BEHAVIOR DISORDERS AMONG FILIPINO CHILDREN

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This retrospective study is a survey of the available actuarial data on emotional disturbances among Filipino children in Metro Manila and two provinces each in Luzon, Visayas and Mindanao. A total of 548 charts were analyzed in terms of: age of application/consultation, sex, father's education/ occupation, mother's education/occupation, frequent caretaker, birth order, chief complaint and diagnosis.

The incidence of mental illness is growing not only in our own country but all over the world. Whether this is related more to their recognition than to an actual increase in their incidence is yet to be determined. But many concerned clinicians and students still bewail the absence of outstanding material and the literature "necessarily lags behind new developments" (Chess & Thomas, 1970). There is, indeed, a surprising paucity of research specifically concerning the psychiatric disorders of childhood. Most articles, according to Chess and Thomas, are anecdotal and impressionistic case studies, reporting clinical vignettes about few patients and stressing metaphysical structures or problems in psychotherapy, rather than presenting a comprehensive clinical description which would aid diagnosis. Thus, Cantwell (in Noshpitz, 1979) concludes that "among all the medical specialties, psychiatry has one of the poorest reputations for research. Child psychiatry, in fact, has essentially no research reputation at all."

Such a dearth in the literature, though, can be easily explained by several factors, foremost among which is the "protection" given by child psychiatrists to their patients, as dictated by medical ethics. One psychiatrist commented, "I will lose all my patients if the parents learn that I have shown my patients' records to other people."

It is also possible that researchers are still not sufficiently clear about which questions the usual clinical research may be able to answer (Feinstein, 1987):

> "Too often, he thinks the only worthwhile question for research to deal with is the question 'Why?' In other words, too many clinicians feel disease and that phenomena whose causes are unknown cannot be properly managed. . . . The most succesful research students must content themselves with the partial answers to the question 'How?' How does this or that phenomena, event or process occur is not only the usual result of investigative work, but also, if answered, generally provide validly useful knowledge. It also forms a firm base for further explorations, of other 'Hows'."

Related to the above observation is the problem of using hospital and clinic records as unobtrusive measures. In addition to the limitations of archival records, some data tend to be more relevant than others, depending on the psychiatrists' orientation. Hence, many of the sociodemographic information being sought for may be obtained in some records but not necessarily in others.

Another barrier to research on behavioral disorders is the long-standing controversy regarding classification of psychiatric illnesses. The absence of taxonomy with which to guide clinicians with "clear, conscious logic in therapeutic decisions and acts and in his clinical judgment of prognosis (Szurek & Philips, 1969) and the belief that descriptions of clinical phenomena cannot be scientifically precise can stifle research activities.

Nevertheless, clinicians and researches must have a common language with which to com-

municate about the disorders for which they have professional responsibility. Planning a treatment program must begin with an accurate diagnostic assessment. The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined (Spitzer, 1980).

Currently, there are at least four nosologies in common use in the field, namely: The DSM III; the Group for Advancement of Psychiatry's Psychopathological Disorders in Childhood (1966); Rutter, et al.'s Multi-Axial Classification (1975); and, Eissler, et al.'s Psychoanalytic Assessment (1977). Hopefully, through clinical and epidemiological studies during the coming years, a consensus will be reached on which of these systems represents the most accurate set of assumptions and criteria about psychiatric disorders in children. Thus far, there are three well-recognized types of psychotic illness in children and adolescents: (a) Childhood Schizophrenia; (b) Early Infantile Autism; and, (c) Depressive Illnesses.

A wide variation also exist among clinician's description of signs and symptoms. Unlike non-psychiatric disease entities that exhibit definitive signs, e.g., green, watery stools for Diarrhea or nuchal rigidity and opisthotonous position for Meningitis, a diagnosis of Schizophrenia cannot be done as easily. One charac teristic though seems to be common: an altered relationship with reality. Thus, a child suffering from schizophrenic type of psychosis is withdrawn from—or perhaps never involve in—the real world of people and their emotional relationships, their aspirations and endeavors. A child who is psychotically depressed sees reality falsely as hostile, rejecting, punishing and unforgiving. A child suffering from organic psychosis may have an altered relationship with reality as the result of with drawal or depression and, in addition, his inertia of mind shows itself in a lack interest in the events of the world around him and a growing self-centeredness, with a loss of social sense and self-control. There is also, without exception, a disturbance or inappropriateness of mood.

Not only are there variations in diagnoses, causative factors, classification and symptomatology, there are also differences in treatment modalities. In many medical centers and clinics, psychiatrists and other clinical psychologists continue to use an eclectic approach, combining family-centered, parent-centered and/or child-focused psychotherapies; drug therapy; and the enhancement of social and educational skills. The present delivery system for the mentally ill cannot be attributed to any single factor. The shift in focus of mental health care from institutions to community, from the medical model to the inter disciplinary team and from society-oriented to patient-oriented developed from the interaction between scientific discovery, public pressure and patient demands.

Notwithstanding difficulties in research work, the sustained interest in child development points to the need for continuing efforts in making "every possible subjective process explicitly conscious and repetitively and progressively clear" (Freud in Szurek & Phillips, 1973). Towards this end, this paper attempts to present actuarial data from records only made availabe by written permission of child psychiatrists, private and public hospitals.

METHODOLOGY

Since the primary objective of the study is to present actuarial data on emotional disturbances among Filipino children, it will only "assess the distributions of the characteristics of the population" (Kidder, 1981), not infer causal relationships.

Setting

In Metro Manila, seven (7) government hospitals/agencies and one (1) private hospital gave written permission for the investigator to look into the patients' records during the periods 1986-1987. Private practitioners in two provinces each in Luzon, Visayas and Mindanao also

allowed the investigator to examine their patients' charts. The choice of the setting was mainly based on convenience.

Subjects

The sample is made up of a total of 548 patients, almost half of whom (46 %) come from Metro Manila. The data were taken purely from hospital and clinic records and no attempt was made whatsoever to interview any of the subjects. Table 1 shows the distri bution of the subjects according to setting.

This study is not a survey on the overall incidence of emotional disturbances in various regions of the country and, therefore, the figures do not necessarily mean that there are more emotionally disturbed children in Metro Manila than in Mindanao or the Visayas or in Luzon in that order.

Table 1. Distibution of Subjects According to Setting.

SETTING:	No. of Subjects:	Percentage (%)
Metro Manila :	252	46
Luzon	48	9
Visayas	69	12
Mindanao	179	33
TOTAL	548	100

For the statistical survey of the sample, eight (8) variables were correlated with emotional disturbances in children, namely: age of application (when consultation was first sought), sex, father's education/occupation, mother's education/occupation, frequent caretaker, sibling order, chief complaint/presenting symptom and diagnosis. All items are stated in discrete (non-continuous) form and treated by a nonparametric statiscal technique (chi-square).

A. Age of Application. The ages of the subjects when they first sought medical consultation ranged from 5 to 19 years. Table 2 shows the distribution by age and setting. A total of 17 children (3%) were the youngest at 5-7 years old, with the greatest number coming from the oldest age range of 17-19 years (272 or 50%). Of the youngest 5-7 year olds, 3 are 5 years of age, 2 of whom are males and all 3 are diagnosed to have organic brain syndrome.

The data in Table 2 seem to suggest an increasing incidence of emotional disturbances with age. This pattern was true for all four geographic settings. Not surprisingly, the last age group had the most cases. This can be attributed to the adolescent having to cope with society's mixed feelings about him as he is torn between remaining a child or becoming an adult. The rapid bodily and emotional changes, with an upsurge of his sex drive, threaten his psychological balance. The emotional upheaval is so pronounced, in fact, that some observers have called adolescence the period of "normal psychosis."

The Isle of Wight studies (in Kashani, et al. 1987) showed that overall, psychiatric disorders were slightly more common in adolescence than in middle childhood. Kashani, et al.'s study in a community sample of 150 adolescents identified 18.7% of teenagers to be having psychiatric disorders. Although sex, socioeconomic status and parental separation were not significantly related to psychiatric disorders, the variables physical abuse, sexual relationships, and cigarette smoking did correlate posi tively with psychiatric disorders. In addition, the diagnosed adolescents reported resolving their conflicts through verbal aggression and physical violence, had significantly lower self-concepts, and viewed their parents as less-caring. Male adoles cents with psychiatric disorders were given higher "externalizer" ratings by their

Table 2. Distribution of Subjects by Age.

AGE (In yrs.)		
5 - 7	17	3
8 - 10	15	3
11 - 13	51	9
14 - 16	193	35
17 - 19	272	50
TOTAL	548	100%

parents, while diagnosed female adolescents were reported to have more somatic complaints.

It is heartening to note that most (493 or 90%) of the subjects in this study reported for consultation as soon as the behavioral manifestations became apparent. The time lapse between the onset of symptoms and the consultation ranged from several days to less than six months. Of the remaining 55 (10%) of the subjects, the initial consultation was made not earlier than one year, but not later than three years after the onset of symptoms, although an earlier consultation was made with an "albularyo" or a known "manggagamot" in the community.

B. Sex. Of the total sample, 312 (57%) are males and 236 (43%) are females, or a ratio of 1.3 males to 1 female. Across geographical areas, the percentages of males were: Metro Manila, 54%; Luzon, 56%; Visayas, 62%; Mindanao, 60%. This finding approxi mates that of Shain and Yannet (less than 2 to 1) but is very much less than Eisenberg & Kanner's 4 to 1 male predominance ratio (in Bomberg, et al., 1973).

C. Father's education/occupation. Not all of the charts contained data on the father's occupation, much less his educational attainment. The entries were non-specific. Neither was there uniform definition of the terms used; in the Visayas, for example, the occupation "farmer," the investigator was told, means "landowner," while in Luzon, this refers to the "tenant." Nonetheless, in this study, "professionals" refer to doctors, engineers, architects, landowners, businessmen and retirees, "non-professionals" to high school graduates, drivers, fishermen, tenants, carpenters, mechanics, and vendors; and "none" refer to the unemployed.

Of the 186 (34%) patient's charts which contained entries regarding father's education/occupation, 120 (65%) were non-professionals, 41 (22%) were professionals, 10 (5%) were unemployed and 15 (8%) fathers were deceased.

In 1944, Kanner (in Bomberg, et al. 1973) reported a preponderance of parents from professional and managerial occupations, in 100 cases of infantile autism which Bettelheim in 1967 surmised as an artifact. He argued that it was probably the well-informed parent who would be more likely to learn of the facilities offered by Kanner and only the well-to-do who could afford to travel to psychiatric specialty centers. Bomberg, et al.'s own study, found the largest percentage of fathers in skilled labor, clerical and sales, similar to the study at hand. Perhaps, psychotic disturbances in children are not limited to any one socioeconomic level, but rather a complex interaction of multiple factors both internal and external. In this study, the finding that there are more non-professionals may be due to the fact that more subjects belonged to the lower middle or low socioeconomic status.

D. Mother's education/occupation. In view of the limited number of entries (185 or 34% of the total 548 subjects), the investigator decided on only two main categories, "Earning" and "Not Earning." Mothers who had income of their own comprised 74 (40%) of the 185 recorded entries, 103 (56%) were non-earning housewives and 8 (4%) were deceased.

The mother's occupation has been found to be highly significant at the $p < .05$ level, i.e., the observed frequencies differ significantly from what would be expected by chance.

E. Frequent Caretaker. In the Philippines, the extended family and the *yaya* system are the rule rather than the exception. Thus, it is not unusual for a child to grow up in the care of a grandmother, an aunt/uncle, an older sister/brother, even a godmother, or a non-related hired help (more popularly called *yaya*).

The dynamics of the Filipino family system is not so easily deciphered (Carandang, 1987). The Filipino family system is made up not only of the parents and the children but also grandparents, an unmarried aunt who may be supporting the whole family financially, an uncle, the *yaya* who knows the child more intimately, a cousin whose parents live in the

province, or an unmarried daughter with several children. Carandang explains that in our extended family system, the child can get lost and may have a difficult time finding a way to be recognized as a unique person. To satisfy his needs, he has to attune himself to the different adults in the family, as well as to his siblings. In such an interwoven system, the dynamics and interrelationships become more intricate.

If only to prove his uniqueness in Philippine culture, it is the only variable in fact, apart from the basic sociodemographic data of name, age, and address which is recorded consistently in 412 (74%) of the total 548 charts studied. Data indicates that 176 (43%) of the subjects were taken cared of by both parents, 192 (46%) by mothers alone, 32 (7%) by significant others and the remaining 12 (3%) were solely in the care of their fathers. This variable, in addition, is highly significant at the $p < .05$ level.

Of the 32 subjects who were under the care of significant others, a third of them were taken cared of by their grandmothers. French (in Carandang, 1987) says that "knowing the real power in the family is very important in deciding the most effective strategy to be undertaken." In many instances, it is the *lola* who is the real power in the Filipino family.

However, the *yaya*, which has become a permanent fixture in many Filipino homes, does not seem to have much "power" in this study. There are more mothers who are not employed in this study and are, therefore, expected to be taking care of their children themselves. Then too, most of the subjects come from the lower socioeconomic group which can ill-afford to hire a *yaya*.

F. Birth Order/Sibling Rank. Only 247 out of the 548 charts studied (45%) contained entries regarding birth order. Table 3 shows their distribution. The data seem to indicate that middle children (52%) are at most risk for emotional problems. However, this figure should be judged *vis-a-vis* the percentage of middle borns in the population as a whole. That percentage in not

Table 3. Distribution of Subjects According to Birth Order

BIRTH ORDER									
Eldest		Middle		Youngest		Only Child		TOTAL	
No.	%	No.	%	No.	%	No.	%	No.	%
70	28	128	52	44	18	5	2	47	100

readily available. But supposing that 70% of the population are middle children, then our finding that 52% of the emotionally disturbed would actually indicate less vulnerability among them.

G. Presenting Complaints. Table 4 lists the presenting complaints in the order of frequency with which they were reported by the parents. Most of the subjects usually had multiple manifestations for which they sought psychiatric consultation.

The rank of these complaints does not necessarily mean that there are more subjects with such symptoms; rather it represents to some degree the order with which parents find these various problems disturbing. The high frequency of affective disturbances as a complaint, therefore, reflects a greater readiness to report the behavior than interest-activity disturbance.

Affective disturbances include:

Table 4. Presenting Complaints

Disturbance	N	%
Affective Disturbances	260	31
Sleeping Disturbances	131	16
Hostile Aggression	106	13
Drug Abuse	79	9.5
Somatic Complaints	71	8.6
Perceptual-Thinking Complaints	65	8.0
Eating Disturbances	37	4.5
Speech Disturbances	34	4.0
Motility Complaints	25	3.0
Social Relationship Complaints	12	1.5
Interest-Activity Complaints	6	7
Toilet Training Problems	2	2

1. Absence of affective expression, e.g., blank stares
2. Manneristic expression of affect, e.g.,

mirthless laughter

3. Extreme fearfulness, phobias, explosive affect, e.g. screaming, violent rages

4. Moodiness, irritability, volatility, manifest unhappiness

Sleeping disturbances refer primarily to insomnia.

Hostile aggression includes:

1. Violent behavior toward self or other-directed

2. Persistent voluntary muscle tension to the point of structural change, e.g., biting

3. Nondiscriminatory physical attack on objects, animals or people

4. Destructive behavior directed toward specific objects or people.

5. Antisocial behavior such as fire-setting and sexual aggression. Only one subject was complained of as having tried to set the house on fire, while two subjects were complained for sexual advances.

6. Verbalized threats of violence or of suicide. There were 23 out of 548 subjects (4%) who attempted suicide, 13 of whom are females and 10 are males, ranging in age from 14 to 17 years. There were 8 who were 18 years old and only one year old.

Drugs problems were stated in various ways: substance abuse, drug abuse, drug dependent or drug effect. Somatic complaints include epileptic seizures, allergic reactions, anorexia, hysterical paralyses.

Perceptual-thinking complaints include:

1. Unresponsiveness to sensory stimuli

2. Confused chaotic behavior

3. Learning arrest

4. Thought aberration such as hallucinations or ideas of reference ("Sinasabihan ako, ang dami kong angeles na katabi"; "I was sent by the Lord to carry His message")

Eating disturbances refer purely to refusal or inability to eat. Speech disturbances other than mutism include:

1. Unintelligible vocalizing

2. Speech arrest or retrogression

3. Limited application of speech

4. Obsessive-compulsive speech

5. Marked use of profanity

6. Manneristic speech, parroting, or echolalia

Motility complaints include:

1. Total inertness

2. Inhibited movement of parts of the body

3. Poor coordination

4. Well-coordinated overactivity

5. Motility restricted by ritualistic or symbolic gestures or movement

6. Random overactivity

Social relationship disturbances include:

1. Isolation from adults, siblings and other children

2. Selective avoidance of others

3. Indifference about appearance; poor hygiene

4. Expressions of interpersonal discomfort as in suspiciousness, or the anticipation of ridicule

Interest-activity complaints include:

1. Massive inhibition of curiosity and exploration

2. Exclusive preoccupation with the body

3. Limited repetitive activity

4. Ideational preoccupation, e.g., religious, somatic, sexual. Only one subject was labelled as sexually preoccupied and another one caught masturbating.

Toilet training problems were noted in only three of the subjects and ranged from incomplete incontinence to playing with the feces.

H. Classification of Sample Into Subgroups. There are seven clinical groups that developed from the diagnostic labels taken from the 548 charts. Some diagnoses were too general, e.g., Emotional Illness, Neurosis, Psychosis, Neuropsyche, Schizophrenic. While others were too detailed: Oedipal conflict, Psychasthenia, Paranoia, Anxiety state, Suicidal tendency. A Few had no diagnosis whatsoever, save for the literal manifestations. In view of the latter two categories (too detailed and no diagnosis), only a total of 481 out of 548 (88%) diagnostic classifications can be accounted for, as shown in

Table 5. Based on the DSM III nosology, this subdivision of the total sample into the seven subgroups is a rough effort to categorize the variety of clinical phenomena encountered in charts of emotionally disturbed Filipino children in seven representative areas of the country.

Three observations have been found to be outstanding as far as diagnostic labels in emotionally disturbed children are concerned. Firstly, not one of the subjects was diagnosed as Borderline Syndrome.

Second, depression as a psychiatric diagnosis was observed to be associated with a major category, e.g., Psychotic depression, Hyperkinesis with depression, depressive neurosis, Adolescent Adjustment Reaction with depression or categorized per se. Actually, the prevalence of childhood and adolescent depression is difficult to evaluate because of the differing diagnostic criteria employed across studies (Faulstich, et al. 1986). In this particular study when taken collectively, depressive states comprises only a small proportion the sample (68 or 14%). The ages of the subjects labeled as depressed range from 7 to 18 years, a majority (46%) of whom are 17-18 years old, favoring girls more than boys at a 1.4:1 ratio. This finding resembles that of Kandel & Davies (in Kashani, et al., 1987) who reported significantly more depressive symptoms in female than male adolescents and an increasing incidence from preschool age and school age.

TABLE 5. CLASSIFICATION OF SAMPLE

Diagnosis	N	%
A. Disorders Usually First Evident in Infancy, Childhood & Adolescence		
1. Mental retardation	12	2.5
2. Anxiety disorders	12	2.5
3. Hyperkinesis	3	0.6
4. Conduct disorder	2	0.4
5. Autism	2	0.4
B. Organic Mental Disorders		
1. Substance Abuse		
a. drugs	92	19.0
b. alcohol	3	0.6
2. Organic Brain Disorder	23	5.0
C. Schizophrenic Disorders	177	37.0
D. Psychotic Disorders Not Elsewhere Classified	33	7.0
E. Affective Disorders		
1. Bipolar	14	3.0
2. Unipolar	3	0.6
F. Dissociative Disorders	12	2.5
G. Adjustment Disorders	93	19.0
TOTAL	481	100.0

Lastly, a closer look at the various diagnoses in Table 6 shows Schizophrenic Disorders as the most common (177 or 37%) emotional disorder among the Filipino children in this study, followed by Organic Brain Syndrome (25%) and Adjustment Disorders (19%).

It is not the category of Disorders Usually First Evident in Infancy, Childhood and Adolescence which is the most common, considering that this is the focus of emotional disturbances in children. Even such a childhood disorder as autism, was seen in only two subjects, a 13-year-old girl and a 10-year-old boy, both of whom are middle children.

The same is true with hyperkinesis where there were only three subjects diagnosed as such, one 7-year-old and two 6-year-olds, all of whom are males (the condition is known to affect boys more than girls, the ratio being around 6:1). Apparently, though, this trend is also true in other countries where the hyperkinetic syndrome accounted for only 2.1% of Hongkong patients and 1.5% of patients in the United Kingdom. However in North America, about 40% of the children were diagnosed with this disorder (Luk & Mak, 1985).

Such data questions whether there is any difference between Childhood Schizophrenia and the Adult type. Where the former ends and the latter begins is yet a crucial concern; at best it can be surmised that the two are the extremes of a spectrum of emotional disturbances. In fact, Bender (in Shaw & Lucas, 1970), in a long-term follow-up cases, found that between 85 and 90 percent of childhood schizophrenics became adult schizophrenics.

Indeed, "psychiatry has a long-established need to deny that an illness as serious as schizophrenia can occur in childhood" (Cantor, et al., 1982). A clear-cut solution can only be made when a more precise identification shall have been found, substantiat ed by closer observation of the symptoms and their specification, designations, rating, clustering, and clinical course. Such investigations can help transform a less explicit study into a clinical science.

Summary and Conclusion

This study is apparently the largest and only available survey of actuarial data on emotional disturbances among Filipino children in Metro Manila and two provinces each in Luzon, Visayas and Mindanao. A total of 548 patients' charts were analyzed. The following findings are deemed to be important in this particular study:

1. The youngest subjects are three five-year-olds who were all diagnosed to be having Organic Brain Syndrome.

2. There is an increasing incidence of emotional disturbances with age. Half of the subjects (50%) are 17-19 year-old adolescents.

3. Ninety percent (90%) of the subjects sought medical consultation as soon as behavior manifestations became apparent. Of the remaining ten percent (10%), an "albularyo" was first approached for advice.

4. There are more males than females (1.3:1.0) who are emotionally disturbed, although the difference apparently is not signifi cant.

5. Most of the fathers (57%) are non-professionals and most of the mothers (56%) are not earning at all.

6. The emotionally disturbed children in this study are primarily under the care of their own mothers. Of the seven percent (7%) who are taken cared of by significant others, the grandmother is the major caretaker.

7. Middle children are at most risk for emotional problems, more than half of whom are males.

8. Of the presenting complaints for which parents sought consultation, affective disturbances, e.g., "natutulala," were the most common, while toilet training problems were the least of their concerns.

9. Not one of the subjects was diagnosed as Borderline Syndrome; depressive disorders comprised only a small proportion of the sample; and, the three most common emotional disorders of the Filipino children in this study are Schizophrenia, Organic Brain Syndrome and Adjustment Disorders.

10. Using the nonparametric chi-square, sex, mother's occupation, frequent caretaker and birth order are considered significant at the p .05 level.

Fully recognizing the limitations imposed by a retrospective study such as this, the investigator suggests a more descriptive anterospective observation in recording behavioral manifesta tions, substantiated by interviews or parents in an effort to recover more fully the early developmental history of emotionally disturbed children.

REFERENCES

American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders. Cantor, Sheila, et al. (1982). Childhood schizophrenia: Present but not accounted for. *American Journal of Psychiatry*, June: 8-762.

Carandang, Ma. Lourdes A. (1987). *Filipino Children Under Stress*. Quezon City: Ateneo de Manila University Press.

Chess, Stella & Thomas, Alexander (1970). *Annual Progress in Child Psychiatry and Child Development*. New york: Brunner/Mazel Publishers.

Faulstich, Michael E., et al. (1986). Assessment of depression in childhood and adolescence:An evaluation of the center for epidemomiological studies depression scale for children (CESDC). *American Journal of Psychiatry*, August, 1024-1026.

Kashani, J.J., et al. (1986). Depression and depressive symptoms in preschool children from the general

population. *American Journal of Psychiatry*, September, 1138-1143.

Kolb, L.C. & Brodie, H.K. (1982). *Modern Clinical Psychology*.Philadelphia: W.B. Saunders.

Luk, S.L. & Mak, F.L. (1986). Hyperkinetic syndrome of childhood. *Journal of Pediatrics, Obstetrics and Gynecology*,. September and October, 7-12.

Noshpitz, Joseph D. (1979) *Basic Handbook of Child Psychiatry*. New York: Basic Books, Inc.

Shaw, Charles & Lucas, Alexander (1970). Childhood schizophrenia. In *The Psychiatric Disorders of Childhood*. New York: Appleton-Century-Crofts.

Szurek, S.A. & Philips, Irving (1973). Clinical work and clinical research as scientific inquiry: Five conceptual barriers to clinical science. In Szurek, S.S. & Berlin, I.N. (Eds.), *Clinical Studies in Childhood Psychoses*. New York: Brunner/Mazel Publishers.