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A study of the problems of children in the latency period referred to the Family Society of Greater Boston for direct treatment between June 1, 1948 and June 1, 1949

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SCHOOL OF SOCIAL WORK

A STUDY OF THE PROBLEMS OF CHILDREN IN THE LATENCY PERIOD REFERRED TO THE FAMILY SOCIETY OF GREATER BOSTON FOR DIRECT CASEWORK TREATMENT BETWEEN June 1, 1948 AND JUNE 1, 1949

A Thesis

Submitted by

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(B.S.Sc., Boston University, 1932)

In Partial Fulfillment of Requirements for The Degree of Master of Science in Social Service

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<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of Study</td>
<td>1</td>
</tr>
<tr>
<td>Definitions</td>
<td>2</td>
</tr>
<tr>
<td>Sources of Material</td>
<td>2</td>
</tr>
<tr>
<td>Methods of Procedure</td>
<td>3</td>
</tr>
<tr>
<td>II AGENCY BACKGROUND</td>
<td>5</td>
</tr>
<tr>
<td>The Family Society of Greater Boston</td>
<td>5</td>
</tr>
<tr>
<td>Casework with Children in the Family Agency</td>
<td>7</td>
</tr>
<tr>
<td>III THE LATENCY PERIOD</td>
<td>10</td>
</tr>
<tr>
<td>Relationship to Parents</td>
<td>11</td>
</tr>
<tr>
<td>Socialization and the Enlarged Environment</td>
<td>11</td>
</tr>
<tr>
<td>Ego and Super-ego Development</td>
<td>13</td>
</tr>
<tr>
<td>IV GENERAL BACKGROUND OF THE CASES STUDIED</td>
<td>15</td>
</tr>
<tr>
<td>Sources of Referral</td>
<td>15</td>
</tr>
<tr>
<td>Reasons for Referral to the Family Agency</td>
<td>15</td>
</tr>
<tr>
<td>Age and Sex Distribution</td>
<td>16</td>
</tr>
<tr>
<td>Home Status at the Time of Referral</td>
<td>16</td>
</tr>
<tr>
<td>Economic Status of the Family</td>
<td>17</td>
</tr>
<tr>
<td>Position of the Child in the Family</td>
<td>18</td>
</tr>
<tr>
<td>Number of Children in the Family</td>
<td>18</td>
</tr>
<tr>
<td>V THE PROBLEMS AND FACTORS INFLUENCING TREATMENT</td>
<td>21</td>
</tr>
<tr>
<td>Problem Classification</td>
<td>21</td>
</tr>
<tr>
<td>Presenting Symptoms</td>
<td>22</td>
</tr>
<tr>
<td>School Adjustment</td>
<td>23</td>
</tr>
<tr>
<td>The Child's Attitude toward the Problem and toward Treatment</td>
<td>24</td>
</tr>
<tr>
<td>Parental Participation in Treatment</td>
<td>26</td>
</tr>
<tr>
<td>VI CASE PRESENTATIONS</td>
<td>29</td>
</tr>
<tr>
<td>Primary Behavior Disorders</td>
<td>29</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>30</td>
</tr>
<tr>
<td>Habit disturbances</td>
<td>35</td>
</tr>
<tr>
<td>Neurotic Traits</td>
<td>38</td>
</tr>
<tr>
<td>Mild Conduct Disturbances</td>
<td>47</td>
</tr>
<tr>
<td>Reactions to specific environmental pressures</td>
<td>49</td>
</tr>
<tr>
<td>Severe Disturbances</td>
<td>51</td>
</tr>
<tr>
<td>VII SUMMARY AND CONCLUSIONS</td>
<td>54</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td></td>
</tr>
<tr>
<td>APPENDIX</td>
<td></td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>SOURCES OF REFERRAL</td>
<td>15</td>
</tr>
<tr>
<td>II</td>
<td>AGE AND SEX DISTRIBUTION</td>
<td>16</td>
</tr>
<tr>
<td>III</td>
<td>HOME STATUS AT THE TIME OF REFERRAL</td>
<td>17</td>
</tr>
<tr>
<td>IV</td>
<td>POSITION OF THE CHILD IN THE FAMILY IN RELATIONSHIP TO HIS SIBLINGS</td>
<td>19</td>
</tr>
<tr>
<td>V</td>
<td>PROBLEM CLASSIFICATION</td>
<td>22</td>
</tr>
<tr>
<td>VI</td>
<td>FREQUENCY OF SYMPTOMS</td>
<td>23</td>
</tr>
<tr>
<td>VII</td>
<td>SCHOOL ADJUSTMENT</td>
<td>24</td>
</tr>
<tr>
<td>VIII</td>
<td>MOTHER'S PARTICIPATION IN TREATMENT AND ITS RELATION TO THE CHILD'S CONTACT WITH THE AGENCY</td>
<td>28</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Within the past quarter of a century, there has been an ever increasing interest in the mental and physical welfare of children. Developments in the field of dynamic psychology have promoted a deeper understanding of the normal in the child's psychological growth processes. This knowledge has been related to emotional and behavior disorders in children with the resulting recognition that these disturbances in the growth process are often an indication of psychological maladjustment at some earlier stage of development.

In present day society there is considered to be in children a period of latency when the child's primitive impulses become latent or dormant and when emotional conflicts within the child become less acute. That this is true of the child whose earlier psychosexual development has progressed normally is apparent; however, there are children who do not conform to this latency pattern, whose instinctual drives do not become latent during this period of their development.

Purpose of Study

It is the purpose of this study to consider a group of such children who were referred to the Family Society of Greater Boston between the dates of June 1, 1948 and June 1, 1949. The following questions will be posed for study:

1. What types of problems are presented by these children who are referred to the family agency?
2. What are the sources of referral and why were these children referred to the family agency?

3. What is the child's attitude toward his problem and toward treatment?

It is further proposed to study the parental participation in treatment and to relate this, if possible, to the treatment of the child. It is hoped that some indication of the value of parental participation in the total treatment process will be shown in this study.

Definitions

The use of the term "latency period" in this thesis is based on the following definition:

The expression, latency period, used principally in psychoanalysis, refers to the psychic period of one's life extending from the end of the infantile stage to the beginning of the adolescent stage. In point of years, it normally begins at about the age of five and terminates at about the age of puberty.¹

The diagnostic terminology, primary behavior disorders, with the sub-groups of conduct disorders, habit disturbances, and neurotic traits is used in this study to refer to behavior disorders which the child develops in reaction to unfavorable environmental influences in the form of persisting behavior patterns.

Sources of Material

The material used in this study is from the case records of the

¹ Leland E. Hinsie and Jacob Shatzky, Psychiatric Dictionary, p. 315.

Family Society of Greater Boston and includes cases which were active at some period between the dates of June 1, 1948 and June 1, 1949. The nineteen cases upon which this study is based represent all of the children in the latency period who were clients of the agency during the period selected for study. These children were all considered to be in direct casework treatment; the child was referred for specific help with his own problems of attitudes or behavior and the child himself was seen in treatment. Sixteen of these cases were still active on June 1, 1949 and three had been closed prior to that date. These cases are from the files of eight of the fourteen district offices of the Family Society of Greater Boston. All of these children were within the age range of six to twelve years when first seen by the agency.

Methods of Procedure

These nineteen cases were made the focus of this study. The records of these children were read and each case was examined on the basis of a schedule for abstracting the material that had a bearing on this study. Seventeen questions were asked which dealt with the referral of the child, the child's problem and developmental history, the family background and family relationships, and the child's and the parents' attitudes toward the problem and their participation in treatment.

For the purpose of study, the cases were grouped on the basis of the diagnostic findings and classified in accordance with the dominant grouping of symptoms in each case. These classifications were determined on the basis of the material in the records together with the discussion of the case with the caseworker, in most instances. It was found that several
of these cases had been discussed by the caseworker in conference with the agency case consultant and in these situations the findings had been recorded and were used by the writer as the basis of classification.

A copy of the schedule questions used will be found in the appendix. Nine cases were selected for presentation in Chapter VI as examples of the types of problems that were shown by the children studied.
CHAPTER II

AGENCY BACKGROUND

The Family Society of Greater Boston

The Family Society of Greater Boston was organized in 1879 as the Associated Charities of Boston and was incorporated in 1881 under this name. At this time there were many charitable societies in Boston, including numerous church and benevolent groups giving material relief. These organizations were not, however, equipped to give service and there was no central registration bureau. This latter fact made for much duplication of effort in relief giving. The Associated Charities was established in this period with a new emphasis on service "to raise the needy above the need for relief" and to prevent duplication of effort.

On November 9, 1920, the original corporate name of the Society was changed to the Family Welfare Society of Boston, although the new name implied no change in purpose. It was felt, however, that this name described more accurately the work which the Society had been doing for the past forty-one years.

On July 16, 1943, although the corporate name remained the same, the Board of Directors filed a statement with the Boston City Clerk indicating that the Society would in the future conduct its business under the name, Family Society of Boston. This change was made primarily to clarify the agency purpose and function. During the depression years of the thirties

the word "welfare" had become synonymous with "relief." It was felt that an organization with this word in its name might be assumed to be primarily or exclusively a relief-giving agency and this might tend to keep those who did not require relief from availing themselves of the agency services.

In 1947, to denote the expansion of its services to the Metropolitan Area of Boston, the popular name of the Society became the Family Society of Greater Boston. At present, the Society maintains twelve district offices, the Fields Memorial for aged clients covering Boston proper, and Metropolitan Service. Metropolitan Service provides casework services to individuals and families living in suburban areas where there is no other organized family service under voluntary auspices.

The function of the agency no longer includes the giving of maintenance relief, since this is the function of the public assistance agencies.

The By-Laws of the Family Society of Greater Boston, adopted at the annual meeting on March 25, 1947, state the following objectives:

In the exercise of its charter powers, the Society aims to promote sound family life through two major functions:

1. Social casework available to individuals in the community who desire help in meeting problems within themselves, in their family relationships, or in their adaptation to their environment.

2. Community leadership in the promotion of education for family living and in the improvement of social conditions directly affecting family life.²

In their casework practice, family agencies have moved more and more

² Ibid., p. 4
toward treatment services for the family as a unit or for the better adjustment of its individual members. This philosophy is evident in the stated objectives of the Family Society of Greater Boston.

Casework with Children in the Family Agency

As the dynamics of family life have become better understood, psychological principles have been applied to the problems of family living and behavior that are brought to the agency. Until recently, the adult members of the family constellation have been traditionally the focus of direct casework treatment. While children's problems were recognized, they were not thought of in terms of child-parent relationships in which the child was seen as an individual playing an active role in such relationships. The present trend in the family agency is to offer direct treatment to any member of the family and this frequently involves casework with the child as a client if he presents difficulties of behavior or development. This trend is a logical outgrowth of the increased understanding of human behavior based on current dynamic theories of growth and development. The realization that the roots of many adult difficulties lie in childhood gives real meaning to helping the child in the formative years within the framework of the family constellation. In the field of social work as elsewhere, this new understanding emphasizes the child as a person in his own right who may have problems which are serious and about which he has feelings. The child's ability to do something about his difficulties is also recognized. The child's role in the family is no longer thought of as that of a passive recipient.

The concept of the child as an active participant in his own fate
is important not only in diagnosis but in providing the basis upon which direct treatment of the child is built -- treatment with the objective of helping him strengthen his capacity to deal with his drives, his environment, and life's events, of helping him become more conscious of the kind of person he wants to be, and of increasing his awareness that he is not a victim but a person who has a choice about what he is and what he will make of his circumstances.

It is generally agreed that problems of parent-child interaction which come to the family agency are treated most successfully when both the parent and the child are directly involved in treatment. Both parent and child can best be helped to overcome problems in their relationships if each can be helped to recognize his part in the problem situation, and to participate in modifying his attitudes and behavior as a mutual responsibility. Work with the parent is basic to the casework process which has as its aim the promotion of normal family relationships. In many cases the parent needs intensive help with her own problems which are influencing her reactions and attitudes toward the child. If the mother is able to use help in understanding this behavior so that it can be changed, this treatment goes hand in hand with the treatment of the child. The latter is then able to carry over the gains he makes in the casework situation and find encouragement in his life situation to continue the normal growth process. When the mother is unable to involve herself fully in treatment, some help can usually be offered to her through the casework relationship in which she can find sufficient support and guidance in her role as a parent so that further breakdown may be prevented.

3 Eleanor Clifton and Florence Hollis, editors, Child Therapy, A Casework Symposium, p. 5
The objective of casework with children is then to help both the child and the parent to achieve a more nearly normal relationship within the family.

Ultimately, the objective is to help the child in a process of growth in which he is being blocked or deflected by unfavorable factors in his family relationships. More immediate objectives are generally to help the parent begin to find more comfort and satisfaction in her role as a parent and to find means of meeting the needs of the child more adequately. At the same time the effort with the child is to prepare him to respond favorably to a more normal approach from the parent.

Casework treatment of parent and child must be oriented to the understanding of the dynamics of family inter-relationships. A dual focus is necessary as the mother shows both a concern for the child and an awareness of her own problems. When the fundamental problems of the mother remain unsolved they exert a strong influence on the child-parent relationship as her emotional needs complicate her attitudes and her methods of handling the child. Treatment of the mother must, therefore, consider her both as a person and as a parent. Her own treatment needs must be recognized as well as her part in the child's treatment. It is frequently difficult for the mother to accept her part in the child's problem since this implies her failure as a parent. Because of this, the mother approaches the treatment situation with feelings of guilt and insecurity and needs adequate support and encouragement for herself before she becomes ready for a fuller participation in treatment in which she may be helped to see the connection between her own problems and those of the child.

CHAPTER III

THE LATENCY PERIOD

The expression, latency period, is principally a psychoanalytic term used to refer to the period in the child's normal psychological development that begins with the repression of the oedipus conflict and extends to the onset of puberty. This period is considered to be a relatively quiescent one in the growth of the child. After the infantile instinctive urges have reached considerable strength during the fifth year of life, the more violent and insistent emotional manifestations seem to recede and a period of relative equilibrium follows.

The child may appear to have made great strides toward becoming grown up, but actually he may be considered to have reached a stage of dormancy in his instinctual development without, however, having brought it to any definite conclusion. He begins to be like the "good child," as he loses interest in the gratification of his instincts. These instincts which during earlier periods caused him to seek satisfactions have not ceased to exist but are outwardly less noticeable. They are now latent and appear again at puberty with renewed vigor.

Thus, in the normal process of his growth and development, the child enters the latency period as a fairly socialized being, as he turns from intense family ties to the school and the society of his own age for much

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1 Anna Freud, *Psychoanalysis for Teachers and Parents*, p. 79.
The text on the page is not legible due to the quality of the image. It appears to be a page from a book or a document, but the content cannot be accurately transcribed.
of his emotional outlet. This interval of rest when the child has learned
to control his primitive impulses and has found relief from the tensions
of inter-personal family relationships is primarily devoted to the develop-
ment of the intellect and the ego. During this period the child is nor-
mally fairly happy and contented, turning his interests with tremendous
energy toward learning about the wider environment. His interests in sex
are more or less dormant and he prefers those of his own sex and age group
with whom he is usually very competitive.

Relationships to Parents

After the solution of the oedipal conflict, the parents continue to
be very important figures in the child's life and provide a security to
which he can return when anxiety or frustration threatens his safety in
the wider environment. The shift away from the parents, begun earlier,
becomes stronger during the latency years, however, as emotional ties are
gradually lessened. This process continues throughout the whole of the
latency period and leads eventually to emotional independence. The child's
struggle between his desire for independence and his wish to retain the
earlier primary relationship to the parents is exemplified by the almost
universal day-dream of this period, the "family romance." By this means
the child is able to give up the idea of the infallibility of the parents
and replace it by his concept of the parents as ideals in the imagination.

Socialization and the Enlarged Environment

It is at the beginning of the latency period that the child is sent
off to school. Although the sixth year commonly marks the start of the
child's formal education, earlier socializing and educational processes
have been going on since infancy. By the time the child reaches school he has learned that he is one among many and that he cannot count on special privileges. He has learned something of social adaptation. He knows that he cannot have his desires immediately gratified, as formerly, but must frequently defer them. He may, therefore, be said to have ceased to live by the pleasure principle and to have come to accept instead the reality principle. He is thus prepared to do what is required of him in this new setting, the school.

The child is psychologically ready to be taught at this age because his interest in seeing and finding out everything regarding his environment has been transformed into a more organized desire for knowledge and a real love of learning; intellectual interests may be said to predominate in this stage of the child's life. Education utilizes this period in which the child is no longer exclusively engrossed with his inner conflicts and is less disturbed by his instincts, to begin the formal training of his intellect.

At the same time that the child is absorbing knowledge, at school he has also to learn to adjust to other children, his teachers, and various academic routines. He has taken a major step away from the primary group, the family, and has become a member of a new and wider group. He forms new relationships with his fellows and with a new parent-figure, the teacher, who assumes the continuation of the socializing process begun

2 Samuel Z. Orgel, Psychiatry Today and Tomorrow, p. 57.

3 Anna Freud, op. cit., p. 80.
earlier within the family. The child's attitudes toward adults and his feelings toward other children become more stabilized as he finds new gratifications in being a part of the group. The child does not find his place in the social world immediately but gradually during the several years of the latency period he progresses toward adequate socialization.

**Ego and Super-ego Development**

During the latency period the child's ego is strengthened by his intellectual growth, his new experiences and his new achievements. Through the mechanisms of repression, sublimation and reaction formation, commonly used during this stage of development, he is able to keep his instinctive urges under control. The child's ego is differentiating itself as the child makes gains in his own self-image and pursues his desire to grow up. As he learns to curb his impulses and postpone their satisfaction, he also begins to modify them along socially acceptable lines as he faces and accepts social reality.

At an earlier developmental stage the child began to incorporate parental demands and dictates which would come to direct his future behavior. By the time the child enters the latency period and is ready to face the larger environment, these parental orders and prohibitions have become an essential part of his being; they have become internalized as the child's own ethical code. The super-ego is enriched during the latency years as the child becomes interested in and inspired by other people. This enrichment is especially furthered through his relationship to his teachers if the teacher-pupil relationship is good.

The child's inner struggle during this period is to be good. He
must meet the demands of this inner force which requires certain standards for his behavior or he will experience feelings of anxiety and guilt.

In the course of growth, this intensified parental part of him assumes more and more the role of the parents in the material world, demanding and forbidding certain things. The ego of the child must henceforth strive to fulfill the demands of this ideal—the Super-ego. The child feels his dissatisfaction as "inner dissatisfaction" when he does not obey it and his sense of satisfaction as "inner satisfaction" when he acts in accordance with the will of this Super-ego.4

For normal growth and development, the child during this period is dependent on his total environment which should balance demands and frustrations with reasonable gratifications and recognition. He needs the opportunities for satisfactory social contacts, school demands which are within his intellectual capacity, and behavior restrictions which are reasonably geared to his capacity to tolerate frustrations and to renounce his impulses.5

All of the child's earlier life experiences, though repressed, still retain their dynamic quality within his unconscious and become patterns for later behavior. During the latency period, the parent, the school, or society may see evidences of maladjustment, often for the first time, if these needs are not met or if the child has not resolved his earlier conflicts satisfactorily.

4 Anna Freud, Psychoanalysis for Teachers and Parents, p. 86.

5 Irene M. Josselyn, Psychosocial Development of Children, p. 76.
CHAPTER IV

GENERAL BACKGROUND OF THE CASES STUDIED

The children studied were referred to the agency because they did not present the picture of relatively quiet emotional and social development normally seen in the latency period. Actually these children had not progressed into "latency." They were referred because they exhibited behavior to which someone objected or over which someone showed concern.

Sources of Referral

Eleven of the referrals were initiated by the mother of the child. Five cases were referred by community agencies and three cases were referred by schools. Table I shows the sources of referral.

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>11</td>
</tr>
<tr>
<td>Other agency</td>
<td>5</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

Reasons for Referral to the Family Agency

Fifteen of these children came from families who had at some time been clients of the Family Society of Greater Boston and were referred on the basis of the previous contact. Nine of these were children who were referred by the parent, two were referred by the school, and four were referred by another agency.
The table below summarizes the data collected from the experiment:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Observations</th>
<th>Average Value</th>
</tr>
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<tbody>
<tr>
<td>Control</td>
<td>12</td>
<td>0.8</td>
</tr>
<tr>
<td>Test</td>
<td>15</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The results indicate that the test condition led to a statistically significant increase in the observed value compared to the control condition. Further analysis is needed to confirm these findings.
Four children came from families who had not previously been known to the family agency. Two mothers asked for help with the child's problem because they had heard that the family agency offered this type of service. One child was referred by the school at the suggestion of a child guidance clinic where the child could not be immediately seen. Another child was referred by a diagnostic clinic. This child had been studied at the clinic and was referred with recommendations for the treatment of the child and the parents.

**Age and Sex Distribution**

These children represented eighteen families. Thirteen of the cases studied, or slightly over two-thirds, were boys and six were girls. The ages of these children ranged from six to twelve years. Table II shows the age and sex groupings of these nineteen children.

**TABLE II**

<table>
<thead>
<tr>
<th>Age</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-7</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>8-9</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9-10</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>10-11</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>11-12</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>13</strong></td>
<td><strong>6</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

**Home Status at the Time of Referral**

With the exception of one child, all of these children were living in their own homes with one or both of their own parents at the time of re-
In this case, the mother and child were living with relatives. One child was living in a foster home when referred and another child was placed in a foster home by the parent during the course of treatment.

Six children lived in their own homes with both parents. The mother was the present parent in each of the twelve cases where the child was living with only one parent. Six of these homes were broken by parental disharmony. In these homes the parents were separated in four cases and divorced in two instances. Death of the father had caused the home to be broken in two cases. Four fathers were out of the home because of mental illness. Table III describes the home status of these children at the time of referral.

**TABLE III**

**HOME STATUS AT THE TIME OF REFERRAL**

<table>
<thead>
<tr>
<th>Home Status</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents in home</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Mother present, father separated</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mother present, father in State Hospital</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mother present, father deceased</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mother present, father divorced</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Foster home</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>6</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

**Economic Status of the Family**

The families of all of these children were in the marginal income group. The family income was adequate with careful management for day-by-day living, but offered no reserve for financial emergencies. In the
seven cases in which both parents (or foster parents) were in the home, the financial support was from the employment of the father. Nine mothers had full support from public assistance, Aid to Dependent Children. Two mothers supported the family from employment outside the home and one mother had a combined income from Social Security benefits and the earnings of an older child.

**Position of the Child in the Family in Relationship to his Siblings**

Ten of these children, or over one-half, were the oldest child in the family unit with from one to four younger siblings. There were five who were second children, with one older sibling and either one or two younger siblings. Three were the youngest child, with older siblings or half-siblings. Only one of these children was an only child.

These oldest children were boys in six cases and girls in four cases. Three of the second children were boys and two were girls. All three of the youngest children were boys, as was the only child. Table IV below shows the relative position of these children in their families.

**Number of Children in the Family**

The largest number of children in any family which appeared in this study was five. This number was found in three cases. In six families there were four children; in five families, three children; in four families, two children; and in one family, one child. The average family group contained 3.3 children.
### TABLE IV

POSITION OF THE CHILD IN THE FAMILY IN RELATIONSHIP TO HIS SIBLINGS

<table>
<thead>
<tr>
<th>Position of Child</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldest child, younger siblings</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>One younger sibling</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Two younger siblings</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Three younger siblings</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Four younger siblings</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Second child, older and younger siblings</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>One older, one younger</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>One older, two younger</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Youngest child, older siblings</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Two older siblings</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Three older siblings</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Four older half-siblings</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Only child</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Summary**

Although fifteen of these children were from families who had been previously known to the family agency and this seemed to be a factor in referral, it could not be determined why these children were referred to the family agency rather than to a guidance clinic. It is interesting to note that thirteen of the children studied were boys as opposed to only six girls, although no conclusions regarding this fact were arrived at as a result of this study. Twelve children were living in homes broken by death, illness, or parental disharmony. The father was the absent parent in each of these cases. The families of all of these children were in the
The table below shows the results of the study on the effect of different factors on the performance of a certain system. The factors include temperature, humidity, and pressure. Each row represents a different test condition, and the columns show the results for each factor. The table is sorted by temperature, with the highest value at the top.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Test 1</th>
<th>Test 2</th>
<th>Test 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp.</td>
<td>30°C</td>
<td>40°C</td>
<td>50°C</td>
</tr>
<tr>
<td>Humid.</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Press.</td>
<td>1 atm</td>
<td>2 atm</td>
<td>3 atm</td>
</tr>
</tbody>
</table>

The results indicate that temperature and humidity have a significant impact on the system's performance, with higher temperature and humidity leading to lower performance. Pressure appears to have a lesser impact, with the system performing similarly under different pressure conditions.
marginal income group. Although poor home conditions, low incomes, and broken homes cannot be considered the cause of the child's problems, these factors do add another element of insecurity for the already very insecure child. The absence of the father, in the broken home situations, was an important factor in the child's handling of the problems of inter-personal family relationships in each of these cases.

Ten of these children, or over one-half, were the oldest child in the family, with from one to four younger siblings. While no definite conclusions can be drawn as to the significance of this fact, it was found that the majority of these children had been pushed toward independence without having had adequate earlier satisfactions. This might well be related to the child's position in the family.
Problem Classification

All of the children studied were referred to the agency because of the behavior manifestations of the child's problem. For the purpose of this study, the cases were grouped on the basis of the diagnostic findings. It was recognized that a child seldom shows only one symptom or behavior manifestation of an inner conflict or an outer struggle. In classifying these cases, groupings were made according to the dominant grouping of symptoms in each case. On this basis, the cases fell into four categories: primary behavior disorders, mild conduct disturbances, reactions to specific environmental pressures with fair general emotional adjustment, and severe disturbances.

Fourteen cases fell into one of the three sub-groups of the primary behavior disorders. Nine cases were classified as conduct disorders, one as a habit disturbance, and four presented neurotic traits as the outstanding symptoms. There were two children with mild conduct disturbances, two were clearly reacting to specific environmental pressures, and one was severely disturbed.

Table V shows the problem classification and includes the mixed types found under the primary behavior disorder sub-groups of conduct disorders and neurotic traits.
TABLE V
PROBLEM CLASSIFICATION

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary behavior disorders</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Conduct disorders with habit disturbances</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Conduct disorders with neurotic traits</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Habit disturbances</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Neurotic traits</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Neurotic traits with conduct disturbances</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild conduct disturbances</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reactions to specific environmental pressures</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Severe disturbances</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>19</td>
</tr>
</tbody>
</table>

Presenting Symptoms

These children showed a wide variety of symptoms. Those found most frequently were various manifestations of aggressive behavior at home or at school. Disobedience was most frequently noted and was found in eleven cases. Six children presented defiant behavior which was the second most common symptom. The adults in the child's environment are most likely to be concerned about the child whose behavior is aggressive, since this is likely to be threatening to the parents and teachers. It was interesting to note that two of the children studied presented symptoms of withdrawal and hypersensitivity which were recognized by the parents as a cause for concern. These nineteen children presented a total of twenty-four differ-
ent symptoms. A detailed presentation of the symptoms of the children studied appears in Table VI.

**TABLE VI**

**FREQUENCY OF SYMPTOMS**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disobedience</td>
<td>11</td>
</tr>
<tr>
<td>Defiance</td>
<td>6</td>
</tr>
<tr>
<td>Fighting and quarreling</td>
<td>5</td>
</tr>
<tr>
<td>Stealing</td>
<td>5</td>
</tr>
<tr>
<td>Poor school work</td>
<td>5</td>
</tr>
<tr>
<td>Marked jealousy of siblings</td>
<td>4</td>
</tr>
<tr>
<td>Truancy</td>
<td>3</td>
</tr>
<tr>
<td>School retardation</td>
<td>3</td>
</tr>
<tr>
<td>Feeding problems</td>
<td>3</td>
</tr>
<tr>
<td>Enuresis</td>
<td>3</td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>2</td>
</tr>
<tr>
<td>Destructiveness</td>
<td>2</td>
</tr>
<tr>
<td>Stubbornness</td>
<td>2</td>
</tr>
<tr>
<td>Fire setting</td>
<td>2</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>2</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>2</td>
</tr>
<tr>
<td>Excessive daydreaming</td>
<td>2</td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td>2</td>
</tr>
<tr>
<td>Sex play</td>
<td>2</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2</td>
</tr>
<tr>
<td>Bullying</td>
<td>1</td>
</tr>
<tr>
<td>Reading disability</td>
<td>1</td>
</tr>
<tr>
<td>Sex apprehension</td>
<td>1</td>
</tr>
<tr>
<td>Fear of dying</td>
<td>1</td>
</tr>
</tbody>
</table>

**School Adjustment**

All of the children studied were in regular attendance at school. Twelve children showed school problems of either conduct or achievement or both. In seven cases, no school problem was reported. Six of the twelve children who had school problems, or one-half of them, had difficulties in both conduct and achievement. Three children had conduct problems but were
doing satisfactory school work. Three were inadequate in educational per-
formance but presented no problems in conduct. A further analysis of the
school adjustment of these children including distribution by sex of the
child is shown in Table VII.

TABLE VII

SCHOOL ADJUSTMENT

<table>
<thead>
<tr>
<th>School Problem</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct disorders and poor school work</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Conduct disorders only</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Conduct disorders and retardation</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Poor school work only</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Retardation only</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Reading disability only</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No school problem reported</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>6</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

Nine boys showed problems in school adjustment in contrast to only
three girls. All three of these girls showed conduct disturbances.

The Child's Attitude toward the Problem and toward Treatment

Directive treatment of children is based on the concept of the child
as an active participant in his own development. The child is an individ-
ual, who can be helped to grow and to become a person in his own right.
Thus the child's feelings about the behavior that has brought about his
referral and his understanding of the meaning of treatment assume impor-
tance. The child himself is not the one who has asked for help, as is
usually the case with the adult client. However, the child usually has
some awareness of being in trouble. Given the opportunity, the child will
express his problem through verbalization or by acting out in the play
### Table of Data

<table>
<thead>
<tr>
<th>Table</th>
<th>Data</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>Note 1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Note 2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Note 3</td>
</tr>
</tbody>
</table>

Note: Additional notes and comments.
situation as he is encouraged to relate to the helping process and enter into the treatment relationship. Most children seem to have fears about coming to the agency as a new and unknown experience. As with the adult, the child needs a clear orientation as to why he is coming and, in order to participate fully in treatment, a desire to keep his appointments and a willingness to accept help. The child grasps the meaning of treatment as he experiences the treatment relationship.

Eight of the nineteen children studied were able to express quite clearly, either verbally or in play, their feelings of unhappiness which indicated an awareness on varying levels that their behavior was a source of concern to them. Of these eight children, six have participated fully in the treatment relationship and it was felt that they had a clear understanding of the purpose of treatment. Two other children have been more withdrawn and have not as yet become involved fully in the treatment relationship.

Four of the children studied indicated that they knew they were getting into trouble at home or at school. All of these children have been able to relate to help. Two of them showed marked caution and apprehension about treatment in the early phases of the process.

Two children showed concern because of their feelings that they were bad. Both showed much early confusion about treatment but were later able to use the casework relationship.

Two children verbalized a conscious awareness of their problems and their desire for help while three others used denial as a means of defense against their conflicts and had many fears about involving themselves in
a treatment relationship. Two of these latter children had been severely rejected and can be expected to participate, if at all, only after their fears have been allayed.

**Parental Participation in Treatment**

During the latency period, the child’s relationships within the family are still of primary importance, although normally the intensity of these relationships gradually lessens. If the child has not had adequate earlier satisfactions within these relationships and has not resolved his earlier conflicts, he may give evidence at this period of more or less serious maladjustment.

The serious problems of this age group are the problems that result from the failures of earlier childhood. If the child has not had adequate emotional security during the previous stages of development, or if his relationship with his parents has been such as to necessitate a distortion of the healthy emotional growth process, the effect may be evident in the poor adjustment the child makes in latency.¹

Both parents and child contribute to these problems in the relationship which arises from the interaction of the individual personalities concerned. Ideally, then, the parent should have an active part in the treatment situation as the child and the parent seek help for these problems for which they share a mutual responsibility. Treatment results are dependent to a large extent on what the parent is willing and able to do to meet the needs of the child as the parent becomes aware of the relation between her own behavior and attitudes and the problems of the child. At

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¹ Irene M. Josselyn, *Psychosocial Development of Children*, p. 77.

² In the American culture, mothers are more commonly involved in the child’s treatment than fathers. Unless otherwise indicated, the term parent refers to the mother.
best it is difficult for the parent to face her own involvement in the problem. Actually it is frequently so threatening that withdrawal from treatment follows when the parent becomes aware of her role in the child's difficulties.

Each of the nineteen cases studied demonstrated marked inadequacies in the child's family relationships. Although in two cases the presenting problems were manifested in the child's reactions to environmental pressures, the child's behavior in these situations stemmed from earlier unsatisfactory relationships. In these two cases, the mother was the only present parent and these mothers were co-operative and interested in the child's treatment although they were not themselves active participants. In the other seventeen cases, the child's problem could be interpreted in terms of active and current dissatisfactions in child-parent relationships. Of these, seven mothers were seen regularly in treatment; two of them were themselves pretty thoroughly involved before they asked for help for the child. One was an own mother and one was a foster mother.

Seven mothers were co-operative to the extent of allowing the child to keep regular appointments but essentially refused treatment for themselves. Three mothers allowed the child to come only irregularly and came for interviews very infrequently themselves. One of the three was an immature, extremely dependent woman who wanted only detailed advice. She was entirely unable to assume any responsibility for the child and her behavior depended largely on the directions of others. Another of these mothers was unable to accept fully the child's need for help because it was so threatening to her as another indication of her own inadequacy.
The third of these mothers was a severely neurotic woman whose own needs were in conflict with those of the child. She was very dependent and showed extreme jealousy of any attention given the child.

In the six cases in which the own father or the foster father (in one case) was present in the household, four fathers were seen at least once. None of the fathers could be considered to be active participants in treatment, however.

Table VIII shows the mother's participation in treatment and the effect of the mother's attitude on the child's contact with the agency. There were only seven cases in which both mother and child were seen regularly in treatment. In nine cases, the mother allowed the child to come to the agency regularly although she essentially refused treatment for herself. In the remaining three cases, both the mother and the child came to the agency irregularly.

**TABLE VIII**

**MOTHER'S PARTICIPATION IN TREATMENT AND ITS RELATION TO THE CHILD'S CONTACT WITH THE AGENCY**

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother and child regularly in treatment</td>
<td>7</td>
</tr>
<tr>
<td>Mother essentially refuses treatment for herself but allows the child to</td>
<td>9</td>
</tr>
<tr>
<td>come to the agency regularly</td>
<td></td>
</tr>
<tr>
<td>Mother comes for interviews very irregularly and allows the child to come</td>
<td>3</td>
</tr>
<tr>
<td>to the agency very irregularly</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
</tr>
</tbody>
</table>
CHAPTER VI

CASE PRESENTATIONS

Nine cases were selected for presentation as illustrative of the different groups into which the problems in the cases studied were classified. The body of the case material is given in each case, followed by interpretation and discussion. These cases were presented to show the child's symptom patterns at the time of referral which caused the parent, the school, or another agency to seek help for the child. Material is included to show the family make-up and some information about family inter-relationships. Parental attitudes and personality traits have also been indicated as significant in these relationships. It is not within the scope of this thesis to present the details of treatment. The writer has attempted, however, to show in each case some of the aspects of treatment in order to indicate the child's understanding of why he was in treatment and something of the nature of parental participation in treatment and its relation to the child's treatment.

Primary Behavior Disorders

Over two-thirds of the cases studied were classified under one of the sub-groups of the primary behavior disorders. The first six cases have been selected as illustrative of these disorders.

The primary behavior disorders are manifested as patterned reactions to unfavorable environmental influences. For diagnostic purposes these disorders are commonly classified under the three sub-groups of conduct disorders, habit disturbances, and neurotic traits. This classification
has been used in this study.

Conduct Disorders

Conduct disorders form the large group of primary behavior disorders. They are manifested by behavior which the child directs away from himself onto the environment. Such a child is in conflict with all forms of authority. The characteristics of the conduct disorder which appear in varying degrees of intensity are excessive aggressiveness, absence or defective development of guilt feeling, and narcissistic self-evaluation.

Conduct disorders persist into latency when there have been severe parental frustrations and restrictions in the early environment and the child has not resolved his earlier conflicts. Because of his overtly aggressive behavior, the child who shows a conduct disorder is apt to be regarded as "bad" rather than as a child who is emotionally upset.

The cases of John C. and Ben S. are illustrative of the group of nine children who showed marked conduct disturbances.

Case 1

John C., aged nine years, was referred to the agency by his mother, who complained of his unruly behavior at home and said that she felt unable to handle the situation. He was destructive and disobedient, resented discipline or correction, and staged temper tantrums. He threw things when he was angry and had recently thrown a knife at his fourteen year old sister. The mother stated that he was especially aggressive toward this sister, who is mentally retarded and has a hearing disability. She feared that John might actually injure her.

In school, John has also been a problem. He won't study, gets

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failing marks, and has recently been truanting. His mother blamed this last difficulty on his association with a boy two years his senior. There was also some question of John's involvement in fire-setting escapades.

The mother felt that, while John had always been what she called a mischievous child, it was only recently that his behavior had given her any real cause for concern. She has attempted to curb him by physical punishment but he does not respond to discipline except to become more resentful and disobedient.

The mother is a tired, highly neurotic woman for whom John's behavior is just an added difficulty in an already difficult life situation. At the time of referral, the father was serving a sentence for non-support. He has been a member of the household very infrequently since John was two years old. He has a long court record for alcoholism and non-support.

John is the youngest of four children. The oldest child, a boy sixteen years old, was born shortly before the marriage of the parents. He is mentally retarded, epileptic, and badly crippled as the result of osteomyelitis at the age of thirteen. The other two children are girls, aged twelve and fourteen. The father has two daughters by a previous marriage who are not living in this household.

Because of the absence of the father and on the basis of her unconscious needs, the mother has put her oldest son in the position of a father-figure in this family. She has leaned on him heavily and he has acted as the disciplinarian of the two youngest children. This has led to much confusion in family interpersonal relationships to which all the children have reacted to some degree.

Although the income is marginal in this family, the home is clean and attractive and the children have always been physically well-cared for as a result of the mother's careful management.

This case shows a child who has externalized his aggression to a marked degree as a reaction to his emotionally unstable family background. The mother is strongly ambivalent in her feelings toward her husband. She has a strong unconscious need to take him back, in conflict with her feelings of hostility toward him. She is still suffering guilt and remorse about her forced marriage.
John has not worked through the oedipal situation and seems to be doing so now to the accompaniment of considerable disturbance and confusion. He is being severely frustrated in his efforts to work this through with his older brother as a very punishing father-figure and his mother as alternately seductive, overprotective, and severely punitive.

It was apparent that the mother needed help with her own problems before she could participate in help for John. After several interviews, it was felt that the extent to which she could use casework was very questionable. She showed confusion about why John was coming to the agency and seemed to be using treatment as another means of punishing the child. At this time, she and John were being seen by the same caseworker and it was felt that, because of the child's hostility toward his mother, his fears were blocking him in participating adequately in treatment. He expressed his idea of the objective of treatment as "being made good."

At this point, John was transferred to a male worker. In this retarded stage of his emotional development, a relationship with a male figure was needed by the boy, who had built up a fantasy figure of a good father to satisfy his need, since he had no adequate father-figure in reality.

During the agency contact, the mother continued to use the worker to threaten the child and was unable to accept help for herself. John is a pretty disturbed boy who can expect to get little support in his home situation for any progress that he may be able to make in treatment. It is likely that he will need more intensive treatment than casework can
offer. In this event, further treatment will be focused on preparing the child for psychiatric referral.

Case 2

Ben S. was first referred to the agency by the school when he was six years old because he was a behavior problem. He was disobedient to the teacher and very aggressive in his behavior toward his classmates. He was then in the first grade but had been considered to be very hard to control during the previous year when he had been in kindergarten. The school advised that his mother wanted help with Ben and the referral was made to the family agency because of the agency's previous contacts with the family.

Mrs. S. was contacted on the basis of the school referral and expressed concern about Ben's conduct at home and at school. At home he was very disobedient and was also a feeding problem. The mother traced this difficulty in getting him to eat to the time when she first gave him solid food at the age of three years. Since that time she had always had to coax him to get him to eat. She said that he had always been a lovable and affectionate child and she had been very lenient in her handling of him. She saw his present behavior as stemming from her earlier lack of strictness.

The mother was divorced from her first husband. There were five children by this marriage. She married Ben's father about three years after her divorce and Ben was born a year later. She was separated from Ben's father when the child was a year old. The father came to see Ben regularly for a few months after the separation and then nothing further was heard from him. He is known to have died when Ben was about four years old.

About eleven years ago Mrs. S's youngest boy, then four years old, was killed when he was run over by a truck. She associates her overprotection and indulgence of Ben with her feelings of guilt and remorse about this accident. She takes Ben to school each day and restricts his play activities to his own yard.

At the time of referral, the household consisted of the mother, Ben, and a half-brother, aged eighteen. This older boy is the mother's favorite. She said that he completed high school, has been steadily employed since, and treats her with great consideration and has never given her any trouble. The other three half-siblings were not members of the household. A boy, aged nineteen, was in the army and a girl, aged seventeen, lived with an aunt in a nearby town. The mother referred to the behavior of this girl as having been very difficult and said that she hadn't been able to handle her. Another boy, aged fourteen, was at the training school for boys because of delinquent behavior.
Ben was quite clearly reacting to a very disturbed family background and was expressing his conflict with his environment through his conduct disturbances at home and at school. After a few interviews with the mother, she said that the situation seemed improved and she could see no reason for continuing the agency contact. She saw no connection between her own problems and those of the child and it is probable that she had come to the agency only because she felt pushed by the school. Her solution of the problem was that she should be stricter in her treatment of Ben. She did not seem to be ready to accept help for either herself or the child and shortly terminated the contact.

A few months later, the school again referred the child. The teacher felt that he was quite an upset child and needed help. At this point, his behavior had become more unruly and disobedient and he seemed entirely unable to concentrate on anything at school. He was a very disturbing influence on the other children. Although he was a constant source of trouble, he was well liked by his classmates. In spite of his difficulties, he did fairly well in his school work, although his performance was not up to his capacity. The teacher said that he seemed contrite and bewildered when reproved for his misconduct but did not respond to discipline with any change of behavior. She expressed concern because he was acting so like his fourteen year old brother did at this age. She said that the brother was definitely mentally retarded, however, and showed a complete lack of feeling about his conduct.

At this point, another attempt was made to reach the mother as it was clear that very little could be done to help Ben as long as she retained her negative attitude toward treatment. Interviews were again initiated with both mother and child and the mother has gained some beginning understanding of the casework relationship, although she is moving very slowly in the treatment situation. To date the focus has been largely on her own problems. It is felt that she needs a great deal of help with these before
she will be able to relate her own patterns to the child's problems. Because of her own unhappiness and deprivations, she sees Ben's behavior as just another part of this total pattern and it is very threatening to her as another sign of her inadequacies and failures.

Ben is a child who has been very cautious and anxious in his approach to the treatment relationship. He is a very insecure little boy who has experienced much of frustration and deprivation. He does seem to have a definite ability to respond in the treatment relationship, however, although his involvement has been very slow.

Habit Disturbances

The habit disorder is manifested in behavior which is directed toward one's self, or erotic behavior suggesting regression. Chronologically in the child's development, the habit disorder is the earliest deviation. The infant who receives an adequate amount of love and approval is able to give up infantile patterns of satisfaction, and sublimation and social development result. The retention of these earliest habit reactions can be thought of as disorders only if they are inappropriately prolonged or unusual in quality or quantity. In the child with marked habit disorders, a large degree of passivity and preoccupation with the self is usually also seen. Van Ophuixaen remarks that the formation of habit disturbances can be related to the economy of aggression. Instead of being used as an offensive rebellion as in the conduct disturbances, it appears to be a stubborn defense of earlier patterns.

2 Ibid., p. 37.
Although habit disturbances were present as symptoms in several of the cases studied, the case of Betty G. was selected for presentation as she was the only child who was referred because of this type of disorder.

Case 3

Betty G., aged eight and a half years, was referred to the agency by her foster mother, because of diurnal and nocturnal enuresis. The foster mother, Mrs. S., was in treatment for her own problems when she requested help for Betty. In addition to her concern about the child's enuresis, Mrs. S. felt that Betty was a withdrawn and unhappy little girl.

Betty had been living in the household for about a year at the time of referral. The foster mother, who had been a close friend of the child's own mother, had taken her a few months after the mother's death. Mrs. S. seemed genuinely interested in the child but felt that she had not adjusted well in the foster home. The foster father was said to be fond of the child but was not especially concerned about her difficulties. There were two children of the foster parents in the household, a girl aged seven and a half, and a boy of four years. Betty's relationship to these children seemed to present no real problem, according to Mrs. S. Later, in the treatment situation, Betty expressed some feeling about the girl whom she considered to be somewhat of a nuisance when she tagged after her when she didn't want her companionship and sometimes tattled on her. At other times, they played together quite harmoniously.

When Betty was seven years old, her own mother had died of a malignant disease after an illness of many months. The child had been badly frightened by her mother's illness and death. During that period the foster mother recalled that the child had seemed very withdrawn and had been entirely unable to express any feeling about her mother.

During the mother's illness, Betty and her brother, now aged four, had been placed by the father with relatives. None of these could accept Betty's enuresis and as a result she was moved about at frequent intervals. Relatively little is known about the father. He is apparently an inadequate, dependent person who has been very rejecting of Betty. He has shown no concern about the child or her problems. Betty's younger brother lives with the father in another town and she visits them occasionally on week-ends. She seems fond of her brother and has said that she missed him considerably.

In this case, no school maladjustment was reported. At home, Betty is withdrawn and sullen. In addition to the enuresis, the foster
mother also complained about her eating habits which she described as almost revolting. She eats like a little animal, pushing her food around her plate and stuffing it into her mouth with her fingers. Punishment has been totally ineffective.

This case illustrates a primary behavior disorder with habit disturbances as the predominating symptoms causing referral. Later it was found that Betty presented a more mixed picture with disturbances in several areas. Although in general a very passive child, she expressed her aggression in a defensive way by refusing to give up her earlier behavior patterns. Little is known about this child's earlier history or about her relationship with her parents.

In treatment, her ability to relate to an adult was seriously questioned. It was felt that she had reacted to parental rejection, although she had not entirely given up her wish for her mother's love. The long illness and death of the mother at this stage in her development was a severely traumatic experience for Betty. She had always felt emotionally rejected and now feared also the loss of her father. Each placement became another rejecting experience for this insecure and anxious child.

Because of her tremendous resistance, it seemed impossible to reach this child in a treatment relationship. In the play interviews she was passive and unimaginative and showed no freedom or spontaneity of expression. She denied her unhappiness and coming to the agency seemed to have little meaning for her.

Although the foster mother had initiated treatment, it was soon evident that she was much too involved in her own problems to fully participate in the child's treatment. As has been previously indicated, the child's father showed no interest whatever.
Betty is unquestionably a disturbed child who will eventually need further help.

**Neurotic Traits**

The child with neurotic traits is no longer purely reactive but has to a greater or lesser degree begun to internalize his conflicts and has turned much of his aggression inward. Unless he also has other symptoms, he is not as readily thought of by his parents as a disturbed child because he is not in open conflict with the environment. His behavior does not make others uncomfortable as does that of the overtly aggressive child.

The repression of the child's impulses leads to symptom formation and anxiety within the child. The picture is not usually clear-cut, however, and is likely to show a mixture of conduct disorders, bodily symptoms, fears, and residual habit disorders.

**Case 4**

Danny E., aged nine years, was referred by his mother because of the behavior which she saw at home which was to her indicative of his unhappiness. He was described as sullen and hypersensitive. She said that he had no friends of his own age and played alone. At the slightest provocation, he withdrew to his room to cry or to be alone.

Danny's father had been hospitalized for a little over a year, due to an organic psychosis, and Mrs. E. felt that the child was harboring a great deal of resentment toward her for his father's commitment. Until the time of his illness, the father had been employed as a skilled worker and the family was financially secure. After he became incapacitated, the mother worked for a brief period, but because she felt that the children were not receiving proper care she gave up her employment to remain at home. Aid to Dependent Children is at present the only income and necessitates careful management.

Danny's mother stated that her children had always been well-behaved and she was obviously very proud of their manners and accomplishments.
This family was a very closely knit group who did things together under the guidance of the mother. Danny was the only boy in the family. He had one sister two years older than he and two younger sisters. He got along well with all of the sisters and was especially close to the oldest sister, although there was considerable rivalry between these two children.

Danny showed the effects of rigid training by his mother, who expected him to be quiet and well-behaved and planned his after-school activities so that he could not play with the other boys in the neighborhood in which they lived, as she considered them to be rough and unmannerly. At her instigation, both Danny and his older sister attended clubs at the neighborhood house each afternoon when school was finished. In treatment it became apparent that Danny had known some love and warmth in his earlier relationship with his mother in spite of this predominating pattern of rigidity and the repression of her feelings.

Danny is quite typical of the "good child" who, because of his quiet and attractive manners and his desire to please, is not likely to be considered a problem by the adults in his environment. He was intelligent and friendly, but his behavior was much too model to be a healthy sign in a boy of his age.

In treatment he was seen to be a basically anxious and insecure child whose primary concern was his anxiety and uncertainty about his own masculinity. He showed an almost compulsive need to please in order to gain acceptance, recognition, and affection, which seemed to be based in his underlying feelings of insecurity. He had repressed all of his normal aggressiveness and hostility as he had come to fear his hostile impulses. They had never been accepted by his mother and, because he wanted her love and approval, he had become the strictly good, well-behaved child that he thought she would like. On the other hand, he still wanted to be like a real masculine person. He had intense feelings of guilt about his "badness".
His verbalizations indicated a strong fantasy life and a pattern of projection of his unacceptable thoughts and feelings. His mother had blocked this boy in his emotional development because of her hostile attitude toward men which she had projected onto her son. Although Danny basically admired his father and wanted to emulate him, his mother's attitude had hindered him from completely working through to a strong masculine identification. He had been able to make some progress in this direction but needed permission and encouragement to continue.

The end-goal in treatment in this case was one of ego-strengthening and the reinforcement of Danny's present ego strengths. He needed help in working through his castration anxiety and support in achieving a stronger masculine identification. It was felt that he needed a positive experience with an accepting, permissive mother-figure who would accept him as a boy, since his presenting problem was in the area of his relationship with his mother. He was able to use the female caseworker in this role. A more immediate goal with this child was to help him express some of his internalized feelings of hostility and aggression which he had previously repressed and about which he showed fear and anxiety.

This child was able to involve himself quite freely in a treatment relationship which offered him security and acceptance. He realized his own unhappiness and, because he had a real desire to be a boy, he soon showed his understanding that treatment was a helping process. He was very non-verbal about his feelings, but acted out his problems and his desire for help in the setting of the play interview.
Danny's mother continued in treatment and, although she has been very resistant about her own problems, she has been able to accept treatment for Danny to the extent at least of not blocking his progress because she has really wanted him to get better. Because she has been sensitive to his feelings and has been able to modify her attitudes to some extent, he has received support in the environmental situation so that he has been able to carry over the gains which he made in treatment.

Case 5

Tom D. was a sturdy, handsome nine year old boy in the third grade at school. He was referred for help by his mother, who had heard that the agency helped children. She was worried because he was extremely retarded at school in reading. She also mentioned that he continually had accidents in which he injured himself. In addition she gave a history of his having had blood poisoning, sinus infections, and kidney infections.

Tom was an only child, conceived before the marriage of his parents. Little is known about his father, who is ten years younger than his mother. He was not a very real figure to Tom since he was a member of the household so infrequently. It is known that he was in the army and returned home when his son was about seven years old. He was there very briefly at that time. The mother's comment is to the effect that things were too quiet for him so he just left.

Mrs. D. had projected much of her hostility toward her husband onto her son. She felt that they were alike in that both are inadequate and restless in nature. She supports herself and the boy through her employment. They now live in the home of an aunt of Tom's father. The aunt seems to have almost complete charge of the boy and her treatment of him has been very lenient and overprotective. The mother said that she had often felt that she wanted to establish a separate household, but fears taking this step on her own. She is threatened by the domination of the aunt, whose authority she resents. She has some awareness of her feelings of guilt and hostility in her relationship with the aunt. In her attitude toward Tom, the mother alternates between seductive and hostile behavior. She is jealous of the aunt, fears she will lose the child, and questions his love for her. She resents his inadequacies and has feelings of guilt around the causation of his symptoms.
In this household, Tom is completely engulfed in a female atmosphere that is, in the main, overprotective and indulgent. He has many questions concerning his father and his whereabouts. He fears that his father may be dead. The fact that an uncle of whom he was very fond recently died has intensified this fear.

In the school situation, Tom is well-behaved and co-operative. The teacher describes him as a tense child who seems to be quite withdrawn. He continually seeks approval, but deprecates his abilities. At times he makes quite good progress in reading and then, for no apparent reason, seems to regress. He does not relate easily to other children and has few friends. At school, he also has many small accidents which seem to be self-punishing or self-destructive in nature.

Tom is a basically insecure and confused boy who showed marked neurotic trends in his behavior. In treatment he was seen to be an anxious and fearful child who showed confusion about his own identity. His guilt about his instinctual drives had caused him to turn his aggression inward against himself. Although he had not experienced enough parental love to give him security, the fact that he was able to relate to the worker seemed to indicate that he probably had some satisfactions from his mother in infancy.

Treatment has been based on a sustained relationship with a male caseworker who gave him warmth and acceptance. Through the medium of this relationship he is being helped to see his identity as something unique and satisfying and separate from his environment. In the play interviews, Tom has expressed his problems in a variety of ways. He was encouraged to express his hostility and aggression so that he could be helped to handle these feelings in a more satisfactory way. His anxiety about these feelings, especially in relation to his parents, was evident. One of his outlets was a vivid fantasy life about gangs, fights, and dire happenings. The resulting guilt in the wake of these thoughts caused him invariably to
attempt some sort of self-destructive play in atonement. Tom showed his feelings of inferiority in the way in which he minimized his own abilities and was threatened by competitive activities. He was able to express his intense hurt at being deserted by his father. He blamed his mother for the fact that his father had left him. Since he had never really known his father, he had many fantasies about him and it is by this image of a father-figure that he has felt abandoned. He also had fantasies about being an adopted child. It was interesting to note that, in the treatment situation, this very insecure child showed many fears about being deserted by the worker.

Tom's reading disability appears as an inhibition in learning as a part of his unconscious conflict, his confusion about himself, and his identity as a person. He fears to express himself because of his uncertainty and his inability to learn may stem from these fears.

English and Pearson discuss briefly the reading disability that is a result of complicated emotional problems concerning the use of language as a weapon of offense and defense. The disability stems from reactions of guilt and fear about the use of language.

In the casework situation Tom has gradually been able to express his fears and unhappiness. He has shown that he was aware of his need for help and has indicated his desire to participate in treatment. His mother has been seen irregularly in treatment. She has many problems of her own.

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but has been quite resistant to using casework help. She has shown little real understanding of Tom's difficulties and most of her feeling in this area arises from her hostility and frustration. Tom is obviously moving much faster in treatment than is his mother and this disparity in using help will probably cause him some degree of frustration in his development.

Case 6

The child who, in addition to being withdrawn or anxious, also shows a disturbance in conduct is more likely to be referred to a social agency because he is causing inconvenience to the adults in his environment. Judy B. is presented as illustrative of the case where mixed symptoms are in evidence. The manifestations of this child's disturbance are in the main neurotic trends, but she also shows conduct disorders and has a history of earlier habit disorders.

The B. family has been known to the family agency at irregular intervals during the past seven years. Although a good deal was known about Judy as a member of the family unit, she was not seen directly as a client until recently when she was eight and a half years old. At this time she had been referred to a clinic by the school because of the problem of educational retardation. The clinic referred the case to the family agency because of this previous contact with the B. family. The clinic felt that the mother needed intensive casework help for herself and assistance in handling the children.

The parents were concerned about Judy's difficulties. The mother said that she was aware that Judy was capable of doing at least average school work and was concerned because the child was in an ungraded class at school. Recently she had a temper tantrum and struck the teacher. This conduct was very threatening to the mother, who emphasized the fact that Judy had always been an excessively good child. At home she is painfully slow in everything that she does and daydreams continually. She is completely dominated by an aggressive sister who is two years younger than Judy. She follows this sister around and has no friends of her own. She is inclined to be quarrelsome with other children.
Both parents are in the home and the marriage is quite a happy one. Both parents had infantile paralysis as children and are physically handicapped as a result of this illness. They are intelligent people and show warmth and affection for their children. The mother is a very reserved person who has had to make many adjustments during the years to keep the home running smoothly. She identifies with Judy as a "person who can't stand up for herself and can't express her feelings." She is inclined to nag at Judy for being so "slow and dreamy."

The father is a person of artistic ability and intellectual interests. He puts a premium on brains and compares Judy unfavorably with the two younger children, who are bright and aggressive. In general, he devotes much time and attention to his family but on occasions he punishes them by refusing to speak to them. The children are extremely fond of their father and compete for his attention and affection.

The two younger children are girls aged six and a half and three years. Both have been tested and have a higher than average intelligence. The older girl is attractive, vivacious, and very aggressive. She easily gains much affection and attention, especially from the father. The three year old child is also aggressive in her behavior and strives continually to hold her own with her older sisters. She has recently begun to show regressive habit disturbances. It is apparent that there is quite an intense rivalry situation among these three children.

The economic status in this family has never been very stable. Because of health problems and the nature of his work, the father's employment has always been irregular. At the time of referral, there were the immediate pressures of serious health and financial problems in this family because of the father's hospitalization for surgery and the prospects of a prolonged convalescence.

Judy has a long history of physical and emotional disturbances which seem to have begun shortly after the birth of her sister. The mother was known to the family agency at that time and was referred to a guidance clinic for help with Judy. She was then three years old and was a feeding problem, had night terrors, sucked her thumb excessively, and pulled out her hair. Shortly after the referral to the clinic the family moved from the city temporarily and Judy was not seen. A few months later the child was hospitalized due to an upper respiratory infection. There was also a diagnosis of secondary anemia.

Judy's present symptoms are seen as indicative of a primary behavior disorder with neurotic traits predominating. Her history shows habit disorders during an earlier stage of her development with the onset at the
time of the birth of a younger sibling. Her present difficulties are considered to be a reactivation of this earlier disturbance with a changed symptom picture. She no longer shows habit disorders but expresses her conflict through neurotic symptoms.

Because of the extent of her disturbances, Judy was referred for psychiatric consultation in order to plan adequately for helping this child. It was felt, as a result of this study, that she was reacting to her failure to compete with her younger, more aggressive sister. Her home life had been much too repressing for this child. The parents are withdrawn themselves but have the need to push Judy into independence. Judy needed help in learning to deal with competitive situations both at home and at school. She needed encouragement to express her own feelings in an atmosphere of acceptance and support toward a more realistic evaluation of herself and her own abilities.

Judy has been referred to a child guidance clinic for psychiatric treatment and is being seen regularly by the family agency caseworker in preparation for this step. The present plan is for the family agency to continue their contact with the parents and to work with them in cooperation with the guidance clinic. One of the goals of this treatment is to help the parents modify their attitudes so that the children will have a less rigid and anxious atmosphere at home. The mother is being seen in treatment and has begun to make use of the casework relationship. She has revealed some of her feelings about having had to adjust her life so totally to the needs of her husband. She has expressed feelings of guilt and frustration in having children who present behavior problems. She will
need much help in understanding and modifying her attitudes toward the children. She has some beginning awareness that Judy is reacting to her high standards for the children's behavior and that she is threatened by Judy's present behavior. The progress that the mother has been able to make in treatment up to the present time is a hopeful sign and her continued participation will be a positive factor in therapy for the child.

Mild Conduct Disturbances

Two cases among the group studied showed conduct disturbances that were much milder in nature than those previously presented. The case of Susan R. is illustrative of this group. This child has shown a disturbance only at home in relation to a severely neurotic mother. She shows ego strengths which can be reinforced through a treatment relationship in order to increase her capacity to cope with the difficulties of her day by day living in a disturbed environment.

Case 7

Susan R. was a bright, attractive nine year old girl who was referred to the agency by the settlement house where she attended activity groups. Susan's mother had complained about her behavior to the worker at the settlement house. The mother considered her to be unmanageable at home. She was saucy and insolent and showed no respect for her mother. Mrs. R. threatened to contact the police, hoping to have the girl sent to the reform school, she said.

The mother was known to have the reputation in the neighborhood of being a trouble maker and was considered to be an extremely difficult person. The worker was concerned because she knew that the mother's attitude was creating a situation that was very upsetting to the child. The case was referred to the family agency because the mother had been known to that agency on and off over a period of many years.

Susan's school record was excellent and her adjustment in other areas was very good. She was well thought of at the settlement house and had many friends. The only situation in which she seemed to have difficulty was in her relationship with her mother.
Mrs. R. is a cranky, whiney, neurotic woman who antagonizes everyone with whom she comes in contact. She is very self-centered and her manner is demanding and aggressive. She has always been very rejecting in her attitude toward her children. Susan's father deserted the family when she was five years old, and her parents were divorced two years later. When the father was at home, he worked very irregularly and was generally irresponsible in his attitude toward his family.

Susan is the second of three children. The oldest, a girl now aged seventeen, was an illegitimate child. She has been married for about a year and does not live at home. She and Susan have not been close but got along reasonably well together. The other child is a boy of eight years. He and Susan quarrel almost constantly and she is quite jealous whenever he is given spending money or new clothes by the mother.

Susan is a reasonably normal nine year old girl whose only problem seems to be in her relationship with her mother. She has made a good school and social adjustment. She comes from a background of real poverty and a broken home. The remaining parent, the mother, is so neurotic that it is impossible for Susan to have a satisfactory relationship with her. Susan's behavior at home may be considered as an acting out of her hostility toward her mother.

The long contact of the agency with the mother indicates that she cannot herself be helped by casework treatment and will not be able to participate in help for Susan. She sees the caseworker's role as that of a disciplinarian who will tell her child how to behave and force her to respect her mother.

Treatment for this child is based on the establishing of a secure relationship which, it is hoped, will offer her support as she continues to cope with this unhealthy environmental situation. Susan's ability to act out her hostility is felt to be a healthy sign. In the casework
setting she has been able to express her feelings quite freely and the treatment goal will be to help her accept her mother as she really is and make an adjustment on this reality basis to the home situation.

Susan has a good understanding of why she is being seen and wishes to continue the contact. The situation at home has caused her much unhappiness and she knows that she needs help with what she considers as "her trouble with her mother."

Reactions to Specific Environmental Pressures

Case 8

Mrs. A. contacted the agency for help in making plans for her ten and a half year old son, Richard, who she felt was receiving unfair treatment at home and in the neighborhood. Richard had become friendly with a boy two years older than he, and about six months ago this boy had encouraged him to "borrow" some tools from a neighbor. The boys needed these tools in a play project upon which they were working. According to his mother, Richard returned the tools when they had finished and was accused by the owner of stealing them. This man referred the matter to the police, Richard was taken to court, and there he was put on probation for six months.

The mother said that the police warned everyone about Richard and since that time he has been taunted continually in the neighborhood and has been accused of everything that happens. Other children tease him and call him "thief." Mrs. A. had become disturbed about the situation, especially since the boy had been coming home crying so frequently and had said that he felt no one trusted him. She felt that he just didn't have a chance to be happy at home and wondered about making plans to send him away to school and thus get him away from the neighborhood.

Richard has two sisters, aged fourteen and sixteen. They also have been very mean to him at home and taunt him continually. The mother said that they had always teased him because he was so sensitive, but their treatment had been more disagreeable since the stealing episode. Mrs. A. works as a domestic and is out of the home all day. Her income is very marginal and both daughters work for their spending money. The family background is one of poverty.

Richard's father died four years ago, when his son was nearly seven years old. Mr. A. was considerably older than Mrs. A. Richard was
said to have been deeply attached to his father and was very much disturbed by his death. At this time, his mother became quite concerned by his grief reactions and took Richard to a child guidance clinic. The boy was seen for a few interviews and then Mrs. A. was advised that he did not need further treatment. She said that she was told that he was a very sensitive child who was reacting deeply to the death of his father and that he needed more outside interests at that time. She encouraged Richard to join a club group in which he soon showed a healthy interest. He became less withdrawn and got along well with other children. His mother ceased to worry about him until this recent episode occurred.

This case illustrates a fairly normal, sensitive child who had reacted not unnaturally to the death of his father. The cause of his recent referral was not out of keeping with a boy of his age and circumstances. When seen by the caseworker, Richard appeared to be a quiet, shy boy with an appealing personality who had been deeply hurt by the pressures of his environment. He still missed his father and his mother could devote very little time to him because of the necessity of her employment.

The treatment was largely supportive in nature on the basis of a relationship in which he found the acceptance which he needed. In this setting, he was able to express his hurt and confusion and was helped to increase his social interests and activities. Because of his insecurity and feelings of inferiority, he needed much encouragement to express himself freely and a great deal of support in gaining confidence in himself. Because of this boy's great unhappiness, he was able to participate fully in treatment.

Richard was seen for a period of about six months, at which time he joined a boy's organization through which camp plans were made for him. A male leader showed a real interest in the boy and it was felt that this relationship with an older man would meet a real need in his life.
No further plans were made for him to go away to school since, at the termination of the agency contact, he felt that neighborhood pressures had lessened and that he would be able to "take it," as he expressed it.

Richard's mother was not involved in treatment. Actually, very little was known about her. She came in for interviews on a few occasions. She was, however, sufficiently concerned about Richard's unhappiness to wish him to continue coming to the agency for as long as it seemed advisable. In this situation, it was felt to be sufficient that she showed an interest to the extent of cooperating with the agency.

**Severe Disturbance**

**Case 9**

Joe was an attractive, frail appearing boy, small for his eleven and a half years. His family had been known to the agency irregularly during the past five years. His mother asked for help because she was worried about his behavior at home. She said that he daydreamed excessively and was a very fearful child. At night he dreamed of a man, who usually seemed to be his father, chasing him in the dark. His mother said that the child was actually very much afraid of his father and has spells of nausea whenever his father is at home. During what the mother calls his daydreams, he stares into space and sometimes mumbles or starts to giggle for no apparent reason. She said that she was also upset because she thought that he masturbated and had attempted to indulge in sex play with his sister.

Joe's father is psychotic and is at present hospitalized. He leaves the hospital occasionally on visit. At these times, the mother at first refuses to allow him to come to the house, but later she invariably gives in to his request to return. When at home, the father becomes very abusive of his wife and children and the children fear him. The mother is very ambivalent in her feelings for her husband. She constantly threatens separation, but has a strong need to take him back. She is many years younger than her husband and he has continually accused her of being unfaithful to him.

Joe's mother is a very rigid person. She was brought up in a convent and she has many conflicts in the sexual area. She is rigid in her treatment of the children and worries about her husband's influence
on them when he is at home. The mother is basically a very dependent person.

Joe is the oldest of three children. He has two sisters aged ten and five years. He gets along well with these sisters, in general. According to the mother, he is a very friendly child and has many companions but seems to prefer younger children to those of his own age.

In school, although his social adjustment is good, his work is very poor. When his father is not at home and conditions are more stable in the household, his work improves considerably.

At the age of eleven, Joe was hospitalized and was operated on for a rupture and an undescended testicle. It was after this, his mother said, that she thought he began to masturbate. In talking with the mother about this, the worker felt that his handling of himself may not have been masturbatory, but rather due to his discomfort in the genital area. His mother said that she had been very severe with him about this and had told him that his behavior was sinful.

This child is a very disturbed boy who will need more intensive help with his emotional problems than casework can offer. When seen by the caseworker, Joe appeared as a friendly child with a sweet, ready smile and an overcourteous manner. He was able to verbalize some of his intense fear of his father, his feelings when the father was so abusive of his mother, and his need to try to protect her although these scenes upset him so much that he became physically ill whenever they occurred.

It can be readily seen that the home conditions have been extremely upsetting to this boy. The mother has tried to use him to meet some of her overwhelming dependency needs, but has much guilt in doing this. He has no satisfactory male identification because of his fear and hatred of his father.

Although the mother realizes that the home situation is bad for the children, she has no real insight into the reasons for Joe's difficulties.
Her genuine concern about him is, however, a positive factor in that she may be expected to be co-operative in plans for this boy. Camp plans were discussed with both Joe and his mother and the boy was referred for placement in a treatment camp for the summer. Because of the realization of this boy's need for psychiatric treatment, the next step in this case will be preparation for referral to a child guidance clinic.
CHAPTER VII

SUMMARY AND CONCLUSIONS

This study was undertaken to determine the types of problems of children in the latency period that are referred to the Family Society of Greater Boston and to examine the sources of referral and the reasons for referring these children to a family agency. It was also hoped to determine the nature of the child's feelings about his problem and his understanding of the meaning of the treatment situation. It seemed important to study also the parental participation in treatment and to determine, if possible, its value in relation to the child's treatment.

There were nineteen cases available for study in which a latency child was seen as a client for specific help with his own problem. This number included all such cases known to the agency between the dates selected for study. The problems presented by these children were classified into four groups. Fourteen of the cases fell into one of the sub-groups of the primary behavior disorder. Of the five other children, there were two with conduct disturbances of a milder nature, two who were reacting to specific environmental pressures and one child who was severely disturbed. In this group of nineteen children, thirteen showed varying degrees of disturbance in conduct. This type of behavior manifestation of the child's problem seemed to be a factor in the referral of these children. They were referred because their conduct was aggressive in nature and as such was disturbing and threatening to the adults in the child's environment.
Eleven children were referred to the agency by the mother; five were referred by other agencies, and three by the school. Fifteen of these children were referred to the family agency on the basis of a previous agency contact with the child's family. The other four children were referred either by a parent or another agency who recognized the child's problem and had knowledge of the family agency as a treatment resource. Beyond this, it could not be determined why these children were referred to a family agency rather than to a guidance clinic, except in two cases where it was known that the child was referred to the family agency because he could not be seen in the near future at a clinic, due to the long waiting lists. It was interesting to note that both of these cases were referred to the family agency at the suggestion of the clinic. In general, it may be said that the referral of all of these cases to the family agency indicates the knowledge on the part of the various referral sources of the family agency as a treatment resource for children.

The writer feels that more of these cases might be referred to the family agency and thus relieve some of the present pressure of over-crowding in the child guidance clinics. The family agency has been working successfully with many of these children and has referred others who, on the basis of study and diagnosis, have been found in need of psychiatric help. Of the nineteen cases studied, twelve children have shown definite gains in treatment, four have been determined in need of help beyond the scope of casework, and three have been in treatment for too short a period to evaluate the outcome. It is frequently during the latency period that the child first shows symptoms indicating some degree of emotional dis-
turbance. Treatment during latency is then indicated in order that the child may be helped to make satisfactory adjustments before he enters the more difficult period of adolescence. Further study might be made of the possibilities of the treatment of more of these children by the family agency. This would involve a more thorough analysis of treatment and treatment results in order to determine what children can best be helped by the casework method of the agency. This study does show the present trend in family agencies to accept children as clients and to consider them as individuals with problems to which they themselves have contributed and for which they are offered help. The writer is definitely of the opinion that this type of service to children should be continued and expanded so that more children may be helped. The value of treating the child as an individual and as an active participant in treatment is already firmly established in present practice; the dynamics of family relationships cannot be ignored, however, and treatment must be oriented to the child as a member of a family unit. The family agency, where the parents are so frequently already in treatment, is in a position to be aware of children’s problems early in their development and can thus evaluate their treatment needs. Whenever indicated, the child can be drawn into treatment by the family agency in order to prevent further breakdown or referred for psychiatric help when necessary.

The problems of all of the children studied were found to be traceable to lack of adequate satisfactions in family relationships. Some of these children had made little progress in resolving earlier conflicts and the adjustments made by others had broken down under environmental pressures.
Thirteen of these children came from broken homes with the father absent. In the six cases where the fathers were present, they were inadequate as father-figures. All of these children had, therefore, been faced with difficulties in solving the oedipal conflict satisfactorily. In the group studied, sixteen of the children had been unable to reach a satisfactory solution of the oedipal conflict and were thus blocked at an earlier level of emotional development. In the cases where both parents were present, earlier disturbed family relationships had the same effect of blocking the child's normal emotional growth.

None of the twelve children who had school problems were found to be incapable of learning on the basis of mental retardation. Here again, their blocking in learning was in the emotional area and was a further expression of the child's underlying conflicts.

As has been said earlier in this study, direct treatment of the child with a problem is based on the concept of the child as an active participant in his development and in the solution of his problem. In each case studied, it was found that the child's feelings about his difficulties were important. Most of these children were able to express their problems and their attitudes toward these problems either through verbalization or through play. Eight children were able to express their unhappiness, which indicated an awareness on varying levels of some degree of concern about their behavior. Four children indicated that they knew they were getting into trouble at home or at school, two children were worried about their "badness," and two children talked quite frankly and freely about their difficulties. Only three children were unable to give any expression of
their conflicts. These children used denial as a defense and had many fears about involving themselves in the treatment relationship.

Although, as would be expected, it was found that some children were able to relate to help more easily than others, all of the children who were able to form a relationship were sooner or later able to participate and involve themselves in treatment. Obviously, the child who is unable to form a reasonably secure relationship with another person cannot be helped through casework treatment which is based on the use of a treatment relationship.

Children's problems are so closely related to their parental relationships that modification of the child's behavior is difficult without the parents' help and their desire to make some change in the environment that has led to the child's behavior. The serious problems of latency are those that result from failures in the earlier stages of the child's development. If parental attitudes remain unchanged, the child finds little encouragement in his life situation to support any gains which he may make in treatment. The treatment of the problems of the parents is, therefore, an integral part of the total treatment process. All of the cases studied demonstrated inadequacies in the child's family relationships. Although only seven of the mothers of these children participated actively in treatment, nine others allowed the child to come regularly for help and showed enough interest to indicate that they wanted the child to be helped and would not block treatment. Three mothers were threatened by the child's problem to such an extent that they were unable to allow the child to be seen regularly.
In the nine cases where the mother was not herself involved in treatment, it was possible to work with the child and the child was able to make progress in treatment. It is, therefore, possible to help the child if the mother cannot participate, if she can accept treatment for the child to the extent at least of not blocking him.

Approved,

Richard K. Conant
Dean
BIBLIOGRAPHY


Bibliography -2


# APPENDIX

## SCHEDULE

<table>
<thead>
<tr>
<th>NAME</th>
<th>PREVIOUS FAMILY CONTACTS</th>
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</thead>
<tbody>
<tr>
<td>BIRTHDATE</td>
<td>ECONOMIC STATUS</td>
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<tr>
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</tr>
<tr>
<td>COLOR</td>
<td></td>
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<tr>
<td>FAMILY SET-UP</td>
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1. **SOURCE OF REFERRAL**

2. **IF NOT PARENT, WHAT WAS PARENTS' ATTITUDE?**

3. **WHY WAS THE CHILD REFERRED TO FAMILY AGENCY?**

4. **PROBLEM AS DESCRIBED AT INTAKE**

5. **DURATION OF PROBLEM**

6. **DID PROBLEM ARISE IN LATENCY?**

7. **PRECIPITATING FACTORS**

8. **PREVIOUS ATTEMPTS AT SOLUTION**
9. RELATIONSHIP TO PARENTS, SIBLINGS, AND OTHERS

10. DEVELOPMENTAL HISTORY

11. PARENTAL ATTITUDES TOWARD CHILD'S PROBLEMS

12. PARENTAL ATTITUDES TOWARD CHILD'S TREATMENT

13. WHAT DOES PARENT SEE AS THE SOLUTION?

14. FOR WHOM HAS THE PROBLEM BEEN A SOURCE OF CONCERN?

15. CHILD'S ATTITUDE TOWARD THE PROBLEM
16. Child's understanding of why he is in treatment

17. Were parents in treatment? If so, summarize, including the extent of parental involvement