THERAPEUTIC PROBLEMS REACTIVE TO MODIFICATIONS IN CHILD-PARENT RELATIONS*

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WHEN parents apply to the Jewish Board of Guardians for treatment of their children,† they usually know the agency is a child guidance clinic offering treatment to emotionally maladjusted children and to their parents. The parent's complaint on intake is often a quite discerning exposition of the child's difficulties in adjustment, and it sometimes happens that the parent also has some insight into pathological features of the home environment and is aware of abnormality in the personalities of significant family members.

Provided the situation is not too pathological and the child seems to be treatable in our agency, optimism about the eventual outcome of the case might be expected to increase in proportion to the preliminary estimate of the parent's insight into the problem and her verbalized readiness to cooperate in the treatment process.

We are inclined to be even more optimistic about prognosis in instances where the client—either the parent or the child—in addition to bringing to the intake interview some relevant understanding of the problem, appears to gain some insight in the interview that the painful situation for which help is sought results from unhealthy interpersonal relationships within the home.

With the further elaboration of these insights during the initial stages of treatment, the client's striving for change in the direction of emotional health and improved relationships is stimulated, supported and developed in the treatment relationship with the case worker. There results a heightening of interest in the areas of difficulty. This therapeutically directed interest can be gradually utilized in exploring the underlying emotional conflicts that may not have been mentioned among the presenting difficulties nor have been available to the client's awareness previously.

At this point in the treatment process, serious difficulties in the treatment relationship frequently appear. Often it is precisely in those cases over which prognostic optimism seemed appropriate that difficulties in the treatment situation come to the fore and the joint collaborative efforts of client and worker reach a stalemate or may even deteriorate, at times irreparably.

In this paper I shall attempt to show how and why serious resistances to treatment almost invariably emerge just at the point at which the underlying emotional difficulties the client has been striving to solve through the treatment relationship reappear in the relationship between the child and his parent in less disguised form than in the original presenting symptoms. I shall try to do this by presenting portions of a case in treatment, and, in so doing, I shall try to illustrate how the Jewish Board of Guardians approaches treatment in terms of philosophy and methods.

I would like to begin by clarifying our concepts of the meaning of symptom formation in a neurotic child. By neurotic child—and this is the group that comprises the bulk of our caseload nowadays—we mean a child who is seriously handicapped or inhibited in spontaneous, constructive interaction with other human beings due to emotional conflicts that have been internalized within his personality. The child may no longer be aware of what he is disturbed about, although he certainly knows that he is not getting much joy out of living. It is mainly because the maladjusted child knows this that we are able to interest him in our offer of help in attaining a more satisfying existence.

But why did these hampering neurotic difficulties develop in the first place? Are they of any use to the child? Do they in any way make his life more bearable to him? It is beyond the scope of this paper to show systematically the process of symptom formation in disturbed children. Whatever philosophy of dynamic psychology one may profess, there is agreement that the symptomatic difficulty reflects and expresses the child's difficulties in relationships with those who are important to him. I should think there would be agreement also that the maladjustment reflects the child's attempts to solve conflicts that have their genesis in the child's strivings for some impelling or necessary gratification that has been thwarted by the parent or other significant person upon whom the child is dependent. In other words, the emotional conflicts that are the driving force in later neurotic disturbances can be seen as the child's early problems in living within the family.

In the treatment, the child initially relates himself to the case worker with the same patterns of behavior and with the same or similar subjective feelings about the worker that have been characteristic of his interpersonal relationships with his parents. This means that the relationship between the personalities of the child and the therapist is mediated through the symptomatic syndrome that has been, so to speak, engrafted onto the child's personality. As treatment progresses, and the child is helped to relate himself to the worker in a more direct, uninhibited manner, the self-limiting neurotic patterns are loosened and gradually discarded. The child then attempts to carry over his new, freer, uninhibited mode of behavior to the home environment, and he is encouraged to do this by the therapist. But at home the pathological family situation that forced the child to utilize symptomatic, neurotic defenses may be essentially unchanged. Even though we may have succeeded in modifying the home environment somewhat, as a result of parallel treatment of the parent, there may be an exacerbation of anxiety in the child about again having to face the original, unbearably painful interpersonal conflicts from which he had fled into illness.

The conflict becomes even more acute when the parent reacts to the child's modified behavior with anxiety, rejection, or other destructive or punitive be-

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* Read at National Conference of Jewish Social Welfare, Baltimore, June 4, 1947.

† *Editor's note:* This paper, together with Mrs. Greenfield's which appears in this issue represent two different points of view with respect to the treatment of parent-child problems. It is our belief that the presentation of these two points of view in juxtaposition will be of value to workers who are concerned with the treatment of children in their own homes.

havior. Small wonder, then, that a variety of serious resistances to treatment occur at these points, on the part of both the child and the parent. To add to the complexity of the therapeutic situation, there are more or less subtle increases in counter-transference on the part of the worker in reaction to this crisis in the treatment. No therapist can remain unmoved when his therapeutic creation is seriously endangered.

The demands upon the therapist at this time are most exacting in terms of alert sensitivity to the dynamics in the total treatment situation and in terms of skilled handling of the resistances. Since modifications in the nuclear relationship of child and therapist are being reflected in modifications in the primary interpersonal relationships with significant parents, and since other important interpersonal relationships of the child—as with siblings, playmates, teachers—are also being dynamically influenced by the central treatment relationship, the area of the therapist's responsibility becomes wider and wider. Can we assume so much professional responsibility? Is a psychiatric case worker in a child guidance clinic equipped to handle so staggering a responsibility, the outcome of which may have lasting effects upon the personality and the mental health of the child?

I would like to approach this part of the discussion with the comment that, if we could acknowledge that a case worker, through the summative development of training, experience, supervision and the use of her personal resources, can acquire the requisite understanding of the client's manifest and intrinsic difficulties in adjustment, the effectiveness of the case worker's handling of the client's explicit difficulties in social adjustment is vastly enriched. In the field of treatment, I know of no other professional group so well endowed—at least potentially—to render integrated treatment for neurotic children for whom the treatment-of-choice is of a socio-psychiatric nature.

Now, in returning to the question as to the case worker's ability to understand thoroughly the dynamics of interpersonal relations and the psychopathology of their disturbances, I wish to emphasize that no case worker in the Jewish Board of Guardians has ever had to assume so vital a burden on her own responsibility. From the moment we begin to explore with a client his wish for our help, to the termination of treatment, the service to the client reflects the direct and indirect contributions of the treatment team. This is comprised basically of case worker, supervisor and psychiatrist and may be augmented by the psychologist and the physician whenever necessary. Except for the physician, all these specialists work together within the framework of the agency in an integrated collaboration out of which has grown, through the years, a socio-psychiatric philosophy and concepts of treatment in child-guidance service.

The fact that our functioning is a collaboration of clinicians with similar—fortunately rarely identical—philosophies of socio-psychiatric concepts may clarify how and why the case worker in this agency has been able to acquire, to a reasonably effective degree, an understanding of differential diagnosis, and to apply this knowledge in influencing the dynamics of the treatment relationship in a manner conducive to a disturbed child's emotional growth. In more familiar phraseology, one might say that the psychiatric case worker, as agency representative, and in collaboration with the psychiatrist, undertakes to treat maladjusted children and parents, many of whose conflicts are of an unconscious nature. But I feel that does not quite do justice to the agency's contribution to the functioning of the therapist—and of other clinicians—within the agency. The professional heritage available to every worker in the agency, as a distillate of the professional contributions of present and past staff members, endows the worker with resourcefulness and skill that are reflected in therapeutic results.

What I have been saying may seem to you to be a digression from the topic of this paper, which is concerned with a characteristic kind of difficulty in the treatment situation. However, before illustrating my comments about this characteristic resistance to treatment with case material, it seemed to me to be desirable to tell you something about the way we think and work.

Esther, just 10 years old, was referred to the JBG by a hospital where the mother was an outpatient in psychiatric treatment. The child was fearful of going to school, and in recent months had had extremely poor attendance. Esther said other children made her nervous by teasing and touching her, and she wanted only to stay with her mother, to whom she clung, crying hysterically when made to go to school. This symptom had been present for about a year, with the child expressing fear of going to school when the weather was bad. Esther had other fears also. She was afraid of being alone, of sleeping in the dark, and she would not let the mother out of her sight. In addition, she had been in the habit of masturbating and of biting her nails for several years.

Esther is an only child, born out of wedlock to the mother and a father married to another woman. We got a history of extreme overprotection and infantilization by the mother, a deeply disturbed woman, who impressed her psychiatrist as suffering from Involutional Melancholia. Our intake worker felt the mother's anxiety and fears about Esther were created by ambivalence and deep guilt feelings that had been transmitted to the child herself, and that these conflicts had in time become incorporated in the child's personality in the form of phobic reactions.

The intake worker's tentative diagnosis—later confirmed in psychiatric consultation—was that Esther suffered from Anxiety Hysteria. Because of experience in the agency with such cases of school phobias, arrangements were made to start treatment immediately. At first it was our plan to see only the child, since the mother was in psychiatric treatment elsewhere. Soon, however, the need for therapeutically modifying the relationship between mother and child led to the plan whereby the mother, while continuing her treatment in the hospital clinic, would come to the JBG for help in regard to her handling of the child.

Esther first came to the agency with her mother when both were seen by the intake worker. After the mother had been alone with the worker for some time, Esther came back to the interviewing room and insisted that her mother go home because Esther was tired of waiting. When asked if she was interested in any of the toys in the room, Esther quickly set about to play, chattering freely all of the time. She made a very quick transference to the female therapist, rushing over every few minutes to throw her arms about her and to ask for help in getting an excuse for school. She told the worker that there were thoughts in her mind which do not let her go to school, thoughts that tell her that she should stay home. These thoughts usually come when the sun is not out. She tries very hard but she cannot overcome her fear. She began to cry as she told that neigh-

bors laugh at her and call her "crazy" or tell her that she is just making believe. She stressed that she was not making believe, that all of this was very real to her and she just could not go to school. The therapist indicated sympathetically that she understood how Esther might feel and that she would try to help her. Then the therapist discussed with the child coming to the agency regularly for help with her problems. As the mother and child were about to leave, Esther came to the worker, threw her arms around her neck and kissed her.

When Esther came to her first treatment session, she greeted the worker warmly and took her arm as they walked to the therapist's room. At the door, Esther became fearful of entering, withdrew a bit, and pressed close to the therapist, who then put her arm around the child and asked, "Are you a little afraid?" Esther smiled, hugged the therapist and ran ahead into the room. The child did not sit down but gazed around her, asking questions, what was this, what was that. Although she seemed delighted with the toys and inspected everything the worker had, she came and stood directly before the worker and refused to sit down. Accusingly, she mentioned that she had had to wait such a long time before the worker called her. Wasn't the therapist thinking about her at all? Esther had thought about the therapist every day and wondered when she would be asked to come. She even dreamed of the therapist. "I dreamed that you were calling me, saying, come Esther dear, come and play in my office." Esther laughed and put her face in her hand. She had also thought of what the therapist would tell her about her fear of going to school. She is trying very hard to go back to school but she's scared. The boys pick on her and pull her hair, that's why she does not like it and the teacher speaks crossly to her. Whenever she wants to go to the bathroom or get a drink of water, the teacher says she is a bad girl for wanting to leave the room. But even when she is allowed to go to the bathroom, she is afraid because she thinks someone is following her. She likes it better at home where she can play and watch what her mother is doing. Maybe her mother is ironing and needs her help. She loves to stay home and trace on paper and watch her mother. Again coming close and whimpering, Esther asked "What are you going to do with me?" The therapist asked her what she wanted her to do and Esther replied "I really want to go to school, I really do, I'm afraid." The therapist told the child she knew she was afraid and that she would help her to go back to school.

Then Esther asked if she could do something today and was told she could do whatever she liked. She chose to draw a picture of a beautiful fairy princess, and then another of a fairy princess who was ugly. Both had the same identity and this princess had a little girl who was bad. The mother doesn't know about the little girl's badness. Asked if there was a daddy, Esther quickly answered "no." With a great deal of stress Esther said "She hasn't got a daddy." This play was ended by Esther clutching herself in the stomach, bending over, laughing and saying, "Ho, ho, ho, I'm so funny."

In the next hour, Esther began to complain about her mother. Her mother does not buy her anything, or take her anywhere. She talked to the neighbors about what a bad girl Esther is. She demanded to know why her mother doesn't do anything for her. She went on to complain that her mother doesn't believe her when Esther says she is afraid to go to school. She does not know why her mother wants to get rid of her. Esther then said that, even though she was afraid, she had been going to school every day.

When the worker indicated she knew from the mother this was not so, and asked why Esther hadn't told the worker about it herself, Esther said she was afraid the worker wouldn't like her any more if she knew Esther didn't go to school. She thought this because her mother didn't like her for that reason. They all call her a bad girl and crazy. Honest, she was sick today from eating a frankfurter. Asked if there was anything else the matter today, Esther said yes it looked as though it were going to rain this morning. She is afraid if it rains she won't be able to get home. She is afraid of the thunder and lightning. She is afraid to get wet. That's why she can't go to school on rainy days.

Up to this point the mother had been seeing the same worker, a situation that provoked some additional anxiety in the child. The mother became disturbed about the change in Esther's behavior towards her. The mother complained that Esther would come rushing to her, but that instead of kissing her as always in the past, Esther bit and hit the mother. Then after Esther hurt the mother so much that she cried, Esther cried too and said she was sorry. The mother indicated her desperation with what she considered to be a change for the worse in the child for whom she felt she was sacrificing her very life. The mother's resistance to treatment increased at this time and she failed to bring the child for her next appointment. The mother telephoned instead and said she had a severe migraine headache and did not feel she could stand the trip to the office. The therapist could hear Esther near the telephone crying and screaming "let me talk to her." Esther told the worker, over the phone, that she wanted to come and she pleaded that the worker make the mother bring her.

It was at this time that the case was divided. Esther remained with the original therapist and the mother was transferred to another worker, who gave the mother a great deal of reassurance and support in handling the child's rapidly emerging ambivalence and hostility. Simultaneously, Esther had gained sufficient security in her relationship with her therapist to be able to act out in play and in verbalized phantasy, her central neurotic conflicts. In the fifth interview—the child's second session following division of the case, Esther, after tiring of the play, sat sadly staring out the window. She asked if the therapist thought it was going to rain tomorrow. She said she couldn't go to school if it were going to rain or if the sun were not out; and suddenly her nose started to twitch and her eyes filled with tears. She cried and said she could not get rid of bad thoughts. She could not say them, but the child wrote on a piece of paper the word dead. The therapist asked Esther if she was afraid something would happen to her mother while she is away at school. This was met with a vigorous nodding of the head and the child's question, "How did you know?" The therapist reassured her and asked what else she thought about. Something dreadful she cannot tell, cannot even write. With more reassurance Esther wrote the Yiddish word for cholera. Again, the therapist verbalized that Esther thinks about cholera when she is away from her mother. Esther said that's why she can't go to school. She continued to cry in the therapist's arms and asked for reassurance she is not bad. The therapist said very seriously there was something she wanted Esther to remember and in this manner got her entire attention. She told the child that thinking things did not make them so and that even if she thought of these things nothing would happen to her mother. The therapist also told her that it was common to everybody at times to love and hate the same person. Esther dried her eyes and

asked, "Can I go to school tomorrow?" The worker said she thought Esther could. The child kissed her at the end of the interview and as she left threw kisses until she was out of sight.

In the next interview, the mother reported there had been improvement. Esther had gone to school every single day and had not complained at all. Gradually, Esther has been able to release from repression her painful doubts and anxieties about herself and her parents, and to work towards resolution of her tremendous hostility towards the mother, whom she unconsciously blamed for the absence of a good daddy.

Recovery from the phobic behavior in the presenting symptoms has been sustained for about a year. Treatment of the child and of the parent has continued with the aim of helping Esther achieve satisfying and secure interpersonal relationships free from the destructive distortions in living caused by her neurotic conflicts.

To summarize this presentation, I have tried to describe a characteristic kind of crisis in treatment that results from a neurotic client's efforts to function without repression of his true feelings. The demands upon the therapist in handling the complicated, disturbed interpersonal situation were touched upon and I have suggested how the flexible, differential use of the agency's treatment resources endows the psychiatric case worker with requisite professional skills and with requisite security in their use. I would like to say just a few more words about treatment resources in a child guidance agency such as the Jewish Board of Guardians. The availability of such services as group therapy, volunteer big brothers and sisters, summer camps, the Children's Court Department, and treatment in the controlled environments of Hawthorne and Cedar Knolls schools, and the fact that all of these services are integral parts of the agency's total service to the community, suggest something of the variety and flexibility of the treatment resources within the agency. Supported within this structural setting, the case worker, as representative of the clinical treatment team, can learn to use her own inestimable resources of emphatic understanding and feeling in the significant treatment of emotionally disturbed children and parents.

COUNSELING IN PARENT-CHILD RELATIONSHIP PROBLEMS*

By BEATRICE GREENFIELD

Jewish Community Services of Queens-Nassau

IN this paper I shall discuss an approach to problems of parents and children used in the Jewish Community Services of Queens-Nassau. We are the only Jewish case work organization in Queens and Nassau counties, New York, except for a placement and adoption agency. Founded only four and a half years ago, the agency is still in the experimental stage of its development.

The work of the agency is carried out in three units, one devoted to services for the aged, one to the traditional family services, and a third to services involving problems with children and youth.

Our Children's and Youth Service Unit handles this last category, which includes all problems in which the child or adolescent is the focus. Requests by parents for help in such matters as nursery, boarding school or institutional care, recreational plans, or help in deciding whether to seek foster home placement, are all referred to this unit. The greatest portion of the caseload, however, consists of parental requests for assistance in coping with problem behavior of children. Although referrals may come from schools, courts, and other non-parental sources, it is mandatory that the parent participate in some manner in making the initial application.

In view of the nature of this session, I am limiting my discussion to a presentation of the use of agency structure in our work with parents and children. Before continuing, however, I wish to make clear that I speak with no air of finality; the agency is still clarifying its techniques in this area, and we realize that ours is only one of many ways of working. Questions regarding our work have arisen from time to time in our own unit staff seminar, led by Mr. Herbert Aptekar, director of our agency; indeed, it is to these seminars that I am indebted for much of the material in this paper.

I wish first to define the scope of our work with "parent-child relationship problems." Situations where parents are struggling with children are commonplace. In many of these, the parents attempt to use various resources, such as outside punishment, family doctors, and, of course, books on child care—to find a solution to their troubles. When such resources have been exhausted and the parents are nevertheless faced with an impasse in the relationship with their children, they then apply to us for assistance. We offer help to these people in attaining a different kind of equilibrium. Our focus is on those forces in the relationship which have created the block, and on assisting the clients to realign those forces into a harmonious relationship.

This is a different kind of orientation from that therapy which attempts to work with reorganizing the whole psyche of either the child and/or the parents.

* This paper was presented at the Annual Meeting of the N.C.J.S.W., Baltimore, Md., June 4, 1947.