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Casework practices in work with children at the Family Service of Brookline

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CASEWORK PRACTICES IN WORK WITH CHILDREN
AT THE FAMILY SERVICE OF BROOKLINE

A thesis

Submitted by

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(B.S., St. Lawrence University, 1952)

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the Degree of Master of Science in Social Service

1957

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CHAPTER I.

INTRODUCTION

The interest in the subject of casework practices in work with children has developed out of the second year placement in a family agency, the Family Service of Brookline, Brookline, Massachusetts.

Traditionally, work with children belonged to the province of child guidance clinics. Caseworkers were concerned with the well-being of the child at home, his health needs, the modification of harmful social influences, and the counseling of the parents about the child. This is no longer recognized as sufficient. With the understanding of the dynamics of individual behavior, social pathology, and complexities of the social pattern, caseworkers came to appreciate the application of psychoanalytical principles in practice. As the interrelationships of family members became better understood, the emphasis of family casework extended to include both the counseling about the child and the actual treatment of the child and his parents.

The work with children at the Family Service of Brookline is based on principles and concepts that have become common in the family field in general. These principles came

about as a result of the absorption and integration of the psychoanalytical knowledge and experience built up in the child guidance clinics.

The child is no longer viewed as an extension of his parents but as a person in his own right. As Lucille Austin wrote:

The child is, from birth, an active participant in the family scene and his own destiny. He is not only acted upon and the object of stimuli but is an active agent and a producer of stimuli . . .

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 treatment of 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.¹

The dual aspect of parent-child relationship remains the central point in any child treatment. Both the parent and the child ought to be included in the treatment. It is a general conviction that children's problems do not stem alone from either the parents or the children but that they are inherent in the interrelationship of the parents and children.

With the Family Life Education programs and discussion.

1. L.N. Austin, "Some Psychoanalytic Principles Underlying Casework With Children," Child Therapy--A Casework Symposium, E. Clifton and F. Hollis, editors, pp. 4-5.

groups that are being offered to the parents by the family agency, greater recognition has been given to the importance of healthy family relationships and creation of child's problems. Parents have come to look upon the family agency as a source of help for their children.

Purpose of the Study.

The purpose of this thesis was to study work with children, both direct and indirect, in a selected group of cases of the Family Service of Brookline.

The following questions were posed:

1. What were the problems seen in the children included in the study?
2. What treatment methods were used in direct or indirect work with children?
3. What changes were reported during treatment?

Method of the Study.

The cases were studied on the basis of a schedule and the material thus abstracted from the case records dealt with data concerning the child and his family, problems as they were seen by the agency during the period studied, the child's adjustments and relationships at that time, the treatment plans, family attitudes toward treatment, and the changes observed during the treatment period.

In addition to reading the records, the case material was discussed with the casework supervisor for items in the schedule not covered in the summarized recording.

Selection of Sample.

The total number of children under thirteen who according to the statistical cards received consideration by the caseworkers in 1955, was fifty-nine. Out of this number were excluded cases in which there was no more than one interview; also excluded were cases in which the main focus of treatment was on the marital problems rather than on problems of children, and cases that were open during only a part of the year 1955. The remaining nineteen cases represent the sample of the study.

The period studied was the calendar year between January and December 1955. The selected cases were opened either prior to or in January 1955 and closed in December of that year, or continued to be open into 1956. Thus the cases were active with the agency for at least one year.

The year of 1955 was selected because the writer was interested in the current practices of casework with children. It was felt that a span of at least one year was needed in order to understand the factors involved.

In eleven cases the children were treated directly through interviews in the office. In eight cases the treat-

ment was indirect through work with the parents. In both groups, especially the latter, the manipulation of the environment was used as a therapeutic measure and included work with schools, referrals to group activities, and usage of community resources.

Limitations.

There are certain limitations within the area of the study. Most important is probably the fact that the study describes casework with children only within a given time period. The sample does not show the entire picture of treatment, especially in cases that were open prior to January 1955. It would have been beyond the scope of this study to consider a sample which would portray casework with children in its entirety.

It is also recognized that although cases were selected with regard to their appropriateness for the study, the recording did not always lend itself for research. The caseworkers frequently resorted to summarized recording which is more appropriate for the purpose of a family agency but presented certain limitations in obtaining the desired material for research purposes.

CHAPTER II.

HISTORY OF THE BROOKLINE FRIENDLY SOCIETY

In the Eighteen-seventies, Brookline Village was for the most part a farming community, situated at the end of the streetcar line. Due to a considerable liquor traffic and a lack of recreational facilities, a need for a welfare work has arisen. Mrs. Anna Mellen Stearns, a wealthy local resident was the first to recognize this need. She enlisted the aid of two other Brookline women and on June 30, 1878, the three ladies organized a temperance lunch and reading room for men, located in the Village Square. During the first winter an average of forty men and boys used the room. Mrs. Stearns and her two aids sent out a number of handwritten letters asking civic-minded citizens for contributions.

Both the reading room and the collection were so successful that at the end of seven months the work was transferred to larger quarters. A piano was donated by an interested friend, and a permanent attendant was hired. Soon lectures were given, interspersed with music and singing. Girls and women were admitted, which increased the audience to one hundred and forty visitors at a time. This

was the beginning of regular work for girls and women which in 1886 took a definite form in the establishment of the Brookline Friendly Union. As the program grew and was recognized for its usefulness, it received the interest of the clergy of the various churches in Brookline. The library was steadily acquiring books and newspapers. Classes of practical cooking for girls were organized and sewing classes were conducted; a "Garment Mission" for distributing used clothing was opened.¹ By then the managers of the original temperance room began to realize that they needed larger accommodations for their various rapidly growing departments. A drive for collecting funds was initiated and the response of the citizens was such that in 1888 a new building on the corner of High and Walnut streets was erected for the various charitable enterprises.

The above mentioned Brookline Friendly Union carried out its charitable work in eight committees, including the Committee on Boys' Clubs, Committee on Girls' Clubs, and Committee on Rides for Children. It also started its own club for boys.

In 1887 the Union changed its name to The Brookline Friendly Society. New activities were added, such as playground supervision, rides for invalid mothers, and

1. The Brookline Friendly Society, Fiftieth Anniversary, 1886-1936, p. 7.

boxes for small children at the main public school, sewing classes for girls, and a system of stamp saving cards. For teen-agers dancing classes were conducted.

In 1905 a medical department was opened and physicians and nurses were furnished to care for needy sick persons in their homes.

In 1912 a counseling service for persons troubled by various problems was started under the name of Social Service Department. Professionally trained personnel was hired for this work which included problems of all sides of family life.

Seeing that undernourished and sickly children were entering Brookline schools, the Brookline Friendly Society organized in 1916 two new departments, Baby Hygiene and the Prenatal Clinic. The modest beginnings of these two services led eventually to the establishment of the Community Health Center whose activities included district nursing, baby welfare conference and other medical programs for the needy. The work at the Center developed rapidly and became a model for other communities as well as for visitors from foreign countries.

In 1926 the Brookline Friendly Society moved to its present quarters at 10 Walter Avenue, a two-story house which was received as a gift from the Brookline Day Nursery. The Society has been located at this address ever since.

In 1957 the Brookline Friendly Society voted to re-organize in order that the professional services of the Family Counseling Service and Visiting Nurse Service might have complete autonomy in the operation of their respective programs and be able to carry out even more successfully the purpose of the Society. For over fifty years this has been a dual agency with a Family Counseling Service and Visiting Nurse Service governed by one Board of Directors. The Brookline Friendly Society will continue as the parent organization and the two divisions which are to be called the Family Service of Brookline and the Brookline Visiting Nurse Service will have equal representation on the Board of Trustees.²

The Visiting Nurse Service offers the following: Well Baby Conference, Immunization Clinics, and Mothers' Classes. The staff of graduate registered nurses with special training in public health give bedside care and treatment to the sick in their homes. They also provide prenatal, post-natal, and newborn care and instruction, as well as health supervision and guidance to individuals and families.

The Family Service of Brookline has on its staff case-workers who are selected because of their understanding interest in people. They are qualified through their pro-

2. The Brookline Friendly Society, Annual Report 1956, unpagged.

professional education in graduate schools of social work and their experience to help individuals with personal and family problems. Both individual counseling and group counseling are available. A psychiatric consultant meets regularly with the professional staff and other specialists are available whenever necessary in order to serve the client most effectively.³

The Board of Directors governing the Family Service is appointed by the Board of Trustees of the Brookline Friendly Society, Incorporated. There are seven standing committees directing the work of the Family Service; their respective chairmen and members are appointed by the Board of Directors. These committees are: Budget, Casework, Personnel, Public Relations, Building, Hospitality, and Nominating Committee. The Board of Directors also appoints an Executive Director who serves for the period of one year. He is the responsible executive and administrative head of the Family Service and as such has general supervision and charge of the operations and personnel.⁴

A leaflet of the Family Service informs the reader that counseling at the family agency seeks to assist families and individuals in developing both the capacity and

3. Ibidem.

4. Condensed from the Family Service of Brookline, By-Laws Adopted 1-21-57.

the opportunity to lead personally satisfying and socially useful lives; and that such counseling is needed by any person who is troubled about his own adjustment in life or about his relationships with other people. It reads in part:

Individuals may bring problems concerning household management and budgeting, physical and mental illness, the handicapped, vocational or school adjustments, anxieties concerned with increasing age, marital tensions, parent-child misunderstandings and individual dissatisfaction, or even a lack of knowledge of community resources that might relieve some of the pressures. Interviews are usually held in the office but they may be in the client's home in case of illness or for other special reasons. Children are seen in a playroom setting so that the child may be comfortable among toys or games suitable for his age. If the particular service desired or needed is outside the scope of our Society referral is made to some other more suitable community resource.⁵

The leaflet provides information on group counseling which is offered by the Family Service through leadership of small discussion groups. Through this Family Life Education Program the agency is reaching more parents in Brookline on a preventive educational basis. The leaflet informs the reader as follows:

These discussions may be focused on parent-child relationships, the normal psycho-social development of children, or on other subjects of close interest to adolescents or adults who wish to strengthen their individual personalities or their relationships with-

5. The Brookline Friendly Society, Family Service, leaflet, unpagged.

in the family or with their associates. The aim of such discussion groups is to help individuals to understand themselves and their reactions, to feel more secure and relaxed, and to enjoy life in spite of the stresses and strains of present day living. Most groups meet for two hours weekly for a period of six or eight weeks.⁶

Since 1947 the Family Service has carried a Child Play Study Project, an observation of selected children three to six years old, in small groups. Two years of experimental work have preceded the establishment of this regular program. The Child Play Study Project helps workers in their understanding of family relationships and problems and the knowledge is utilized in the work with the parents either to secure individual help for the child or to strengthen the parent-child relationship. The Family Service plans to publish the findings of this research project in the near future.

The services of both divisions of the Brookline Friendly Society are available to all, regardless of race, creed, religion, or economic status. Fees are charged according to a sliding scale based on size and income of the family. The maximum fee approximates the actual cost to the Society. Group fees vary according to the number of sessions and the ability of the members to meet the cost. Both individual and group counseling are available without cost to persons

6. Ibidem.

unable to pay the fee.⁷

A few figures taken from the annual report of the Society for the year 1956 will show the extent of its activities. The Visiting Nurse Service took care of 1,568 patients with a total of 16,009 visits. In addition, eighty-two clients received tuberculin tests, 422 were treated at the Dental Clinic, and 740 were given physical examination in Well Child Conferences. The Family Service helped 253 individuals in their personality adjustment; thirty-seven elderly people and 114 families with children were given help to meet social and environmental problems; 146 couples came because of poor family relationship and 125 couples asked for help with economic problems.⁸

Total receipts of the Society for the year 1956 were about \$86,000 and total disbursements, about \$90,000, with a deficit of some \$4,000. The Society is financing its work from private contributions as well as from the proceeds of Community Chest collections, operating as one of the Red Feather agencies.⁹

The Brookline Friendly Society is a member of various national organizations of social work, including Family Ser-

7. Ibidem.

8. The Brookline Friendly Society, Annual Report 1956.

9. Ibidem.



vice Association of America and National Conference of Social Work. The agency is a member of the United Community Services of Metropolitan Boston. The Society offers experience in field work to students of school of social work from Boston University, Boston College, and Simmons College.

CHAPTER III.

THEORETICAL DISCUSSION OF CASEWORK WITH CHILDREN

In the function of the earlier family agency we found little emphasis on children's work per se. The traditional family agency of the past had an eye on the adult; casework treatment was rather adult than child oriented. The emphasis was more on the educational and interpretative approach, to assure a satisfying and useful modus operandi for the individual family, and consequently community. Casework services were set up to help families whose function was impaired to help them, as M.E.Rich put it,

. . . develop freedom and that dynamic pattern of living relationships that will result in personal satisfaction and social usefulness for its members . . . the interest is in people rather than in problems.¹

The services to children consisted by and large in improving parent-child relationship, establishing parent educational groups, nursery groups, and group activities for adolescents. The essential function of a family agency was seen in administration of  services and concrete help, such as relief. These  services were not given for

1. M.E. Rich, "The Philosophy and Program of a Private Family Agency," The Family, 9:283, January, 1939.

their psychological effect but rather social effect--to promote the well-being of the family as a whole through its individual members. Children's services would sometimes be categorized under "problems of personal adjustment to family life." It was then believed that "freedom of interest in an individual does not imply the capacity to administer to the individual's every need."²

The early efforts of casework, however, implied the already important fact of stimulating people towards a desired change and to influence them to participate in the solution of their problems. The philosophy of the philanthropists that originated in giving concrete services was soon challenged by the fact that the mere supply of physical services and giving advice did not always result in improvement.

Workers realized that personality differences accounted for such facts as that one child referred to a recreational agency gave up his delinquent behavior while others did not; that only some parents could benefit from advice. There was the recognition of internal forces influencing individual situations but the knowledge of dynamic psychology was lacking.

Already Mary Richmond pointed out the presence of inner

2. H.H. Aptekar, "The Essential Function of a Family Agency," The Family, 7:231, November, 1939.

factors. She called them "insights" and believed that they were necessary for understanding of individual differences and personality characteristics; she called the outside factors influencing the environment "actions."³

When psychoanalytical thinking became available and began to affect the casework field, family agencies readily saw its application to personality problems of their clients. The new knowledge has helped them to understand the causation and the inner forces that were often blocking improvement. Elements concerning the relationship and the knowledge about the unconscious became better understood.

Today family agencies view the family as having "major responsibility for child rearing and for preparing its members to fulfill their social roles at the progressive stages of their development."⁴ In the dynamic sense this implies understanding of psychoanalytical principles of the child's development, of behavior, and consequently efforts to focus on the prevention of a family breakdown. In order to maintain as much as possible the family unit intact, the trend has been on treatment of children in their own homes.

From the psychoanalytical knowledge made available by

3. As quoted by A. Garrett, "Historical Survey of the Evolution of Casework," Principles and Techniques in Social Casework, p. 397.

4. The Family Service Association of America, Scope and Methods of the Family Service Agency, p. 1.

psychiatry the emphasis is placed upon the dynamics of personality and study of parental relationships as they affect the child's psychological growth. The problems of children are seen as resulting, in Professor Austin's words,

. . . from their own success or failure in mastering inner conflicts and integrating environmental situations as these are combined in different constellations throughout the stages of growth and maturation. Personality development is assisted or deterred by constitutional predispositions to strength or weakness --instinctual drives, native equipment of physical health and appearance, adequacy of intellectual endowment--and by the favorability of the environment, including parental support and socializing opportunities.⁵

The caseworkers have found it necessary to extend their primary area of specialization--the social reality--into the realm of individual behavior, social patterns and social pathology. With their understanding of the dynamics of individual personality, therapy became inevitably a matter of concern to the present caseworker. Therapy is no longer confined to the province of child guidance clinic but is practiced by both professions; the psychiatrist and the caseworker, each extending his interests into the realm of the other's profession but both maintaining their professional identity. As Gordon Hamilton said:

The dynamic level at which the two professions meet is the so-called "ego level" . . . The missing link bet-

5. L.N. Austin, "Some Psychoanalytical Principles Underlying Casework With Children," Child Therapy--A Casework Symposium, E. Clifton and F. Hollis, editors, p. 5.

ween disorders of social adaptation and the correlated unconscious distortions is a definition of ego functioning . . . In child and family guidance the approaches of psychotherapy and social therapy are interdependent.⁶

Casework with parents is basic to any casework with children. This is true whether children are treated directly in the office or indirectly through treatment of the parents, modification of the environment, or constructive use of resources. As one authority put it, ". . . the question is not whether to work with parent or with child, but whether to work with only the parent or with both."⁷

Parents are not only concerned about the problems of their children but also about their own successes or failures as parents. To determine the appropriate type of treatment the individual family members need to be understood in terms of their interrelationships, needs, and capacities. Only if the needs of the parents are being met can they sustain the child through the treatment process. The caseworker needs to convey the lost confidence to a parent whose self-esteem is damaged when he has to seek out the help of the agency because he has a "problem child." The caseworker works with the parents, not for them. Often the anxiety of the mother is so great that she needs to be defensive and

6. G. Hamilton, Psychotherapy in Child Guidance, pp. vii ff.

7. E. Jonquet, "Family Casework Services For Young Children," Journal of Social Casework, 9:342, November, 1947.

guard any revelation of her own feelings. She may come with a desperate request that something be done quickly. The caseworker needs to recognize the parental feelings first, rather than to overconcentrate on the problem of the child or the specific services that can or cannot be given by the agency. Although the parent is troubled about the child, it may be often the case that the real difficulty lies in other areas--in the marriage or in the feelings the parent has about himself. It was said, "The troubled parent has other relationships besides parenthood and we err in our terminology by thinking of him as a parent first and as a person only incidentally."⁸

The treatment of parents or direct casework treatment of the child needs to be based on a thorough diagnostic study of the family unit. It should include:

. . . the assessment and evaluation of the functioning of all family members in their normal roles and the nature and degree of their psychopathology; the marital relationship and how this contributes or interferes with the functioning . . . the relationship of each parent to the child--the problems created for the children and the contributions to their development; the relationships among siblings and the forces for growth or interference . . . these relationships create.⁹

The caseworker does not rush into a treatment plan but

8. A.W. Barauck and others, "Casework for Troubled Parents," Social Casework, 3:113, March, 1950.

9. A.R. McCabe, "Casework With Children in a Family Agency," Casework Papers 1956, p. 111.

takes time to diagnose what needs to be done. He may want to observe the child during the study period in order to evaluate the problem and the degree of the child's disturbance. It is preferred that both parents be seen in the initial interviews, so that the worker can evaluate their relationship and attitudes towards the child. This information is important to determine the suitability of treatment for the parents since "if they are not to some degree accessible to treatment, casework with children cannot be even partially successful."¹⁰

Spurgeon English feels that the psychological role of the father has been at times neglected, yet it can be of great diagnostic value in examining

. . . how much of the psychopathology . . . has been due to the indifference of the father to the mother even though he was devoted to the child . . . to his favoritism for a certain child in the family . . . to his indifference or unwise management of the child himself?¹¹

Joint interviews provide an opportunity for parents to participate in a responsibility that belongs to them. They allow for the development of the relationship with the caseworker. This is necessary for the parent if he is to feel comfortable about sharing the child with someone who may be

10. Ibidem.

11. S.O. English, "The Psychological Role of the Father in the Family," Casework Papers 1954, p. 29.

regarded as a competitor for the child's affection.

With the majority of children under six, treatment rests to a great extent with the parents. These children not only have limited capacity to express their thoughts and feelings verbally but also at this period of development

. . . the neurotic tendencies are not yet internalized and are still, in a large measure, capable of modification through parental handling . . . The majority of problems of this age group can be effectively handled through parent counseling.¹²

The same author further states that

. . . the period of childhood which precedes the establishment of the super-ego (roughly the first five years of life) is an especially rewarding one from the standpoint of prevention and early correction of emotional disorders.¹³

However, when the conflict between the child and his environment has become internalized, has restricted or invaded the ego structure, and is revealed as a conflict between the impulse and the super-ego, treatment of the parents only, or treatment through environmental modifications, is usually not sufficient to improve the child's functioning. In evaluating the child's problem, caseworkers are less interested in the symptomatology per se but rather in the way the symptoms have affected the personality structure. In considering treatment plans the nature and degree of the

12. S. Fraiberg, "Counseling for the Parents of the Very Young Child," Social Casework, 2:47, February, 1954.

13. Ibidem.

child's problem must be understood in terms of the stage of his libidinal development and age, as well as in terms of the familial interrelationships, capacities, and needs of the parents.

From six years to adolescence casework is usually directed to parents and children simultaneously. Here the work with parents is of great importance since it can help the parents to understand the child's problem and encourage modification of attitudes and handling so that the child can function more adequately. Often manipulation in the child's social environment, camp planning, and resources in the community are included in the treatment plan.

When the bulk of the work rests with the parents who are receiving casework help in the child's behalf, the worker may have concurrent contacts with the child as a part of the family treatment plan. The purpose may be to observe the child or help him to deal with some immediate situation in his life for which another adult than the parent is needed. Contacts of this nature are usually periodic, are carried out only for a short time, and are not considered as direct treatment of the child.

In the past, when treatment of children belonged exclusively to the province of child guidance clinic, caseworkers were hesitant to consider treating children directly because of the myth that children's play has to be under-

stood only in terms of the symbolical representations and disguised meanings. With experience they have found out that this is not always necessary. If the child has a capacity to establish relationship and can express his feelings through the play material that is available, this in itself may be a valuable growth experience to promote better functioning regardless of whether the symbolism of the play was fully understood or not. The more experienced worker may extend his treatment goals and handle the subtle symbolism as well. The level of therapy needs to be decided upon in psychiatric consultation, as Professor Hamilton said,

. . . whether a primarily supportive or uncovering type of treatment is indicated, or whether therapeutic task is mainly a question of changing the external conditions of the patient's life. For social work the latter has been generally considered to be the appropriate role, but, as we shall see, in child and family guidance the approaches of psychotherapy and social therapy are interdependent. . . I should say at the outset that I believe the evolution of psychotherapy is a specialization, though a legitimate and appropriate specialization, within the larger field of social work.¹⁴

In general, family agencies deal with the less disturbed children who fall into the approximately normal or near normal range. In this group the following criteria can be applied for the selection of cases:

14. G. Hamilton, op. cit., p. xii.

When the child's current difficulty can be realistically understood in terms of reaction to factors in his current situation which are unfavorable to normal growth in the child's current stage of development.

When indications are favorable for the parent's use of casework in becoming more comfortably and normally responsive to the child's needs.

Direct work with the child is indicated:

(a) because the meaning of the current difficulty to the child is such that he cannot be expected to change spontaneously as the disturbing factors in his situation are relieved;

(b) because the child needs support during a period of treatment of the parent;

(c) because the child's active participation in treatment will have a beneficial effect on the parent's use of treatment.¹⁵

When direct treatment is examined in terms of aims,

Alice McCabe describes these as follows:

(1) to improve the child's functioning by fostering the process of normal maturation and help the child to utilize to his fullest capacity his potentials for healthy adjustment. The process is then directed toward relieving the child from unhealthy external pressures; enable him to identify with desirable ideas and values; building up his capacity to face reality, reinforcing his controls over destructive impulses;

(2) to improve the child's functioning by correcting some of the psychological impediments within him which interfere with normal maturation and the fullest use of his capacities. This is achieved by resolving the inner emotional conflicts.¹⁶

15. E. Jonquet, op. cit., p. 344.

16. A.R. McCabe, op. cit., p. 114.

When the child is treated directly it is imperative that the parents be sympathetic with the treatment plan and be willing to continue with the caseworker in the child's behalf. They need to be aware that they have a responsibility in the problem so that they would not need to project the blame on the child and the responsibility for change onto the worker. For this reason it is preferable that the needs and feelings of the parents be explored first or handled before the child is taken into treatment. The parents need to understand the nature and purpose of the play interviews; their preparation of the child for the interviews as well as expression of approval and encouragement of the plan in their discussion with the child is of great importance. Resistance on the part of the child usually means that the parents have not worked out their feelings about coming for help.

As mentioned earlier children are considered for direct treatment only if the pathology of their behavior is so gross or deep seated that it cannot be handled through environmental change or modification of the parental attitudes.

The room where the play interview is held is equipped for this purpose. The play material can be very simple, since elaborate array of toys only distracts the child's attention from his own feelings. The play is "free" rather than being directed or manipulated by the caseworker. The

only limitations imposed are restraint of physical activity in case the child would want to hurt himself or the worker. The knowledge that he is protected from his own "dangerous" impulses implies security to the child. Verbally or play-wise no subject matter is excluded.

The special technique in therapy with young children is the use of the play interview. Through play the child can externalize his phantasies, build up a world of make believe which is just as real to him as reality; it is the medium through which the child communicates with the adult world. Gordon Hamilton summarized it this way:

Play offers opportunity for growth, for release of tension, for practice in new achievements, for testing and development. Through it he learns how to meet new situations, to increase his motility, to bring together phantasy and reality and distinguish the two, to build ego strength, and to dilute frightening and traumatic events by reproducing them in harmless disguises.¹⁷

The therapy is not in the use of play per se but in the relationship the child is experiencing while building a world of his own in which the therapist participates. The play roles become then means of communication. In treatment with adults painful experiences of the past and present are discussed; similarly, the child reveals in play the disturbing events that are active at home. In the words of Professor Hamilton again,

17. G. Hamilton, op. cit., p. 182.

He discharges his emotions and transforms frightening or unpleasant experiences into more pleasant ones. Thus he can assume a "role" other than the one assigned to him by a cruel fate."¹⁸

The role of the therapist is to assume the attitude of tolerance towards the child no matter how hostile, messy or "naughty." The worker never condemns the child for what he does. This attitude of tolerance and time and space limitations emphasize the special character of the play interview:

The aim is to create a psychological situation in which the child feels secure and can be "himself," free from the pressure of having to play a part, be a certain kind of person in order to secure approval or to live up to his own conception of a lovable human being. Such relationship provides the setting in which a child may be able to give expression to desires and feelings that, in accordance with cultural prescriptions are usually kept from view or neuratically repressed.¹⁹

The worker facilitates this relationship but does not respond in kind. The child needs to have explained the nature of the interviews--why he is coming in, how the worker can help him. All this promotes his feeling of security if he is to share his thoughts freely.

The value is not so much in the content of the play but in the naturalness with which the child is able to share himself with the worker, whether verbally or through activity.

18. Ibidem, p. 183.

19. H.L. Witmer, Psychiatric Interviews With Children, p. 42.

A quotation from Frederick Allen will elucidate this contention:

Therapy must occur within the framework of a relationship that is established through the participation of two people. What the child is doing is less important than his freedom to do something.²⁰

Because the worker deals with the child's feelings and not with the problems or causes of the behavior the therapeutic relationship acquires special significance. While maintaining interest about what has gone wrong in the past, the caseworker is focusing on what the child can begin to do to improve his situation. Working on the principle that children accept guidance from persons they love and seek to gain their approval, the worker is using the accepting attitude as a means to influence the child in the desired direction. The therapeutic attitude is of paramount importance as the new experience can be assimilated through repetition. The focus of the treatment will depend in a large part on the nature of the disturbance. To use Frederick Allen again,

The child is accepted as having within himself the potentiality for achieving a new inner balance as he is helped to find value in a living relationship. The therapist becomes the growth inducing influence.²¹

20. F.H. Allen, Psychotherapy With Children, p. 124.

21. Ibidem, p. 115.

CHAPTER IV.

DESCRIPTION OF THE FAMILIES STUDIED

This chapter presents a survey of the nineteen cases selected for the study; in this group children received casework help between January and December, 1955. The children were all under fourteen years of age.

The following background information was studied: number of children in direct and indirect treatment; length of time the families were known to the agency; source of referral; reasons for referral; age and sex distribution of children under treatment; family constellation; problems of children at the time of the study.

Number of Children in Direct and Indirect Treatment.

In the study of the nineteen cases there were eight families from which children were treated only indirectly through the work with the parents, and eleven families in which children received direct casework help.

In the group in which children were treated directly casework with the parents usually occurred simultaneously with the individual treatment of the child and frequently included casework services to the siblings of the treated

child or other family members. The problems of the siblings, however, were such that they could be modified through casework with the parents. Because of the limited scope of the study the writer is not concerned with these indirect casework services offered to the siblings. The focus is kept only on the children who were treated directly by the caseworkers. It was felt that the example of the indirect treatment would be sufficiently clarified by the study of the group of children who were treated only indirectly, through casework with the parents.

Upon examining the group of children who were treated directly it was found that with the exception of one family who had two children under treatment, there was one child in each family receiving direct casework help. We shall refer to these children as receiving direct treatment.

In the group in which children were treated only indirectly the following distribution was found: in one family there were four children considered in work with the parents; in two families, three children were considered; in three families, two children were considered, and in two families, one child was under consideration. We shall refer to these children who were treated through the parents as receiving indirect treatment.

In both groups it was usually the mother who worked with the agency since the fathers were often unavailable

for treatment or were living away from the families.

The Length of Time Families Were Known.

The length of time the families that were dealt with in this study were known to the agency ranges from one to ten years. The distribution of cases in the direct and indirect groups did not show any concentration on any particular year period but was spread rather evenly over the ten year range.

TABLE I.

LENGTH OF TIME FAMILIES KNOWN

Years	Children In Treatment	
	Direct	Indirect
1	3	-
2	1	2
3	2	1
4	1	1
5	1	1
6	1	-
7	1	1
8	-	-
9	1	1
10 and longer	-	1
Total	11	8

In the group receiving direct treatment three families were known for one year and the remaining eight families, between two and nine years. In the indirect treatment

group eight families were known between two and ten years span period, with one family being known for thirteen years.

The Source of Referral to the Agency.

In order to ascertain the number of families showing some awareness of existing difficulties the sources of referral were examined. The information obtained at the time of the most recent intake was taken into consideration with the following findings:

TABLE II.

SOURCE OF REFERRAL TO THE AGENCY

Source	Children In Treatment	
	Direct	Indirect
Self-family	5	3
Court-probation officer	2	-
Neighbor, friend	2	-
Hospital, Social Service department	1	2
Minister	1	-
Family physician	-	1
Health center	-	1
Child caring agency	-	1
Total	11	8

In both groups the greatest number of referrals was made by the families themselves. There were five self-re-

referrals in the direct group and three self-referrals in the indirect group. Out of the eight self-referrals in both groups four families were directed to the agency by an outside source: two families by United Community Service; one family by school and one family by a child guidance clinic. Nevertheless, these were considered under the self-referral because the parent himself made the first initial contact with the agency requesting help.

In the direct group beside the five self-referred families two referrals were made by the Court and two by an interested neighbor who was concerned about the existing situation in the family. This may be significant in this group since it may indicate that the children's problems tended to be more severe, were no longer confined to the family situation but were already known to the community.

In the indirect group four of the referrals came from medical settings where the families have been known previously. This may indicate that there were already problems connected with the children's health or illnesses within the families.

The larger number of self-referrals in both groups may have resulted from greater awareness of the problems on the part of the parents and their more intense desire to secure help which would not be present to the same degree in the families who were referred by an outside source. The fact

that a parent comes to an agency concerned about his child indicates the degree of responsibility he feels he has in the situation. His participation and interest is vitally important in the consideration of any treatment plan, especially if the child is to be treated directly by the worker.

Reasons for Referral.

Next, this writer deemed it useful to analyze certain information obtained at the time of the latest intake in order to ascertain major problems that brought the families in question to the agency. In some cases it was the family's first application for help; in other instances it was a re-opening of a case that was known to the agency previously. The following distribution of the problems was observed:

TABLE III.
REASONS FOR REFERRAL

Problems	Families
Parent-child relationship	16
Temporary care of children	1
Marital difficulties	<u>2</u>
Total	19

It is interesting that despite the number of years that have elapsed in some cases since the last intake, in sixteen out of the nineteen families at that time already the problem was that of strained parent-child relationship. Only in two cases the referral was made solely on the ground of marital difficulties and in one case children needed temporary care because of the mother's illness.

As might be expected, difficulties in parent-child relationship were not the only problems in the families at the time of the referral. There were others, in addition, and their distribution is as follows: in four families there were marital problems; in five families there were financial difficulties; one mother had problems regarding non-support; one was upset because of the children's visiting with the divorced father; and in one family there were home management problems due to the retardation of the parent. In several cases these other problems were brought out by the family after the referral. Some were related to the parent-child difficulty, others were not.

Age and Sex Distribution of Children Under Treatment.

Table IV shows the distribution of children according to age and sex. It was prepared in terms of the direct and indirect treatment groups for the purpose of comparison.

Of the nineteen cases which were studied eight families belonged in the indirect group and the casework here involved eighteen children. The direct group consisted of eleven families who had twelve children under direct treatment.

TABLE IV.

AGE AND SEX DISTRIBUTION OF CHILDREN UNDER TREATMENT

Age	Children Treated			
	Directly		Indirectly	
	Male	Female	Male	Female
4	-	-	-	1
5	-	-	3	-
6	1	-	-	1
7	1	-	1	4
8	1	1	-	-
9	3	-	1	-
10	-	1	2	-
11	2	-	-	1
12	-	-	-	1
13	1	1	-	3
Total	9	3	7	11

It is to be noted that in the direct treatment group there were three times as many boys as girls under treatment, while in the indirect treatment group there were more girls than boys being treated.

The impressive difference in the sex ratio seems to support the present day observation that more boys than

girls during the latency and pre-latency period come to the attention of social agencies because of their problems. It is during this period that much of the contained aggression in a child needs expression, and frequently results in acting out (anti-social behavior). The families and the community alike are usually more concerned with this kind of child rather than with those who are equally disturbed but show symptoms of withdrawal and indications of neurotic behavior.

The ages of the children in direct treatment ranged between six and thirteen, with heaviest distribution around the latency period, especially for the boys. The sample is too small to afford any deductions regarding the predominance of boys over girls in this group. However, it seems significant that direct treatment did not begin with this group until the children were at least of school age. This supports the belief of the agency that casework with children under six rests to a great extent on the work with the parent. This is further evident when we examine the distribution of children in the indirect treatment group, in which the ages ranged from four years up, with more than one half of the children receiving help between four and seven years of age.

Family Constellation.

The following Table deals with the family status of the nineteen cases that were studied. The classification "broken home" refers to a home that was incomplete, lacking one of the natural parents either because of divorce, desertion, or death, or to a home with the history of a previous marriage in which the child under study was conceived. The term "natural" refers to a home in which both natural parents were present and lived in the household with the children.

TABLE V.
FAMILY BACKGROUND

Type of Home	Families of Children In	
	Direct Group	Indirect Group
Natural	6	5
Broken	<u>5</u>	<u>3</u>
Total	11	8

Although in the majority of instances children came from natural homes it seems significant that in eight out of the nineteen cases the family background was atypical with a history of home disruption.

In the direct group four fathers were living away from the homes because of a divorce or separation; another father

had remarried and there were children from both marriages.

In the indirect group one father had remarried having children from his first marriage; one father had deserted, and one was absent because of a prolonged hospitalization.

It is to be noted that in the cases with disturbed family histories the children's adjustment was seriously affected by the marital conflicts or by the father's absence.

In the six families from which the fathers were absent the children reacted to the broken home with confusion and hostility. With the mothers the attitude of rejection--overprotection was encountered most frequently. In the two families in which the fathers had remarried there were problems concerning the relationship with the stepparents, and an atmosphere of open or disguised rejection.

The picture of the family backgrounds in these atypical families indicated that most of the referrals could have been justified on account of the home situation alone.

In the families of children receiving direct treatment the ordinal position of the twelve children treated was as follows: in four instances the child under treatment was the younger of two children in the family; in one case the child was the youngest of four children; in another case, the youngest of six children; in two instances the child under treatment was the only child in the family; only in two cases the child was the second oldest in the family of four, and

in one case, two children under treatment were from a family in which a third (youngest) child was born after one parent had remarried.

It follows from the above that out of the twelve children requiring direct treatment eight were either the youngest ones in their respective families or were the only children.

CHAPTER V.
ANALYSIS OF CASES

This chapter deals with the presentation and analysis of the following material: the symptoms of the children in the study, the problems of their parents, the attitude of children and parents towards the treatment, the type of treatment used with the families, and the changes that were observed as a result of the treatment at the end of the study period.

Symptoms of Children In Direct Treatment.

In the direct treatment group nine out of the twelve children studied (see Table VI) were in conflict with their environment, showing symptoms of aggressive, acting out behavior at home or in the community. Negativistic attitude, defiance towards authority, and aggressive behavior were the most frequent symptoms. One child was stealing and lying, and three children had additional problems of sibling rivalry. Six out of these nine children had additional difficulties in adjusting to the school situation because of their behavior problems.

TABLE VI.
SYMPTOMS OF CHILDREN IN DIRECT TREATMENT

Family	Immature	Difficulty in Making Friends	Fears, Anxious	Retarded	Hates School	Learning Diffici.	Peer School Adjustment	Overactive	Quarrelsome	Openly Aggressive	Lying, Stealing	Temper Tantrum	Demands Attention	Sibling Rivalry	Physical Handicap	Illness	Environmental Difficulties
Anna A.	X																
Bob B.		X					X	X	X				X				
Cathy C.							X		X	X	X			X			
Daniel D.							X		X	X		X		X			
Earl E.		X					X		X	X				X			
Frank F.									X								
George G.	X	X	X				X	X	X	X							
Helen H.		X			X		X		X								
Hubert H.					X		X			X							
Ivan I.																	
John J.		X	X	X					X	X							
Kenneth K.			X	X			X		X	X							

Doing well, case ready to close, open only to implement plans for Big Brother.

Six children in the study showed neurotic tendencies and problems of individual adjustment through symptoms of fear, anxious and retiring behavior, and general immaturity. Five out of these six children were also having behavior problems. Only one child who had difficulties in making friends, was retiring and immature and did not act out his conflicts in the environment.

With the exception of two children who were retarded, the health of the children in the direct treatment group was generally good and there were no known problems as a result of illnesses or physical handicaps. In one instance the child under treatment had no problems any more, was making a good adjustment, and the case was kept open only to implement plans for a transfer to the Big Brother.

Indirect Treatment Group.

The problems of the children in this group were different in kind and degree from those of the children who were treated directly. There were fewer children with antisocial behavior. Some of the problems resulted from the children's illnesses or physical handicaps. Other children were in need of summer recreation and opportunities for social contacts. See Table VII.

In this group the agency worked with eight families who had eighteen children. Eleven children had behavior diffi-

TABLE VII.
SYMPTOMS OF CHILDREN IN INDIRECT TREATMENT

Family	Immature	Difficulty in Making Friends	Fears, Anxious	Retarded	Hates School	Learning Diffic.	Peer School Adjustment	Overactive	Quarrelsome	Openly Aggres.	Lying, Steal.	Temper Tantr.	Demands Attn.	Sibling Rivalry	Physical Handicap	Illness	Environmental Difficulties
Abe L.	X			X													
Bob L.							X		X								
Cyril L.										X							X
Dick M.	X	X		X					X			X					
Billy M.	X	X		X													
Fanny M.	X	X		X			X										
Gerald M.	X			X									X				
Hugh H.							X						X				
Irene O.				X			X										
John P.	X														X		
Kay P.															X		
Lydia P.																	
Mary Q.																	
Nancy Q.									X								X
Oliver R.	X								X								
Peter R.	X																
Rudy S.	X																
Therese S.																	

Well adjusted; needs help in providing social & recreational opportunities.

culties, but these showed on the average through one or two isolated symptoms rather than through a multiplicity of symptoms, as was the case of children who were treated directly. Four children were noted for demanding attention.

Six children were retarded and their low intellectual capacity accounted partly for their poor adjustment at school, immature behavior in general, and unsatisfactory contacts with their peers.

Three children had problems because of prolonged illness in the past or because of physical handicap. One of the three was blind from birth; two had cerebral palsy and in one of them this was complicated by a partial deafness; five children were lacking opportunity for summer recreation and social activities.

Problems of Parents In the Direct Group As Related To the Children's Symptoms.

The various symptoms that were seen in the children appear to be related to the problems of parents, and especially to the particular parent-child relationship that existed in these families. Table VIII portrays the major problems of the parents in the direct group with the exception of difficulties in the parent-child relationship that existed in all families.

TABLE VIII.
PROBLEMS OF PARENTS IN THE DIRECT GROUP

Problem	Family											K ^b
	A	B	C	D	E	F ^a	G	H	I	J		
Housing	x			x								
Illness	x			x				x				
Financial	x	x	x	x	x			x	x			
Marital	x				x		x	x	x	x		
Father alcoholic	x				x		x					
not assuming responsibility	x				x		x	x			x	
lives away from family		x	x	x		x						
Mother insecure as parent, wife		x	x	x						x	x	
compulsive, controlling				x				x			x	
has psychoneurotic complaints				x								
rejecting				x	x		x				x	
overprotective		x										
Conflicts with relatives					x			x				
Other personality problems of parents	x	x	x	x	x	x	x	x	x	x	x	

^a Mother receiving treatment at a psychiatric clinic.

^b Insufficient knowledge about the family; parents were reluctant to share information.

In the direct treatment group five families were involved in serious marital difficulties, and in one family marital tension existed. Their children were caught in the middle of the disturbed parental relationship, and they reacted with confusion. In three families the marital discord was caused mainly by the fathers' alcoholism and their inability to assume responsibility as fathers and breadwinners. In one family the mother identified the child's weaknesses with her disliked husband; in the second family the child protested at being left at home with the father who lost his job while the mother worked; the third couple was on the verge of separating, the husband wanted to leave the family and the wife felt too upset to handle the children alone. In another family the child was exposed to an overcontrolling, anxious mother who was suspecting her husband's infidelity and feared his desertion. One mother who was anxious to succeed as a stepmother was irritated by her husband's passivity; her feeling of inadequacy resulted in her being domineering, nagging the children to a better performance. Another mother felt bound to an immature, alcoholic husband with the consequences of having to carry alone the responsibility for the household and large family, and this in turn left the children deprived and insecure.

In four families the fathers lived outside of the home because of separation or divorce. One mother feared that

she would be unable to bring up her boys because of "lack of male influence," as she put it; she was frustrated trying unsuccessfully to assume the role of both mother and father. Another deserted mother was overwhelmed by inadequate housing, financial difficulties, illnesses, and the children's behavior problems; as a result she sank into a passive state, while the child under treatment was dominated by an older sibling.

In five instances the mothers felt inadequate in their role as parent or wife, this being especially true in the broken homes. Invariably in every family one parent or both had personality difficulties which affected adversely their marital adjustment and attitudes towards the children.

Problems of Parents In the Indirect Group As Related To the Children's Symptoms.

Here again most of the symptoms of children were linked to the parental difficulties. See Table IX.

In six families children were exposed to parental discord. In one family the drinking father was leaving home periodically, and when home he was rivaling with the sons for their mother's attention. In another family the underlying marital tension caused disagreement between the parents in regard to handling a pre-delinquent boy, and this heightened the mother's feeling of inadequacy. The problems of another

TABLE IX.

PROBLEMS OF PARENTS IN THE INDIRECT GROUP

Problem	Family							
	L	M	N	O	P ^a	Q	R	S
Housing		x						
Illness					x			
Financial	x	x				x	x	x
Marital	x		x	x		x	x	x
Father alcoholic	x			x				
not assuming responsibility	x			x				
lives away from family							x	x
Mother insecure as parent, wife		x	x			x	x	x
compulsive, controlling			x			x		
has psychoneurotic complaints						x		
rejecting	x	x		x				x
overprotective					x	x		
Conflicts with relatives				x				
Other personality problems of parents	x	x	x	x		x	x	x

^a In this case again insufficient knowledge about the family was obtained because of the mother's reticence.

family in which there were children from both the father's and mother's previous marriages were aggravated by the father's drinking and a rejection of a difficult stepchild.

One neurotic mother was holding on to an unsatisfactory marriage because of her masochistic needs, dwelling on psychosomatic complaints and projecting her anxiety onto the children. Another wife was "tired of being a mother" and was rejecting her children because she identified them with the drinking husband.

In another instance, where the father was hospitalized for years, the mother was finding it difficult to bring up children alone, yet she feared the husband's return and felt ambivalent about him.

With the exception of one family the personality problems of the parents in this group were mirrored not only in the inadequate marital adjustment but also in the disturbed relationship that existed between the parents and children.

Attitude of Parents Towards Treatment.

In an attempt to evaluate the parental attitude towards treatment, a three-point scale was used. The "accepting" and "resisting" ratings are self-explanatory. "Verbally accepting but actually resisting" category implies psychological and emotional resistance to treatment which was pre-

sent despite the verbal acceptance. See Table X.

In the direct treatment group three mothers had accepting attitude towards treatment while six mothers were continuously resisting. In the indirect treatment group only one mother had positive feelings towards treatment while four mothers were verbally accepting but actually resisting.

TABLE X.
PARENTS' ATTITUDE TOWARDS TREATMENT

Attitude	Families of Children	
	In Direct Treatment	In Indirect Treatment
Accepting	3	1
Verbally accepting but actually resisting	2	4
Resisting	<u>6</u>	<u>3</u>
Total	11	8

Among the mothers with the accepting attitude, records disclosed that one mother was willing to involve herself in treatment and was fairly able to use the agency for casework help; another was dependent on the relationship with the caseworker to share her feelings regarding her children, marriage, etc.; still another mother had a good sharing relationship and was supporting the agency's plans; one was reported to

have a very good relationship and relating well to the worker.

The mothers whom this writer classifies as verbally accepting but actually resisting were parents who according to case records had the following attitude: one mother was intellectually accepting of treatment but unable to become a part of the treatment situation; one was wanting help for her son because she was threatened by his behavior, yet resisted to accept further clinic help; another mother hoped, as she said, that "the agency can help her because children have problems," but was unable to elaborate on given information; one was able to identify with the worker and relied on the agency, but had a need to dispute what the worker said, this being her reaction to persons in authority; another mother was accepting the possibility that she had contributed to the problem, but tended to project her child's difficulties onto the husband; one was dependent on the agency, wanted an advice, but was unable to follow suggestions.

The group of parents with resisting attitude consisted of: one mother who continuously denied the seriousness of her child's behavior; two mothers who tended to deny problems until they were pressured to do something about it; one mother who had a close relationship with the agency, but tended to deny feelings about her problems; one who was relating to the caseworker as to motherly authority, was de-

valuating the agency and would have preferred psychiatric help instead; one who was rationalizing and projecting the child's problems on the school; one who was leaning on the agency but became hostile when efforts were made to help her understand her own part in the children's difficulties; one who refused help of any kind for herself or the child, and said that she was "fed up" with the situation; and one who was fearful to involve herself in the relationship, kept on coming, however, saying that she had "no problems but might."

Attitude of Children.

This concerns only those children, twelve in number, who were treated directly by the caseworker since the children who were treated through their parents often did not have any contacts with the workers, or the contacts were infrequent or casual.

Three of the twelve children could verbalize freely, seemed to be wanting to come to the agency, but were distrustful of the workers and continuously tested the limits of the therapeutic relationship.

One child was unable to express any feeling, was shy and non-verbal, although not fearful of the agency.

Four children were unwilling to acknowledge having any problems or being worried. Of this group one boy was coming "because it was mother's idea" and put it this way:

"It is not true that I have problems, but mother has." Another child denied having any negative feelings about his home situation; one boy would dwell on philosophical discussions rather than speak about his family; one girl seemed to be wanting the relationship but kept on being evasive when the worker tried to discuss her family's matters.

Three children were accepting of the agency and of the therapeutic relationship. Of this group one girl related well, could discuss her frustrations about her home situation, and asked for continuation of the treatment at the end of the school year; another child, also with a good relationship with the caseworker, used the interviews to express his sexual anxiety and destructive impulses; one boy could accept the temporary relationship with his worker when he was being prepared for the Big Brother--he loved the idea of having a big brother.

One boy was coming gladly to the agency because he was told by his mother that he "will get help with the school work"; he was reticent about family difficulties but the fact of his being non-verbal seemed to be due more to his retardation than resistance.

Criteria Used In Assessing Casework Treatment.

In an attempt to evaluate casework treatment this writer used Professor Austin's definitions. These may be defined

as follows:

Social therapy, which consists of the use of techniques designed to influence factors in the environment and social resources. The casework relationship is an object relationship used to help the client make use of resources and opportunities and to change negative factors in the environment.

Psychotherapy, which consists of the use of techniques designed to bring about modifications of behavior and attitudes. There are three types:

1. Ego-supportive. This consists of the use of techniques designed to influence factors in the environment but differs from social therapy in that the transference relationship is used to support the client's aims, protect them from undue pressure, and to prevent break-down. Change in the personality structure of the client is not the goal of this type of therapy.

2. Intermediary. This is a blending of ego-supportive and insight therapy. The goal is to bring about some change in behavior and attitudes through better adaptation within the present personality structure. This change is accomplished by the use of transference as a dynamic for providing a corrective emotional experience and stimulating growth, especially in the social reality. Selected dynamic interpretation can be used. Insight is not the main goal.

3. Insight therapy. The goal of insight therapy is to bring about change in the ego by developing the client's insight into his difficulties and increasing the ability of the ego to deal with them. The transference relationship is used to help the client understand his irrational impulses, how they arose in the past and how present situations differ so that he may modify his behavior accordingly. Since interpretation is used to produce greater awareness of unconscious motivations, psychiatric consultation is necessary.¹

1. L.N. Austin, "Trends in Differential Treatment in Social Casework," Journal of Social Casework, 6:203, June, 1948.

Under social therapy in this study is included work with schools, clinics or hospitals, use of recreational and group facilities or work with other agencies in behalf of the child or his family, as the situations of individual cases required.

In the cases studied treatment is categorized as ego-supportive when the predominant part of treatment aimed at strengthening the client's ego. In some cases treatment during the study period began as intermediary but had to be dropped and changed to supportive treatment because the parent was resistant or unable to involve himself in any deeper relationship. Because in these instances supportive treatment remained the predominant technique of working with the parent during the period studied, it is classified also as ego-supportive. Equally, the classification of intermediary treatment is used when this was the predominant treatment method in these cases.

Only results of casework with children receiving direct treatment are given. The limited scope of the study does not make it possible to portray treatment situations with each child.

Treatment of all children receiving direct help was on the reality level, the dynamics of treatment being the relationship between the caseworker and the child. Play interviews or spontaneous discussions were used as the medium. The aim was to help the child verbalize his inner conflicts

or express them through free play so he could achieve a better adjustment for himself and a healthier relationship with his family.

Types of Treatment of the Families in Direct Group, and Results.

In assessing the types of treatment in this group, Lucille Austin's definitions were used. For the survey of results of treatment, the evaluation by the caseworkers was employed as it was found in the agency's records. For the types of treatment, see Table XI, and for the results, Table XII.

In the group of parents of children receiving direct treatment only one father was treated, while in all the other cases it was invariably only the mother who received treatment.

The one father was treated with the aim to help him and his wife accept a referral of their child to a child guidance clinic. This failed because of the strong resistance and fear of the couple to face the situation. The fathers in the other families could not be included in treatment because they were either absent from the families or resistant to work with the agency.

In one family in which it appeared that the father might have been able to accept help attempts were made to include

TABLE XI.
TREATMENT OF PARENTS WHOSE CHILDREN
WERE TREATED DIRECTLY

Family	Type of Treatment	
	Mother	Father
Case A.	Social therapy and ego-supportive	Not in treatment
Case B.	Social therapy and intermediary	Not in treatment
Case C.	Social therapy and intermediary	Not in treatment
Case D.	Social therapy and intermediary	Not in treatment
Case E.	Intermediary	Not in treatment
Case F.	Not in treatment	Not in treatment
Case G.	Social therapy and ego-supportive	Not in treatment
Case H.	Social therapy and ego-supportive	Not in treatment
Case I.	Social therapy and intermediary	Not in treatment
Case J.	Social therapy and ego-supportive	Not in treatment
Case K.	Ego-supportive	Ego-supportive

him in treatment but failed. In this instance the marital tension at home was undermining the progress with the child in treatment, and consequently the child's difficulties at

TABLE XII.
RESULTS OF TREATMENT IN THE DIRECT GROUP

Family	Results	
	Parents	Child
Case A.	Mother tends to deny feelings about problems; agency's support sustained her through crises; using agency when unable to handle pressure.	Progress slow; denies feelings; responded to relationship; is more outgoing.
Case B.	Benefitted from support; feels she has been helped; incapable of deeper relationship; real involvement has been slow.	Has identified with male worker; verbalized negative feelings; still testing relationship.
Case C.	Some progress in adaptation to child's needs; wants to continue work on problems.	Is admitting worries, but is very fearful of relationship.
Case D.	Benefitted from support; more aware of own and children's needs.	Identified well with male worker; able to express aggression, sexual conflicts; needs less limits, referred to BBA.
Case E.	Benefitted from support; more realistic about marriage; functions better as wife and mother.	Improved school adjustment, relationship with peers and brother; evasive in discussing home situation.
Case F.	Made much progress in past treatment; able to accept further help at psychiatric clinic.	Good adjustment at home, with peers; loves idea of Big Brother; being prepared for transfer.

TABLE XII (cont'd)

RESULTS OF TREATMENT IN THE DIRECT GROUP

Family	Results	
	Parents	Child
Case G.	Used relationship to satisfy own needs; interests of her own; is encouraging child to be independent.	Improved adjustment at home, with peers; active in sports; continues to feel inferior.
Case H.	More secure as mother; less controlling of children; used help on educational level.	Girl: benefitted from relationship; less resistant to stepmother; verbalized some problems. Boy: did well with groups; dependent on worker; wants to continue treatment.
Case I.	Mother: used help only with physical problems; resisted involvement. Father: attempts to initiate treatment failed.	Cannot establish relationship; non-verbal; withholding feelings.
Case J.	Attempts to work towards personality changes failed; benefitted from support; less controlling as mother and wife.	Responded with limitations; good adjustment at school, with peers; continues denying problems at home.
Case K.	Did not accept idea of a clinic; both parents resistant to treatment; withdrew when boy promoted.	Relationship never established; extremely shy, non-verbal.

home did not diminish although he was able to make better adjustment at school and with peers.

In eight cases social therapy was used along with indi-

vidual treatment of the parents.

Five mothers received ego-supportive therapy; one mother felt dependent on the agency but could not maintain continuous relationship with the worker, using him only in time of crises which prevented her from getting the full benefit of treatment; one mother felt too threatened by the problems of her child and by the agency, could not establish working relationship despite the interest and support of the worker, and eventually withdrew from treatment. Three mothers benefitted more fully from supportive treatment and were able to carry the gains of treatment into their relationship with the children.

Five mothers received intermediary therapy; one mother, although unable to involve herself sufficiently in treatment, could gain some understanding of her marital difficulties and of child rearing procedures; one mother was unable to move into a deeper therapeutic relationship but could be helped through selective interpretation and support to the degree that she could see a change in herself and her child saying that they both "have been helped to grow up."

Three mothers were able to achieve some understanding of their own behavior in the children's problems which led to an eventual improvement of the parent-child relationship and better adjustment of the youngsters.

It is significant that when mothers were resistant to

treatment because of their own anxieties or unwillingness to share their real feelings, their children could not respond fully to the therapy either. This trend was observed in the majority of cases under study.

Types of Treatment of the Families in the Indirect Group, and Results.

The types of treatment in this group were once more surveyed according to Professor Austin's criteria, while the findings of the caseworkers covering the results of treatment were again taken from the agency's records. Table XIII portrays the types of treatment and Table XIV, the results.

In the families of children treated indirectly, two fathers were involved in treatment. In both instances the support and interest of the caseworker brought good results. One father used the therapeutic relationship to satisfy his dependency needs and to ventilate hostility about the child with whom he was in conflict. In another family where the child's behavior was indicative of delinquency the support of the caseworker evoked in the parents the feelings of responsibility in the problem and resulted in their decision to accept transfer to a child guidance clinic for further treatment.

Social therapy was used invariably with all families. Ego-supportive treatment was used with five mothers. One

TABLE XIII.
TREATMENT OF PARENTS WHOSE CHILDREN
WERE TREATED INDIRECTLY

Family	Type of Treatment	
	Mother	Father
Case L.	Social therapy and intermediary	Ego-supportive
Case M.	Social therapy and ego-supportive	Not in treatment
Case N.	Social therapy and ego-supportive	Ego-supportive
Case O.	Social therapy and ego-supportive	Not in treatment
Case P.	Social therapy and intermediary	Not in treatment
Case Q.	Social therapy and intermediary	Not in treatment
Case R.	Social therapy and ego-supportive	Not in treatment
Case S.	Social therapy and ego-supportive	Not in treatment

mother derived sufficient strength from the support of the worker so that she was able to accept clinic plans for further treatment.

Three mothers were limited in their ability to involve themselves in the relationship. One mother was limited intellectually as well as being chronically upset; however, the

TABLE XIV.
RESULTS OF TREATMENT IN THE INDIRECT GROUP

Family	Results	
	Parents	Child
Case L.	Father: was drinking less; better relationship with son. Mother: more accepting of boy's positive feelings for father; resisted involvement, could use support only.	Boy enjoys visits with father; school more accepting of retarded boy.
Case M.	Able to manage home and children with help; agreed to institutionalization of retarded child; progress slow because of mother's limitations.	Better adjustment at home; school more understanding of family situation, is working with agency.
Case N.	Parents helped to get more involved with psychiatric clinic; accepted treatment plans for all three children.	Prepared for treatment at child guidance clinic.
Case O.	Family could not be reached by casework; mother insists on placement; case transferred to child caring agency.	Girl helped to establish positive relationship with new worker and teacher.
Case P.	Good understanding of individual children's needs; less protective of handicapped children; confident to handle situation herself.	Boy made steady progress in adjustment at home, school; normal child no longer competitive with blind child.
Case Q.	After eight months remain unable to discuss personality problems; no change in marital situation or parent-child relationship.	Girls responded partially to mother's more relaxed handling but this was only temporary.

TABLE XIV (cont'd)
RESULTS OF TREATMENT IN THE INDIRECT GROUP

Family	Results	
	Parents	Child
Case R.	Used worker to gain approval; no longer denying problems but able to discuss some; more able to involve herself in treatment; less overprotective of children.	Minor improvement in adjustment at home; both children did well at, and enjoyed, camp.
Case S.	More giving to children; wants to continue "getting advice"; supportive relationship meaningful; still unable to involve herself in treatment.	Little change noticed in children's behavior.

support and help with reality planning sustained her in functioning on the border-line level and helped her to accept institutional placement for one of her retarded children. To one mother who was unable to relate, the support and interest of the caseworker carried sufficient meaning so that she wanted to continue with the agency, saying that she is doing so "just in case there should be problems with the children in the future"; during the study the children could not be reached through the mother because of her resistance, and there was no change in their behavior. Another mother was very slow in establishing relationship but gradually

ceased to deny that she had problems, and began to share more of her worries about the children and herself; she could consider camp planning, and this was used by the worker to establish a more sharing relationship.

In one case which can be considered a hard core family the stepmother could not be reached by casework at all; the parents were rejecting the child, said that they "did not want any help," and insisted on placement away from home. Since the child herself seemed to prefer placement, the case was transferred to a child caring agency already working with the family.

Intermediary therapy was used with three mothers. In one case the mother was able to achieve considerable understanding of her needs and behavior with the children; she was able to change some of her functioning which resulted in steady improvement of the children's behavior.

In two cases the results of the clarifications attempted were limited and the mothers seemed to derive the greatest benefit only from the supportive relationship with the worker. One mother remained resistant to discuss her personality problems and consequently there was little change in her attitude towards her children who continued to be difficult. Another mother who was equally fearful of revealing herself in the treatment situation, could achieve only intellectual acceptance of her son's positive feelings for her

husband although emotionally this continued to be threatening. In this family the father has benefitted some from the therapy he himself was receiving, and while his drinking diminished and the marital relationship became less strenuous the parents were able to give some consideration to their children. The results were that the relationship between the parents and children improved at least temporarily.

CHAPTER VI.

SUMMARY AND CONCLUSIONS

The purpose of this study was to examine casework with children in a family agency. The writer was especially interested in:

1. the problems seen in the children;
2. the treatment methods that were used;
3. the changes observed in the children and parents as a result of treatment.

In the past, casework with children belonged to the province of the child guidance clinic; caseworkers were concerned with counseling of parents about the well-being of their children, and modification of harmful social influences. This is no longer true since with the access to new psychoanalytical knowledge and the results of experiences that were made available to family agencies by the child guidance clinics the interest of the caseworkers expanded to include both the counseling and the actual treatment.

Children in a family agency can be helped through direct or indirect treatment. Direct treatment involves individual work with the child through play interviews. Indirect treatment is accomplished through the work with the parents while the child as a rule is not seen by the caseworker. The de-

Decision whether the child is taken for direct or indirect treatment rests on many factors, such as the diagnosis and severity of the child's disturbance and the parents' awareness of their responsibility in the problem and their sympathetic feeling towards the treatment.

For this study nineteen families were used: eleven families in which children were treated directly and eight families with indirect treatment. The nineteen families under study had thirty children; twelve children belonged to the direct group and eighteen to the indirect group. All families were known to the Family Service of Brookline in the calendar year 1955. They all had problems in the parent-child relationship and all had one or more children under the age of fourteen in treatment.

The study was based on the material from the case records. The information regarding the length of time the families in question were known, the source and reasons of referral, family constellation, symptoms of children, problems of the parents, attitudes of families towards treatment, and treatment results were studied and analyzed according to the schedule prepared by the writer. Since the families fell into two groups, direct treatment and indirect treatment, the writer has attempted to handle these groups separately whenever possible, for purposes of comparison.

The length of time the families were known to the agency

ranged from one to ten years, the distribution of the direct and indirect group being spread over the ten year period. An analysis of the sources of referral showed that out of the nineteen cases there were eight self-referrals made by the families themselves. In the direct group more referrals were made by sources in the community than in the indirect group. This would seem to indicate that the problems in the direct group were more severe and extended into the community which thus became concerned. Sixteen families came to the agency because of problems in parent-child relationship.

The age and sex distribution of children under treatment showed that in the direct group there were three times as many boys as girls, while in the indirect group eleven girls and seven boys were treated. This supports the hypothesis that more boys than girls need help on account of aggressive behavior around the latency period. Most boys who came to the attention of the agency were between the ages of six and nine. In the direct group the treatment did not begin until the children were at least of school age, while in the indirect group the ages ranged from four years up, with more than one half of the children receiving help between four and seven years of age.

A study of family constellation revealed that children from eleven out of nineteen families came from broken homes, six fathers being away because of illness, desertion, or di-

force. In all instances the disturbed or broken family unity had adverse effects on the children. The children were affected directly because of the financial stresses that prevailed, and indirectly because of the emotional deprivation. In regard to the ordinal position of the children in the direct group it was found that eight out of twelve children were the youngest ones or the only children in their respective families.

The problems of the children in the direct group in nine instances revealed conflicts in the environment, with symptoms of aggressive, acting-out behavior, and defiance for authority. With five children these were the main problems, usually associated with poor school adjustment on account of the primary behavior disorders. In four other children the aggressive tendencies were coupled with neurotic symptoms, such as anxiety, fears, and retiring behavior. One child showed shyness and reticence as his main problem. Another child was anxious, fearful, and retarded. One boy made a good adjustment, exhibited no gross problems, and waited to be transferred to the Big Brother.

In the direct group the problems of the aggressive children showing reactive behavior disorders tended to be rather severe and no longer confined to the home situation alone. They affected adversely the child's school and social adjustment as well. This seemed equally true in the children with

psychoneurotic disturbances whose fears and anxieties were curtailing the psychological and emotional development as well as their social life.

In the indirect group one third of the children had problems because of intellectual retardation, such as poor adjustment at school, immature behavior, inability to get along with peers, and some acting out. Three children in this group had problems on account of their illnesses or physical handicaps; the symptoms here were immature behavior, temper tantrums, poor relationship with peers, and poor school adjustment. Three children showed aggressive acting-out behavior, and two children had problems of poor individual adjustment with symptoms of withdrawal and inability to get along. Three children had problems because of sibling rivalry, learning difficulty, and quarrelsome behavior. In one instance the case was ready to be closed as the child has made a good adjustment and awaited transfer to the Big Brother.

The problems of the indirect group with the exception of children who were severely retarded were found to be less serious, with fewer symptoms indicating open aggression than in the direct group. The problems were different both in degree and in kind, and in general were influenced either by the constitutional make-up of the children, the physical factors, or environmental difficulties.

The children in the families under study mirrored the problems of their parents. Difficulties in parent-child relationship were inevitably present in all families. In addition to this all parents showed personality problems of their own which affected their marriage and their attitude towards their children. In twelve families severe marital problems or tensions were present. Five fathers were alcoholic; they abandoned their responsibilities. The mothers were preoccupied with their own difficulties and directly or indirectly deprived their children of the attention and love that were needed. Half of the mothers felt insecure in their role of mothers and wives.

The treatment of the children in the direct group consisted of spontaneous play activity, on a reality basis, where the relationship between the caseworker and the child was used as the medium. The aim was to promote a verbalized expression, real or phantasied, in the child and help him to identify with the worker who represented standards he could accept and incorporate. The play sessions were not included in the study. Rather, the emphasis was on the work with the parents which was the vital aspect of treatment of children in both groups.

The attitude of parents and children towards treatment influenced the results of the therapy in both groups. In the indirect group it was the mother in all cases who was treated

and only in two instances, the father. From the eight families half of the parents verbalized their acceptance of treatment but were resisting it emotionally or psychologically; three parents were resisting treatment and one was accepting it.

In the direct group the attitudes of both the parents and children were examined. Nearly half of the parents were resisting treatment and one fourth was accepting it. The study revealed that out of the twelve children treated directly eight have been affected by the underlying feelings the parents themselves had towards the treatment plan. In the two situations in which the parents were verbally accepting but emotionally resisting treatment, their children accepted the worker on a superficial level but continued to test the relationship or denied having any negative feelings about the home situation. In another case emotional acceptance of the parent was conveyed to the child. Attitudes of other five parents who were resisting treatment affected their children who became either resisting to the direct treatment, continued testing the relationship, or were unable to verbalize any difficulties.

The type of treatment used with the parents was rated according to Lucille Austin's classification, the evaluation of the treatment and the results being taken as much verbatim as possible from the case records. Social therapy was used

In the majority of cases in addition to intermediary and ego-supportive psychotherapy, the latter predominating.

In the direct group all parents responded well to the supportive treatment. They were able to make a good use of it in improving their home situations and their relationship with the children. In the cases in which intermediary therapy was attempted, the results depended on the willingness and ability of the parents to involve themselves in a deeper relationship. Such willingness and ability were absent in most of the cases.

All children in the direct group, with the exception of one child, benefitted in various degrees from the direct treatment. Where fear and inability to bring out their problems were present, the gains were made from the meaningfulness of the relationship with the worker. In cases in which the male worker was used as a father substitute for a male child the results were especially favorable.

In the indirect group treatment efforts on the average brought less satisfactory results, because of the chronic pathology that existed in many of the families. Severe personality problems of the parents, intellectual retardation and open rejection by the parents presented real obstacles to the workers' efforts to rehabilitate these families. Often the accomplishment consisted of helping the family to maintain a minimal adjustment, or the mere fact of establishing a re-

lationship meant progress. In cases in which the parents were able and wanting to involve themselves in treatment the situations of the children improved accordingly. One family in this group could not be reached by casework at all and the case was transferred to a child caring agency which was already involved with the parents.

The study would appear to demonstrate that casework with children, whether this involves direct or indirect treatment, is a valid and valuable aspect of the family field. Family agency is equipped to give skillful help to families in which parent-child problems exist. Casework with children and family service are synonymous, "since we have learned that family relationships established in childhood are the determinants of the adult's achievement of relative maturity."¹

1. J.L. Gregory, "The Generic and Specific Aspects of a Family Casework Program," Social Casework, 7:290, July, 1950.

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APPENDIX

SCHEDULE

CASE NUMBER

FAMILY NAME

CHILD

Name

Date of Birth

Sex

Religion

School Grade

FAMILY SET-UP

Member	Name	Age	Sex	Occupation
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Father

Mother

Siblings

HOW LONG KNOWN TO AGENCY

LAST REFERRAL

Date

Source

PROBLEMS SEEN AT LAST INTAKE
PRIOR TO JANUARY, 1955

PROBLEMS SEEN IN JANUARY, 1955

CHILD'S ADJUSTMENT

At Home

At School

SCHEDULE (cont'd)

ATTITUDE OF PARENTS TOWARDS TREATMENT

Accepting

Verbally Accepting But Actually Resisting

Resisting

ATTITUDE OF CHILD TOWARDS DIRECT TREATMENT

METHODS OF TREATMENT

Social Therapy

Psychotherapy

Ego-supportive

Intermediary

Insight

CHANGES RESULTING FROM TREATMENT

In Parents

In Child

*Accepted
8-2-57
E. Swengel*