Brit. J. Psychiat. (1973), **123**, 575–8

Consciously Rejected Children

By D. A. PEMBERTON and D. R. BENADY

Introduction

Children who are rejected give a clinical impression of making interpersonal relationships with difficulty. Wolberg (1944) described the consequences of parental rejection as depending upon the age of the child at the time of the rejection, the manner in which frustration was imposed by the parents, the nature and extent of compensatory gratification from others, and the success or failure of spontaneous reparative attempts on the part of the child to establish accepting relationships. Earlier studies of the child's reaction to rejection were marred by the tendency to define rejection too loosely, so that both conscious and unconscious forms were included as well as more frequent ambivalent parental attitudes, with a resultant wide scatter in the form of the children's responses. However, it has been shown by comparison with accepted children that the rejected child is uncommunicative, rebellious, less friendly, and bewildered about life (Symonds, 1938). Rejected children have been noted to be hypersensitive, and it has been speculated that this stems from feelings of insecurity and of not belonging to a permanent setting (Childers, 1935). The types of reaction to rejection were sub-divided into two broad groups—aggressive and submissive (Newell, 1934). Aggressive behaviour, including rebelliousness, disobedience, temper tantrums, quarrelsomeness, stealing and truancy occurred when the parental handling was consistently hostile; while submissive behaviour, including shyness, seclusiveness, cravings for attention, occurred more frequently when the parental behaviour was consistently over-protective (Newell, 1936). The aggressive response to hostile rejection was confirmed by Wolberg, who also thought that the symptoms of delinquency, truancy, enuresis and frustration intolerance should be interpreted in the larger framework of the child's attitudes towards himself and the world.

The reasons for maternal rejection have been studied, and it has been found that rejection is primarily due to the mother's unhappy adjustment to marriage which, in turn, is usually a result of immaturity and emotional instability on the part of one or both parents (Newell, 1936).

At this clinic it became apparent that the consciously rejected child seemed to show clear-cut clinical characteristics, whilst the parents themselves appeared to have common features. For the purpose of this study, consciously rejected children were defined as those children whose parents had excluded them from the family and had taken active steps to have them placed elsewhere; subsequently most of these parents had severed all contact with the child. We postulated that the consciously rejected child showed a specific behaviour response to the insult of rejection.

Methods and Findings

The data concerning all the consciously rejected children, eight boys and four girls, who were seen at the clinic between 1967 and 1969 were collected in a retrospective and prospective study. Our controls were the next patient referred to the clinic of the same age and sex. Because of insufficient information, it was not possible to match for social class; we could postulate that social class as a random factor was equally distributed between both groups.

The Children

1. *Age*

The mean age of the sample group at referral was 9·0 years with a standard deviation of 3·25 years, and the control group 9·1 years with a standard deviation of 3·4 years.

2. *Source of referral*

The sample group children were referred to the clinic from various agencies, unlike the

https://doi.org/10.1192/bjp.123.5.575 Published online by Cambridge University Press

control group who were predominantly referred by doctors.

3. *Ordinal position*

In the sample group the mode was 2 : 4 and in the control group 2 : 3.

In the sample group the presenting child was never the youngest member of the family.

4. *School career*

The school careers of the children were studied from psychologists' reports and social histories. The difficulties they had in attending school, in continuing to attend school, in establishing working relationships with their teachers and their peers, and with school work revealed no significant difference between the sample and control groups.

5. *Presenting Symptoms* (*Table 1*)

The symptoms of day wetting, nocturnal enuresis, encopresis, stealing, lying, aggression, negativistic attitude and rejecting attitude to parents which the consciously rejected children presented with are shown in Table I. These symptoms are significantly more common in the sample group, except for day and night wetting.

TABLE I

Presenting symptoms

		Sample (n=12)	Control (n=12)
Day wetting	Present ($p > 0.05$ n.s.)	5	2
Nocturnal enuresis	Present ($p > 0.05$ n.s.)	9	6
Encopresis *	Present ($p = 0.002$)	10	2
Stealing *	Present ($p = 0.006$)	9	2
Lying *	Present ($p < 0.002$)	10	1
Aggressive *	Present ($p = 0.018$)	10	4
Negative behaviour *	Present ($p < 0.002$)	10	1
Rejecting attitude *	Present ($p = 0.006$)	9	2

6. *Intelligence*

The educational psychologists measured the child's intellectual abilities with either the Stanford-Binet or the W.I.S.C. tests.

No statistical difference in intellectual abilities between the two groups was found.

The Parents

1. *Mothers*

The mother's descriptions of their own personality and of their childhood, as well as the presence of chronic or severe physical illness in the mother, the presence or absence of periods of separation from the child of greater or less than one month, and the mother's attitude to the other children differed little in the two groups.

The mothers of both groups of children had a high incidence of chronic or severe physical ill-health.

In only one family had the mother consciously rejected more than one child.

2. *Fathers*

In the sample group eight of the fathers also had rejecting attitudes towards the children.

TABLE II

		Sample (n=12)	Control (n=12)
Marital disharmony	Present ($p = 0.002$)	12	5
Physical assaults on children	Present ($p = 0.002$)	12	2

3. *The parents' marriage* (Table II)

Marital disharmony was present and had been present for many years in every marriage of those parents who consciously rejected their child but was also present to a degree in the

https://doi.org/10.1192/bjp.123.5.575 Published online by Cambridge University Press

control group. However, the difference between the two groups is highly significant statistically.

In the sample group the parents tended to remain together with only one family being completely disrupted. However, in most cases there were either temporary separations of varying time duration or threats of departure. The origins of the marital difficulties were not satisfactorily elucidated in any of the families. This was due to a lack of co-operation and an unwillingness to attend the clinic on the part of the parents. Similarly, the families rejected any form of intervention by the social agencies including psychiatric social workers, education welfare officers and mental welfare officers who were trying to maintain contact once the child had left the home.

4. Assaults on children

The parents who consciously rejected their children assaulted them physically, but as far as is known they only inflicted 'soft' tissue injuries. These parents were vituperative in their description of their child. The following is a sample of their comments: 'She smells', 'He's destructive', 'A champion liar', 'Swears and is never satisfied'. The rejection of their child was expressed in many ways: 'I just hate that child', 'I can't stand her about the house', 'Not our child', 'He could have been changed at the hospital without us knowing', 'Not worth bothering about. I don't care where he goes', 'I don't care about him. I hate him.'

Disposal of Children (sample group only)

One child was able to be reintegrated with his family. Of the remainder, six ended up in the care of the local authority, five attended special schools for maladjusted children, two lived with grandparents and one was returned to her adoptive agency after 12 years. Three of the children in care also attended special schools.

Discussion

This survey confirms the earlier American studies that the consciously rejected child shows more symptoms of aggression, rejecting attitude to parents, negativistic attitude, stealing, lying and encopresis. Newell's studies on the pathology of the parents were supported with the evidence that the parents were unstable and had been so for years, and that the mothers were unsure of their role. This study also appears to demonstrate a reactive phenomenon to a clearly defined environmental stress which appears to be unrelated to the child's personality.

The origins of the scapegoating process were never fully elucidated in any family because of the parents' dislike of discussing their problems and their eagerness to focus attention on one child. The reasons for choosing one particular child were also obscure. However, the child's behaviour in every case served to strengthen the process of rejection. Prolonged emotional deprivation during the earliest years of life did happen to some children, but not all, and when it did occur some had brothers and sisters who had similar experiences yet did not show the same rejection picture. The lack of support from outside the family was noticeable, and it was our impression that the majority of the families were prone to frequent geographical moves.

The process of scapegoating appeared to produce a fragile kind of stability in the rest of the family. Even when the child was removed, the families in all but one case remained together and offered some care for the other children, without the process of scapegoating extending to them.

The consciously rejected children were subsequently seen to be severely damaged by their inability to establish close relationships with other significant persons in their life such as their peers and teachers. This observation was supported by the children's behaviour away from home. Initially they appeared to invite rejection, and only gradually did they show any warmth in their relationships with staff. However, under stress the symptoms returned, indicating the severity of their impairment. These children present a difficult therapeutic challenge where close co-operation between the people looking after them is essential. It is easy even for professionals to reject either the child or the child's family, perhaps needlessly polarizing the negative aspects of the relationships. In all honesty, it is sometimes extremely difficult to find any positive feeling from the family towards the child, and inescapable

https://doi.org/10.1192/bjp.123.5.575 Published online by Cambridge University Press

separation of the child from its family comes about. Whilst this separation may be beneficial in the short term, the difficulty these children have in establishing interpersonal relationships gives rise in their teens to a sense of emptiness and to acting-out behaviour which even whilst understood is extremely difficult to cope with.

It would appear that further studies are needed to assess the subsequent development of these children.

This study of consciously rejected children is incomplete in that it only includes the children referred to the clinic and does not include any children who were rejected in infancy.

Summary

A symptom-complex of aggression, rejecting attitude to parents, negativistic attitudes, stealing, lying and encopresis is described in twelve consciously rejected children. The parents of these children have unstable marriages and this instability antedates the rejection of the child.

Acknowledgements

We should like to express our gratitude to the whole Child Guidance staff of the Salop Clinic, and in particular to Mrs. Janice Hughes for her patience and help in preparing the manuscript.

References

Childers, A. T. (1935). 'Hyperactivity in children having behaviour disorders.' *American Journal of Orthopsychiatry*, **5**, 227–43.

Finney, D. J. (1948). 'Fischer-Yates days of significance in 2 × 2 contingency tables.' *Biometrika*, vol. xxxv, Paris, 1 and 2.

Newell, H. W. (1934). 'Psychodynamics of maternal rejection.' *American Journal of Orthopsychiatry*, **4**, 387–401.

—— (1936). 'A further study of maternal rejection.' *American Journal of Orthopsychiatry*, **6**, 576–89.

Symonds, P. M. (1938). 'A study of parental acceptance and rejection.' *American Journal of Orthopsychiatry*, **8**, 679–88.

Wolberg, L. R. (1944). 'The character structure of the rejected child.' *Nervous Child*, **3**, 74–88.

A synopsis of this paper was published in the April 1973 *Journal*.

David A. Pemberton, M.B., Ch.B., M.R.C.Psych., *Senior Registrar*,*

D. Roger Benady, M.B.B.S., M.R.C.Psych., D.C.H., *Consultant Children's Psychiatrist, Salop County Council Child Guidance Clinic, Shirehall, Shrewsbury*

* Now Consultant Psychiatrist, Bellsdyke Hospital, Larbert, Stirlingshire.

(*Received 31 October 1972*)

https://doi.org/10.1192/bjp.123.5.575 Published online by Cambridge University Press