THE LENGTH OF TREATMENT IN A CHILD GUIDANCE CLINIC*

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A MAN walking in hilly country carries a heavy burden and sighs deeply. On turning a corner, he meets a farmer working on the roadside. He asks how long it will take him to reach the next village. The farmer looks him up and down, then silently continues with his work. The man repeats his question—the farmer repeats his behavior. This makes the man angry and while taking up his pack and marching on again, he thinks to himself: "This seems to be a rude fellow—or maybe he is a deaf-mute." At this moment, he hears the farmer shout after him, "It will take you about an hour and a half to reach the village!" The man asks amazed, "Why didn't you answer me before?" "Because I first had to watch how fast you walk!"

This little story is a good simile for the prognosis of the length of treatment. As with all such similes, it gives us a quick flash of pleasurable, intuitive understanding of the vicissitudes involved in pressing into static figures a dynamic process before it has completed its course. But as with all such similes, it has thus served its purpose and to satisfy our scientific minds, we have to be more accurate. Both the walking man and the farmer know the goal, they agree on its existence as a concrete thing. We are in a less favorable position—we will have to define our goal and it will turn out to be, we can all predict that, something fairly intangible. Secondly, it does of course happen that a man travels by himself through hilly country—but a client is never "alone," neither in being sick nor in being healthy, least of all in *getting* healthy. He is a living human being and therefore a knot in the net of relationships; his pace is related to the pace of all those who depend on him and on whom he depends. Thirdly, the farmer evaluated the man only approximately, but even if he wanted to be exact, he would have to examine the heart, the lungs, the muscles, yes, even the character of our traveller—he might give up easily, get tired and take a nap in the shade, or he might get frightened at crossing a wild little brook by jumping from rock to rock, and turn back altogether, etc. As you all know, I am sure, I am talking of the necessity of making a careful diagnosis of all clinical and all social factors, and of the manifold resistances the client will put up against reaching the goal. Therefore, it seems to me, the length of treatment will depend on an evaluation of all the factors involved, made as carefully as possible.

Let us first define the goal. As all the children treated in the Child Guidance Clinic of the Jewish Board of

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Guardians are living at home, either with both their parents or with only one—this is in most instances the mother —it is our immediate goal to help these parents and children to find a happy and healthy mode of living together. This appears sometimes impossible to achieve while they live together, and placement, in order to facilitate treatment, is arranged. This is, however, regarded as a temporary measure; the goal is still to work with the family as a unit, to have the child return home. What we are working with is the child-family relationship which, in the great majority, is crystallized in the mother-child relationship.[1] We can say with deep conviction, because we have experienced it so often, that the mother-child relationship is a form of folie-à-deux; for example, every paranoic develops for himself a partner, a paranoeé, or an alcoholic man is married to a certain type of woman who will, against all expectations of her logically-thinking friends who want to "save" her, *return* to him and nurse him until he is strong enough so that he can go on a drinking binge again. Such emotional symbiosis is always rooted in unconscious needs of the one person, which are so strong that they mold the Unconscious of the partner who was chosen for his responsiveness. This explanation is based on the findings of analytic psychology and I assume that we all stand on the same ground in this respect. It is a known fact that it is almost always the oldest child who presents the painful disturbance in the home —we hear it over and over again, "When I see Johnny (the oldest) bite his nails, I go crazy and I nag him for it. When Dickie does it, I do not mind." This is irrational behavior and we have learned to interpret irrational behavior as stemming from the Unconscious which is not subject to the rules of our logical thinking. We find that the oldest child has a different meaning to a mother than the next children have—and is it not quite understandable? The first child is the one that makes her a mother, and we know that this reactivates feelings and wishes experienced in early childhood and buried, repressed, forgotten since. The little girl has been deeply jealous of her mother for the love her father showed his wife, she has envied her the privilege of giving birth to his children, and she has had very ambivalent feelings toward the babies, which she has often only been able to master by fantasying that they are her own. How often can we see a pregnant mother walking with her little 5 year old daughter and the little girl will imitate her mother in posture and gait so characteristic of pregnant women—the little girl is living out her Unconscious fantasy of being pregnant too! And how difficult is it for the little girl to accept that the next baby is a boy and is treated quite differently from her—he is not only permitted, but expected to be aggressive, he will get more education than she, he will perpetuate the family name! All these various forbidden feelings will come to life again with her first baby—this happens also, of course, in a normal, healthy mother, but her guilt and anxiety will not become permanently manifest in her relationship to her child (i.e., in a disguised form representing her own undissolved childhood difficulties). A little girl who was not imbued with fear for feeling jealous, envious and hateful at times toward her parents and siblings, and who had felt free to express these feelings, and therefore was

[1] This has been described lucidly in the 11th Chapter of Gordon Hamilton's book, "Psychotherapy in Child Guidance."

not forced to repress them into unconsciousness, will be able to recognize the repetitiousness of these feelings when they emerge toward her own child, and she will deal with them the same way as her parents dealt with them years ago—she will accept them in herself and then transform them into positive ones.

Competition and identification, both with the mother as with the mother's child, are the main emotional attitudes that are repeated more or less unconsciously toward the oldest child mainly. The child, who is in his most formative years and dependent on the love and approval of its mother, will mirror her ambivalence and confusion and will develop an Ego containing almost no genuine feelings of his own. What we are working with in a Child Guidance Clinic is this entanglement, this result of emotional inducement from generation to generation.[2] Our goal therefore is, as we predicted, a fairly intangible one because we have to free both mother and child from serving each other's unconscious pathological needs; we have to, most of all, provide for the child the possibility of further normal growth. In most cases, we will not be able to achieve the same with the mother, i.e., we will not help her straighten her distorted personality, we will not cure her of her neurosis. But it will become part of our diagnostic evaluation to examine how much work has to be done with the mother in order to free the child.

We have, unfortunately, done little work with fathers and very often have only indirect contact with the father, i.e., the father will be affected by the changed distribution of attachments in his family, when the mother, in the course of treatment, will seek more mature and more healthy outlets for her needs and will make different demands on her husband. Timing is here of the essence, because if one or the other partner is overburdened by changes that are imposed too quickly, the family is likely to prefer to withdraw from treatment altogether.

The main considerations for the length and type of treatment in a Child Guidance Clinic are therefore the strength and power of the disturbance of the mother and how much of it is focused in and projected on the relationship to the child in question, and secondly, how integrated and well-functioning a person the mother seems to be otherwise—in other words, the strength of her Ego. The same will have to be evaluated in the child in order to determine what he will need and how long it will take him to reach the point from where we can release him to meet whatever influences he will have to contend with in his life.

Needless to say, organicity, traumatic circumstances and lack of resources for sublimation will play a big role. So will the skill of the worker who will have to work with the resistances put up one after the other against the giving up of the status quo. Cure, as any other change, is regarded as a danger to the balance reached. I shall now present two cases of different length to illustrate the points made.

The first is a case of a boy who is now fifteen years old, still under treatment, who was referred at the age of 11, mainly for his stuttering which started before school—the mother did not remember the exact time. He was not interested in studying, the teacher considered him dreamy and in a daze. He often talked to himself, was shy with strangers. He showed exaggerated concern over illness in other people, especially in his sister and mother. His mother described him as a "sad, unhappy boy." He cried easily. His I.Q. had been 88 at the age of 8, but the validity of the test could be questioned in the face of so much emotional disturbance. A retest after two years of treatment rated him of average intelligence. Both parents were depressed people with heart conditions; the father also suffered from colitis. The father is the mother's uncle and much older than she. Neither the father nor the mother have been able to work steadily because of sickness. They come from a family with high academic standards and put much value on educational achievement. The older daughter is a brilliant student, though quite withdrawn. The diagnosis for both the mother and the boy was "mixed psychoneurosis."

When David started public kindergarten, his mother was asked to withdraw him after a few weeks because he stuttered so badly and seemed socially immature. This was a terrible disappointment to the parents and they openly compared David unfavorably with his sister and called him stupid. The mother had at that time obtained a job, while the father was sickly, stayed home and did the housework as well as he could. David stayed home with his father and started to occupy himself with building things. This interest in mechanics became his main defense; he used it to defy his parents who despise manual work, he used it to cover up his stuttering because when you work, even though you work with other people, you don't have to talk so much. He used it to withdraw from regular contact with boys his age because he had started a workshop in a cellar and spent most of his time there. The boy and the mother started treatment with separate workers. The mother did not keep regular appointments from the start, used sickness as an excuse, and later stated directly that "nothing could be done to help her. It is too late for her, she gets along as well as anyone who has had as much trouble as she has had." She could not see any connection between the family life and David's difficulties, said "this was the newest fashion in psychology but she did not believe in it—she thought he was plain lazy, and in addition, there was the organic speech difficulty." When it was pointed out to her that she was not able to express any negative feelings directly (she had been missing appointments instead of coming in and discussing her dissatisfaction with treatment), she gave worker several examples of the disasters that followed when she had voiced hostility. All these examples were taken from adult life. Mrs. L could not be induced to talk about her childhood other than to say that she had been very unhappy. Her last defense was to say that "she sometimes thinks she has no feelings at all. She is cool about everything. Things happen and she has no reaction to them at all."

The last interview ended rather pathetically by the mother admitting symbolically that she cannot help her son grow up but we might:

> "As she was leaving, she commented on the plant in my office which she thought was growing so well. She saw some dirty water a child had left in a bottle and asked if that were some special preparation I used for the plants. When I told her it wasn't, she wanted to know exactly what I did to the plant to enable it to grow so well. She then said that she loves green things but has no luck with them. Everything she tries to grow, dies."

On the whole, Mrs. L was seen eleven times over a period of a year and then

[2] See Lia Knoepfmacher, Child Guidance Work Based on Psychoanalytic Concepts, The Nervous Child, Vol. V, No. 2.

discontinued coming altogether. The father never came though he was invited in the beginning. The family did not directly interfere with David's coming —and he came religiously for the first two years—but indirectly made it difficult for him by ridiculing remarks and by attempts to probe him about what happened in his interviews, but he would never talk about it.

David used his interviews to demonstrate his main resistance—he worked diligently on different projects and was silent for most of the interview—week after week. His first products were boats, airplanes, a shoeshine box. Then he started on a little table which he took home. At last he made a bookcase for the worker's office. The worker's task was mainly to watch him at work, later to serve as an assistant. After two years of this "baby-sitting," it was decided in psychiatric conference to place David in an activity group where he would be able to work with other boys under the leadership of a male leader and to try to involve him more in verbalization during the individual interviews. His stuttering had improved somewhat by this time, but was still marked when he felt tense and anxious. The plan worked out well and David attended the group for a full year. David started to open up a little bit with his individual worker but then insisted that he could only talk if the worker asked him questions, but when she did, he would avoid answering. It was quite clear that he wanted to repeat the home situation. When this was pointed out, he began to want to change the appointment time and missed appointments if this were not done. The next step in treatment was to show him that he was afraid of his own anger and could not express it directly. David came back the next time and reported he had announced himself at the switchboard and he had not stuttered. This started a real exploration of his feelings toward his family and others which was always followed by "experiments." One of these consisted of trying not to "build" something, but to concentrate on "living" (these are his words). The result was that he became quite depressed. This was proof to him that he used the constant occupation with mechanical things as a cover-up for his feelings. Very slowly it emerged what these feelings were—he feels lonely, he has no friends, he is different from other boys. He knows stories and jokes as they do, but he is afraid to tell them because he stutters. Also he has less money than the others, he can't take a girl out—they will go to the circus but he can't. When the worker offered him money for his birthday to use for whatever he wanted, he decided to buy a motor for one of his inventions; then he saw that this again was an escape.

In the summer, David, for the first time, agreed to attend camp and the worker arranged it for him.

After the summer, there were difficulties in starting—worker and David could not find a convenient hour, David could not come because he was working, then he did not want to travel during holidays, then his mother left the state to visit her parents and he had to help at home, then he had to study for examinations. When at last an interview was held, David came out with complaints about the camp—he said it was a "concentration camp," he had been hit by the counsellors, the children had all been smaller than he. He will never go again. Worker said he must have been angry with her and this must have been one of the reasons for his not coming. He denied this and changed the subject,

talking about school. He stuttered badly. Then, after a long silence, he burst out and said there was no use wasting time. What were the experiments he had tried last year? Well, he knows he stutters less when he expresses his anger directly but when he does, he gets into trouble. It had taken him three months to tell about camp—but what now? He thought worker might not like him. From then on, feelings were gradually discussed more freely, especially around shyness with girls and the choice of profession. David still wanted to become a mechanic, though his studies and his speech continued to improve, until an interview in March, 1949, which went as follows and will show you an adolescent freely discussing his usual conflicts:

There was some confusion about our previous appointment and David was angry and felt I was not interested in him. If I had been, I would not limit the time and I would see him on my own time. He commented he had seen some drunks in the Bowery and was worried that he could be like them if he let things "pile up." These men were all mixed up and figured day and night were the same and he said they drink to escape. They are not crazy, but there is a mix-up. He felt he had to be careful of himself. But then he thought of the differences, that he has hobbies. He likes to build, etc. He would never be bored so that he had to resort to anything like this and that made him feel better.

He talked of his feeling that nothing can turn out well. He tries to avoid disappointments in that way and then there is another device where he tries to feel it makes no difference to him, and that, however, interferes with his appreciation of things.

When I offered him time to make up the appointment, which he had missed in the confusion, he wanted to know if I wanted him to come or if it was a favor.

This case illustrates our thinking as formulated in the beginning. Here was a boy, born to depressed, sickly parents, who rejected him from the start and who could not be mobilized into participating in the process of freeing this child for normal growth. Though we do not have any proof, it is likely that this boy represented the punishment for the sinful, incestuous relationship between uncle and niece. The older child, a girl, seemed to have escaped rejection by being "too good for this earth," she was shy, submissive and only interested in studying. The boy had to take over the whole burdensome responsibility for his own change. Had treatment been broken off after the first two years, which had produced almost no change, we would have thought this boy untreatable, but because his basic defense, the preoccupation with building things, was understood as binding his anxiety and covering up his feelings, and because he was given the necessary "time to let himself get deeply involved in the resistance, which he did not recognize as such, to work it through and to overcome it,[3] he was able to "get down to the bottom," as he called it—his feeling of being weak, that people don't like him and that "he is against himself."

When we remember the last words of his mother, "Everything she grows, dies," we will understand where his feelings of inadequacy and of his not having an easy time to like himself stem from. But he started to separate himself from this induced death—he has started to see his worker as a real person and has said to her that he would like to live a life that is more useful and more happy than his family lives, a life like the worker lives. It was important to stand by this boy until he had gone half-way through puberty, and had worked out to a certain extent his

[3] Freud, "Remember, Repeat, Work Through," Internat. Journal for Medical Psychoanalysis, Vol. II, 1914.

fears and wishes about sex. From here, he will be able to go on on his own. Had it been possible to treat the mother, the boy's treatment would have been accelerated by providing a more favorable atmosphere.

The second case is that of a 4½ year old boy who was referred because of temper tantrums and mood-swings. When he was depressed, he invented stories about animal children who got lost and were brought up by strangers. He was enuretic. All these difficulties had developed at the time that his sister, who was two years younger than he, had been hospitalized and died while he himself had developed pneumonia. The mother was a few years older than her husband. She was a masculine-looking woman who suffered from deep depressions, at which time she considered leaving her children and husband because she was not worthy of having a family. At other times, she could scream at the children, beat them, and be generally cruel and uncontrolled. She had often had suicidal thoughts, alone or taking the children with her. She was physically healthy and had been working and supporting herself from early youth. The husband was an immature young man who had been spoiled as the only son of well-to-do parents, who was very dependent on his wife, unable to take the role of father and provider of the family. Both parents were highly intelligent people, but at the time of referral were working at jobs below their capacity. The mother's parents had been separated and Mrs. D recognized very early in the contact that she had resented her mother bitterly for depriving her of the love of the father, but also fearing the father while he was still living with them because he was cruel and punitive. The father never made a living for the family—like Mr. D—and the mother had to go out and work hard to support the family—like Mrs. D. When Mrs. D's mother came home from work, she was tired and irritable and had no understanding for the needs of her children. Mrs. D was the oldest child and from her earliest youth had had to take responsibility for the children of her parents. She resented especially the youngest brother who was born after a long separation in a period of reconciliation. After the birth of this brother, the father left the house for good and Mrs. D, at that time thirteen years of age, and very well-developed, felt deeply ashamed about this child. Our little Barnett was the "spitting image" of this brother while his father, Mr. D, had so many characteristics of Mrs. D's father. This brother had been the pet of Mrs. D's mother and Mrs. D constantly wavered between identification with her mother—loving Barnett in an exaggerated, seductive way—and identification with her father—wanting to abandon the child, or punish him cruelly.

Because of the suicidal risk, Mrs. D was steered into analysis after half a year of treatment at the agency. But even in this short time, her attitude toward the child and her husband had changed to the extent that she took a leave of absence in order to stay home and give the boy more care and security. The father was seen several months after the mother had started private treatment. He was seen only to discuss the role he had to take over with his son—to accept Barnett's aggression only to a certain limit, to share his interests and to leave most of his physical care to his mother or rather, to Barnett. Mr. D had tended to partly perpetuate in his son his own spoiled existence that

had not known any frustrations, partly he was very jealous of him because of Barnett's position as the only grandchild. The father had read a good many books on child psychology and his interviews were used by him to show his superiority over the worker by showing off with his superior intellectual knowledge. This attitude was accepted and after only a few interviews, understood as the repetition of this son's attitude toward his father in his competition for his mother. He had always won there, but in his competition with his son for the love and attention of his wife, he seemed always to lose—this made him hate both of them. This second attitude was also repeated in his attempt to break up the relationship between his son and the worker. After a while, he secured a better job and also started to do artistic work in his free time that gave him great satisfaction and brought in some extra money—he was no longer the dependent person in the household that he had tried to be before. Treatment of the child cannot be described here in detail; it was conducted almost entirely by play therapy through which medium the boy worked over his oedipal strivings, his ambivalence over the arrival of his sister which had been covered up by a depression at her death, and his confused identifications—should he become a man and act more or less like his mother, or should he become a woman and act more or less like his father.

Ferenczi, in an article published in 1928, felt that the dissolution of castration anxiety, manifested in the female patient by penis-envy, in the male patient by anxiety about passivity, had to be reached in order to make treatment successful. Freud regarded this as a standard too high to reach even for analysis. We do not achieve such changes in our mother-clients but we do quite frequently in our children.

I will read you part of an interview as an example of how Barnett reacted at one of the last interviews when ending had been agreed upon between him and the worker. He constantly asked the worker to reminisce about the earlier parts of treatment, why he had come and what had changed. "Now I'll go to the bathroom and do it in your face. No, that's a lie. I make up lies all the time."

Worker: You mean you want to do it and you talk about it, but you don't do it.

Barnett: Yes, but I was awfully close to doing it when I came here. Remember when I talked about beating my father to death? (Silence.)

Barnett: I want to go explore on the next floor.

Worker said, "Your wanting to go explore means that you want to know something which you cannot ask—what is it you want to know?" Barnett nods. "I am jealous of my father." This led to a completely verbalized discussion of his relationship with his father. On this day, he was wearing a polo shirt that he constantly tried to slip over one shoulder. He looked a little coquettish. I said to him, "You would like to be a girl again for a little while," but he said with great pompousness, "No, I like to see girls. I like to fight. If I were a girl, I would be out of luck. What kind of a girl is it that likes to fight?"

By that time, he had lost all his symptoms, was behaving normally at home and in school and gave the impression of a happy, cheerful, energetic youngster. He had grown and become husky. In a conference with the therapist of Mrs. D, where he reported on her complete recovery from her depression and a much

improved marital relationship, closing of the case was decided upon, and the parents agreed to this decision. After the summer, which had been very successful for the whole family, they called in the fall stating that the boy had gotten all his symptoms back and they were in the process of breaking up the marriage. They wanted the boy to continue treatment. Worker called both parents in and after two interviews, in which their anxiety about taking the full parental responsibility was discussed with complete understanding, they agreed to worker's refusal to continue treatment. General follow-up contacts during the next four years confirmed that the worker had been right in her evaluation of this situation and her decision to terminate treatment at a point where she was sure, from her knowledge of the dynamics of both the child and the parents, that they were ready to live peacefully without any further help.

It is important to state that both father and mother were well organized, physically healthy, intelligent and feeling people who had participated in the process of mending their respective relationships and who had brought their little boy to treatment at a very early age when children can be worked with so much easier if they receive the necessary understanding and support from their home environment during and after treatment.

Barnett produced many poems, stories and drawings during his treatment. The following, he wrote in his last interview:

Time, time,
The effort of time always does it.
Let time go,
And you will go with it.

I cannot forego the temptation to tell you, in closing, some of the thoughts about "time" that came to my mind while I was trying to write this paper. Psychotics, as we know, have more or less lost their sense of reality. Every intern knows that he has to interrogate a patient whom he suspects to be psychotic, about his orientation as to time and space. "What year is it now" and "How do you get from Times Square to your apartment in upper Manhattan?" We know that this sense of reality is a function of the Ego and it fits into this concept that the core of a psychosis is a disease of the Ego (as Federn puts it—a lessening or a lack of cathexis of the Ego-boundaries). Psychotics are not able to form a transference-neurosis, or, in other words, to perform the transference of their earlier object relationships to the therapist because they have not developed object relationships in the full sense, they have remained egocentric, narcissistic. That is, in a way, the reason why they suffer in this part of their personality, the Ego. While neurotics have developed complicated structures—defenses—to hold the door between their Ego and their instinctual wishes, the Id, closed, the psychotic seems to use one of those swinging doors that are very practical between the kitchen and the dining-room—but give a lot of trouble in the psychic household of a human being—he is never safe from his own Unconscious walking in on him and taking over the reins. There is only one explanation for all these three phenomena: the disorientation as to time and space, the inability to form a transference (i.e. the same as a neurotic) and the closeness to the Unconscious—that the Unconscious is timeless. While our logical thinking is done by projecting our thoughts through the framework of time and space, our Unconscious feel-thinking is not bound that way, as our dreams show.

We all agree that treatment is an emotional process, both for the client as for the therapist. This puts the obligation on us to be able to understand the Unconscious and to be able to work with it, again both with the client's and with our own. We have to accept this working condition of the Unconscious—its timelessness, which is expressed in its violent resistance to change. If everything is today as it was yesterday and as it will be tomorrow, it is as if no time had elapsed; there is no process of growth, no process of maturation, no death.

But, you will say, we know that in spite of this violent, timeless Unconscious, people do grow up, they do change and mature, and they get old and die. Yes, this is done, and our treatment should copy the method by which it is achieved in healthy people in a natural way. In the natural growth process, this is done by the child's wanting the relationship with the parents more than its own wishes, and the parents, understanding these wishes, granting the necessary amount of satisfaction on each level, and holding out hope for the best satisfaction in mature life, i.e. a tender sex partnership with a member of the opposite sex. In treatment, this is achieved through transference by which the client relives his traumata and feelings and wishes with a person who is first not recognized as a real person but as a duplicate.

The word "relive" should make us suspicious that the Unconscious is trying to get its way and impose its condition on us—because there is no such thing as "dipping your foot into the same stream twice." Here, in the transference, and here alone, living takes over the form of timelessness, because it is happening now and here, and at the same time, then and there. It is therefore true that transference is the magic sphere through which the sick have to walk to get to life.

But what hope can we hold out for the Unconscious that is strong enough so that it should want to give up its wish for "deep, deep eternity" (as Nietzsche lets it be sung by his Zarathustra)? I suspect that we will find it as a stowaway despite whatever change may take place. The hope for the treated person is that he will be able to enjoy life more. This is made possible by knowing and accepting his own Unconscious, welcoming it into the household, integrating and not repressing it. It can remain unchanged though excluded from unreasonable action. It will not be permitted to behave like the posthorn that was blown by the postman in olden days on a frosty night, so cold that the tune was frozen. In the morning, however, when everybody was sleeping, the sun melted the melody and it could be heard released at the wrong occasion and time.

Still where is the timelessness of the Unconscious hidden in the Ego of the treated person? The Ego has regained its continuity; there is, ideally speaking, no break in its development. In treatment, people remember forgotten incidents and gradually piece together the story of their emotional life. Past Ego-states get to be at the conscious disposal of the present Ego. To achieve this takes long and patient effort from both the client and therapist. Continuity is a higher concept of timelessness than unchangeability, and this continuity spills over the boundaries of our individual existences because who can say when the individual life comes to be and when it starts to end?