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Intellectual Giftedness and Associated Disorders: Separation Anxiety Disorders or School Phobia

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ABSTRACT

Although a great amount of literature about the definition and education of gifted students exists, information about gifted students with associated disorders is not so abundant. In this paper, we use case studies to share how separation anxiety disorder affects gifted children. The first case is a girl who suffers from symbiotic separation anxiety. The second case deals with a girl suffering from threatics. The question is: Is the child afraid of going to school or is there a fear that she would be unable to adapt as a gifted child? Is the child afraid of being separated from her parents or does she suffer from anxiety at the thought of new responsibilities? The two case studies highlight these intriguing questions.

Introduction

As with other children, gifted children may suffer various disorders which prevent them from performing well at school and hinder their social and emotional development. According to Maureen Neihart (1999): "...you have some kids that have certain personal characteristics and whether they're gifted or not, they're going to have difficulties. It has nothing to do with being gifted. Their giftedness might exacerbate their difficulties". (p.6)

The term "gifted with handicaps" refers to children who show giftedness coupled with some handicap (Clark, 1992). Children suffering from one or more of the following are felt to be handicapped: learning disorders, hearing impairment, visual impairment, neurological disorder, emotional disorders and motor disorders (Whitmore & Maker, 1985; Yewchuk, 1985).

In the bibliographical review of the first and second editions of the *Handbook on Giftedness and Talent*, and a search on the Internet, we located the following references within the field of gifted children with disorders: visual, hearing (Yewchuk & Lupart, 2000) and motor disorders; emotional disorders (Yewchuk & Lupart, 1993), depression (Webb, 1993), learning disorders (Butler-Por, 1993; Yewchuk & Lupart, 2000) and attention deficit hyperactivity disorder (Kaufmann & Castellanos, 2000, Yewchuk & Lupart, 2000; Webb & Latimer, 1993). Regarding emotional disorders, Yewchuk & Lupart (2000) write about underachievement, suicide and anorexia nervosa among gifted children as a consequence of stress they may carry because they are expected to have high ability in all areas. But, just like non-gifted children, they also need guidance to deal with life's everyday stresses. Another psychological disorder of gifted children mentioned in the literature is depression. In his work, Webb (1993) talks about differentiating endogenous and exogenous depression among gifted children. The first one, according to him, is due to 'gifted children [being] able to perceive personal shortcomings equally as well as perceiving personal possibilities'. As for exogenous depression, Webb mentions that this can appear 'when the environment (e.g. home, school, friends) is not supportive of the

child's needs, and he/she feels trapped' (pp. 531-532). However, no references exist on separation anxiety disorder among the gifted.

Anxiety caused by separation is a normal occurrence and is both necessary and to be expected during the development of any child. This phenomenon, which is a reaction to a feeling of lack of protection when the baby is separated from the physical presence of the main figure of affection (usually the mother), appears at six months. At times it can be observed at five months, sometimes at three and a half months, with frequency peaks between eight and eleven months. It is found in nearly all infants between 12 and 24 months (Bailly, 1997).

In 1956, Estes, Hayzlett and Johnson in the *American Journal of Psychotherapy*, first described Separation Anxiety Disorder (ADS) as "a pathological emotional state in which the child and his parents, normally the mother, are involved through a hostile dependency relationship mainly characterised by the intense need to remain together in close physical proximity both on the part of the child as well as the mother".

This disorder was later forgotten as it was considered to be only one of the many possible psycho-pathological mechanisms involved in school phobia. School phobia can be seen in children who, for irrational reasons, refuse to go to school and resist, with extreme reactions of anxiety or panic, any attempt to force them to go (Ajuriaguerra & Marcelli, 1987). This type of anxiety disorder has been mainly observed in first-born girls and is usually interpreted by the parents as a result of the failure of the educational system to adapt to the needs of the child.

We analyzed through clinical observations how this disorder affects gifted children. The first case concerned a girl who suffered symbiotic separation anxiety. The second case dealt with a girl suffering child threatics. The question is: Is the child afraid of going to school or is there a fear of a lack of adaptation as a result of being a gifted child? Is the child afraid of being separated from her parents or does she suffer from anxiety at the thought of new responsibilities?

Case 1

Maria first came to us in March 1998 when she was six years and ten months, as a result of anxiety and failure to adapt at school. Maria had been diagnosed with depression by the psychiatric and psychology departments of the National Health Service.

She showed precocious attention to parents from birth: "From when she was three months old she grabbed or tried to grab everything that drew her attention. In the pram she smiled when one week old, was able to look up at one and a half months and, reacted to any noise she heard with her eyes wide open. She crawled with tremendous agility. She was calm, happy, inquisitive and always smiling".

Regarding disorders and illnesses in early infancy, she had problems when weaned from breast-feeding, and separated from the mother. Until the age of approximately two and a half, she was constantly at her mother's side. At eighteen months, she could memorise stories, songs and sentences; at twenty-one months she watched the TV serial *Celia*; at age two and a half she could count to ten and draw human shapes. At age three she showed a curiosity for things and asked exploratory questions. Now she is interested in the issue of God and the universe; she would ask for example, "If Jesus Christ is the Son of God, how can there be two gods?" She started counting time in hours at age four.

Her parents described Maria as more mature than normal, responsible, creative, perfectionist, shy, with a sophisticated sense of humour, extremely kind, very understanding and generous, but with "something inside her" that prevents her from showing her true self and from being happy. Maria is easily embarrassed although she gets on well with other children. She prefers to play games with children who are two or three years older although she also plays with children of her own age. She also likes to play alone part of the time. Since childhood, she has sung and danced well but her shyness prevents her from doing so in public. She finds it impossible to attend a dance school although she would like to. At a swimming course that she asked to attend, after two days she suddenly and inexplicably became anxious and frightened and was unwilling to go, when she was forced to go, she ran around the pool in her bathing suit but refused to go in with the other children. Something similar occurred in the school dining room, and she is now afraid that if she goes to another activity the same thing might happen. She is missing out on the chance to do a lot of things that could benefit her as a result of her fear of going to places or activities where she does not know anybody.

Her behaviour within the family is described by the parents as "maladaptive". She has problems eating and sleeping, and suffers from anxiety, fear, insomnia and aggressiveness. She is permanently worried about life and death. She is passive, sad, tired and indifferent: "I know nothing and I don't want to learn", "It would be better to be dead". She gets worried if her father returns home late from work and thinks that she is going to be abandoned, left alone. She is afraid of monsters. This situation

has worsened over the last year.

Maria has a younger sister, Ana who is one year old, with whom she gets on well most of the time but of whom she is occasionally jealous. Maria's emotional problem, however, was observed before the birth of her sister. Significant events in Maria's life included her mother's post-natal depression and fear of breast cancer as well as problems at work for the father for a period of six years.

She did not go to kindergarten and started school at three. She found it difficult to adapt, was shy and was affected by things said to her by her teacher and classmates. During infant school she had tremendous difficulty attending school. Her teachers thought that she was an extremely shy and mature child. The psychologist also thought that she was highly responsible. Her first year infant school teacher was very surprised by her drawings. Maria drew like a girl of five. Her parents felt that her problems began at the age of four or perhaps earlier. However, since she started school and over the last year the situation had worsened. Now she is afraid of everything and at bedtime constantly needs to go to the toilet. She also lacks interest in doing things. During the whole of this period she has complained of stomach-ache and she still finds it hard to go to school. Maria says that she is bored in class - "The teacher thinks that we are stupid". She is generally cheerful at school but displays a lack of interest, and is frequently late. She is placed at grade level.

During assessment, she was polite and calm, although not very communicative. She gave the impression of being older than her age, and when performing tasks, she was a perfectionist, gave a lot of thought to what she was doing and was persevering. She was independent in her work. She had a high capacity for concentration and was not afraid when faced with anything new, accepting the situation without fear or inhibition, and with caution. Her test results were extremely high for visual memory and visual-constructive skills, corresponding to age ten according to the correct answers obtained and according to an evaluation of the errors to age ten (*Benton Visual Retention Test TRVB*, $PDA = ?$, $PDE = 6$). Perceptive maturity was high and correlated to age seven and a half (*Reversal Test*, number of errors expected 11.1, obtained 4, Percentile: 87). IQ scores were high (Higher Intelligence *Stanford-Binet: Form L-M [SB: L-M]*, $IQ = 129$; *WISC-R*, $IQ = 116$; *MSCA [McCarthy Test]*, $GIQ = 140$). Mental age on the *Stanford-Binet* test was nine and two months. Abstract reasoning capacity was average-low (*Raven Color*, Percentile: 35 corresponding to six and a half-year-olds). General reasoning capacity based on the use of concepts expressed using pictures or geometric shapes was very high (*Columbia*, Percentile: 99; score, age of deviation = 136). In practical intelligence, Maria obtained a PIQ of 154 (*Alexander scale*) indicating exceptional ability. In oral comprehension and fluency she showed an age of around nine and a half *Picture Vocabulary Test (Peabody PPVT-R)*, confidence intervals equivalent to nine years old and one month to ten years old.

Based on the overall evaluation, Maria has been diagnosed as a girl with a high degree of intelligence, gifted (intellectually gifted) with a high capacity for learning, a high degree of visual memory, practical intelligence and creativity. Her inability to adapt at school and emotional imbalance does not seem to be

*=The TRVB norms are for children 8 years and older, and both girls are younger than 8.

linked to inadequate intellectual capacity or cerebral disorders or dysfunction. Variations observed in psychometric tests on the measure of intelligence seem to be due to emotional traumas. In our opinion, according to the DSM-IV, Maria also suffers from Separation Anxiety Disorder in Early Infancy. What is considered fundamental in this diagnosis is the prevalence of anxiety caused by separation from the primary attachment figure. Also significant are the unrealistic worries regarding the harm that important figures in her life might suffer or the exaggerated concern that some misfortune might separate the child from the primary attachment figures. These children refuse to go to school, do not want to sleep away from home and when they are separated from the primary attachment figure, appear sad, distance themselves socially and suffer nightmares (Millon & Davis, 1998).

A sense of depression, apathy, sadness, feelings of guilt and a lack of attention have been observed in Maria. She seems unhappy and sad, shows a lack of interest, passivity and has sleep disorders. This disorder has on occasions preceded an anxiety disorder with agoraphobia as had happened in the swimming pool. This lasted over four weeks and led to significant clinical discomfort and social isolation. The start of school was the triggering factor, linked to excessive maternal dependency, possibly caused by the temperamental characteristics of the child (vulnerability, with a biophysical base, to the anxiety and the threat feeling) and the mild depression her mother previously suffered. Separation anxiety disorder tends to occur in very close knit families. The failure of the school system to cater for her educational needs might have worsened the problem of adaptation, together with the birth of a sister and the father's problems at work.

The acute anxiety crisis (separation anxiety) is often linked to the start of schooling. Somatization exists at all school ages, although real school phobia appears later, between ages eight and ten. It is characterised by a fear of learning, a fear of the institution itself, the teacher or of new relations with classmates (Ajuriaguerra, 1980).

Case 2

Clara came to us at age six in July 2000 due to her inability to adapt at school.

When her mother was expecting her, complications developed during her 42-week pregnancy. The mother was forced to rest due to the threat of miscarriage, sickness and sciatica, and had an emergency Cesarean birth because of fetal suffering. Clara had a disorder at birth (Down Hypoplasia) and her tongue muscle was not fully developed. She had eating disorders, and vomiting due to gastric problems. She was admitted to hospital for a week due to gastrointestinal problems. She slept little as a child and at six months old slept only at night. She displayed intense reactions to noise and pain. When she was hurt, it was impossible to calm her down to attend to her. She has never tolerated excessive noise. At twelve months she knew the colors, at two and a half years old she could draw a human figure, memorize stories and songs, was interested in how words were spelt and could do 20-piece puzzles. At age four she

pondered on the infinite as well as the question of spirits and souls, the first men to walk the Earth, who they were, if science says one thing and religion another and so on continuously. At fifteen months her vocabulary was advanced for her age and she could form correct complete sentences. Since eighteen months of age, she has asked the meaning of words she does not know. She started reading at the age of five years and six months and could read a book easily at five years and ten months. During her development no ambidexterity has been observed but dyslalia was. At the age of four she changed the smooth /t/ for the /d/.

Her parents describe her as a girl interested in her surroundings, her house and her place. "When she engages in new things she goes through a period of anxiety. Initially she rejects everything". She does not keep still and is too sensitive. Since the age of two any reprimand has been met with intense crying, and she responds in a similar manner even with television images and cartoons. She is a perfectionist and is not very tolerant towards frustration: "She does drawings, letters, numbers, and games over and over again until they are nearly perfect (for her age)"... "When something didn't work out as she hoped she got very angry at herself. She finds it difficult to accept her own mistakes"... "She shows great concern for her attitude both at home as well as when she is out, and tries to correct what she sees as wrong. She is also very concerned with her physical appearance and sometimes tries too hard to get dressed and get herself ready". She is highly responsible, and extremely sociable, with a notion of justice, of good and bad, perhaps too much so for a child of her age. Even at the age of three she paid attention to detail and was very concerned with order. Each crayon had to be in its place, each doll on its shelf, each dress on its hanger. All of her things had to be in their place, as did everything in the house. She would not accept untidiness. Everything has its place, its rhythm and anything that alters that rhythm disconcerts her. She is extremely imaginative and liable to imagine situations. Since the age of two to three it was necessary to deny her certain television programs, books and any other media that conveyed acts of violence or injustice that might cause her a great deal of anxiety as she was a girl who cannot accept lies, betrayal, disobedience, violence and selfishness. She worries a lot and attaches great importance to everything. She is very fearful and often wakes up at night with bad dreams. If Clara hears news of "the death of two tourists, attacked by a tiger on a safari" (as happened about a year or year and a half ago), it creates such a feeling of insecurity and obsession that she might spend weeks 'pondering' the news. This leads her into a nervous state to the extent that she can't sleep or wouldn't leave the house or the immediate environment for fear that it might happen to us. For example at the moment she is obsessed with rapists and thieves. She is terrified at the thought that I (her mother) might be raped or killed or that she might be robbed. This was brought on when watching a film on this subject one afternoon and her reaction has so far lasted six days. It is worse at night when her anxiety is enormous. There are times when she demands to be told that there are no thieves, there is no hunger, no bad people, that murders don't happen and a long succession of tragic cases, injustices that for her are of vital importance and prevent her from controlling her emotions arising out of lack of compassion,

intolerance...”.

Clara's parents have observed that she has often complained of stomach-ache, difficulty eating, problems sleeping and psychosomatic illnesses. “Nights have always been a headache. At six to eight months she only slept at night. The problem got worse and worse. She couldn't sleep for three hours without waking up startled. By reading the book *'Duermete niño'* [“Sleep little child”] we managed to solve the problem for a year and a half but bed-time has once more become a major trauma for her”. “Reading at bed time helps her to sleep more or less alright at night and when she wakes up early in the morning with nightmares a little reading relaxes her quite a lot. There are days when she goes to school hardly having slept at all. Night-time brings her major distress. Every six weeks she suffers a relapse of three or four days, which before was for a week..., with a high temperature that didn't go down without any apparent center of infection. They didn't know what the cause was. The first term this year she missed fifteen days. When school starts so does the earache, visits to the emergency ward, etc. As of Easter this year, and since she has been receiving natural medicine treatment she has improved. She suffers a lot from stomach-ache. When she has a temperature, the stomach-aches start. Before coming to Valladolid for the evaluation she had a temperature Friday, Saturday and Sunday. In summer she is fine”.

Clara is a very sociable but at the same time selective girl when it comes to choosing “her” friend. If a classmate says or does something that she does not agree with, she tries to avoid her. She finds it hard to accept that people have both their good as well as bad side and that people make mistakes. However, in her world there is no room for evil, intolerance, hypocrisy, which creates serious conflict for her. She does not understand her friends' ‘white lies’, which irritate and hurt her too much. Her emotional development is not that of a normal girl. Clara calls other children to attention when they insult, disobey or do not stick to the rules. Clara's stepbrother, on her father's side is just as inflexible and obsessive. He would not tolerate homosexuality or brothers wearing ear-rings. He went out with a girl but as things did not turn out as he had expected he quit the relationship. He is also left-handed like Clara. In her case, it is possible there is a temperamental basis that is hereditary.

According to her parents, Clara was really looking forward to going to school. After a few weeks she started losing interest and had not wanted to go back, although she had no problems with either teachers or classmates and even made friends with children from other classes and of other ages. According to her personal tutor she is well adapted to the group, has friends, accepts rules and plays both alone, and with friends. She focuses hard when playing. Rosa was her tutor in the first year and alerted them to Clara's abilities as soon as school started. A month after talking to the tutor Clara no longer drew. She scrawled like the rest of the children. Nor was she happy but cried and cried and did not want to go to school. The teacher advised the parents to take her out of the school dining room and to read *'Duermete niño'*. In second and third year infant school, her teacher Carmen did not want to have anything to do with a problem that in her opinion did not exist. The last school year has been the worst for Clara according to her parents. She has been

going to school without any motivation, downcast and with no enthusiasm: “At times she told her mother that they didn't understand her and everything was her fault, making her feel bad because there are days when she is really depressed because she has to go to school. Every morning during the school year is an ordeal. She clutches the pillow, hides under the bed, and cries her eyes out, although she can hardly be heard, as she is ashamed of her attitude. She resigns herself to going and goes off to school like a lamb to the slaughter. She is too sensitive and over time her sensitivity, her perception has increased and matured, something she demonstrates continually”. She relaxes on Fridays but from Sunday to the following Friday she finds it hard to sleep. They think that Clara lacks any kind of motivation towards school as a result of what she hopes to learn but is not taught. They feel that she is disappointed, as the three years that she has been going to school have failed to fulfil her and she feels bored, as the speed at which she is taught is too slow for her. Her parents feel that those responsible for Clara's education (teacher and psychologists) believe that the problem is the parents', whom they feel want her to be taught more.

During assessment, Clara was calm, thoughtful, hard-working and conscious of adult praise. She required praise and affection. If she was not sure that she was able to do a task properly she preferred not to do it. She made the following comments: “I don't want to go to school but after I do go I have a great time”, “I'm afraid that my parents might die”, is what she thinks when she goes to bed at night. “I get sad”. At school she thinks of her mum and dad a lot and thinks: “When classes are over I want to go home”. During assessment the girl expressed a fear of rape and of being separated from her parents.

According to her parents, during her stay in Valladolid she had a hard time. She hardly ate and said that she wanted to be sick. Her world revolved around going home, but she liked the sessions. “The same thing happened last year when she went camping in the mountains. She gets very nervous. When she is at home, she keeps asking her father when her mother is coming home although she knows that mum is working and what time she will return”.

Observations during assessment recorded from other reports (e.g. the psychopedagogical report by the school counselor and the psychological report by the Health Service in Navarra) show that Clara has a clear preference for being at home with her parents and for holidays. She is very much a perfectionist who does not like to be told off either at home or in school. She is sociable. She displayed no rejection either towards school or the teacher”. “She says that when she gets up she does not want to go to school but that once there she is happy. In her social conduct she is affectionate. She plays, and interacts with her companions. No rejection of school or activities has been observed. She is affectionate and obedient in her relationships with adults, and shows no dependence on adults. She displays a high degree of self-control when expressing emotions and feeling. She showed anxiety when faced with certain issues and questions and when her errors were pointed out to her. She has improved greatly in this area during the year”. Basic behavior patterns for learning at school are well developed. She maintains eye contact and works extended periods with an adult. Her

ability to concentrate is extremely high and she shows no difficulty following an adult's instructions. No pronunciation problems have been detected. She uses her left hand for drawing and writing.

Her parents have tried to deal with the problem in the following ways.

"During the first year we simply observed her and tried to calm her down and let time pass, thinking that the problem would sort itself out eventually. In second year infant school, firstly on the advice of the National Health psychologist we left it to the teacher but to no effect due to the teacher's refusal to co-operate. We also sought help from the school counselor on the advice of the previous psychologist and we were given the following guidelines:

- Limit the time spent on her hobbies. Reduce the time spent learning to read, and not let her draw "so much". In short, if Clara liked reading, writing and so on, that we should limit the time spent on these activities, to half an hour at most, and that we should make her play with other things such as balls, dolls, and games that she is interested in but that do not take up as much of her time as her crayons, books, clay.
- That we should not teach her anything at all to do with reading or writing at home, so as to remove her 'obsession' with them and so as not to interfere in the teacher's lesson plan.
- That we should reward her with sweets, stories or whatever at the end of the school day.

We followed these guidelines during the year to no avail and far from solving the problem, the situation only got worse. During the school year Clara was frequently ill but we never kept her at home unless her illness was due to something "serious" (high temperature, asthma attack, etc.). In third year infant school Clara started school with the same apathy, lack of enthusiasm and excessive anxiety. About half way through the year, we decided to take her to a Pedagogical Center (Aula 2) on our own accord. She was given an intelligence test and we were told that there was a "problem" and that the solution would involve the co-operation of her school and family environment. The tutor did not offer any co-operation. We were told not to attach too much importance to her attitude and that if she asked to be taught something at home that we should not refuse. During this year her teacher told us once again that she could count to ten and add up using these numbers, which was not appropriate since during the year she should only learn from 1 to 5 and addition within 5 (for example, $2+1=3$, $3+1=4$). She criticized us for having taught the girl numbers and some letters and said that we should not teach her anything, as our 'system' was not the right one and that we were damaging the rhythm of the other pupils. The year passed and Clara got worse both physically as well as in morale. We pressed the Advisor at the Center to solve her part of the problem, demanding the assistance of the CREENA (Special Resource Department of the Navarra Government). She was given another intelligence test in twenty minutes with an IQ of 124 and we were advised to be patient for another two years as then, more effective attention could be paid to the girl as Clara would be eight and the tests could be carried out more accurately. Once again we felt let down and had

nothing to help Clara to solve a problem that nobody could tell us the cause of'.

The results obtained with our assessment showed high visual memory and visual-constructive skills, corresponding to an age of around eight according to the number of correct answers and less than eight according to the mistakes made (*TRVB*, $PDA = ?$, $PDE = 4$). Visual-motor ability was average (*Bender*, number of expected errors 8.6, obtained 8, equivalent age approximately six). Perceptive maturity was average-high, equivalent to age approximately seven (*Reversal Test*, number of expected errors 14.2, obtained 9, Percentile: 70). Association speed was high and corresponded to an age of +6.5 (*WPPSI*, *Animal House*, $Pt = 18$). IQ scores were high (Higher intelligence *Stanford-Binet: Form L-M*, $IQ = 140$; *WPPSI*, $IQ = 133$; *MSCA*, $GIQ = 143$). Mental age on the *Stanford-Binet: Form L-M* was eight and eight months. Abstract reasoning ability was average (*Raven Color*, Percentile: 50 scale corresponding to six years old). General reasoning ability based on the management of concepts, expressed through pictures or geometric shapes, was average-high (*Columbia*, Percentile: 88; *Score. Age of deviation = 119*). In practical intelligence, indicating an aptitude for technical studies, greater ease in learning using technical means than traditional theoretical models and ability to resolve practical problems that are not strictly academic, Clara obtained a PIQ of 194, (*Alexander scale*) indicating extraordinary skills. In oral comprehension and fluency she reached an age of approximately eight (*Peabody Picture Vocabulary Test PPVT-R*), confidence intervals of ages equivalent to between seven and four months and eight and two months.

Based on the assessment as a whole, Clara has been diagnosed as a girl with exceptional intelligence, gifted (intellectually gifted), with an exceptional ability to learn, a high level of visual memory, practical intelligence and creativity. As with the case of Maria, she has not adapted to the school environment and her emotional problems do not seem to be linked with any traumas or brain disorders. The anomalies observed in the psychometric tests on the measure of intelligence seem to be due to emotional imbalance.

In our opinion, according to the DSM-IV, Clara suffers from Early Separation Anxiety Disorder, and according to the DSM-III, Excessive Anxiety Disorder in Infancy. A mild case of **child thretics** can be seen in Clara with a biophysical vulnerability towards anxiety and the feeling of threat. This fear predisposes her towards avoiding the unknown, thus reinforcing her dependence. At certain critical periods, this difficulty is aggravated.

According to Millon & Davis (1998), unlike the "symbiotic child" who experiences morbid parental attachment, the thretics child is much more nervous and tense, whereas the symbiotic child is so only when separated from the person to whom he is strongly attached. The thretics child may frequently suffer anxiety crises when faced with new responsibilities and the fear that this involves. Fear might be displayed in anticipation of abandoning familiar and safe places. Excessive anxiety or worry is characteristic, as is fear that is not determined by a situation or any specific objects.

Threetics children seem hyper-mature due to their worries, and they also have a tendency to be perfectionists, have an excessive need to be calmed down, have somatic complaints, experience acute feelings of tension and exhibit an inability to relax. Any source of tension whether external or based on the control of impulses may lead them to an anxious conservation of energy. They have learned that weakness and fragility cause others to be protective; thus they may be tempted to succumb to physical fatigue or illness to ensure desired response. Physical problems or illnesses save them from having to face up to routine tasks. The fear of making mistakes and accepting risks is common. They are meticulous and fussy. They move within a limited sphere and refuse to accept the risk of making a wrong choice. In some cases such as Clara's, they occasionally show signs of suspicion, irritability, obsessive ideas and a severely critical attitude. They defensively deny the existence of psychosocial problems, and might suffer from a mild persecution complex. They are indignant and critical towards other people's lack of perfection and point out others' shortcomings, and criticize them as incorrect or unsuitable. There is a pattern that they usually avoid situations that might lead to censure or mockery, with a fear of making mistakes or accepting risks that might lead to disapproval. As a defensive maneuver, they restrict their activities, move within very tight limits and confine themselves to a rigid and at times rigorous conformity to rules and norms. The inadequacy of teaching towards their educational needs might have aggravated their adaptation problem. In these cases, in general any kind of imposition, which is still common, only serves to exacerbate the symptoms (Ajuriaguerra & Marcelli, 1987).

Normally the gifted girls that we have observed with this kind of trauma tend to be highly disciplined and hard-working. They like doing homework and are perfectionists. They complain of not having friends, have problems sleeping, and their level of independence drops. For instance, if they knew how to dress themselves, they stop doing so.

This trauma can appear after a stressful situation (for example the death of a relative or a pet, an ill child or family member, a change of school or neighborhood or emigration). This may start early, at pre-school age but may also appear at any age up to eighteen. It is unusual, however, during adolescence. Adolescents affected by this trauma, especially males, may deny anxiety through separation. This may be reflected through a limited independent attitude and a refusal to go out. In older cases, the trauma at times restricts their ability to cope with changes of circumstances (for instance, moving to a new house, marriage). Adults suffering from this trauma are too worried about their spouses and children, and experience tremendous unease at being parted from them.

Separation anxiety disorder is more commonly seen in girls. According to the DSM-IV, separation anxiety disorder is not uncommon, and is estimated to affect around 4% of children and young adolescents (Pichot, 1995).

Conclusion

Making a suitable diagnosis allows for adequate educational, social and emotional intervention to meet children's needs. It also gives a more realistic picture to the parents, who in general feel very guilty and frustrated about the cause of the disorder and about its implications and educational limitations in their children.

In both of these cases, the difference between chronological age and mental age, coupled with the feeling of frustration brought on at school regarding learning achievement and social environment, leads to even more acute disorder symptoms. In fact in some of the above cases, when the parents' behavior and attitude towards the child changed, the child improved significantly over a short period of time.

In the cases we have been dealing with, the first treatment involved personalized curricular adaptation to fit the rhythm of learning and avoid boredom. Behavior therapy was also conducted in the school as well as in the family environment so as to avoid excessive attachment behavior in both these areas.

The amount of time the girl stays at home and is absent from school is kept to an absolute minimum. It was initially necessary to offset secondary gain from a prolonged stay at home. The girl started to attend school gradually at the earliest possible moment and initially attended for only brief periods.

Given the characteristics of the girl's intellectual giftedness, it was possible to conduct individual cognitive-behavior therapy (systematic desensitization), the aims of which were:

- to increase relational behavior as opposed to avoidance behavior;
- to modify irrational or overly strict cognition;
- to reduce automatic responses to specific stimuli.

In the second case it was necessary to include treatment with drugs, specifically an anti-depressant, as it is well known that ansiolytics are recognized as not usually being effective in children with anxiety disorders. In cognitive-behavior therapy, in the second case, the aims were to locate and stabilize the inflexibility towards herself and towards other people, promote a decisive approach, ease the intense inflexibility, lessen concern for rules and reduce blame and self-criticism.

It should be highlighted that phobic behavior (not wishing to spend time alone, avoiding school), is an extremely significant factor and is due to anticipation of future suffering when faced with situations which are both specific as well as different such as examinations, suffering pain, acceptance by schoolmates, anxiety with regard to competition in certain areas, and being abandoned by parents.

In Clara's case, the following treatment was begun under our control. It was necessary to explain to the school psychologist the need for changes in the syllabus. Since the child was slow when it came to doing schoolwork and not skilled in a social environment, the psychologist had ruled out the possibility of considering her as gifted and including her in any educational programs for the cleverest children in the class. The psychologist needed to be made aware that it is hard to keep the attention of a girl who has hardly slept and eaten for hours, who cannot work

with any degree of consistency and who during class time shows anxiety about the need to return home or is preoccupied with school, her home, her parents and her environment. This makes it difficult for the girl to concentrate and even more so if she is offered teaching that holds no motivation for her.

The psychologist also needed to be made aware that teaching which is both motivating and adapted to the girl's needs can help overcome inhibition and thus avoid the negative Pygmalion effect that can appear in cases such as these.

Assistance is also essential if the girl is to integrate and play with her friends, thus preventing isolation and her playing alone; we should not wait for her to take the initiative "to join in", and expect her to sort out her problems by herself, based on the conclusion that "she does not want to play with the other girls" as a result of her being gifted. Understanding and cooperation between the school and the family was also favored, as the relationship between the two had gradually deteriorated due to the girl's problem, with both sides blaming each other.

Regarding monitoring by the psychiatrist, it was decided to keep up the medical treatment and at her suggestion to discontinue the girl's psychoanalytical therapy that had been started so as not to interfere with our cognitive-behavioral therapy. However, it was felt to be a good idea to continue the bond of affection between parents and child, the parents attending fairly regular sessions with the psychiatrist without the girl.

Within the family environment, the main goal to be achieved was getting the girl to sleep at night (she woke up eight times a night on average and usually got to sleep after one in the morning), as this led to a great deal of anxiety in the family. To achieve this, it was proposed that the girl should not be rewarded at night by the presence of her parents, and especially the mother. The girl was asked first to do a drawing of the "bad dream" that was the cause of her fear (normally these dreams reflected fear of separation, of being abducted). Without the drawing she could not call her parents. This also served as a distraction, as a means of halting the thought process and channeling her fears in another direction. If having finished the drawing, the child decided to return to bed without calling her father or mother, she was rewarded the next day (through a points system previously agreed upon). If she called her mother or father, she did not receive any reward.

This apparently simple approach was not in fact so easy to put into practice as when the father had to get up often if the girl called out at night. He became irate and ended up calling the mother (it had previously been agreed that the parents would take turns so that it would not always be the mother or both who got up at the same time). This obviously led to a continuation of the child's dependency on the mother and a perpetuation of the undesirable bond between them. It was also necessary to "forbid" the mother to reward the girl excessively as she tended to do so more than had previously been agreed when the child slept for more prolonged periods.

Given the girl's cognitive development, her level of understanding and conceptualization, it was possible to use "specific visual images" and self-instructions to modify unsuitable thoughts with her during personal therapy. With one

or two exceptions, this broad-based approach led to the girl gradually sleeping more nights right through, eating better, being happier and showing a more positive attitude in school.

Implications for Practice and Future Research

This article was inspired by the traditional precept in medicine: "Do not ask yourself what illness the patient has, but who the patient is who has the illness" (Millon & Davis, 1998). To talk about a gifted student's problem when, as we have seen before, these students are very heterogeneous is quite artificial. It is necessary for both teaching professionals and parents to comprehend that education is only possible if it starts with an understanding of the individual child.

Nowadays, an understanding of gifted children's characteristics is more relevant than some years ago, since this knowledge will enable professionals to quickly understand the context in which the student's problem arises. This information is more important than ever since professionals have the means available to help students.

In the case of children with associated disorders, it is unusual for there to be only one kind of treatment. By 'treatment', we are referring to any action which is necessary to optimize the child's development in the family, school or social environment.

This may involve several approaches: educational, pharmacological and psychological.

Educational

- Special lessons
- Tutoring
- Correcting, etc.

Pharmacological

- Nervousness, aggression, tantrums usually respond favorably to anti-psychotic drugs.
- In Attention Deficit Hyperactivity Disorder (ADHD), stimulants reduce the symptoms in 75% of cases.

Psychological

- Behavior therapy
- Counseling for parents and family
- Personal psychotherapy support
- Multidimensional model of treatment that may include some psychological therapies: individual psychotherapy, family psychotherapy or guidance for parents, behavior modification.

Disabled gifted children are under-assisted and under-encouraged (Cline & Schwartz, 1999). The focus of the adaptations for their disabilities can exclude the identification and development of their cognitive abilities. It is not unusual, therefore, to find a huge discrepancy between the mean academic potential in these students and their actual performance at school (Whitmore & Maker, 1985). For these children to reach their potential, it is necessary for their intellectual strengths to be recognized and developed and for their disabilities to be properly adapted (Willard-Holt, 1994).

In the specific case of gifted children with associated anxiety disorders, it is recommended that experts as well as teachers and parents bear in mind the following considerations

and suggestions. To achieve a return to school and integration into the classroom, it is advisable that this should be done gradually. The teacher should maintain as little anxiety as possible in the child through "sweets" or through any other pleasant activity. Any activity that leads to pleasure and enjoyment will achieve this. Since anxiety causes a lack of attention in the child who does not normally perform well in class in any case, and as the child appears to be adapting, many teachers feel that there is no need to implement any kind of change in the syllabus as the child does not finish work in class before the rest and makes basic mistakes. This leads to a vicious cycle which worsens the child's lack of adjustment, increases anxiety and lack of attention. As no "special" behavior is observed in the child, schools do not usually intervene but rather insist that the child has an emotional problem and that once it has been overcome, they will be able to get on with normal school work either through adaptations in the syllabus or intensive programs. Without the right encouragement, a vicious cycle develops which intensifies both the lack of motivation and apathy towards school as well as the family belief that the child's situation is due to lack of adequate teaching at school. Moreover, the child may see everyday experiences as a cause for anxiety (such as the teacher correcting work or having to go to a new activity), making it even more desirable to look for contact, mainly with the maternal figure. Therefore, work needs to be carried out on the issue of fear in individual therapy.

There is a tendency on the part of the mother to blame the school and to request that special attention be paid towards her child. Work on family therapy is thus required. Parents need to feel at ease when leaving their children in the care of the school, and farewells should be short and warm. Parents' own anxieties need to be kept under control (problems leaving the child, mistrust towards those in charge of the child, a sense of guilt when leaving). Children who notice that something is wrong with the parents will think that there is a problem. Parents also need to take their children's anxiety seriously and react patiently, calmly and understandingly instead of making the child feel worse by blaming and reproaching them for their behavior. They should prepare the child before the separation and explain when they will be back and above all should make sure they return on time or give prior warning if they are not able to do so.

As regards diagnosis, possible variation in psychometric tests should be taken into account, as a result of anxiety or sadness and apathy on the part of the child. As with other diagnostic tests, but even more so in these cases, it is important to apply many different psychometric tests. Special attention should be paid to high scores on these tests, as these are never the result of chance.

An awareness and understanding of this disorder together with the importance of educational and pedagogical intervention for gifted children is clear, as all too often it is the lack of an adequate educational program which is the triggering factor behind the disorder. Family involvement and individual therapy are also key factors, as is the need for a broad-based approach to treatment, since without it, the child is unlikely to adapt and progress.

References

- Ajuriaguerra, J. (1980). *Manual de Psiquiatría Infantil*. Barcelona: Masson, 820-822.
- Ajuriaguerra, J., & Marcelli, D. (1987). *Manual de Psicopatología del niño*. Barcelona: Masson, 396-399.
- Alexander, W.P. (1978). *A Performance Scale for the Measurement of Practical Ability*. Madrid: TEA Ediciones.
- Apgar Test (2000)*. Manual Merck, Edición Centenario. Barcelona: Harcourt. Section 19, 2292.
- Bailly, D. (1997). *Angustia de separación*. Barcelona: Masson, 3-11.
- Benito, Y. (2001, 2^a edition). *¿Existen los superdotados?*. Barcelona: Praxis, Monografías Escuela Española.
- Benton, A.L. (1986). *Visual Retention Test (TRVB)*. Madrid: TEA Ediciones.
- Burgemeister, B.B., Blum, L.H., & Lorge, I. (1983). *Columbia Mental Maturity Scale*. Madrid: TEA Ediciones.
- Butler-Por, N. (1993). Underachieving gifted students. In K.A. Heller, F.J. Monks & A.H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 656-657). Oxford, UK: Pergamon.
- Clark, B. (1997). *Growing up gifted: Developing the potential of children at home and at school*. Columbus, OH: Macmillan Publishing Co.
- Cline, S., & Schwartz, D. (1999). *Diverse populations of gifted children*. Upper Saddle River, NJ: Prentice Hall.
- Dunn, L.M. (1981). *Peabody Picture Vocabulary Test (PPVT)*. Madrid: Mepsa Ediciones.
- Edfeldt, A.W. (1988). *Reversal test*. Barcelona: Herder.
- Estes, H.R., Hayzlett, C. H., & Johnson, A. M. (1956). Separation anxiety. *American Journal Psychotherapy*, 10, 682-695.
- Feldhusen, J.F., & Jarwan, F.A. (1993). Identification of gifted and talented youth for educational programs. In K.A. Heller, F.J. Monks & A.H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 233-251). Oxford, UK: Pergamon.
- Kaufmann, F.A., & Castellanos, F.X. (2000). Attention-deficit/Hyperactivity disorder in gifted students. In K.A. Heller, F.J. Monks & A.H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 621-632). Oxford, UK: Pergamon.
- McCarthy Test McCarthy Scales of Children's Abilities* (1986). Madrid: TEA Ediciones.
- Millon, T., & Davis, R.D. (1998). *Trastornos de la Personalidad. Más allá del DSM-IV*. Barcelona: Masson, 116-117; 541-543.
- Münsterberg, E. (1968). *Bender Gestalt Test for Young Children*. Buenos Aires: Ed. Guadalupe.
- Neihart, M. (1999). *The social-emotional health of gifted children* [<http://ctdnet.acns.nwu.edu/resources/articles/Neihart.html>]
- Pichot, P. (1995). *DSM-IV, Manual diagnóstico y estadístico de los trastornos mentales*. Barcelona: Masson, 118.
- Raven, J. C., Court, J. H., & Raven, J. (1996). *Raven Progressive Matrices (CPM-SPM-APM)*. Madrid: TEA Ediciones.
- Terman, L. M., & Merrill, M. A. (1976). *Stanford-Binet Intelligence Scale: Form L-M (SB: L-M)*. Madrid (1976) Espasa Calpe.
- Webb, J. T. (1993). Nurturing social-emotional development of gifted children. In K. A. Heller, F. J. Monks & A. H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 531-532). Oxford, UK: Pergamon.
- Webb, J. T., & Latimer, D. (1993). *ADHD and children who are gifted*. ERIC EC Digest #522. [http://www.kidssource.com/kidsource/content/adhd_and_gifted.html].
- Wechsler, D. (1974). *Wechsler Intelligence Scale for Children (WPPSI)*. Madrid: TEA Ediciones.

- Wechsler, D. (1974). *Wechsler Intelligence Scale for Children, Revised (WISC-R)*. Madrid: Tea Ediciones.
- Whitmore, J. R., & Maker, C. J. (1985). *Intellectual giftedness in disabled persons*. Rockville, MD: Aspen.
- Willard-Holt, C. (1994). *Recognizing talent: Cross-case study of two high potential students with cerebral palsy*. Storrs, CT: National Research Center on the Gifted/Talented.
- Yewchuk, C. (1985). Gifted/learning disabled children. *Gifted Education International*, 3, 122-126.
- Yewchuk, C., & Lupart, J. (1993). Gifted handicapped: a desultory duality. In K. A. Heller, F. J. Monks & A. H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 709-725). Oxford, UK: Pergamon.
- Yewchuk, C., & Lupart, J. (2000). Inclusive education for gifted students with disabilities. In K. A. Heller, F. J. Monks & A. H. Passow (Eds.), *International handbook of giftedness and talent* (pp. 659-670). Oxford, UK: Pergamon.

Glossary of Major Terms Used in the Article

Separation Anxiety

What is essential here is the dominant feeling of anxiety when the child is separated from the primary attachment figure. It may appear at any stage in development but is usually found in children between two and three years old.

Bailly, D. (1997): *Ansiedad de Separacion.*, Masson (p. 3), Barcelona.

Separation Anxiety Disorder

The major characteristic of this disorder is the excessive level of anxiety, beyond that expected of a child at his developmental level. This anxiety is related to separation from the primary attachment figure. When the separation takes place, the child's anxiety could be close to panic. According to the DSM-IV TR, the disorder should last at least four weeks to be diagnosed as Separation Anxiety Disorder.

Bragado, C. (1994). *Terapia de conducta en la infancia: trastornos de ansiedad*. Fundacion Universidad-Empresa (p. 50), Madrid.

Symbiotic Child

A child who experiences a morbid attachment to parents leading to major separation anxiety and a failure to acquire independence. Unrealistic concerns are also noticeable together with school refusal, and refusal to sleep away from home (separation anxiety disorder).

Millon, T. & Davis, R. D. (1998). *Trastornos de la Personalidad. Más allá del DSM-IV*. Masson (p. 350), Barcelona.

Excessive Anxiety Disorder in Childhood

The main feature is over-concern and fear, not linked to any specific situation or object. At a critical time when the child starts nursery school or a brother or sister is born the pathological nature may appear - threatics child (Millon & Davis, 1998). In contrast to the other anxiety disorders reactions don't appear linked to any specific situation or object. The child shows a great concern about future events or about the right performance of his/her duties (Bragado, 1994).

Millon, T. & Davis, R. D. (1998). *Trastornos de la Personalidad. Más allá del DSM-IV*. Mason (p. 350), Barcelona.

Bragado, C. (1994). *Terapia de conducta en la infancia: trastornos de ansiedad*. Fundacion Universidad-Empresa (p. 61), Madrid.

Threatics Child

A threatics child is one who is more anxious and tense. Whereas the symbiotic child experiences anxiety only when separated from the primary attachment figure, the threatics child suffers anxiety when faced with any new situation. The behavioural characteristics seem to precede an obsessive-compulsive personality disorder.

Millon, T. & Davis, R. D. (1998). *Trastornos de la Personalidad. Más allá del DSM-IV*. Masson (pp. 350 & 541), Barcelona.

School Phobia

Extreme fear, obsession and feeling of anxiety that overcomes children in relation to school. It usually appears between eight and ten years old and is characterised by a fear of learning, a fear of being taught, of the teacher or new relationships with classmates. Children who suffer from school phobia have no difficulty when going to other places or when faced with other kinds of situations.

Ajuriaguerra, J. (1983). *Manual de Psiquiatria Infantil*. Masson (pp. 821 & 822), Barcelona.