THE TREATMENT OF A TYPE OF CHRONICALLY REJECTED CHILD *

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Families Requiring Long-Term Treatment

THE interest in writing this paper arose in the course of a study in our agency concerning the nature of our long-term cases, i.e., cases that have been or are anticipated to be active for more than two years. The paper does not, however, intend to survey all of these cases but rather to focus on a particular type of long-term case, the treatment of which has been found to be alternatingly frustrating and rewarding.

The type of case I wish to discuss is the one where the child with whom the family and the agency are concerned suffers from chronic maternal rejection, a rejection which is actively aggressive and punitive.

In general, the element of maternal rejection is to a considerable extent accountable for the long-term nature of the treatment required. However, this element is often not discovered or fully taken into account, and, therefore, tends to bedevil the treatment process. This bedevilment takes two forms: apparent improvement takes place after a period of treatment, only to collapse again; secondly, when the contact is then resumed and continued with little further movement one begins to question the usefulness of continued treatment and grows anxious about what seems to be a waste of time.

It is, of course, true that in all cases treatment should be based on a thorough understanding of the intrapsychic and interpersonal dynamics. However, I think that the element of rejection is often overlooked because other factors are also observable, seemingly accessible to treatment and appear to be sufficient cause for the presenting problem. (The presenting problems may actually be of any variety—behavior disorders, neurotic traits, borderline functioning, and so on.)

A brief word about literature on the problem: We have of course become quite familiar with the concept of rejection in the guise of overprotection. Dr. David Levy's book on *Maternal Overprotection* published in 1943 and papers written by him and others dating back to about 1929, have defined and elucidated this concept. We have also a number of papers on the individual treatment of rejected children. At the same time we find frequent comments on the difficulty of treating rejected children because their mothers will sabotage treatment.

About the latter type, some comments should be made regarding the concept of rejection. The one word actually covers a rather intricate process and

* Presented at the Annual Meeting of the National Conference of Jewish Communal Service, Atlantic City, June 4, 1962.

may in a sense be a misnomer except where applied to a situation where the mother has lost all interest in the child. We do use the term *rejection* when we mean the opposite of acceptance. When the mother feels "I can't stand this child; I'd like to get rid of him; he feels like a stranger," we call it rejection. The interesting point is, of course, that she never does what she wishes to do; the rejection never becomes a *fait accompli.* Psychically, the mother needs to have things just as they are, wishing to rid herself of the child and keeping him. From the point of view of the child's psyche this experience of being unloved yet kept also becomes of central importance.

There are a variety of needs in the mother which lead to the wish to reject the child. The particular mother type I am planning to deal with here is the one who unconsciously is using the child as a whipping boy for wrongs she feels have been perpetrated upon her. She might be called the punitive mother, and in the course of being punitive she may also become neglectful, let alone depriving.

I mean to discuss here the treatment only of those cases where a specific child is rejected and other siblings are essentially accepted although they may have various emotional difficulties too. I am excluding the mother who is borderline and whose general ego fragility requires a special kind of treatment approach.

Further, I am referring to rejection which began in early infancy, where we have a history of the mother never being able to feel that she could adequately meet her child's needs. However, in telling us about this the mother will typically speak of the child being "difficult from the start," not that she herself was having difficulties.

It is this very blaming of the child for the difficulties that makes the treatment task so complicated. Sophisticated mothers of our day may of course say that "it must be my fault," but essentially the mothers I have in mind genuinely feel that it is the child who is difficult and provokes their wrath. They will admit their reactive rejection of the child, but not the basic rejection. Their guilt also will be both conscious and unconscious—their conscious guilt brings them for treatment, makes them superficially co-operative often to the point of achieving superficial improvement. Unconsciously, however, their rejection of the child continues and both this and their ensuing unconscious guilt prevents their being related to the child's needs. The child, on his part is of course truly deprived and truly afraid. In addition, however, his behavior becomes geared toward maintaining himself by being especially controlling and toward revenging himself on the rejecting mother. The fact that he is constantly confronted with his mother's greater acceptance of his siblings adds to the fire. The vicious cycle is thus firmly established.

When we try to understand the punitive mother's need to reject the child we find that this is in response to a sense of herself having been deserted, deep down by her own mother, although consciously she may speak of desertion by mother substitutes which may include sisters, mothers-in-law, even husbands. The resulting rage is expressed toward the child because its actual source cannot be faced. What is referred to here is, of course, the re-awakening of old unresolved dependency problems, not the transitory sense of heightened dependency experienced appropriately by the pregnant woman, or the mother of a newborn infant. If she is left in the lurch during this period for reality reasons she may develop intrapsychic problems, but these are more accessible to consciousness and more easily

resolved; she is better able to "forgive and forget" and allow herself the joys of motherhood.

Interestingly enough we find that where rejection of a child takes place there are usually not the overt troubles with families of origin that we find in other situations. It is as if the dependence-independence struggle, the struggle over control and submission, had been suppressed only to re-emerge between mother and child with redoubled force. We find further that there are often no overt marital difficulties but more often that the parents superficially form an alliance against the rejected child. Thus, in a sense treatment of these cases can mean that in order to help the child a lot more people have to become upset than were so originally. The difficulty is, however, that we are often dealing with people whose overall adjustment and functioning in other areas are only "fair" and their ego strengths are not such that one can sanguinely trust that they will survive satisfactorily a challenging of their present adjustment.

Mother's Treatment Needs

In considering treatment approaches in these cases I think we must be really prepared to meet the clients where they are—the reasons why they come and what they expect from us runs mostly counter to why we see them and what we expect to do for them. There is usually a request for the child to be "corrected, straightened out, made to realize . . .," the mother, herself seeks "guidance and advice . . ." which, if given she subverts and if withheld she will seek elsewhere. All attempts at confrontation or even at being related to her feelings will be strongly resisted with denial, cancellations, excuses, etc. It is therefore quite difficult to establish a "therapeutic alliance." I think that actually the first year needs to be devoted to establishing a relationship of some sort which permits a therapeutic focus to be found. The mother will often continue contact purely in order to assuage her guilt and rather than fight with this, we are best advised to use this time to assess her personality and her needs from stray remarks, behavior, and all available forces, and from a diagnosis more or less "in spite of her," as her direct statements will usually all be geared to how impossible the child is and everything else will be denied. I have found in a particular case that I have been treating, that this groundwork was laid while mother and child had separate workers and that during this time they each felt cared for. The case was then assigned to me for work with both mother and child and interestingly enough I felt that both now benefitted from my knowing the other and my being able to appreciate what they were talking about when they complained. I have also found, with some surprise that my interest in her child and my observations have cheered the mother. It is as if this had given her some hope of yet climbing out of the abyss of guilt and despair. We must remember that the need actually to bring the child for treatment is a shock to the mother because it means that the dangerous game she has been playing has actually had bad results.

It is only when the child has made some progress and the presenting problem is somewhat ameliorated; when the mother herself has felt fed by our interest in the problem she brings—I am putting it this way rather than our interest in her because she cannot usually stand too direct a relatedness to her feelings—that we can begin to ask the question "Suppose your problem with your child were quite resolved, how would you feel?" The particular mother I have in mind replied jokingly "Oh, I

guess I'd have to find someone else to beat up." Never had she admitted directly that she beats the child out of her own need. Then she added with seriousness "I do so wish, though, that I would not do it to a living thing." It was relatively soon after this that she casually began to ask for help with her being generally so aggressive with all her children and for the first time we began to talk directly about her feelings. However I carefully avoid questioning her behavior with her children but I rather use opportunities to express concern about how hard she is on herself. I similarly avoid reference to any negative feelings she might have towards her own mother but note silently that there are more frequent references to the spirit in which her mother raised her.

As this type of mother is in a treatment situation only because of her child and is easily frightened off by anything that suggests her own need for treatment, I use opportunities to comment on her feelings towards her child which are so painful to her. Surprisingly enough when I ask her "What do you think your child really needs?" she replies "If he were treated with kindness and patience he would prosper." What now becomes revealed is that essentially it is masochism that prevents her from allowing herself to be a good mother. She, the punitive mother, is essentially self-punishing. She deprives herself of the enjoyment of meeting her child's needs, she burdens herself with guilt. She punishes herself for her resentment of her own mother.

If at this point we bring her mother in by asking "What would be your mother's attitude on this or that question?" we begin to get a feeling response: "Oh my mother . . . with her there was no such thing as 'I don't want to,'" and so on.

Treatment Needs of the Child

Children who suffer from maternal rejection, I often think, are comparable to children who have been severely physically malnourished or undernourished. Their presenting problems are not necessarily directly attributable to maternal mistreatment or deprivation. However, just as in the case of physical illness the patient will recover more or less successfully in accordance with the relative strength and sturdiness of his body, so the child with a specific psychological disorder will respond more or less successfully in accordance with the relative sturdiness of his ego.

The child who is subjected to maternal rejection, as well as suffering from specific problems in functioning or adjustment, needs to be fed as well as helped to correct his ideas. As in the case of physical undernourishment this process is complicated. The digestive system having adjusted itself to a starvation diet can only absorb small quantities of nourishment and if tempted to take in too much will respond with upset. In psychological terms this is equivalent to the psychic system being threatened by the offer of too much love. In fantasy the affection starved child will long for the good mother, similarly as the person suffering from hunger will dream of the banquet. The disturbed child will have fantasies of being adopted by the worker, fantasies which will occur in response to anyone who is related to the child in an interested, unambivalent manner as long as the child is still capable of affect hunger. These fantasies are accompanied by guilt towards the parents in defense against their jealous retribution. Awareness of this on the part of the worker is of the greatest importance. The child must be given to in order to be strengthened and yet care must be taken that not more tension is created than is bearable. Around

this issue runs the debate pro and con actual physical feeding and giving. Essentially one wants to create an atmosphere and offer a relationship that will be conducive to growth and the correction of misconceptions. This, in itself, is the true gift to the child (or any client or patient). Essentially whatever therapist and child client do together must be justifiable in these terms, the relationship must remain a distinct and special one, not play into the fantasies of the child but be conducive to their revelation. This is, of course, in a sense a professional platitude and true of all therapeutic relationships. I am, however, stressing it here because the emotionally rejected child presents a special appeal to the sympathetic adult. As mentioned initially several papers have been written describing in detail the treatment of individual children suffering from rejection and it is not my plan to do this here but rather to point out how some of the difficulties can be coped with. For the sake of accuracy, however, I want to qualify the above by saying that in actuality the rejected child, of course, often presents himself in a manipulative, controlling and often suspicious and highly guarded manner distrusting the very offer of a good relationship.

Theoretically the child could be helped by being transferred to a different, loving environment. In reality we still think that the trauma is too great and recommend placement only in those cases where the active pathogenic factors in the home environment outweigh the trauma of forced separation. The cases which we are discussing here are those where there is enough parental interest in the child that can be positively mobilized.

Why does the treatment of these children take so long? As described above, the child has to take in the therapeutic experience little by little if he is not to get into unbearable conflict with himself and his environment. The contact may therefore continue over several years with the frequency of interviews adjusted to current needs. On the whole, interviews held once a week are more advisable than more intensive contact, in order to avoid over-stimulation.

What the therapist provides apart from a different emotional experience is a means of strengthening the child's evaluation of reality. In a sense the development of seemingly unhealthy defenses were necessary for the child. Protected by guardedness, suspiciousness, manipulativeness, control, he can lead his own life, restricted, deprived but with relative equanimity. Therapy is an interference with these defenses, a demand is made on the child to exercise his critical faculties and keep alive his desires to gain gratification from his environment. This, however, must be done with such caution as to prevent depression or inappropriate acting-out.

Another reason for the long term treatment needs of these children is the fact that the more the child is biologically dependent on the parent the more will he be oriented towards the parent. He can, therefore, only tackle certain problems in his relationship with them as he gains relative independence. From this one might plan to provide contact according to the needs of the developmental period: periods where work with parents is more intensive than with the child and periods where one would encourage the provision of other resources (group work centers, camps, big sisters or brothers) in order to provide special nurture. Then there can be times when only the child is seen weekly and contact with the parents is less frequent.

Treatment Approach with Fathers

In discussing the treatment needs of the fathers of maternally rejected children, I am limiting myself to highlighting

what I think are some of the characteristics of their position. We distinguish them here from those fathers who themselves reject their child in primary fashion because the child is experienced as a rival for the fulfillment of their own dependency needs. As in the case of the mothers, I am excluding here too, borderline individuals who need a special treatment approach.

In the cases under discussion our assessment of the family as a whole suggests that the essential treatment considerations need to be given to mother and child. However, we find that the father often has potentially many positives to offer and in involving him it is our intent to help him find areas where he can use himself constructively in furthering the growth of the child without threatening the mother.

Initially, however, he is likely to be in a state of anger, guilt and helplessness. No rational behavior on his part appears to be of any use vis-à-vis the unconsciously determined attitude of his wife. Of course being himself subject to unconscious needs, he will identify with either the aggressor or the victim or punish them both by withdrawing emotionally.

As mentioned initially, we frequently find such a father in superficial alliance with his wife. Having often been somewhat removed from the situation during the child's infancy, having relied either on his wife's apparent "strength" in managing or on the help she received from others, he does not become involved in the problem between mother and child until it has clearly developed to the point where the child has become "the problem" and he feels called upon to exercise his authority to enforce respect for the mother.

As also mentioned above, marital problems are frequently denied in these cases, although their existence is evident from indirect remarks. Just as the child is not enjoyed and is experienced as a burden, so the marriage is not enjoyed actively, there are trivial complaints and the absence of open friction is mistaken for happiness. I think that frequently the husband and wife have met with some defeats in the course of their marriage which have re-aroused old feelings of inadequacy. They feel guilty and in the ensuing mild depression they withdraw from each other and retreat to a somewhat more immature level than they are potentially capable of.

We frequently find that when we first suggest to such a father that he become involved in the treatment process he is quite unproductive. He comes because his wife wants him to, feels that it would be sufficient to work with her as she and he are in agreement one with the other, or that the problem lies between mother and child and he has nothing to do with it. He often disengages himself after a brief contact in the beginning but his interest in what is happening can become aroused at a later point.

When we discover at a later stage that these fathers are capable of making a contribution to the resolution of the problem, we frequently chide ourselves for not succeeding in involving them earlier. However, I think, it may well be true that mother and child have first had to feel the need for treatment and have derived some benefit from it before the father is willing to contribute.

The father will of course have his own personality problems which we would want to understand, however, as long as we are clear that the problem is chiefly between mother and child we may have to let father be out of it until he himself is ready to come. In the particular case I have in mind, the father has been reinvolved through monthly joint interviews with his wife (in the meantime he has regularly brought his daughter for her interviews). I involve him in this way when his wife reported some casu-

ally expressed interest by him in the child's treatment and at the same time some wish for his wife to withdraw from treatment herself as she became more acutely upset with herself.

The Integration Process

I should now like to discuss briefly the possibilities of helping the parents and the child to accept each other. This, I think, essentially depends on the degree of movement that the mother can make and in the case I have alluded to above I think this might be possible. As with the mother, with the child, too, we find considerable masochism. She is enjoying the relationship with the worker, has gotten a good deal of negative feelings towards her mother off her chest, but she refuses to talk in response to direct questions, she maintains that "you cannot make me talk" and that she will keep her "secrets." This opportunity for opposition to the worker is welcome as she can live it out safely. Gradually of course the secret begins to emerge—it is her power of being able to make her mother punish her by being very bad and then making her forgive her by being very good. Why should she give up these powerful secret weapons unless she can really be sure that her mother would love her voluntarily? Both mother and daughter can now be shown how they interact and they begin to have a sense of choice about it. The father has been helped to find a place for himself which is neither "away from it all" nor "right in the middle" so that now he is available to do some rescue work when mother and child have gotten themselves into an impasse, and at this point of treatment they will permit him to do this. I think with this we should be able to envisage the maintenance of improvement. Depending then on the age of the child and his growing strength to face up to his own problems some further more individually geared and insightful therapy might be considered.