucleus of facilities available to children from lower income groups which include: (a) clinic facilities on an out-patient basis for the large proportion of ambulant cases, (b) hospital
care for bed cases, (c) institutional care, and (d) foster home care. These facilities take various material forms throughout the city, and offer diverse professional services. These are generalized facilities, and do not all specialize in the care and treatment of allergies; but, they are specifically for children, and the treatment of allergies is a distinct part of their programmes. Within the professional span, as a whole, there are many different philosophies on treatment and diagnosis. It will be best to discuss the available facilities in more detail under appropriate headings.

**Out-patient Clinics.**

In the out-patient clinic field the Health Centre for Children of the Vancouver General Hospital probably offers the broadest programme of facilities. This clinic is the setting for the present study, and eligibility requirements were outlined in Chapter I. Children attending this clinic are first examined by a paediatrician before they are referred to the various specialized clinics. The Allergy Clinic was one of the first five specialized clinics organized when the Health Centre for Children opened on June 4, 1948. During the first month only three allergy patients were treated. During May, 1949, the final month of the first year, ninety-six children with various allergic disorders were cared for, with a total of six hundred and ninety treated throughout the year. It is now one of the largest specialized clinics within the Health Centre and it continues to increase in size.

The Allergy Clinic is at present held on one afternoon a week. It is staffed by two specialists in paediatric allergy, and uses the general staff of the Health Centre including internes, nurses and a pathologist. Vancouver General Hospital facilities are also available to this clinic. For example, the services of dieticians may be necessary for
the treatment of food allergies, and the services of the physiotherapy department for posture development and breathing exercises for certain cases of asthma.

At the Health Centre, there are two full-time social workers and one on part-time; they are attached to the Social Service Department of the hospital, and receive casework supervision from this department. The part-time worker, who is in attendance three days a week, has just recently joined the staff and has been placed at the disposal of the Allergy Clinic. The doctors in attendance in this clinic are aware of the emotional component in the group of disorders in which they are specializing, particularly in application to children; and in the past, they have made use of the social work services available in the Health Centre on a number of occasions. Unfortunately, these services have been most inadequate, only one worker having been there, for most of the time since it opened. Moreover, Health Centre workers carry cases in the Children's Ward and at the Infant's Hospital in addition to their clinic work. There is still a great deal of ground to be covered in mutual interpretation between doctors and social workers, and at present, there seems to be an excellent opportunity for social workers to pave the way for a balanced and cooperative service for children with allergies. No matter how well trained and experienced the social workers may be, their services are useless unless they are adequately used by doctors within the hospital setting.

The Allergy Clinic offers its patients standard medical diagnosis and treatment, including physical examination, allergic history, skin tests and elimination diets. Hyposensitizing injections are given in an attempt to immunize patients against offending allergens, and drug therapy is used for the relief of some allergic symptoms. There is still much to be done in the study of basic causes, and treatment is as yet in the
experimental stages.

The Children's Hospital, located in Vancouver, B. C., also has an out-patient clinic. Although this is not a specialized allergy clinic, allergic children can receive treatment here. This clinic is available for the use of any child in British Columbia from birth to sixteen years of age. There are no eligibility limitations, the fee charged being fifty cents per clinic attendance, or whatever the patient can afford to pay up to this amount. No patient is turned down as a result of inability to pay. Many parents prefer to take their children to this clinic rather than to the Health Centre for Children because they feel that the tone of charity is eliminated. This hospital is supported by fees and voluntary contributions.

There is a doctor who specializes in allergies on the staff of this hospital, and the standard medical techniques are used in treatment and diagnosis. There is no social worker at the present time, though there was one on staff for over a year. She left recently and the position remains vacant, this little real help is given to the patient, at the present time, with the emotional problems that so often surround allergic diseases. Excellent medical care is provided by this hospital.

Hospital In-patient Care.

Children who require to be treated in bed, as in cases of severe attacks of asthma or in major skin allergies, may be admitted to the Children's Ward of the Vancouver General Hospital as staff patients, if their parents are unable to afford the cost of medical treatment. Unfortunately, there is an extreme shortage of beds at the present time; as a result, patients are only admitted in the acute stages of allergic diseases and discharged at the earliest possible date. This creates a number of problems if there are psychogenic factors involved in the illness. If a
patient is referred to the Social Service Department early referral from
the doctors and immediate attention on the part of the social workers is
absolutely necessary. The social worker's services include casework with
the patient and his family, home visiting, subsequent contact and referral
to other agencies for placement where necessary. It can be seen therefore,
that cooperation between doctors, nurses and social workers is necessary to
maintain a high standard of care for the patient.

The Infant's Hospital, a West End section of the Vancouver
General Hospital, provides similar services. This hospital serves children
from birth to two years of age.

In-patient care at the Children's Hospital is similar to that
given by the Children's Ward at the Vancouver General Hospital. Standard
medical treatment is used, and there is the added advantage of a high
humidity ward which alleviates the necessity of using individual tents for
children suffering from bronchial asthma. This is one, of only two such
wards on this continent, the other being in Boston, U.S.A. There is a
considerable staff interest in allergic disorders in the Children's Hospital,
particularly among the dieticians, but little understanding of the emotional
content of these diseases. Qualified school teachers aid the children in
continuing their studies while they are in hospital, and the doctors provide
medical and surgical care. This care is available to any child from any
part of British Columbia.

Hospital facilities are also available at St. Paul's Hospital.
This is a general private hospital for in-patient care, but staff beds are
very limited. A children's ward offers standard medical diagnosis and
treatment; and a newly formed social service department offers casework
services for all cases referred by the doctors.
Other Community Facilities.

The Vancouver Preventorium should be considered as a resource for the care of allergic children, though it only accepts a few asthmatic patients at a time. The primary purpose of the Preventorium is to build up the health of children, infected with the germ of tuberculosis. Children are accepted from age two years to twelve years and no fee is required. There are no eligibility limitations, but, as a rule, most children admitted, are from lower income groups. The major portion of the budget is derived from Vancouver's Community Chest, the Provincial Government, and the City of Vancouver.

This institution is under the direction of Tuberculosis Control, a service of the Provincial Government of British Columbia designed for the prevention and cure of tuberculosis throughout the Province. All applications for admission to the Preventorium are selected by the medical staff of Tuberculosis Control. Children may remain in the institution as long as it is felt that they need care. The staff includes two graduate nurses, a school teacher, and six nurse maids in addition to domestic staff. Forty patients are cared for. Treatment is individualized according to the child's particular needs, and general physical care is of a high standard. The Preventorium is situated on eleven acres of ground and has excellent facilities for both rest and play.

The staff of this institution has an awareness of the emotional content of asthmatic attacks, but little further understanding of causation. Little work of a social nature is done with patients, or with relatives outside of the institution, and the parental cooperation does not appear to be utilized in treatment. The focus is upon the child himself while he is in the institution. There is no social worker, but the Social Service Department at Tuberculosis Control is available to the Preventorium.
Some children with allergies require foster home care as part of their treatment, as it provides a controlled setting; while others, for various reasons, need foster home care because they are unable to receive proper parental care. Whatever the reason, one may request the services of the Vancouver Children's Aid Society's temporary foster home placement plan. Children can be accepted as non-wards, and, if so, are supervised by social workers in selected foster homes. Parents retain guardianship in these placements and are asked to contribute to their child's maintenance so far as they are able to do so. Those, who are unable to contribute, are not penalized in any way. Medical treatment is carried on as though the child was in his own home. The Catholic Children's Aid Society offers a similar programme for Roman Catholic children.

There are many varied opinions on what care allergic children require, and from the foregoing description of the available facilities for the treatment of allergic children in Vancouver, many varied opinions could be given. Some authorities think that a high standard of physical care is the sole basis of a good programme, others feel the need of additional services to handle the emotional field before the programme can class itself as adequate. If it can be assumed that every case of allergy in children includes some physical and some emotional content, with the balance differing widely in each individual, then, it will follow, that the best professional services that can be provided today are in the form of a cooperating team of doctor, nurse and medical social worker. Available to this team, there must be all the usual facilities of a modern clinic or hospital, in addition to the special facilities commonly used in the treatment of allergies.

It is clear, then, from the study as a whole, that children with allergies have certain needs besides those of medical diagnosis and treat-
ment. Case examples show that these needs are of a psychic, emotional and social nature. From a large number of the case examples given in the thesis, it is also obvious that unless these needs are met, medical treatment is either slow in producing positive results, or it is rendered useless.

These psychic, emotional and social factors can be dealt with, most adequately, by a medical social worker, who is equipped to do so. However, in order that the most adequate service can be provided, the doctor must have an awareness of the special contribution of the social worker in the medical setting; and, as leader of the treatment team, he should be able to make the best use of the social worker's skills for the benefit of the patient. With her concern for the individual human personality, the treatment work of the social worker is necessarily slow; and, consequently, for the most adequate results, it is necessary that the doctor should have an understanding of this fact.

The medical social worker is able to offer a number of different services within her area of work. The following six services may be included. (1) Assistance to the doctor in understanding the child for diagnosis and the planning of treatment. The reason for this is that in the clinic setting, the social worker can give information on the child's environment and any particular family problems. (2) Casework service to both the child and his family. She can support the child in medical treatment, give help to overcome any fears that may arise in this connection, offer encouragement in personality development and foster independence. The parents too, can be helped to understand the aggravating problems which concern the child's development and thus relieve the child, indirectly, of considerable physical tension. (3) Preparation with the family and child for psychotherapeutic treatment, where this is required, in the more severe cases. (4) Consultation with other interested persons
(teachers, nurses, physiotherapists, etc.) to facilitate understanding of the child with a particular problem. (5) Mobilization of community resources for the benefit of the child or other members of his family. (6) Study of the psychogenic factors involved in the allergies of children.

From the statements given it is obvious, then, that the medical social worker has a responsibility in that, she must be aware of and understand the contributions of the other members of the treatment team, the doctor, nurse, dietician, physiotherapist, etc.; and she must be able to cooperate with them in the interests of the patient.

It is evident from discussions stated in this chapter that the needs outlined above, are not always being met with; and as indicated earlier in the study, records prove that, in many instances, little cognizance is being taken of the social factors involved in the cases treated. Successful results demand that each child be considered as a "whole person" and that all phases of his disorder should be treated by those people who are equipped to do so. It would be useless, for example, to administer only medical treatment to a girl who continues to have severe asthmatic attacks whenever her relationship with her mother is threatened, as can be seen in the case of Sylvia A. It is the doctor's job to provide medical care, including the alleviation of the severe symptoms in this case, and the social worker's job to assay and treat the emotional aspects of the mother-child relationship.

Most of the eighteen cases referred to the social worker, in the study group, have allergies of a severe and chronic nature, and have required special attention; but, it should be realized also, that cases of less severity may likewise need similar attention by the medical social worker, in addition to that given by the doctor. In order to facilitate the best services, all cases referred should come to the attention of the
social worker as early as possible.

It is, of course, also made evident in this Chapter that there are not enough medical social workers in Vancouver clinics and hospitals. At present, the Health Centre for Children of the Vancouver General Hospital, offers the most sufficient service according to the criteria arrived at in this study; but here, also, there is a need for a larger staff in the Social Service Department, in order that a more adequate service can be given.

One important aspect of this study, not yet discussed, is that of research. Considerable data on all aspects of the subject of allergies has been accumulated since the beginning of this century, with a stress on everything from chemistry to heredity, and many of these studies have shown that psychogenic factors are of significance. However, to a large extent, allergies remain a mystery. Thus, to relieve the suffering of thousands of people throughout the world, further research is essential.

In the light of the findings of this study, it would seem, then, that any further research should not omit consideration of the psychogenic factor.

"Since ill-health is only one of the common disturbances of family equilibrium, and since dislocation cannot be separated from the normal life of the family, the medical approach gives only a limited view of the family problem. The case worker, with her broad base in the community and her specialized skill, is in a strategic position for the assay of this equilibrium and of the indications for a coordinated treatment; whether to protect the weak areas or to reinforce the strong; whether to concentrate on some one area or to strengthen the family structure as a unit. It is true that she is not trained like the physician to know what is going on inside the body, or like the psychiatrist to explore the depths of the mind; nor has she the training or skills of the public health nurse for the promotion of health or the prevention of illness. Nevertheless, in this jigsaw puzzle of the family life she has many pieces in her hands, and she has a view of the design as a whole."

APPENDICES
<table>
<thead>
<tr>
<th>TYPE OF ALLERGY</th>
<th>MANIFESTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASTHMA</td>
<td>Paroxysmal attacks of shortness of the breath, commonly attended with cough, wheezing, and constriction of the chest.</td>
</tr>
<tr>
<td>HAY FEVER</td>
<td>An acute affection of the conjunctiva and upper air passages, characterized by coryza, sneezing, rhinorrhea, headache, and intense itching of the eyes and upper air passages. Syn. Allergic Rhinitis.</td>
</tr>
<tr>
<td>URTICARIA (Hives or nettle rash)</td>
<td>A skin condition characterized by the appearance of intensely itching wheals or welts with elevated, usually white, centres and a surrounding area of erythema. They appear in crops, widely distributed over the body surface, tend to disappear in a day or two.</td>
</tr>
<tr>
<td>ECZEMA</td>
<td>An acute or chronic, non-contagious, itching, inflammatory disease of the skin; usually characterized by irregular and varying combinations of edematous papular, pustular, scaling, thickened, or exudative lesions.</td>
</tr>
<tr>
<td>VASOMOTOR RHINITIS</td>
<td>An affection of the upper air passages characterized by sneezing, headache, and itching of the eyes and upper air passages. (a) Allergic Rhinitis. (b) Hay Fever.</td>
</tr>
</tbody>
</table>
Appendix B.

BIBLIOGRAPHY


Dunbar, Flanders, M.D., Mind and Body: Psychosomatic Medicine, New York, Random House, 1947.


Richardson, Dr. Henry B., Patients Have Families, The Commonwealth Fund, New York, 1948.


Vaughn, Warren T., M.S., M.D., Primer of Allergy, A guidebook for those who must find their way through the mazes of this strange and tantalizing state. The C.V. Mosby Company; St. Louis, 1939, 1943 (second edition).


Weiss, Dr. Edward, and English, Dr. O. Spurgeon, Psychosomatic Medicine, The Clinical Applications of Psychopathology to General Medical Problems, W. B. Saunders Company, Philadelphia, 1943.