Loners

The Life Path of Unusual Children

Sula Wolff

Foreword by Leon Eisenberg, MD
Harvard Medical School

Loners

Loners describes a unique group of solitary children who were unable to adapt to the social and educational demands of school life. All were seen in a child psychiatric setting over a twenty-year period. Some of these children were gifted; most coped better once they had left school.

Sula Wolff brings together the results of a number of studies of these 'schizoid' children and illustrates the findings with detailed case histories. The condition of the children is thought to represent a constitutional deviation of personality development. It is discussed in relation to Asperger's original description of autistic psychopathy of childhood and in relation to current diagnostic practices in child and adult psychiatry.

Loners makes the case for the clinical recognition of such children although they are on the whole not nearly as impaired as those children who are currently given a diagnosis of Asperger's syndrome. Even when mildly affected, they and their parents need a treatment approach which differs from that for children with disorders due to adverse life experiences.

Loners will help psychiatrists and other professionals towards a realistic approach to the treatment and education of people with this condition, both children and adults.

Sula Wolff, a child psychiatrist, formerly at the Royal Hospital for Sick Children, Edinburgh, is Honorary Fellow at the University of Edinburgh Department of Psychiatry. She is the author of *Children under Stress* (1968; 2nd edn 1981) and *Childhood and Human Nature: The Development of Personality* (1989).

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The Life Path of Unusual Children

Sula Wolff

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Foreword

Loners is destined to be a clinical classic. Sula Wolff has described a group of youngsters with socially isolated personalities and unusual interest patterns who do not fit criteria for other established clinical entities. Her analysis is based on remarkably broad personal experience, not only with the initial evaluation of such youngsters, but with the course of their development into young adulthood. The syndrome she has described is important because the clinical management of youngsters with this personality pattern is distinctly different from that appropriate for others. Customary approaches based on psychodynamic investigations and therapies aimed at altering intrafamilial relationships are contraindicated. Parents need to be helped to understand that the prognosis, for the most part, is relatively good; that these youngsters need support at school and at home to cultivate the assets they have; and that pressure for socialization by joining clubs and groups is likely to be counterproductive.

The last chapter of this book is no less fascinating than the rest. In particular, Dr Wolff suggests that Ludwig Wittgenstein may well have been such a loner. I, for one, am persuaded by the evidence she presents, though, of course, it suffers from being limited to a retrospective search for data. Not many loners will grow up to be Wittgensteins, though I would not be surprised to find his counterparts among mathematicians, philosophers, lighthouse keepers and forest rangers – individuals who have chosen careers which usually limit their social interactions. Let me at once confess that I do not know, either socially or professionally, any lighthouse keepers or forest rangers; I do know academics who fit the pattern!

In the Preface to his *Tractatus Logico-Philosophicus* Wittgenstein (1922) wrote that the whole meaning of his book could be summed up in the following words:

> What can be said at all can be said clearly; and whereof one cannot speak, thereof one must be silent.

Wittgenstein does not seem to me to have lived by his aphorism; the *Tractatus* is not always clear and it was not always persuasive even to Bertrand Russell, his mentor. Sula Wolff, on the other hand has observed his injunction with great fidelity. What she says, she says clearly. Her style is simple and direct. And whereof she cannot speak, such as the causes of the syndrome, she is silent as all must be until these are uncovered.

In the more than forty years I have been an academic child psychiatrist, I have emphasized to trainees the importance of clinical descriptive and phenomenological research. Most demur on the grounds that 'everything has already been described'. *Loners* proves them wrong. The task of separating out new clinical syndromes is not easy. It takes a good clinical eye; it requires being willing to stick by families and support them even though one is frankly puzzled about the best tack to take and uncertain about outcome; it takes a mind that is not hobbled by conventional modes of thought. The notion that children may differ in personality for reasons which are not experiential is no longer radical. It was very much so when Sula Wolff began her clinical work. Psychodynamic *furor therapeuticus* was ubiquitous. Watchful waiting has never been easy for doctors; it is, however, the only safeguard against iatrogenic disease when uncertainty abounds.

I wish I had had *Loners* to read when I began my career. I would have avoided clinical errors I made and only remedied after reading Dr Wolff's earlier papers on the subject. I commend this book to all those starting out on their mental health careers as an insightful portrait of an important condition and as a standard of clarity and brevity for their own research and writing. I commend it as well to mature clinicians whose understanding will be sharpened by studying its contents. This monograph demonstrates the importance of careful clinical longitudinal observation and incisive thought for the provision of appropriate psychiatric care for children and their families.

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REFERENCE

Wittgenstein, L. (1922/1981) *Tractatus Logico-Philosophicus*. Translated by C. K. Ogden. London: Routledge and Kegan Paul Ltd.

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Most of all, I want to thank the many former child patients and their parents who told us about themselves and their lives and often made us welcome in their homes. Their readiness to keep in touch, sometimes for very many years, helped us to gain a new understanding of important aspects of personality development.

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Author's note

All names of the participants of the studies are fictitious, and the case histories have been somewhat disguised in order to preserve anonymity. But what the children, the children grown-up and their parents actually said has been quoted verbatim, because no secondary account can ever do justice to the vividness with which people communicate about their life experiences.

Wenn wir einen Chinesen hören, so sind wir geneigt, sein Sprechen für ein unartikuliertes Gurgeln zu halten. Einer der Chinesisch versteht, wird darin die *Sprache* erkennen. So kann ich oft nicht die *Menschen* im Menschen erkennen.

(If we listen to a Chinese, we are inclined to regard his speech as inarticulate gurgling. Someone who understands Chinese will recognize it as *language*. In the same way I can often not recognize *the humanity* of another human being.)

(Wittgenstein, 1991, p. 18)

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Introduction

IAN had serious behaviour problems at school from the age of 9, and at 14 he was referred to a child psychiatrist. He did not share the interests of the other boys, who found him snobbish and 'precious'; he was temperamental, aggressive and sullen, annoying other children until they retaliated; then he would lose control, screaming and holding his head. He had only one friend, and got on better with adults, conversing with them at a level beyond his years and his just average intelligence.

Ian could not tolerate quite ordinary stresses, running away at the prospect of an immunization and weeping when put into the second instead of the first of two music groups. He had only a single friend. Once, when his school books were torn up by other children, he simply threw them away on his way home from school. Ian's abiding interest was music, and his favourite composers were Benjamin Britten and Shostakovich. He played percussion in the school orchestra and had just started to learn the piano. His school work was adequate, except for maths. His total preoccupation with musical interests and his special musical gift were insufficiently valued at school.

In an essay about his life, Ian wrote: 'I like classical music which I regard as a serious art. . . . (one) of the periods which I dread most is PE. I am never very good at it. I have tried to play but if I am playing tennis or badminton I usually miss the ball. . . . Most of the people in my class do not have the same interests as me; they usually scorn and laugh. . . . I would really like to create some kind of friendship with my contemporaries in my class. I have difficulty in communicating with them because they either talk about sport or what they did last night. I definitely think that they can see that I have not a very good sense of humour. I have tried to change my way before but I seem to be falling into the same old rut again. . . . I seem to get on better with adults than I do with people of my own age.'

Ian had been a healthy but irritable baby, born by Caesarean section because of his mother's ill health. His general development was normal, but he had always been solitary, a poor mixer, rigid in his views and unable to adapt to the wishes of others. As a little boy he often lost his temper. He needed little sleep, contentedly lying awake at night, thinking or reading. He had enjoyed play group, but never fitted in at school. From the age of 3 he listened to modern composers, such as Gustav Holst, with passionate interest. Ian's father, a withdrawn and uncommunicative man, taught music, and two of his grandparents had also been musical. The mother, warm and affectionate, did her best to smooth Ian's path.

In his mid-teens Ian joined a youth orchestra, but fell out with the instructor and was asked not to come back. He was thought to be arrogant. He said: 'I was wanting to move forward more and they thought it was big-headed. If a point wasn't right, I'd explain it to the instructor.' The instructor, in turn, thought the boy was undermining him, and said: 'If Ian comes back, I'll retire.' His music tutor was more tolerant, merely smiling when Ian stamped his feet or said 'you can't teach me anything', so that the lessons continued.

In his final school year, Ian was chosen from among 400 candidates to join a prestigious youth orchestra. He went to music college and ended his course with distinction. It is remarkable that in later years he seemed to get on better in foreign countries, where a language barrier may have disguised his persisting difficulties in making emotional contact with other people. For his post-graduate studies he went to Europe and now, at the age of 28, after a period of real difficulty in finding work, he teaches orchestra to children in the Middle East.

On reading an account of the study to be reported in this book, he wrote that he 'recognized the observations contained therein only too clearly' and would like 'younger people at school [to] avoid the situation that the other participants and myself experienced during our time spent at school.'

All teachers but few parents know that some children are loners. These children cannot fit in, especially at school and, while sometimes gifted, their odd and eccentric behaviour creates trouble for themselves and others. The causes of these difficulties are often misunderstood. Parents may be blamed for failing to discipline or even for emotionally harming their offspring. This is especially so if, as often happens, the parents themselves have some of their children's personality traits.

This book sets out to give an account of a group of eccentric loners who were disturbed enough to be referred to a child psychiatric clinic, and who were followed up into adult life. Throughout, comparisons will be made with a control group of other referred children also reassessed in later years.

Some of the affected children were gifted and established successful working and family lives for themselves. Some, if also intellectually impaired, tended to remain solitary and dependent on their families. A few had a delinquent development, especially when exposed to social demands beyond their competence, and a very few became mentally ill.

This book has two aims: one practical, the other more speculative. The practical aim is to help parents, teachers and young people themselves to identify this particular personality constellation, which can make for major difficulties, especially at school. A degree of conformity is called for at school that is not experienced within the family or nursery group in the early years and will rarely be experienced again later, when most people can chose and structure their social and working lives to fit in with their personality make-up. Loners, often exquisitely sensitive, find the school years of gregarious conformity painful; noisy rough-and-tumble, competitive games and a prescribed syllabus are not for them. It is essential to identify such children so that their school life can be structured to meet their special needs; secondary emotional and behavioural disorders can be avoided; and the children helped to make the best use of their intelligence, interests and gifts.

The second aim of this book is to set out what is known about the nature of the condition. A number of aspects will be considered. These include: the range of severity of the disorder, from serious abnormality through mild eccentricity to a normal variety of personality functioning; its sex incidence and the manifestations in boys and girls; its frequent association in childhood with specific learning difficulties; the occasional association with both high intelligence and special giftedness; the numerically very slight risk of developing a mental illness in later life; its association with delinquency; and its possible genetic basis.

The descriptions of the childhood picture and of outcome in later life are based on clinical experience and on research findings. Most of these have been published and will be presented in summary form, with references to the fuller research reports. In the absence, at present, of systematic studies of the effects of different treatment interventions and of the educational needs of affected children, discussions of these topics can only rely on clinical experience.

1 Early observations

THE FIRST ELEVEN CASES

Some thirty years ago, as a child psychiatrist working in a children's hospital, I noticed that out of my first just over two hundred consecutively referred children, eleven had a particularly puzzling clinical picture. Many of their behavioural difficulties were exactly the same as those of other children attending the child psychiatry department, but the child's life history and family circumstances did not, as they usually do, reveal the explanations for the disorders. Most psychiatrically disturbed children have suffered from traumatic life events or chronic social, family or educational adversity, often from both, and their parents are only too aware of what the causes of the trouble might be. In a very few children disturbed behaviour is clearly due to some organic brain impairment; but these eleven children were physically healthy and only a few of them had been exposed to adverse circumstances.

All these children were boys; they ranged in age from 7 to 14 years; they were of normal, some of superior, intelligence; and nine had fathers in professional or higher managerial occupations. Ten of the eleven were referred because of marked difficulty in social adjustment at school, and eight of these were also failing educationally. The one child referred because of difficulties at home – stealing from his mother – had been solitary at school.

All the parents described their children as finding it hard to make friends and join in with group activities. School entrance precipitated the difficulties of one child; return to school after an illness those of another; a change of school those of a third; and going to boarding school was the trigger for those of two others. All these children found school life stressful, but coped with it in different ways. Two of the younger children refused to talk in class – in one case, if the teacher wanted a response, she would get the boy to write it down. A third boy, now older, had not talked in school throughout his first year there. These children had suffered from what is called 'elective mutism': they talked at home but not at school. Three children attempted to avoid going to school altogether and, if pressed, developed aches and pains: they presented with the syndrome of 'school refusal'. Another would stand by the school gate, refusing to enter until the janitor rang the bell. One boy, then 13, avoided gym and all school games, becoming panicky to the point of tears if urged to take part, so that finally the school made other arrangements for him during periods of gym and sports. Altogether seven of the eleven boys said they hated school games.

The mothers of all these children described difficulties as having existed since the pre-school years, but as not severe enough for them to have sought help. When 2 years old, one boy refused to wear a blazer, 'because if you wear a blazer, you grow up and if you grow up your parents leave you'. His mother then put his teddy bear in a blazer, and gradually her son too accepted this garment. Ten of the mothers were puzzled by their sons, concerned because they found they did not really understand them. One said: 'I don't know him as I should.' Other parents described their children as 'remote', 'lacking in feeling', 'solitary'. One mother said: 'He never lets his feelings go although he looks as if he'd like to'; another: 'He finds it difficult to show affection. Questions only result in a closing up'; and a third: 'There's a strangeness about him'.

A second characteristic reported by seven mothers was their children's difficulty in adapting to new circumstances and negativism or obstinacy over particular issues for reasons the child never made clear; if pressed to conform, temper outbursts occurred. Among other difficulties mentioned were: extreme modesty, despite the absence of parental prudishness, in three of the children; compulsive motor habits in three; and difficulty in falling asleep at night, also in three of the eleven.

One of the children, DAVID, had had two brief paranoid illnesses in which he thought a hidden tape recorder was recording him and that people were after him. To avoid this, he had to 'pay penalties' in the form of whistling and singing to the imagined tape recorder. At school he felt other people looked at him, 'because I invented this hymn'. He said: 'The main idea of the tape-recording thing was the year was not 1960 but two centuries later, and the experiment was to find out what a man was like now, and I was chosen and this was mixed up with the idea . . . I hummed songs to myself and I imagined little tape recorders all over the place. I didn't see them. I got a few theories of a whole model town . . . '

In the families of the children the most striking feature was that in five cases one of the parents, and in two other cases a more distant relative, was withdrawn and unsociable and made poor emotional contact with other people; and that in three other families one of the parents was found to talk all too freely, to have an impaired sense of what was socially appropriate, to show a mood state not apparently congruous with what was being discussed, and to have some unusual, metaphorical ways of expressing him- or herself in words. Although coping well with their work and family commitments, these three parents found tidiness and punctuality difficult to achieve.

One mother described a transient delusional experience following her last pregnancy: she found herself wandering out of the house along a country lane in a changed mood state, longing for her husband to fetch her back and feeling that if a cliff had been near, she would have thrown herself into the sea. She then heard a radio discussion and suddenly felt that the broadcaster could help her. She wrote to him, and to his response she attributed her subsequent recovery.

Four parents spontaneously likened their children to themselves or to an affected relative. One father said: 'He demonstrates a number of things which are personality characteristics of my own, I'm afraid', and went on to describe how a minor professional disagreement with a colleague had led him to give up a better paid job in order to devote five years of his life to a research project designed to prove his point; which he achieved. Of his son he said: 'His approach has been to bang his head against a brick wall. I've a sympathy for him, but his mother says she can't understand him.' One mother, who likened her son to her father, described the latter as 'brilliant but odd and impossible to live with. He couldn't make contact with other people and preferred to live alone.' Another mother felt her son resembled her brother: 'a spitfire as a child and a lone wolf who never made friends and isolated himself with his books'.

The family life of nine of the children was harmonious, and six of these had not experienced major *stressful life events* either. Two children had parents in discordant (including one disrupted) marriages; and three others had been exposed to major traumata associated with physical illness (namely, the mother's repeated stillbirths; the mother's increasing incapacity because of disseminated sclerosis; the child's own cancer and its treatment).

Like their unusual relatives, the children themselves fell into two groups: four were withdrawn and uncommunicative; seven outgoing and communicative.

The *withdrawn, uncommunicative children* engaged in the most limited conversation and play. Three of the four were extremely shy. The fourth lacked affect, discussing his stealing, for example, with detachment, and reporting one day: 'The conductor never took my bus fare today and I spent the money on sweets. . . . I had that happen before.'

Among the *communicative, outgoing* children, all of whom were of superior intelligence, two were hostile and paranoid. Faced with a family move and change of school, one boy said: 'People tell you you have to make friends and then when you do, you have to move and they want to get rid of you.' This boy preferred animals to people: 'Animals can't talk back. You don't really get to know animals and don't notice when they go away. I can't put up with other human beings. They're a nuisance more or less.' He was drawing two dinosaurs and I commented that even his dinosaur had a mate. He replied: 'Not a mate, but a sworn enemy. Would you like it if a certain animal wanted you for food?' The other somewhat paranoid boy also said: 'I prefer animals to human beings. They don't pick fights with you unless you bother them.' These two were the most rigid and obstinate of the seven communicative children, reacting with rage to demands for conformity. The remaining five were communicative and sensitive, revealing symbolic thought content unusually freely. Their conversation was characterized by emotional detachment, literalness and much use of metaphor.

One boy, in anticipation of coming to the hospital, thought: 'They're going to make a human being of me'; and after his first interview he said: 'It's as if I've been very, very sick and we've cleared up all the sick . . . [and] the smell.'

All the children said they felt different from other people. The oldest, then 14, put this most clearly: 'I'm an odd person, different from most people. I have different tastes. I like being by myself. It's my nature. I'm more fond of things than people. I see a lot of people with each other and I can't fit in. They have interests like fishing and pop records and I'm a square. I don't mind it, it's other people who object. They're nasty to me and I have to put up with it. I don't like fighting back much. I'm not a destructive type of person.'

This sense of being different and a preference for being alone was expressed by the children in different ways. One said: 'I'm different from the rest. I was called "posh one"'. Another boy said: 'I just can't make friends. . . . I'd like to be on my own and look at my coin collection. . . . I've got a hamster at home. That's enough company for me . . . I can play by myself. I don't need other people.' Another put it this way: '[I make friends] at school but not with people in the street. They like Cowboys and Indians and football and I don't. . . . I like to get away from people. . . . . I watch my mice.' A fourth boy said: 'I just don't think I'm like any of them [his mother, his father and his brother] . . . My friends are not like me. I don't talk very much. I prefer to be by myself.'

Both the withdrawn and the outgoing children had a number of *specific interests* which they pursued with unusual single-mindedness: stamp and coin collecting; music; reading; pet animals. The communicative children in addition had areas of extraordinary competence compared with their often poor school performance. The two paranoid children were very well informed and had strong views about politics. Two of the boys were exceptional at mechanical constructions, although their products were sometimes very odd. Another was expert at electronics and had made several radio and television sets. This boy also had a vivid fantasy life, which had preoccupied him for years and was to form an important part of his inner self well into his adult years. From the age of 5 he had had 'a dreamed-up island, square and on wheels on the ocean bed', which he described in a never-ending series of stories and cartoon strips.

EARLY ATTEMPTS AT TREATMENT

Seven of the children were initially diagnosed as having a psychogenic disorder, that is, their symptoms were thought to be due to adverse life experiences. A psychotherapeutic approach, however, failed to increase the therapist's, the patients' or the parents' understanding of what had brought the difficulties about. After four months of regular encounters with the 13 year old who had a phobic avoidance of gym at school, the significance of this symptom remained as obscure as before, although he was a talkative and forthcoming boy. After three months, a non-communicative 7-year-old boy was as quiet as ever, always played with his back to the room, whispered his sparse verbal responses, but told his mother that he loved coming. No change whatever had occurred in his behaviour at home, at school or in the clinic.

Attempts to urge the children to reveal their feelings more freely, or to explain to them that their symptoms might have an underlying meaning (for example, that the delusional experiences of one of the boys might reflect his worries about his mother's health) sometimes led to transient disorganization of behaviour. In one case a sudden outburst of anger – 'get away with you!' – unacknowledged even seconds later, followed such an intervention; in another case there were sudden tears and a paranoid feeling that the therapist's smile meant she was 'trying to get the better of' him.

So long as the treatment staff conveyed to the families that the child's difficulties were environmentally produced, that change in the child was expected and that the onus was on the families, with help, to bring this about, understanding between treatment staff and families remained limited. Children and parents continued to be as anxious as ever and no progress was made. But as soon as the child's symptoms were recognized as springing from his particular and inherent personality make-up, unusual but not unheard of, and certainly not caused by faulty parenting, poor teaching or ill will on the part of the boy, an understanding between treatment staff and families was established, and the child's own perceptions and those of his parents were confirmed. This brought relief to everyone, including the teachers, especially when a new spirit of hope could be introduced as well.

This hope relied on two quite specific therapeutic interventions. The first was to convey to the families and the education authorities that the children's basic personality characteristics could not be expected to change; and that the parents and the schools would need to make allowances for what the children could and could not manage, in order to help them adapt to school life. Often this meant that the child was officially allowed to avoid particularly stressful settings, like school games or a noisy playground. Sometimes education in smaller, more flexible classes was called for, and teachers were encouraged to build on the children's special interests and abilities in their educational endeavours. The second intervention engendering hope was to indicate to everyone that the child's future outlook was likely to be good. This was thought to be justified even at that time, when no systematic follow-up studies were yet available, because many of the children resembled other family members in their personality features, and these relatives had in general managed their adult lives well. Moreover, it was thought even then that, once out of school, free to avoid noisy social groups and free also to pursue their own interests and ambitions, these children might find life a good deal easier than during the regimented years of school.

WHAT SHOULD WE CALL THIS CONDITION?

Because the characteristics shared by the eleven children described above resembled those found in the older and also in the then current psychiatric literature under the term 'schizoid personality', this was the initial diagnostic label chosen for the children's condition (Wolff, 1964). It was recognized even then that this term might be misunderstood and could convey unintended prognostic gloom, because schizoid personality traits had been found to excess in the past histories of schizophrenic patients and in the biological relatives of such patients. The point needs to be made right away that, even if this is so, this tells one nothing about the frequency with which people with schizoid traits can be expected to develop this serious psychotic illness. In fact, as we shall see later, the risk is likely to be very small. What is