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**PSYCHOANALYTICALLY
BASED CONJOINT
THERAPY FOR CHILDREN
AND THEIR PARENTS**

American Handbook of Psychiatry

Psychoanalytically Based Conjoint Therapy For Children And Their Parents

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Psychoanalytically Based Conjoint Therapy For Children And Their Parents

In this chapter, interest centers predominantly on the various modes of psychotherapy that are based on concepts of how the child's mind develops from infancy into adulthood. Before describing and illustrating current approaches to child therapy, however, some historical perspectives will be outlined in order that present trends can be understood in this wider context.

The Psychohistory of Childhood

The history of civilization is in substance a record of man's thoughts about himself, the universe, and the relationship between the two. However, no attempts were made to understand the mental life and development of man as an infant and a child, with few exceptions, until the work of Charles Darwin, Sigmund Freud, and, more recently, Heinz Werner and Jean Piaget.

Attitudes toward the mental life of children, throughout history, have been determined by assumptions and preformed concepts of what a child is. The frescos of ancient Egypt depict infants and children as miniature adults. Indeed, the changing bodily form of infants and children at various ages was not acknowledged in paintings and drawings throughout antiquity. These developmental sequences of infancy and childhood were not recognized until the flowering of civilization in Greece and Rome, when infants and children

came to be depicted by sculptors and painters of that era in their true physical proportions. Even so, the dominant social attitude of that time gave children the status of property—an attitude still prevalent in the custody and divorce proceedings of our day. The pregnant and nursing mother did receive special status and attention in ancient Greece, but in other respects both women and children shared the fate of being outside the social, political, and economic power structure of society.

Concepts of Women and Children in the Past

The history of man's thoughts about childhood is, understandably, directly related to the history of his thoughts about the place of women in society. Now, throughout history, man's thoughts about himself—particularly about his origins, his place in the universe, and his ultimate fate—have been dominated by illusions and myths. Such myths have provided a transitional model of thought around which these complex issues can be organized before more certain knowledge is possible. Concerning present matters, one consistent aspect of many myths was the belief that women had closer contacts with evil, supernatural forces—that is, the unknown—than did men. This view of women probably stems from the mystery surrounding the female generative capacity. Before men understood their own role in impregnation, women were looked upon as creators of life; and, according to the ancient Egyptian myth of the Osiris and Isis, women also had power over

death. Dominance of social institutions by men, some postulate, arose from man's jealousy of this power of women.

Both the over- and underestimations of women and children by men in a phallogocentric culture helped men deny the significance of the mother-infant bond. Extreme views have always dominated men's thoughts about children, women, and minority groups. The infant has been viewed either as innocent, touched by godliness, and full of unlimited potentialities—a "tabula rasa"—or tainted by original sin, animal-like in disposition, and devoid of meaningful sensitivities or thought. The tragic children's crusade of 1212 a.d., which sent many thousands of French and German children to their deaths, was organized and supported by adults who believed that children could convert the Moslems to the Christian belief (Gray, 1970). The thought of the child as a distinctively unique kind of human being, with a growing and changing capacity for feeling, learning, thinking, and acting, instead of simply as a potential adult, was not a consistently held concept until quite recently. Even now, the full implications of the child's own development are barely understood or acknowledged in actual practice. For most adults the child is either a container to be filled with ideas from adulthood or an undifferentiated, amoral being whose basic sinfulness, dirtiness, and ignorance of truth must be replaced by the righteous motives and knowledge of adults. It is often asked: When does the child gain distinctive feelings, thoughts, and reasoning ability? When can a child be accepted as a witness?

The assumption behind these questions is that at some point the child becomes adult-like. The issue of distinctive feelings and thoughts characteristic of each developmental phase of infancy and childhood is thus bypassed.

Interestingly, the development of man's thinking about the child parallels the history of thinking about the "insane" adult. Hard-won insights into understanding both "insane" adults and growing children are often washed away by a return to more simplistic notions of organic causation and original sin. Even among students of human behavior and mental health workers, the capacity for sustained empathy with insane adults and with children is evanescent and fragile. It readily undergoes repression and requires continuous relearning. Genetic epistemology (the development of man's thoughts about his capacity for thinking) must be recapitulated in each new generation of mental health workers. Society engages alternately in progressive and regressive attitudes toward children. This is oftentimes reflected in the liberal-versus-conservative views on funding such social institutions as aid to needy children; foster home care; care of the handicapped; legal and social attitudes toward child abuse; education, particularly the "soft" aspect of education involved in the arts and social science courses; and, last but not least, the extreme ambivalence of society toward the development of adequate child mental health programs. Thus the past is still with us in terms of both the "empathy gap" in adults approaching

child care, and the social attitudes toward children and child-care institutions. The extremes dominate now as in the past. (A new journal, *The History of Childhood Quarterly*, is attempting a scholarly review of childhood in history.)

A recent evidence of society's reactionary attitudes toward children was the "Sputnik neurosis." All of this now seems quite remote, in light of repeated landings of man on the moon by the United States from 1969 to 1973, and the new political attitudes of "detente" with the Soviets. But when on October 4, 1957, Soviet scientists launched a small satellite in orbit around the earth by means of a powerful rocket, there was a reaction of amazement and shock in this country. The reaction received a further boost when these same scientists succeeded in orbiting a dog, accompanied by another collection of impressive hardware. In fact, as we in the United States compared ourselves with our chief competitors for world status, our feelings of esteem varied in direct proportion to the number of pounds of thrust produced by our rockets as compared to theirs, or by the weight of our satellites as compared to theirs. Clearly, for many of us it was a case of competition for mother earth, accompanied by phallic envy and its associated feelings of anxiety. We seriously questioned our own functioning and, as is characteristic for our time and culture, declared the schools to be the source of our trouble: we should stop coddling our children and start to get tough with them.

The Modern Era

When the infant, child, or adolescent is brought for "therapy" the child psychiatrist, child analyst, or other child mental health worker by either the parents, the school, or child protective services, the problem, variously stated, is either that the child is not behaving as he should or that the child's intellectual development is impaired. More often, the parents or the school are having difficulty managing the child's behavior. Rarely is there clear concern about how the child himself is feeling or whether his present problem will impair his future potential for personal, affective functioning. Doing well scholastically is often equated with good mental health. Most of the people who refer or bring the child for help rarely appreciate the fact that the child himself may be able to express and clarify the nature of his own distress either in language or in play. Often the child has been quite explicit and even eloquent, but no one has listened. The child's statement of the problem deserves detailed attention.

These attitudes of present adults and social agencies illustrate the fact that the child is still being viewed in "moral" terms. The paramount issue is seen as one of how to make the child behave, how to guide the child into adult mentality, how to control the child, how to eliminate undesirable behavior or promote desirable behavior. These are the issues that bring children to therapy. The ideas of protecting the child so that his own developmental

potential might be reached along his own inherent maturational lines, and of understanding how the child is thinking and feeling, are still foreign to most adults dealing with children. Therapy is often seen as a danger that presents a risk of damage to the child. In fact, the parent's fear is that the child's suppressed and repressed sexuality and aggression will run rampant if the child is allowed and, indeed, encouraged to explore his thoughts and feelings. Parents also often resent the privacy between the child and the therapist. Frequently this is because they are concerned about the child's interest in and attachment to the therapist, who is thus seen as a rival by the parent. And finally, a common fear is that the record of the child will become blotted by having had to go to a psychiatrist.

Problems of Strategy in Case Management

Diagnosis and treatment are not the first issues with which the child psychiatrist or child analyst is confronted. Before them come the initial telephone contact or letter communication and the structuring of expectations in the child and the parent by the referral source. The preconscious expectations and fears of the parents as well as those of the therapist must also be sufficiently understood and resolved before evaluation can proceed. Many dropouts from therapy could be prevented if these initial strategic issues could be adequately appraised and resolved. Exploration of this often treacherous territory requires a subtle combination of good sense

and deep insight into one's self and others, including those who refer child patients for help.

On the practical side, we may cite a few rules:

1. Always respond to telephone or letter inquiries promptly, preferably within twenty-four hours. A well-timed response is more efficient because it is less guilt-burdened. It can be brief and helpful. If the patient cannot be seen because of time limitations or other reasons, the rejection and referral elsewhere will be less traumatic if it is not compounded by delay which is taken as an additional rejection by both child and parent.
2. Determine the referral source as soon as possible, since the patient's expectations are often pre-structured by the referral source. If continued contact with the referral source is likely, ask for permission to discuss the problems with the referral source prior to the first visit.
3. Ask who is most concerned or interested in evaluation and determine what expectations this person has for the evaluation and its outcome.
4. Find out what concern the person calling has about bringing the child to see you. He or she could at first be more concerned about you and what you intend to do than about the child.
5. Determine whether the child has any known concerns about himself or his family.

6. Find out what the father and mother think about the problem.
7. Answer questions about fees and time considerations as directly as possible, but keep communication open on these issues.
8. Help parents prepare the child for the first visit by telling the child who you are, what you are going to do, what is expected of him, and when this is going to happen. One or two days' notice is sufficient.
9. Determine what attempts have been made previously to help the child, and their results.
10. Try to outline what can be expected in the way of time and interviews, with whom, and what additional information may be needed.
11. Express an expectation of seeing both parents and other centrally involved adults.

All or some of these considerations may be dealt with in part at the first telephone contact and preferably no later than the first visit with the most involved parent.

When to See the Child

The child's general appearance, initial response to the therapist, reaction to separation from the parent, and other behavior such as play,

verbalizations, drawings, and expressed fears and fantasies provide the surest guide to his problems. Not infrequently, they also provide significant clues to problems in the family. Once the therapist has seen the child, he becomes a more creative listener as the parent describes his view of the evolution of the child's problems. The therapist, by virtue of having some primary data from the child, may have some basis for independent judgments that allow him to observe gaps, omissions, and differences in emphasis offered by the parent. Each of these provide clues to the nature of the parent-child relationship. It is therefore highly desirable to see the child as soon as possible. In many situations this can and should be done even before the parent is seen in the first interview. Most parents welcome this approach. Children less than three years old should initially be seen with their parents in the same room. After initial introduction and warming up, the therapist can set the stage for separation and observe the child's reaction to and recovery from this all-important event. Over the age of three, many children can tolerate separation from the parent and enter the interview room containing play materials with very little anxiety. All of this initial structuring is very different, of course, in dealing with an adolescent.

In the case of the child who is likely to be seen in psychoanalytic treatment, on the other hand, it is desirable to delay contact with the child until such time as continuity and intensity of contact can be assured. The child may be seen very briefly, at first, until the arrangements for psychoanalytic

treatment are completed with the parents. The reason for this is that the transference relationship with the child in psychoanalytic treatment must be preserved from the beginning. More will be said about these differences in approach later.

Sharing of Information Between Child and Parent by the Therapist

In child psychiatric practice, the younger the child, the more information is to be shared in both directions between therapist and parent as to what the child has said and done. The therapist may gain considerable cognitive and affective leverage on the child's play, fantasy, and dreams by sharing such information with the parents and including parents in the elaboration and understanding of such material. Latency-age and pre-adolescent children, as well as adolescents, can rightfully expect the therapist to keep some private information absolutely confidential—such as, for example, masturbatory fantasies, sexual and aggressive urges and actions, and oedipal wishes. And when the parent shares the same such information about the child with the therapist, the therapist is to make use of it only to improve his own listening and empathy.

It is sometimes helpful for the therapist to share with the parent certain puzzling play sequences that the child has produced in his visit, for further comparison, associations, and interpretations. This is particularly true of the

younger child, when play is the major mode of communication and requires translation. For example, a five-year-old boy engaged in repetitious designs of an airport, with jets frequently crashing into the buildings. The sequences were repetitive and suggested a traumatic origin. On sharing this information with the mother, she stated that the father made frequent airplane trips away from home and that separations took place at the airport. She reported that the child was very frightened of the noise made by the jets. This information was crucial in formulating interpretations of the play taking place in the interview room.

When One Parent Is "Opposed" to the Therapy

Not infrequently the mother will report that the father believes everything is fine and that only she is concerned about the child, and indicates the father's unwillingness to participate in either the evaluation or the therapy. Occasionally this is true, but more often, when direct attempts are made to involve the father in the evaluation, he is quite willing to come and often offers valuable insight and perspective into the problems in the family. Situations of this sort often emerge from an unresolved mother-child symbiosis. The father regards the therapy as just one more example of his being excluded from any libidinal claim on the mother.

Occasionally career-minded mothers suggest that the father should

bring the child to therapy or that a maid or other relative should take responsibility for the evaluation. This usually indicates a serious estrangement between the mother and the child that cannot be resolved without contact with the mother. When she is seen, the focus often shifts from the child to the marriage or to the mother's problems.

Extended Evaluation and Goals

Since the child's problems are so often intertwined with those of other family members (as will be described later), it is good practice to proceed with the evaluation over an extended period of time, if necessary, in order to evaluate the inherent pathology and strength of each family member and of the family interaction. This evaluation may require several months. In younger children with developmental disturbance, etiological factors in the child's illness and in the family interaction are particularly difficult to pinpoint early in the contact. Nor is it always easy to determine the future potential for growth in the child without a series of evaluations extending over several months or years. A single determination of speech retardation or autistic behavior, for example, cannot provide the basis for an ongoing prognosis. Parents can be quite understanding of such a need and often welcome the opportunity for a more leisurely and extended contact prior to any clear commitments to therapy. The need to establish a clear-cut diagnosis (including quantitative appraisal of etiological factors) and to outline a course

of definitive treatment in one family member is probably a greater need for the therapist than it is for the family.

Goals of evaluation and treatment should be discussed with both the child and the family. This can be done in stages rather than all at once, beginning with what is required during evaluation and then proceeding to additional goals once this is achieved. Near the final phases of therapy, goals should again be reviewed along with the entire course of treatment. Such a process strengthens the healthy ego in building a therapeutic alliance.

Physical Problems

If the parent does not present a concern about physical or neurological difficulties in the child during the initial contact, it is appropriate for the therapist to introduce these topics so that they may be resolved, clearing the way for psychological work. Correct evaluation of the child's physical status includes a detailed medical and neurological history and physical examination as well as a history of psychological development beginning with conception. A record of all illnesses, hospitalizations, and injuries, together with the treatment given and the complications ensuing, should be listed. A detailed neurological evaluation by a competent pediatric neurologist, electroencephalographic evaluation by an electroencephalographer acquainted with normal developmental shifts in the EEG in children, an

educational evaluation, and psychological testing for the more subtle kinds of organic brain damage are all procedures that should be utilized with clear indications in each case. All of this information on the child's physical status must be appraised, organized, integrated, and synthesized with the child's history of psychological development, since it pertains very directly to the child's growing self-concept. It should be remembered that the first self to gain mental representation is a bodily self.

Origin and Development of Psychopathological Behavior in Childhood

Child behavior can be analyzed in many different ways. If, indeed, one begins with the assumption that infants and children are unique individuals whose development and behavior are first and foremost to be understood (even when changes are considered desirable for the child and from the parents' viewpoint), one soon realizes that the child's history of psychological development—including any behavior, attitude, symptom, or functional limitation—is highly relevant and in fact indispensable to an understanding of such behavior. This process of understanding has often been bypassed in the past. It is often bypassed at present by symptomatic approaches to therapy that proceed immediately with reactions to the child's behavior or are designed to eliminate or modify behavior on *a priori* moral grounds—those of adults who deem what is desirable or undesirable for the child. Work however, with infants and children has provided and is continuing to provide

new understandings to the developmental processes that underlie all subsequent behavior. Child behavior does not arise *de novo*; it is a product of interactions between inherent tendencies, maturational patterns and environmental influences.

The human infant is born in the state of adaptiveness to the average expectable environment. He begins the process of adaptation to the specifics of this environment soon after birth. Each infant, for example, makes a specific adaptation to his mother's specific feeding style (Call, 1964). Many studies have shown significant differences between individual infants and between boy and girl infants (Call, 1971). Thus Richard Bell (1971) has shown that hyperresponsive male infants at birth have a disproportionately higher incidence of behavior disorder and social isolation in the preschool period.

Developmental Origins

The treatment process in child psychiatry and child psychoanalysis requires an understanding of both normal and psychopathological development. When normal psychological growth is compared with psychopathological development at each age period, the contrasts suggest that the process of adaptation is active and oriented to inner as well as outer events, and that it involves the child's attention, sensorimotor functioning,

and, later, his intellectual functions. Given a physically healthy baby at birth, a supportive environment, "good-enough" mothering (Winnicott, 1965), and subsequent social and educational experience, the individual emerges with continued capacity to adapt. Plasticity of function is preserved in both the psychological and intellectual areas. Remaining growth potential and the capacity for creative problem-solving and invention continue to be demonstrated. These are all hallmarks of the psychologically healthy individual.

Psychopathological development may arise from organismic limitations or faulty personal, social, or educational experience. But regardless of the relative importance of specific etiological factors, the overall result in psychopathological development is the same: a narrowing of adaptive capacity; a fixation and overspecialization of psychological and intellectual processes; and a serious limitation in possibilities for further growth, creative problem solving, or invention. Any psychologically-based treatment procedure should attempt to assess and resolve issues that have led to psychopathological development and augment factors that would promote normal psychological and intellectual growth.

During infancy and childhood, developmental deviation, symptoms, and psychopathological character development must be distinguished from the following:

1. Normal maturational crises.
2. Transient growth crises.
3. Temporary reactions to interpersonal or environmental stress.
4. Regression in the psychological functions associated with physical illness and injury.
5. Normal plateaus and quiet periods in development.

Such distinctions are not always easy, especially if one is committed to identifying early signs of psychopathological development or to applying early treatment in order to prevent significant later pathology. A listing of the most serious (as contrasted with the least serious) complaints of parents about their children or of symptoms in children has not yet been developed—nor is it likely to be, since any externally observable behavior may emerge from a wide variety of underlying conditions. The significance of a "symptom" must be evaluated in the background of ongoing developmental progress. In clinical situations where the meaning of a given behavior, symptom, or reaction may be in doubt, the best one can often do is to help the parents stay in good communication with the child, become good observers of themselves as they relate to the child, follow further progress, and report back at reasonable intervals.

It is an interesting paradox in the field of infant and child psychiatry to

discover that what appears at first as a psychopathological development—that is an overspecialized adaptation to a non-average acceptable situation, to not good-enough mothering, and so on— may emerge over a period of a few months as a useful and more generally applied adaptation to the wider environment. Heinz Hartmann referred to this process as that of a symptom or conflict gaining secondary autonomy. The price paid for such a symptom-oriented adaptation is constriction of ego functioning. The infant or child may make an appropriate adaptation to the mother or to other environmental situations, only later to discover that the adaptation doesn't serve him well in the world at large. This is probably the reason most child psychiatric referrals of even severely disturbed children do not occur until the child is evaluated within his peer group by persons outside the family, such as when he begins attending nursery school or kindergarten. This is an example of how an early, successful adaptation that was originally conflict-free becomes conflict-ridden.

The dynamics of psychopathological development change with time as a child's normal psychological growth proceeds. Among such growth processes are the following:

1. Ego functions become more coherently organized.
2. Object relations proceed from a "boundless" quality to a clear, distinct separation of self from others.

3. The capacity to master the environment increases.
4. The child's capacity to form a mental representation of his own experience with the mother and his capacity to remember the mother as a person even when he is anxious, gradually increases.
5. Superego and ego ideals change.
6. Processes of identification begin in the first years of life with imitative behavior and piecemeal incorporation of the attitudes and feelings of others, with progress to identification with the aggressor and identification with the provider (see below), and finally to the use of the love object as a model around which the child organizes his own character.

Stages of Development

The stages of psychopathological development are discussed briefly below.

Birth to Age Three: Early Adaptations and Developmental Detentions

John Benjamin (1961), some years ago, showed that the predisposition toward anxiety that is the basis for symptom formation in later development is established by the age of three months and results primarily from the way

in which the infant and mother resolve problems of sensory overload (from within and from without) in the first three months of life. This process depends upon the timing and character of soothing and protection offered by the mother—that is, her style (Call, 1966). Study of the earliest deviant behavior in infancy, such as pathological head-nodding, turning away, failure to thrive, projectile vomiting, difficulty in establishing eye contact, and rumination, are at first an adaptation of the infant to his experience and particularly to the mothering he has received. Such adaptations, if continued, may later become the basis of true symptoms.

Some symptoms in early infancy may reflect deficits in underlying neurological organization, such as the inability of an infant to hold its head up, irritable crying, colic, and disturbances in its capacity to maintain a state of quiet sleep or quiet attentiveness. Other symptoms may arise from deviant mothering and still others from specific kinds of disturbance in the mother-child relationship. For example, psychogenic megacolon in the early months of life has been found to arise from a pathological "tilting" of the relationship between the mother and the infant to anal-erotic modes of communication between mother and infant.

*Ages Three to Five: Symptom Formation
and Family Dynamics*

The capacity to form a symptom presupposes a psychological conflict

between the expression of an instinctual drive and the defense against it. Instinctual drives become conflicting if they are experienced as dangerous. They become dangerous if the infant is capable of perceiving his abandonment by the love object. The love object does not exist separate from the self until the infant achieves beginning resolutions of the separation-individuation phases of development. Thus, true symptoms turn an external conflict into an internal one and represent an attempt at conflict resolution—that is, a compromise formation.

Examples of such early symptom formation may include the following:

1. Withholding of bowel movements. Here the conflict involved is between the impulse to smear and touch and to aggressively expel bowel content, and the fear that the parent will disapprove. The child's resolution of the conflict is to withhold.
2. Night terrors—that is, images of being bitten, eaten, or chased by wild animals. In this case the child's hostile, angry, destructive biting feelings are displaced onto the animal, which represents both self and disapproving adult.
3. Phobias of early childhood, such as fears of certain places or situations or of persons who are actually associated with threats of abandonment. These phobias are elaborated by the child's fantasies of what would happen in such a situation.

4. Eating disturbances, failure to speak, bizarre play, rocking, head-banging, tics.

At this stage of symptom formation, the symptom is intimately interwoven in the system of communication with family members, particularly parents. The symptom may also be a response of the child to parental communications. Because of the child's own fantasy (to project his own impulses to primary figures in disguised form) and his capacity to internalize an external conflict, he goes beyond the stage of adaptation to the stage of symptom formation proper.

Ages Five to Ten: Internalization and Acting Out of Conflict

At this stage in development, the child's defenses are more firmly organized. Each child shows a more consistent preference for particular defensive operations. The child's object relations have become clear—and also more complex, since the complexities of the oedipal situation present a three- rather than two-party conflict situation for the child to resolve. It is within this context that the "infantile neurosis" was originally conceived by Freud. What has been described in the preceding stages could be referred to as the early infantile neurosis before age five.

There are two major ways for the child to resolve conflicts characteristic of this time. He may either completely internalize the conflict—

as observed, for example, in the obsessional neurosis—or he may act out elements of the neurotic conflict in relation to peers and other adults outside the family. Since normal latency is characterized by heightened mobility and action as a normal mode of communication, acting out of neurotic conflict should be considered an age-appropriate mode of expressing neurotic conflict.

Symptom patterns during this time are characterized by the following problems: bowel and urinary problems; lying; persistent fearfulness regarding school, other children, and new situations; finickiness with food; persistent phobias; open masturbation or sexual exploration (which normally would be private and with consenting peer-group members); overdependence; fire setting; pseudomaturity; running away; nonadaptive neatness; persistent thumb-sucking; strange, bizarre, or withdrawn behavior; uncommunicativeness; cruelty to animals; no friends; lack of interest in appearance or development of skills; disturbed sleep and frightening dreams and nightmares; persistently upset by changes; excessive clinging to transitional objects; withdrawal; obsessional behavior; speech problems; and hallucinations.

Ages Ten to Thirteen: Regression

Pre-adolescence is a confusing time for teachers, parents, and therapists

because, as a preadolescent begins contemplating the advent of adolescence (that is, the loss of original love objects and the shift to new ones), he resumes the earlier psychological stance of the preoedipal child. Earlier defensive organizations are weakened. Pregenital behavior emerges. Language function regresses and undergoes re-instinctualization. Anxieties increase. Both boys and girls become preoccupied about the earlier preoedipal attachment to the mother, showing a liberal reorientation toward oral and anal erotic activities.

Symptom patterns reflect this situation. They include characteristic problems, as follows: depression; antisocial behavior; suicidal attempts or rumination; use of dangerous drugs; avoidance of school; school failure; reversal of value systems (rather than testing of value systems); no friends or personal interests; promiscuous sexual behavior; anorexia or obesity; avoidance; persistence of conforming or passive behavior; lack of interest in future; sudden total personality change or deterioration in mental functioning; acute phobia or obsessional behavior: excessive preoccupation with body; persistent somatic complaints without organic disease: and regressive behavior.

*Ages Thirteen to Fifteen:
Reconstruction*

Rapid physical growth and the appearance of secondary sexual characteristics propel the child into adolescence proper. This, incidentally,

has been occurring at younger ages (at the rate of four months per ten years) since the onset of the twentieth century, so that the onset of puberty now occurs twenty-eight months earlier than in 1900. No single factor (for example, nutrition, urbanization, mass media, a change in parental expectations, or some racial or climatic influence) has been sufficient to explain this earlier onset of adolescence. A combination of factors seems the most likely explanation.

Puberty refers to bodily changes induced by the secondary sex hormones. Adolescence refers to associated psychological processes, which may precede or follow puberty by a highly variable time interval.

The search for new love objects may at first turn the adolescent toward objects of the same sex or toward group identifications. Such a move may be the best compromise available to the adolescent in dealing with renewed oedipal struggles and as a defense against heterosexual object ties. During this phase of adolescence, new capacities for intellectual, social, and physical functions do emerge as a child's greater social perspective increases. Symptoms reflecting this underlying state of affairs do not differ significantly from signs of disturbance found in early adolescence. Increased intellectual growth, self-awareness, and capacity to verbalize provide the mid-adolescent with increased leverage in getting his complaints heard and responded to either by family or social agency.

Ages Fifteen to Eighteen: Consolidation of Symptom Trends and Character Traits

As reconsolidation of the personality takes place during this period, both the strengths and the vulnerability of the emerging independent person are revealed. A second opportunity for resolution of the primary oedipal ties and pregenital fixations presents itself during this important phase of adolescence. While the role of parents is less intense in terms of actually monitoring the details of daily experience, the shift toward independence provokes children and their parents into a further loosening of ties. This forces a reorientation on both sides toward one another. A new period of growth can emerge from such reorientation. Some of the characteristic problems in psychopathology for this age group include: schizophrenic reactions, in contrast to adolescent turmoil; delinquency; obsessional neurosis; depression; abuse of drugs; and school failure.

Dynamics of Psychopathology in Parent-Child Relationships

Projection, Identification, and Narcissism

Diagnostic manuals are oriented toward the phenomenology of psychopathology in the individual. Yet much of what the child and family specialist is called upon to "treat" is found in disturbed interrelationships rather than clearly in one or another of the individuals involved. Folie a deux

and sadomasochistic relationships are illustrations of similar phenomena from the field of adult psychiatry. The psychopathology of interaction between parent and child is very complex, because it is closely interwoven with the child's prolonged normal relative dependency on the parent. Also, the full complexity of verbal and nonverbal patterns of communication in the family does not make an impact of equal significance on the infant and child at all stages of the child's development. The influences that family interaction will have on the child depend on the child's level of psychological development, intelligence, and special characteristics at specific ages. In addition, family organization is not only complex, it also changes as parents themselves change and as the ages and characteristics of the children in the family change. Thus, no two infants growing up in the "same" family ever actually share a truly similar experience.

Parental caretaking and protection involve matters of body illness, injury, nutrition, and interpretation of the world to the child. The physiological and hormonal changes of pregnancy prepare the way for a psychological reorientation of energies and interests on the part of the mother in the direction of infant feeding and care, together with a willingness and even eagerness to assume such responsibility for the infant. This leads to a state of normal psychological symbiosis during the first year of life. The mother functions as an auxiliary ego for the child, as a protective shield, as a source of narcissistic "supplies," as a source of stimulation for the

development of the child's cognitive functioning, and as a libidinal object. On this last depends the infant's capacity for developing loving bonds with other human beings.

From the child's second year of life on, the parent is called upon to facilitate individuation through a series of separation-individuation phases of development. Congenital abnormalities, physical illnesses, hospitalizations, and psychological disturbances in this early period of life call for even more highly specialized adaptations of care by the parent, since such disturbances inevitably distort the normal phases of attachment, symbiosis, and separation for the parent. The capacity to let go or to allow the child to emerge independently after such intense involvement, and yet to continue functioning as a parent in more subtle ways, is a task that many parents find particularly difficult. (Infantile attachment, symbiosis, and separation issues emerge for reconsideration in adolescence.)

One of the requirements of good-enough mothering is the capacity to endure what the infant projects onto the mother. That is, the projection of aggressive, destructive impulses is likely to arouse retaliatory feelings in the mother, who must inhibit or displace these feelings or turn them upon herself. This is the rub of motherhood, and it provides a major root for masochism. However, it is not limited to women who care for infants but is found in all helping relationships. It probably has its origins in man's

development as a social animal. Much of the disturbing sadomasochistic relationship that may exist in a marriage is borrowed from infancy.

On the other hand, one of the psychological tasks of infancy and childhood is to endure what the parent projects onto or acts out with the child. It is out of such stuff that confusion and ambivalence in all human relationships grow. Thus, everyone is destined to become somewhat confused and disillusioned with everyone else, no matter how gratifying the relationships otherwise are. *The problem in all human bonds is to find the capacity to endure so that some love is possible.*

Another basic fact of human experience is that the infant is experienced more or less as an extension of the parent. The parent is thus narcissistically identified with the infant, making it possible for many parents to care for an infant when they would not have been able to do so out of a sense of empathy. Many parents were themselves insufficiently cared for as infants and children and do not have within themselves the memories, models, or skills of good-enough parenting. Or else they have gaps and odd points of emphasis, making parenting a series of disjointed communications and responses in relation to the child. For such parents the narcissistic model of child care is the only possible outcome short of abandonment of the child, but narcissistically-oriented child care fails as the child strives to maintain self-esteem during the process of separation and independence. Many parents whose care is

predicated on the narcissistic model vacillate in actual practice between deep infantile narcissistic orientation of self-object attachments and abandonment of the child, thus recreating their own life history. (These and similar problems are expanded upon in a recent valuable edition to the literature, *Parenthood: Its Psychology and Psychopathology*. [Anthony, 1970]) Certain children also elicit specific underlying sensitivities and vulnerabilities of the parents and rekindle their primitive mental life.

Taking care of others—a task so ubiquitous, so necessary, and so much a part of being human—is humane, high-minded, socially-sanctioned behavior that serves to ensure survival of the species. It is also a means by which each human being attempts to recreate the gaps and traumas from his own past in a belated attempt at mastery. Because of this, taking care of others can at times become confusing and self-defeating. Parents and therapists, particularly those who work with children, share this common maturational struggle. Becoming a parent and taking care of others offer another chance for reorganizing one’s primitive psychic life.

The child, narcissistically identified with the parent as self-object, feels himself to be what is projected onto him by the parent. His feelings of self-esteem reflect changing moods and feelings in the parent. Many mothers and fathers will confirm that their own feelings of self-esteem are regulated by the child and his responses to their care and affection.

Example: Mrs. Page, one of our longitudinal case-study mothers, got off to a good start breast-feeding her child. Things were going well despite the fact that the family was looking for a new house during the child's first two and one half months. When some tensions originating from this source erupted openly between the parents, the mother felt angry but could not acknowledge or express such anger to her husband. She carried this anger and its associated depressive feelings with her to the evening nursing of her child. The infant reacted with irritability and crying. The mother's anger then erupted more openly. She became angry with the baby and said in a loud voice, "Stop complaining!" A vicious circle ensued during the next twelve hours, which kept both mother and infant awake through the night. These emotions were finally quieted by exhaustion and apathy.

Comment: This example is presented not because it is unusual but because it is typical. Suppressed and repressed anger and hostility in the mother resulted in depressive affect and displacement of angry feelings toward the child. The physiological letdown of milk was disrupted. The child experienced feelings of helplessness and rage. The mother was again confronted with her own hostility returned to herself, and a vicious circle was set up that finally resulted in apathy and withdrawal. This experience set the stage for further cycles of the same behavior. The parent-child problem was intertwined with marital difficulties, the past family history of each parent, and the social context of the family (looking for and financing a new house). A

transient, self-limited feeding and sleeping problem emerged in the infant. Under some conditions the infant might have reacted with respiratory symptoms or with a skin rash or another form of bodily communication. If the cycles of tension had continued, apathy might have become well established, and failure to thrive could have been the result. If the parent had more fully acted out hostile feelings, child battering could have resulted. However, in the example cited above, the house problem was solved by a low-interest, government-insured loan. The marital relationship was not disrupted, and as the child progressed to more independence, the relationship between mother and child eased.

Unresolved Parent-Child Symbiosis

Psychopathology in the parent-child relationship emanating from psychopathological deviations from normal parent-child symbiosis may be seen in the symbiotic psychosis of childhood described by Margaret Mahler (1952), in the gender disturbances described by Stoller (1968), in the prolonged disturbances and distortions of the feeding process that result in anorexia nervosa and obesity (Bruch, 1973), and in the mutually inhibiting parent-child symbiosis often observed in handicapped children (Call, 1958). Recently Anthony (1969) studied parent-child interactions involving a psychotic parent and found that in 5 to 10 percent of children involved in a close relationship with a psychotic parent, the syndrome of "super-normality"

developed. This was characterized by the child's taking care of parenting responsibilities in the home, including care of the psychotic parent. I had observed this pseudo-mature syndrome in some children with handicapped siblings. The same problem has been observed in children of alcoholic parents. This is probably an exaggeration of the same but more subtle process occurring in normal children. The child identifies with the provider or caretaker and feels responsible for and responds to the needs of parents and other children, just as the parent feels responsible for and responds to the needs of the child. Recently Margaret Mahler (1972) reconceptualized the infantile origins of the borderline patient. She believes that the predisposition towards the borderline state may emanate from the failure to resolve later stages of separation-individuation.

Example: In a group discussion, Mrs. S. said, "You know, doctor, I've been thinking about something for a long time. I've wondered if it means I'm crazy or something. I haven't told anyone about this except my husband." She then said with some surprise and embarrassment, "I sometimes feel as if II. (a handicapped child, age two and a half) is part of me. I don't see her as an individual. I see S. (a younger, normal child) entirely differently. I see his individuality and his special characteristics, but not so with H."

Incorporation of and Acting Out of Marital Conflict by the Child

Children not infrequently incorporate and act out with each other both sides of the marital conflict. They may also simultaneously displace onto siblings unresolved aspects of both pre-oedipal and oedipal struggles. These complex phenomena are generally described under the very descriptive but undynamic term of "sibling rivalry."

Example: Marvin, age ten, depreciated, tormented, and often physically abused his younger, admiring brother. This brother was born when Marvin was three. Until then Marvin had been maintained as an overprotected child, still in psychopathological symbiosis with his mother, whose clinging to him was determined by her own earlier losses and thinly disguised threats of marital disruption by the father. As Marvin's real struggle with his mother was identified, he allowed himself friendship with the brother.

Comment: The issue here was not rivalry with the brother for their mother's affection. It was how Marvin could liberate himself from the infantile ties with his mother and vice versa. Fighting with baby brother was Marvin's way of fighting with baby-self-mother. Terms such as sibling rivalry, maternal rejection, and dependency refer to the epiphenomena of object relations.

The Sick Role and Scapegoatism in the Family

Treatment of children with a severe psychologic disturbance such as

schizophrenia, severe psychosomatic disease, anorexia, delinquency, or psychogenic megacolon has repeatedly demonstrated to clinicians that when the seriously ill child threatens to get better, or in fact makes very definite and highly visible progress, the most involved parent frequently attempts to re-establish the illness even when the mechanisms underlying the illness have become clear and are under the conscious control of the parent. An alternative is for the parent to become ill. The identification of a sick child in the family does a great deal to provide the illusion of mental health in other family members. Relieving the child's illness is like opening a Pandora's box containing the rest of the family pathology, or like removing the scapegoat in the school or classroom.

Example: An eleven-year-old girl, Janet, was brought for treatment (once or twice a week for one year) because of a clearly defined phobia that gradually had been getting worse over the past two years. The child could not leave home except when the mother took her to school and returned her home from school, because she was afraid that she would see a cripple, someone with an arm or a leg missing, someone in a wheelchair, or someone old (about to die). As the sources of this phobia were identified in dreams and in fantasies using the squiggle game (referred to below under "Drawings and Use of Plastic Media" [p. 221]), the child responded very favorably to classical interpretive techniques and not only resolved her phobia but liberated herself from a pathological symbiosis with the mother. When this happened, a

serious marital difficulty that had existed for years came to a head. The parents separated. The mother was temporarily relieved but remained deeply disturbed herself, showing depression and suicidal tendencies, which she attempted to utilize in setting up a highly eroticized symbiosis with her therapist. Her underlying borderline state was soon clearly revealed.

Identification with the Provider and the Aggressor

Identification with the provider has already been described above in the case of the pseudo-maturity syndrome. Identification with the aggressor is an unconscious defense mechanism described by Anna Freud," referring to how the individual deals psychologically with externally perceived aggressive threats that elicit anxiety. The individual takes onto himself certain aspects of the threatening external aggression. For example, he may take on the total identity of the aggressive person, or he may take on only one aspect of the threat situation and act this out in other situations. The clearest example would be the child who, in the face of significant castration threats from the father, becomes cruel to a younger sibling.

How a Child Makes Known His Inner Psychological Life and Ongoing Experience

Play

Play is the universal language of childhood, and it remains more or less available to older children and even to adults. Play sequences can be analyzed just as verbal sequences can be analyzed. Repetitious play and play paralysis are usually indications of underlying neurotic disturbance or ego deficits.

The term "play therapy" is misleading because it suggests that play in itself is therapeutic. Play becomes therapeutic only when it is understood and responded to as a communication about oneself. Melanie Klein (1932) was the first to interpret the child's play as a projection of his inner psychological world onto the world of small objects. Play can be interpreted to the child either directly or within the metaphor.

Example: George: (Enters office and engages in favorite play activity of recent sessions: that is, filling ashtrays with "will-hold" glue, dropping in paper clips and coins, and placing the ashtray on the window sill to dry.)

Analyst: Glue is a way of holding on to good stuff and making sure it stays there.

George: (Looks at analyst, says nothing. Brings glue-filled ashtray containing paper clips and coins from prior session to desk and chips glue away to remove paper clips from gluey mass.)

Analyst: Those paper clips are like your coin collection.

George: I can clean my coins with glue. It makes them look like new.

Analyst: That "will-hold" glue is really good stuff. We need a good supply of it.

George: (Spreads glue on hands, waves hands to speed drying of glue, and peels off glue.) Look how clean my hands are when I peel it off.

Analyst: Yes, and you always leave a nice neat pile of it for me to take care of, so I'll be sure and remember you and have some of you left here even after you're gone.

George: (Looks up and smiles while continuing to peel the dried glue from his hands.)

Analyst: Did you think I'd forget, like when your daddy went away, if I didn't have something special from you to remind me of you?

Comment: The choice of these remarks by the analyst was determined by the analyst's empathy with the boy's shame and anxiety in connection with his problem of fecal withholding and soiling, and his current attempt to bring these problems under his own control. The bowel problem had resulted from, among other things, "separation fears" that could be more precisely stated as his fear of being forgotten; toilet fears that, more precisely, are related to fantasies he had that a hand inside the toilet could reach up and pull him down into the pipes; and his mother's willingness and unwitting collaboration in continuing to involve herself in all aspects of his toileting activity, including wiping his bottom so it wouldn't get sore. This had evolved into one of the methods he utilized in controlling his mother.

An effective interpretation is like the day residue of a dream: lodged in a preconscious state, eventually establishing connections with contents of the id that are striving for conscious representation. Well-phrased and well-timed

interpretations thus lead to new material in the therapeutic process, just as the mother's empathic holding of the infant (without limiting the infant's capacity to contribute to reciprocity with her) leads to psychological growth. Use of the metaphor in the above example (the neat pile of glue on desk referring to a fecal mass inside and outside) and casual openness in speaking of the anxious situation as revealed in the transference (being forgotten by the father, displaced onto the mother, and then onto the analyst) aid the ego in recovering control and resolving conflict.

Words, Action, and Stories

Even before the child can express himself in coherent verbal language, an illusory verbal dialogue can take place between the child and the therapist relating to the activities, reactions, and play of the child. When verbal language does become available to the child, it is highly egocentric and is often at first utilized in a highly condensed fashion organized around the child's internal thought processes. A common and almost universally successful method for encouraging verbal productivity in therapy with a child is to have the therapist dovetail words with play and offer a parallel verbal comment to play sequences or other physical activity.

Example: I asked Mark if he had any dreams, "scary" or otherwise. He said "No." Later, while engaged in tossing a ball back and forth, I asked him

the same question in the same words. He replied "Oh, yes," and went on to describe what he said was a "funny" dream but turned out to be a dream of getting lost on the freeways in Los Angeles and not being able to get home. Associations were to the many losses and changes of living situations he had experienced.

Comment: Action is a primary mode of communication. Tossing the ball back and forth is an action metaphor for verbal exchange. I've found such action a useful method in facilitating conversation. In my experience, playful activities of this type, with reciprocity of affect between the patient and the therapist, often overcome both suppression and repression, thus facilitating therapeutic communication with a child. A skillful therapist will not confine himself to asking questions. He will encourage running commentary, story telling, and dramatic play action as a means of facilitating verbal dialogue with the child.

Drawings and Use of Plastic Media

When the child has been able to make reference to some event within his life, either in the outside world or in connection with his fantasies, wishes, or dreams, the therapist may choose to respond by inviting the patient to make a drawing or diagram of what has been described in words; or else the therapist may respond to some aspect of what has been described by making

a drawing himself. Frequently the full impact of the event then becomes clear to the therapist. Clay and paint can be utilized as well as pencil, paper, and Crayola's. David Reiser (1972) has made effective use of drawings to help the child express conflict situations.

Examples: John, a fire-setter age eight years old, had quite matter-of-factly told the therapist that he slept in the same bed with his mother. The therapist responded by drawing a room with a bed, and a mother and a boy in the bed. The therapist showed the picture to John, asking him if he meant "like that." John then became anxious and held his penis. He told his therapist that the boy and his mother were not so close in the bed, to which the therapist replied, "Getting too close to the mother in bed could make a boy excited and then scared of what could happen to his penis if the father found out. Hot feelings are like fires."

Tim, age four, was being seen in the same visit with his two-year-old sister, Marie, and an eight-month-old brother, Peter, who was held during the visit on his mother's lap. I drew a diagrammatic representation of a face and gave it to Tim without comment, along with a pencil and another piece of blank paper. Tim drew a face and looked up at me. I asked him who it was. He said "Peewee." His mother laughed and said that the baby brother, Peter, was called "Peewee." Tim had only recently given up his position on the mother's lap. Tim then spontaneously drew another, more primitively organized figure

identified as a "monster." Following this, both he and his sister pranced about the room pretending to be giant monsters. The mother commented that they often played monster like this at home. I asked if she had any idea why, and she replied that they had seen monsters on television.

Comment: My drawing and accompanying question were designed to elicit relevant data in a spontaneous way, such that it might be relied on in providing Tim with the chance to tell his own story without distorting points of emphasis by using leading questions. Tim's drawing of a face (including hair, eyes, nose, mouth, and ears, all in the proper location) not only revealed his good intelligence and perceptual capacity but also identified the main character and theme in his stream of thought. The spontaneous behavior that followed—first the drawing of the monster and then the dramatic acting-out of monster play with his sister—confirms that the drawing had in itself been an effective means of opening up access to Tim's inner life experience and communicating it to other people. The mother's participation with me in attempting to translate the meaning of his behavior, in all probability, had a liberating influence upon her son. The entire sequence could be translated into any one of the following: "Peewee is a monster," "Peter is a little Peewee baby and I am all grown up like a monster," "Peewee has a tiny peewee and I have a big one," and "When I feed Peewee, I feel like a monster." Any one or all of these statements might be acceptable translations. At this point, however, the important issue was not the precise translation of this sequence

but, rather, the use of the drawing in opening up the possibility of Tim telling his own story.

Donald W. Winnicott (1971) devoted a book to the use of the squiggle game in understanding and interpreting the child's mental world. This game is played by one person making a line, series of lines, or marks on a piece of paper, and the other person adding additional marks or lines to complete a specific representation. I have combined the squiggle game with a story-making technique.

Example: Janet, a phobic girl of eleven, and I took turns in completing squiggle sequences until five were completed. The five squiggle objects in sequence were: (1) a nose; (2) a smiling face; (3) a snake; (4) a horse; and (5) flowers. She was then told it might help "in our work together" to arrange these in any order and tell a story about them. The story she told went as follows. "There was this girl who liked to put her nose into things. She always smiled except when she met a snake. One day her horse won a race and they gave him a ring of flowers over his neck." To which the therapist replied, "Horses love flowers and hate snakes, and have you ever noticed that the nose is prettiest on a smiling face?" Janet loved to play this game and insisted on playing it in subsequent visits in which the stories were utilized as a basis for self-reference. This eventually evolved into a method to deal with anxiety-ridden situations.

Affectomotor Patterns

The child may reveal more about himself in his postural and motoric activities than he does in words, drawings, or play.

Example: Gerald often became restless if he was not seen immediately on his arrival. On one occasion, instead of waiting for the analyst he immediately left the waiting area, went back to check on his mother, and then subsequently entered the analyst's office in a very excited manner, asking where the analyst had been and why it took him so long to meet him. By this time, the analyst had become aware of an unconscious anxiety situation which gave rise to this behavior, so he replied, "When a boy is afraid of being forgotten he has to keep track of where everybody is and it makes him angry if people aren't there waiting for him. The boy always feels angry if he has to wait for somebody else." Gerald's reply was, "Are you talking about me again?"

Displacement onto Others

Children often refer to others, including adults, pets, siblings, and teachers, as a way of making reference to themselves. It is common for children who have few friends, for example, to claim that others are unfriendly with them or don't like them. Such children often provoke negative responses from others.

Example: George, age eight, began the hour rather excitedly, going to the toy closet and selecting a puppet whom he immediately named E. Howard Hunt. He began beating on the puppet saying, "E. Howard Hunt is a criminal. He broke into Daniel Ellsberg's psychiatrist's office. He took pictures of the records. He broke into the National Democratic Headquarters at the Watergate Hotel, bugged the telephones, and stole records." At this point, George filled the puppet with paper money and continued beating until the money was squashed out of the puppet and scattered on the floor. The analyst knew that George had been watching the Watergate investigation on television and was aware that Hunt's personal life had been discussed, namely, the tragic loss of his wife in a plane accident six months after the bugging incident. It was also known that George's behavior toward many of the objects in the therapist's office was as if they were his own, and he made a special point of collecting valuable objects. This was, in part, an identification with his father. In addition, he had engaged in childhood extortion tactics in controlling his mother. The analyst's response was as follows:

Analyst: Do you think, George, that E. Howard Hunt had a problem?

George: I'll say he had a problem. He was a criminal, and now he's getting punished. Bang, bang.

Analyst: Yes, he certainly has gotten a lot of beatings. He was even beat up and robbed when he was in jail.

George: It serves him right. He was a robber himself.

Analyst: But what do you think was his problem?

George: He liked to tell tall stories and he wrote books. I have some of his books.

Analyst: So you've become an expert on E. Howard Hunt, and now he's getting what's coming to him because he was a criminal?

George: Yes.

Analyst: Are we forgetting something about E. Howard Hunt?

George: You mean because his wife died in the plane crash?

Analyst: Something scary like that could make a person feel real bad.

George: But this money makes him feel better, and that's why he's a thief.

Analyst: It's too bad he didn't have anyone to talk to about his problem. Maybe he wouldn't have got into so much trouble.

George: You psychiatrists have everything figured out, don't you?

Comment: The analyst is focusing more here on the therapeutic process than interpretation of this material. An effort is being made to help the patient see how he himself can move the analysis forward. Experience with George has shown that he often responds to interpretations as castration and ceases supplying more material. It is sometimes more important that the therapist understand the therapeutic process than that he interpret the unconscious meaning of the material.

Dreams

Dreams may play as important a role in child therapy as they do in adult therapy, particularly if they have been frightening dreams or nightmares that reveal the underlying sources of anxiety and conflict in the child. Young children often present clear wish-fulfillment or anxiety dreams. Older children, beyond the age of five or six, often present dreams as highly elaborate and disguised as those that adults present. The use of dreams in psychoanalytically based child therapy is deserving of a detailed chapter or book.

Choice of Therapy

The choice of therapy offered in a situation in which the child's problems are presented by the parents is determined by many factors besides the nature of the child's problem in itself. Such factors include the following:

1. The training and experience of the therapist.
2. The limitations of time available to both the therapist and the parents at the time of consultation.
3. The financial resources of the family.
4. Transportation arrangements to and from the therapist's office.
5. The level of understanding and psychological-mindedness of the parents.

6. The nature and intensity of unconscious resistance both in the child and in the parents.
7. The stage very often having been set ahead of time by the referral source, in determining the expectations of the parents.

The range of possibilities and the interaction of the variables that determine the choice and nature of the therapy and its outcome can best be understood by reviewing a series of briefly presented case studies. Long-term follow-up information is available on these cases, which constitute the remainder of the article.

Marvin, a Nine-Year-Old: Psychoanalysis

Marvin was brought for evaluation by his father on referral from the father's former analyst, because of Marvin's poor grades in school, lack of friends, withdrawn and sullen behavior, and sadistic attacks on his brother (two and one half years younger), whom he said he wished to kill with a knife. Marvin also suffered from asthma since the age of four, with attacks occurring three or four times a week during six months of the year in the fall and spring. Other reasons included withholding of bowel movements, bed wetting, "hateful" attitudes toward all women and girls, and pervasive, general misery. The father had had two years of psychoanalytic treatment because he himself was uncomfortable with his periodic, overt, homosexual interests, in which a sadomasochistic relationship with a partner was acted out. His wife was

unaware of his homosexual activity. Psychoanalysis had helped him stabilize his work and his family role, and had reduced but not completely eliminated his homosexual interests. The father had been openly suicidal when the patient was about four years old. The mother was a schizoid, withdrawn, mechanistic person without psychological insight, but she was quite conscientious and wanted to help. Both parents were frightened of Marvin's behavior toward the younger brother and did not expect him to be able to continue living at home. They suggested the possibility of admitting him to a hospital. A school report confirmed what the parents had said.

In the first visit Marvin presented himself in a highly provocative way, acting the part of an anxious dictator with the analyst. I pointed out to him that he must have been pretty scared coming here, thinking that I would be the one to decide what to do about him. I told him that I could see he wanted to be the boss of this situation and tell me what to do, rather than have me tell him what to do. He calmed down considerably in response to these brief comments and then went on to play with his favorite objects, airplanes. I agreed with the parents on the serious nature of his difficulty, but I told them that I thought Marvin was extremely anxious, knew that he was in trouble, and had responded to me as a person who might be able to help him. I told them that in order to do so, it would be necessary for me to see Marvin four or five times a week, and that his treatment would probably extend at least two years. I also indicated that it would be necessary and important for me to

meet with them from time to time, and that I would welcome any information from the school. The parents agreed to this as the best alternative open to them, both from the financial viewpoint and from the viewpoint of Marvin's future. They were confident that analysis could help Marvin as it had helped his father.

Marvin had been considered a relatively quiet baby, was bottle-fed, was left in his crib a good deal as an infant, and had experienced separations from his parents for several weeks at a time at the ages of eight months and thirteen months. At the age of two and a half years his brother was born. Two months later the two boys were left with their maternal grandmother, who hired a nurse to care for the new baby while she and a grown but unmarried son cared for Marvin. Toilet training was achieved during this time by the maternal grandmother and the uncle, who gave him model airplanes when he produced on the pot. His attachment to his father was always more significant than that to his mother. When the father became depressed and suicidal when Marvin was four, the child had his first brief asthmatic attack. This was repeated at age six and had worsened since then. Marvin continued to suck his thumb and pull his ear simultaneously until the age of six, when he gave this up suddenly after a brief trip to a distant city with his father. The difficulties that led to treatment had been increasing over the past three years. The main methods of dealing with Marvin's difficult behavior at home included making him sit on a chair for several hours at a time, and spankings

administered by the father. The parents had also attempted a variety of pacifying and manipulating maneuvers that resulted in two-way bribery and extortion between the parents and the patient.

During the initial phases of the analysis the patient developed a positive attachment to the analyst, and he began to experience increased feelings of confidence in himself as a working alliance developed. In his omnipotent attitude with the analyst he pretended to be the frightening monster who controlled, sadistically attacked, and castrated the analyst. This was interpreted as his fear of being controlled, castrated, and attacked by others in the environment and being destroyed by the monster within himself. His behavior at home and school improved considerably. Marvin reserved the most primitive aspects of his functioning for the analysis. Gradually the analyst came to be identified as a cruel, bad person from whom he felt he must defend himself. Thus he projected his attacking superego to the analyst, externalizing an internal conflict in the transference neurosis. The major modes of communication included dramatic play actions, provocative behavior with the analyst, many drawings in which he depicted the violent struggles between good and bad (wars), and other drawings, writings, and puzzles in which his dual sadistic impulses and defenses against these impulses were illustrated. His disappointment with the cool, relatively unyielding mother was illustrated by his expectation that the analyst could not give him what he needed. Each hostile attack toward an outside object—

including the analyst, the brother, girls, and his own prized belongings—occurred in the context of a threatened deprivation.

When it was possible to interpret the earlier origins of such feelings in relation to the brother and parents, the attack would subside and actions could be replaced by words. For example, Marvin literally wanted to exhibit his "piss and butt" to the analyst repeatedly. He would often back up, behind first, onto the therapist's lap. These behaviors were determined by several causes. They represented his concerns about castration, his fixation on anal matters, and his anxiety concerning wetting and soiling, which he did periodically. These elements were interpreted to him and resulted in a temporary lessening of anxiety. In one session he gave an important clue to the analyst when he recalled scenes from the age of two of his brother's nurse holding and feeding the brother and changing his diapers. The attentive care this brother received was considered more desirable to Marvin than being bribed with small model airplanes to produce bin's on the toilet. The interpretation was then made to him that he had wished to be taken care of like he saw his brother being taken care of, receiving all of the attention to his "piss and butt," and that he wished I could do the same for him now—and was angry because I didn't. It was suggested that he must have been very angry then, too, when his parents weren't around to take care of him while his brother did get taken care of by a nurse.

The exhibiting, provocative behavior had another derivative too: namely, the sadomasochistic relationship with the father, who had engaged in a good deal of spanking, after which father and son would engage in a mutually satisfying make-up. Marvin wished something similar with the analyst. The model airplanes offered as rewards for the deposit of bowel movements in the toilet became transitional objects for him, a way he had of dealing with separation anxiety. He also did a number of things that were calculated to make sure I didn't forget him between visits. He liked to leave his mark in my office. Sometimes this consisted of a pencil mark on the wall, his phone number written down for me, a drawing on my blackboard, or a pile of toys in the middle of the floor. All of these leavings-behind were interpreted as having their origin in his fear of being forgotten. A reunion following a separation was most difficult for him to deal with, and on each return he became provocative. Eventually he learned to express his concern and resentment before the separation and then to reconstruct the events after the separation.

Comment: It is easy in retrospect to agree that psychoanalysis was the treatment of choice in this case, since many such children are hospitalized or placed away from home in a highly structured and controlled environment. "Bad" behavior often stems from anxiety. It was clearly recognized in the beginning that Marvin's acting-out behavior was a reflection of an underlying neurosis. Also, Marvin's response to my initial interpretation assured me that

an all-out attempt to deal with the problem, utilizing in-depth psychological understanding, might be successful. Follow-up information confirmed that the effort was indeed worthwhile and perhaps the most economically feasible of alternatives available.

Byron, Age Eighteen Months: Parental Guidance Based upon Psychoanalytic Understanding

Byron was a bright, precocious boy brought for consultation at the age of eighteen months because of biting behavior. He was his mother's first and only child. At the time of referral he bit everybody, showing no remorse when he was reprimanded. When attempts were made to control him, he would bite even more aggressively. The mother was an intelligent young woman; even though she was concerned about his behavior, she also was puzzled by it and wanted to understand it. Her main idea was that Byron was not getting enough love. She felt guilty about working and gave him extra attention. I told her that in order to understand him, we would reconstruct how his thinking and feeling had developed from birth.

I met with the mother and stepfather twice before seeing Byron. In those two visits it was possible to formulate a hypothesis about Byron's biting. The mother was at first not consciously aware of the importance of the continuity of a good maternal relationship with Byron. She herself had experienced many separations and discontinuities with her parents, and by a

superhuman effort she had lifted herself from an uneducated status to that of a successful, semiprofessional person, still very much interested in her own education. The pregnancy with Byron was unexpected, although wanted. She liked Byron as an infant but went to work when he was six weeks of age, leaving him in the care of a motherly person with three children of her own. At three months his care was shifted to a loving, easy-going, child-oriented woman who had animals in the house and who provided a great deal of affection both for Byron and his mother, a young woman who thrived on affection. At age one year and four months this woman was no longer available, and Byron was given over to the care of a younger woman who was very perfectionistic, rigid, and enforced many strict rules. It was within a few days of this transfer that Byron's biting behavior began. It did not cease, however, when Byron was transferred to the care of another, more loving person two months later.

Byron had learned to talk at eleven months, and his speech continued to develop in a precocious manner. He was very attentive and precocious and listened well to everything said. (Both Spanish and English were spoken at home.) He told me when I saw him that "biting is good because it makes me feel good." When not biting, he was a delightful, cheerful companion who was very attentive to adults and who showed a good sense of humor. He would pretend to be afraid of dogs, and he preferred to have the light on at night. He was somewhat afraid of loud noises made by trucks. Two sides to Byron

emerged in the history and in direct interviews with him. On the one hand he showed many precocious and independent attitudes (pseudo-precocity). On the other hand there was a clear wish— although not easily identified—to recapture some of his position of being a favored and loved baby, which had been disrupted at one year and four months of age.

Byron listened very attentively to me when I told him that I understood that biting made him feel good, because it was his way of getting hold of things that he, loved and wanted to have for himself so that he could be a big baby boss. I told him he needed to be a baby for a long time before he grew up. This eighteen-month-old child repeated these statements to his mother at home, and for the next week he often mentioned his visit with me: the toys and play at my office, and the things we had talked about. Subsequent visits with the mother and stepfather revealed that Byron often sought his mother's lap, insisted on being held, returned to the bottle briefly, enjoyed affection by his mother, and stopped biting. This dramatic change in Byron's behavior was sufficient to force the mother to reorient her value systems and attitudes. She delayed her plans to go to school and work and developed a strong attachment to Byron, to some extent living out her own earlier deprivation through narcissistic identification with her son. A follow-up two years later revealed Byron to be asymptomatic and progressing smoothly in his development.

Comment: It is often said that if problems could be identified early, they would be more easily and successfully treated. This, in fact, seems to be borne out in Byron's case. The child's biting behavior served as a catalyst in the mother's own development. The treatment approach involved an interpretation to the mother through the child, which the mother then responded to by providing maternal care to the child and vicariously, to herself.

Norman, an Eight-Year-Old with Tics and Talent: An Eighteen-Year Follow-Up

Norman was the firstborn child of intelligent, accomplished parents. He was planned for, but he was born early in the father's career while the parents were living in the East. He was a full-term baby, healthy in every respect, and was described as being happy, alert, and active. His mother felt that she did not have enough milk to breast-feed him, so he was bottle-fed. He had colic until the age of three months, for which a darkened room was prescribed. In the first few months of life he seemed especially sensitive to the noise of the piano and would stop crying if he heard such a noise. His mother was tense, frightened, and somewhat depressed with her first child and felt as though she didn't quite know how to satisfy him.

Norman remained an active, wiry, and somewhat tense child. He smiled but often also stared at his mother. At about the age of two he became afraid

to go to sleep at night without the light on. This fear persisted throughout his early years. There were several moves by the family when the child was between the ages of eight months and five years, due to the unsettled nature of the father's occupation.

Norman's development was quite rapid. He sat at four months and walked with minimal holding-on at eight months. He was able to speak in brief sentences at fourteen months. He was quite outgoing and, as the mother said, "into everything." The mother continued being quite perplexed as to how to manage him. A sibling was born at age three and another at age five. Intense rivalry developed shortly after the birth of the first sibling.

Norman was referred for psychiatric consultation at the age of eight because of eye-blinking and head-shaking movements, unusual voice sounds, grimacing, and unusual hand movements. Bed-wetting had been present from the age of four until the age of eight, occurring once or twice each night, and Norman was beginning to say such things as, "I wish I were dead." All of this had become worse since the family's recent move at the age of five, at which time Norman felt uprooted from friends that he had in the neighborhood. The first eye-blinking and head-shaking movements—the beginning of the "tics"—occurred one afternoon when his mother told him not to go outside without a hat on. He defied her, went to a baseball game, and shook his head to see whether he were getting a headache. It became a pleasurable activity

for him, and he later said that he needed to have his "habits" because they were a source of pleasure to him. Also, it was learned that the father's method of discipline had consisted of spanking whenever he lost his temper. Norman had become somewhat defiant and obstructionistic, although he had done well in school. He was preoccupied with television shows of violence, read the newspaper about accidents, and had himself been subjected to the bullying of older boys in a new and unfamiliar neighborhood following the move. He preferred girls to his male peers. His speech difficulty (consisting of unusual voice-cracking sounds) accompanied the tics, along with grotesque facial expressions. Meanwhile Norman began to teach himself the piano. His mother had played the piano and he seemed to be learning very rapidly by himself.

Comment: It was apparent, in the extended evaluation of this family, that the mother displaced some of her resentment from the father onto Norman. She concealed this by over-solicitous attentiveness to Norman's health needs. Norman sensed the tensions between the parents and, particularly, his mother's dissatisfactions with himself, and he acted this out in his rivalry with the younger brother. Initial contact with Norman convinced me that the visits were useful to him and, also, that I could not work extensively with the parents. I referred the mother to another psychiatrist for her depressive symptoms and saw the father occasionally, while continuing once-a-week visits with Norman from the ages of eight through twelve and once-a-month visits from the ages of thirteen through seventeen. The ties

diminished considerably by the age of ten and dropped out almost completely at the age of fourteen. In pre-adolescence Norman began to express many of his pregenital anal and oral concerns, using the primitive "gutter talk" characteristic of the era. He revealed to me his "unclean" fantasies about the dignified adults in positions of authority around him. This was associated with transient episodes of paranoia.

More interesting than the disappearance of Norman's symptoms was the emergence of an obvious musical talent. By the time he had finished high school he had not only mastered the piano, including the most difficult Chopin and Beethoven, but had begun composing on his own and had taken up the organ because he felt it offered greater variability in depth of musical expression than the piano. A fascinating sidelight was how Norman "practiced" the piano. Practicing consisted of hearing the music in his head, including all the intonations and variations in style. Once he had been able to do this in his head, the playing of music (including the difficult fingering) came relatively easily, with an actual minimal amount of time spent at the piano—on the order of one half hour every two or three days. I was reminded by this of what Norman had told me about becoming an expert Little League pitcher in baseball at the age of eight, when his tics were still very obvious. While occupying the pitcher's mound, Norman went through the entire repertoire of his facial, head, and bodily movements and voice-cracking sounds. Then he would suddenly throw a finely-executed curve ball over the

plate. His tics were, in part, a rehearsal for action. I have wondered about his listening to his mother's piano music as a child. Was listening to and then recreating his own mental music a transitional phenomena for him, and—as Winnicott suggested—a basic source of creativity?

Norman completed one year of college, after which he volunteered for a period of two years of community work in a poor country among the underprivileged. There he met a woman four years his senior, with two young children. He appreciated her sensitivity and understanding of him. She mothered, loved, and charmed him and supported him in his pursuit of music as a career. His parents objected to his announcement of his intentions of marriage, but he returned to the United States with her and her children. He eventually married her, completed college, and continued his musical career as composer and teacher with good success, both artistically and financially. His speech is fluent, his affect is free, and he has received no further psychiatric care. In retrospect, this eighteen-year case study seems to justify the choice of therapy that was originally made: namely, to see the child individually, even though problems of significant proportions were present in the family. This decision was based primarily upon the fact that the child himself felt estranged from the symptom and was interested in tracing its origins and resolving it.

Steve, a Seventeen-Year-Old Football Player: No Consultation with Parents

Steve, age seventeen, had made the first string on his high school football team. He managed a successful window-washing business on off hours and showed himself to be of excellent intelligence on psychological testing. But he felt extremely uneasy with girls, was failing in all his school subjects, and was extremely testy with boys. He himself requested psychiatric help. The choice was made to see him alone without seeing his parents, unless he requested that they be seen. His initial history showed that he had had an extensive medical evaluation two years previously because of "elevated blood pressure." He feared that he might have irreparable kidney damage and would not live very long. Much of his time was spent in angry, depressed brooding over this problem (which he dared not reveal, since he had passed the physical to join the football team). Other boys spoke of masturbation in usual terms and described sexual exploits with girls. He equated masturbation with homosexuality and any kind of sexual interest in a girl, or any girl's sexual interest in him, as dirty and degrading.

After a full medical evaluation, including a review of previous investigations of hypertension and "kidney difficulty," it was found that there was no physical basis for his fears about hypertension and a short life with kidney damage. He had misrepresented some bedside doctor talk during the discussion "on rounds." None of the tests showed any significant organic pathology. Occasional blood pressures of 130/70 was noticed when he was anxious. He could hardly believe that this was the case when the details were

presented to him. However, his anxiety diminished in all areas, his grades improved, he got a girlfriend, he masturbated freely with heterosexual fantasies, and on his own he decided to discontinue therapy after three months of once-a-week visits. A follow-up a year and a half later showed Steve doing well in a college business course. He continued in competitive sports and had a steady girlfriend.

Comment: Steve was against having his parents involved in the treatment process, and his wishes were respected. He himself decided on the frequency of visits. When the medical information turned out negative, he was overjoyed but unbelieving. Nevertheless it had a significant impact upon his outlook, and his anxious brooding ceased. It was as if he no longer had to behave as if he were castrated or about to be castrated. It was helpful for him to have someone with whom he could discuss his sexual development.

Judy, a Beautiful, Bright, Autistic Girl of Two and One Half: Treatment Strategy and Outcome

At two and one half, Judy could be described as a delicate, beautiful, neat little wind-up doll. Her first response to me and my office with her parents was to touch her own and her mother's feet and knees and look at the overhead lights. Everything else between was seemingly ignored or looked through. Her mouth was set in a semi-closed position. She quickly put the pieces of a puzzle together and demonstrated a repertoire of three nouns on

cues structured by her mother: "elbow," "toy-toy," and "knee." She previously had been able to say "money" (mommy?) and could play pat-a-cake and wave bye-bye, but these achievements had disappeared during the past month. She fingered her shoes and socks and touched her colorful dress with her fingertips, and she repeatedly touched her own knees and ankles in a ritualistic fashion. She had passed the sequin form-board at age four. Her health had been good. Pediatric examination including neurological evaluation, and amino-acid screening of the urine, was normal. Her height was at the 50th percentile level and weight at the 20th percentile. Her diet had become restricted to milk, crackers, and hamburger. She awakened at 4:00 a.m.

This pregnancy was the first for the twenty-three-year-old mother and twenty-seven-year-old father, and it occurred as the mother was finishing college. The father had had labile hypertension since age sixteen. He became very anxious when he married; this worsened, with exacerbation of high blood pressure, when he discovered his wife was pregnant. His pretty young wife responded to the situation with a thirty-five-pound weight gain and a quiet, cautious attitude toward him. Judy weighed six pounds nine ounces at birth and was described as a beautiful, shiny child with a big nose. "She was real pretty." However, she seemed "independent" from the age of two weeks on. She awakened at least once a night through the first two years of life and spit up a lot during the first year. She was cared for intermittently by the

maternal grandmother because the parents were often away, including a trip for four weeks when Judy was six months of age. Judy's response to her mother on their return from this absence was to finger the buttons on her mother's dress. Relatives observed that "she seemed to want to be alone" at age ten months. Her first words, "elbow" and "banana," appeared at fifteen months. Placement in normal nursery school at age two years was recommended by the pediatrician. She failed to respond favorably. Further regression in social behavior and speech developed.

Thus by any standard it was clear that Judy's developmental level in social and speech areas was seriously impaired and that a full swing to regressive functioning was in progress. The parents were discouraged and expected continued regression in Judy's behavior. The father compared Judy to his sister, now in her twenties, who did not talk until age five and was diagnosed as "schizophrenic." The father had shared responsibility for the upbringing of this child (five years younger than himself) until he was in his teens, and he had intermittently been seeing the same psychiatrist who treated her (with ECT and medication) for several years. The father also had an aunt in a hospital for the retarded. He spoke readily of his hypertension, his anxiety at work, and his phobic and counterphobic attitudes in social settings, together with the worsening of these symptoms with his marriage and the mother's pregnancy.

Paradoxically, Judy reacted more playfully with the father than with the mother. The father had become increasingly less interested in sex with his wife since the marriage and had expressed no romantic interest at all in her since the pregnancy. The mother was more worried and cautious about the father than about the child. She was only vaguely aware of her depression and withdrawal, as she had become increasingly apathetic and discouraged. She was aware of and clearly expressed the concerns she had about her husband's inability to accept the responsibility of marriage and family life. She had attempted to shield him from burdens of this kind by leaning on her parents.

The father was seen individually and soon revealed some of the deeper origins of his own anxiety hysteria. As he began separating his own problems and prior family problems from those of his current family, the mother (who had unconsciously blamed herself for her husband's distress) became less depressed and withdrawn and became increasingly interested and affectively available to her child. Child and mother were seen in joint interviews, utilizing a psychoanalytically-oriented educational approach. For example, Judy's avoidance of the face and attention to the extremities (including the tail of their cat and an avoidance of the cat's face) was traced historically by the mother. Judy's attention to the buttons on her mother's dress and avoidance of her face at the age of six months was recognized as the first identifiable beginning of Judy's social isolation. Judy's lack of concern about separation from the mother and her "independence" were soon replaced by the

development of a strong attachment to a now more responsive and affectively available mother. When the mother's depression was linked up with her low feelings of self-esteem due to her husband's lack of interest in her, the guilt she had in relating to Judy's deviant development diminished considerably. The mother added that another factor in her depression had been her disappointment in not having a man like her father in the household.

Judy's improvement during the early months of this therapeutic program was phenomenal. Within four months she was up to her age level in vocabulary, had good eye contact, and showed only faint reminders of her earlier autistic behavior in the form of transient echolalia. By the age of four she could write her own name, was playing well with other children in a nursery school, and had completely dropped any affectations in her speech or behavior. Her adjustment to kindergarten public school was excellent. She is now in the second grade and is considered by her teacher a "gifted child." There are no social difficulties. Another child was born when Judy was five and a half, to which development she has adjusted very well. On the other hand, the father's problems have not been resolved, since he could not commit himself to intensive psychotherapy or psychoanalysis once Judy's problem was resolved. He did gain sufficient relief to permit another pregnancy without regressive behavior.

Comment: Because the problem of autistic behavior in children is of

such considerable interest, and because the diagnosis of autism often carries such a pessimistic prognosis, Judy's case deserves detailed attention because of the success of the treatment strategy applied at an early stage of the child's development. On the surface, the history of Judy's "independence," beginning at age two weeks, *could* all be interpreted as stemming from an inherent developmental deviation in the child. The histories of delayed speech and subsequent schizophrenia in the father's sister and serious mental illness in the father's aunt were factors that might suggest transmission of genetic vulnerability to schizophrenia in Judy. The father's obvious fear of marriage and of pregnancy, supported by the exclusively biological orientation of his psychiatrist (who also treated his sister), all prepared the way for a frighteningly pessimistic attitude toward Judy's future. Judy was, in the father's mind, identified with his sister. He considered himself the bearer of bad genes transmitted to Judy, and he behaved toward Judy as he had earlier to his sister, when he had shared responsibility for her care.

The psychodynamics of the father's anxiety attacks had not previously been explored. While his genetic identification with the sister had been recognized, his psychological identification with the sister and the psychological meaning of his daughter as "another sister" had not been recognized by the father. In this case, the father's psychopathology was a major point of psychological vulnerability in the family. The significance to and impact of this problem on the mother and, through her, on the child had

not previously been assessed by two excellent pediatricians or by the father's psychiatrist, who had in fact foreclosed the necessity of a psychodynamic investigation in favor of his own biological orientation.

It is important to note that the mother was not herself aware of depressive feelings. Only as she began to observe the significant impact that she could have upon the child in the context of our joint, psychoanalytically-oriented, educational approach to both child and mother could she realize that she had been depressed. This is not infrequently the case with mothers who have children with significant developmental deviation. In the mother's case, depression had been masked by apathy and cautiousness. In fact she *could* not allow herself depressive affect, in view of the dominating influence of the husband's anxieties and phobias. Like many such mothers, she was psychologically strong and felt the need to support her husband and child rather than experience her own feelings.

On first observing her, it would appear that Judy had a more healthy interest in her father than her mother. In retrospect, however, Judy's greater playfulness with the father could have reflected a deeper underlying attachment to the mother, against which she defended. In other words, she responded to father as a way of avoiding mother. The same mechanism was illustrated in her attention to the buttons on her mother's blouse rather than her face. Her interest in feet and knees—the lower end of the spectrum—

when faced with a stranger (myself) in the playroom also suggested Judy's "autistic rituals" as a clear manifestation of defense against the strong affects aroused in making social contact.

Nursery school is often recommended for an unsocialized child. However, such recommendations can induce further regressive autistic behavior in children already showing autistic behavior as a defense against social contact. Nursery-school experience can apparently be of great help to the child who has experienced social deprivation and under-stimulation, but it cannot help the child who is in the stage of defensive autistic withdrawal. Judy did benefit from nursery school experience *after* she had broken through the autistic barrier separating herself from her mother, and also during the later phases of separation and individuation that followed her establishment of a meaningful symbiosis with her mother. Thus, nursery-school experience must be utilized with sensitivity and care in the treatment of children showing autistic behavior. This point has been emphasized by Margaret Mahler (1952).

John, a Nine-Year-Old Boy with Asthma: A Brief Transference Cure

John, age nine, was referred for psychiatric care by a pediatric allergist who had been unsuccessful in bringing frequent asthmatic attacks under control, either by medication or by desensitization. John's asthma had started

at age three and had become worse during the year following the separation of his parents. Since then the maternal grandmother had moved into the home, burdening John's mother with her impending death due to metastatic carcinoma. One aspect of John's problem was that he wouldn't take his pills. It was soon discovered that taking pills had become a serious issue of control between John, his mother, and his grandmother, and that John's father didn't believe in pills. During the first session with the medical student involved, the elements of this struggle were identified. John was helped to express his resentment against the three-way struggle between him, his mother, and his grandmother. He quickly developed a very positive attachment to the student. He demonstrated to the student how he could start an asthmatic attack by coughing. His asthma quickly cleared, and for the next three weeks of contact with the medical student he had no attacks (his longest free period in several years). His fantasy play and drawing activities in the sessions with the student patently revealed his concern about the death of the grandmother and mother and the loss of the father. This is shown by the following, when John spent the first part of the visit making a paper airplane.

Medical Student: Can you tell me who is going to fly the plane?

John: My mom. She used to take flying lessons, you know, but she had to quit.

Medical Student: Where do you think she is going to go?

John: To the Devil's Triangle (at this point, a large smile grew across his face). Do you know where that is? (There had been a recent television show about

this area off the coast of Miami, where many airplanes and ships have mysteriously disappeared.)

Medical Student: I have a vague idea. Why don't you tell me about it?

John: (Still smiling.) Well, that's where you go when you disappear.

Medical Student: Where else might your mother go?

John: To the rocks.

Medical Student: Rocks?

John: Yeah, you know (as he simulates the nose-dive of the airplane, crashing it into the ground).

Medical Student: What about your dad, where might he go?

John: He'd go to work.

John then drew a picture of himself and the medical student in the lead car of a train, pulling in sequence "my mom, my new dog, my grandma, my daddy." He placed his sister on top of the train (not inside it). The last car was a dining table with seats for all family members.

Follow-up six months later revealed that the mother had died as a result of an auto accident caused by her drinking. John and his sister were seen at this time by another therapist. Both children expressed foreknowledge of the mother's self-destructive behavior, and they were relieved when what they considered inevitable actually occurred. They have thus far made a good

adjustment to life with the stepmother and father. John's asthma has not been a problem since it disappeared following the first visit with the medical student. The stepmother finds John an acceptable child with no problems. His sister's rivalry remains a problem.

Comment: The disappearance of significant asthmatic symptoms in John, and his improvement in overall functioning, can be understood as an immediate response to catharsis and to an attachment to the student as a substitute for the missing father. A response to this, together with the fact that John demonstrated at least some conscious control of his asthmatic attacks, indicated that his problems were not solely determined by internalized neurotic conflict. The treatment choice should be one offering an open resolution of family conflicts and a restoration of contact with the father, and/or a reassurance that the father remains interested in and committed to John's future development despite the divorce and the acrimony between the parents. The issue of the grandmother's death was openly broached by the medical student for the first time in the evaluation study of this family. John's 'rivalry' with his sister was a displacement and acting out of these complex problems. This was a source of considerable tension in the family. Many children with somatic symptoms, hypochondriasis, and so forth gain such symptoms through identification with others when they are faced with death and separation fears. Transference "cures" such as that shown in John's case should be regarded with suspicion and should involve detailed follow-up

study. The mother's death appears to have been anticipated and represented in John's airplane play regarding the "Devil's Triangle."

Concluding Remarks

While psychoanalytic developmental psychology is far from having achieved a fully articulate theory, it now provides a sufficiently broad base of empirically decisive propositions about human infancy, childhood, and family life to provide the rationale for a wide variety of treatment approaches to many kinds of childhood and family emotional disturbances.

Any treatment approach to the child based upon psychoanalytic understanding should facilitate the child's statement (in words, action, play, drawing affect, or dreams) about what ails him. The therapeutic task is first to help the child make his own statement in his own way, and then to help the child discover the meaning of what he has been able to say.

The psychology of parenting, particularly the father's psychology, is not very well understood. Parents and surrogate parents need to be included in the treatment programming for the child.

As the progressive and regressive processes, so well understood in symptom formation, become the focus of attention in normal development, it can be proved that new advances in treatment will be made in other areas

offering exciting future prospects for new treatment approaches in the better integration of studies of normal narcissism with the main body of psychoanalytic developmental psychology.

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