THE TECHNIQUE OF PSYCHOTHERAPY

PSYCHOTHERAPY DURING CHILDHOOD, ADOLESCENCE, AND OLD AGE

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Psychotherapy During Childhood, Adolescence, and Old Age

There are critical stages in the development of personality in which crucial incidents and experiences have a destructive impact that are not registered during another period. The stages of weaning, habit training, bodily exploratory activities, entry into school, puberty and adolescence, marriage, pregnancy, child rearing, and retirement and old age pose special problems that influence psychotherapeutic interventions when these are needed.

CHILD AND ADOLESCENT THERAPY

Psychopathology in children must at all times be viewed against the backdrop of developmental norms. Moreover, it must be considered in relation to existing family and social distortions that deprive children of needs essential to their growth or subject them to rejection, violence, or overstimulation with which they cannot cope. Among common noxious influences are parental absence, rejection, seduction, overprotection, or cruelty. Contemporary disruptions in family life, such as a detached and disinterested father, subjection to television bombardments of violence and sexuality, poverty, lack of intimate family ties, and racial conflicts at school, exaggerate the normal problems inherent in growing up. Fears of separation, resistance to socialization, defiance of discipline, sibling rivalry, and Oedipal crises may also interfere with the resolution of developmental disturbances. Emotional difficulties in childhood usually express themselves in symptoms of excessive irritability, hyperkinesis, fearfulness, daydreaming, obsessions, compulsions, bed-wetting, or excessive masturbation. Sleep, speech, eating, and learning disturbances are common, as are psychophysiological manifestations such as tics, spasms, vomiting, diarrhea, headaches, asthma, ulcers, and colitis.

During the first three years of life, excessive and continuous crying unrelieved by attention from the mother signals a state of unresolved tension (Cramer, 1959). Inordinate rocking, thumb sucking, head rolling, sleeplessness, food refusal, vomiting, retention, soiling, temper tantrums, ritualistic behavior, defiance, stammering, and unusual aggression often indicate disturbances in the child's environment, particularly in the relationship with the mother. In a small number of instances, these are manifestations of organic physical or neurological ailments.

During the fourth and fifth years extravagant fears, nightmares, excessive masturbation, and enuresis reflect sexual identity difficulties. Overactivity, tantrums, negativism, and destructiveness constitute another type of patterning for conflicts developed during this period. Such difficulties are often nurtured by sexual and hostile acting-out in parents and by their seductive use of the child to satisfy their own neurotic needs.

Neurosis during the sixth to ninth years of life frequently manifests itself in failing adjustment at school, the outcroppings taking the form of school phobias, truancy, aggression toward fellow pupils and teachers, and learning disabilities. Outright neurotic symptoms may appear in other types of phobias, tics (blinking, grimacing, jerking of the head and extremities), stammering, compulsions, and conversion phenomena. Excessive withdrawal and daydreaming or aggressiveness and antisocial activities (e.g., stealing, exhibitionism, fetishism, peeping) interfere with social adjustment. Frank, unbound anxiety may erupt. Eventuating psychophysiological disturbances may derange various organ functionings.

In the preadolescent (latency) stage, between nine and twelve, there may be enhanced aggressiveness, fighting with siblings and friends, and occasional depressive states stimulated by disappointments and failures.

During adolescence, potential problems incorporate the full spectrum of psychopathology from behavior disorders to psychoneuroses to psychoses. The emotional disorders that are most common in

adolescence, however, are adjustment difficulties, personality disturbances, scholastic failure, school phobia, enuresis, psychosomatic complaints, delinquency, anorexia, bulimia, and identity disorders.

In the tumultuous growth period of adolescence, with the extensive alterations in the physical, biochemical, and emotional makeup characteristic of this epoch, therapists must, in judging the degree of disturbance, take into consideration the normal anxieties and concerns that plague individuals.

Adolescents have a need for both uniqueness and difference, a desire to conform and a fear of being different from others of their age and sex. Strong and strange impulses dominate the body as the sexual glands mature and the adolescent comes under the influence of erotic thoughts and feelings. New demands are made by family and community; no longer is the youth considered a child. Swings into independence and aggressiveness are followed by refuge in childish dependency and passivity. The need for recognition vies with the impulse to defy. Drives for success and prestige are paramount, while conflict rages over issues of religion and death. A fluctuating sense of values and confusion in identity add to the adolescent's turmoil.

Constructive solutions will be needed. The adolescent must first dissipate dependency ties sufficiently to enter into a more assertive and independent attitude toward the world. This is especially necessary in a society where the burden of one's own support and ultimately that of one's family will fall on the individual's shoulders. Second, the adolescent must learn to control sexual feelings so that there will be a proper balance between restraint and expression. Evolvement of adequate sexual role identification is mandatory. Third, one must change from the subordinate manner of a child to the dominant habitude of a grownup, to feel equal with other adults. Fourth, one must develop a cooperative attitude toward authority, without feeling victimized or excessively hostile. Fifth, one must learn to be assertive and creative and to assume leadership on occasion, without ulterior motives of control or power. A proper educational and career choice must be made.

In primitive cultures the adolescent struggle is less intense than in civilized societies because there is much more continuity in the behavior patterns of child and adult. Primitive economies are less complex and consequently afford an easier and earlier emancipation from parental support. Child marriage and premarital intercourse are more or less condoned. This sanction affords the growing child an outlet for energies. Civilized societies impose barriers against which the adolescent will struggle. While relatively mature biologically, the adolescent cannot become economically self-sufficient until well along in adult life. A large proportion of today's young people are forced by the requirements of their chosen careers to enter into a long and expensive period of study that must be financed by their parents.

Hostility and resentment are frequently the outcome of the conflict between the impulse to break dependency ties and the need for material help and support. Although adolescents feel an urge to lash out at their parents, most realize that such action will result in retaliatory measures that threaten personal security. In addition, the hostile urge clashes with some of the adolescent's ideals. Thus a youth is at the mercy of many ambivalent and conflicting values and goals. Sometimes the child is driven by contradictory impulses reflecting both the secret sexual and delinquent wishes of one or more parents that they have projectively and covertly conveyed to their offspring, as well as guilt feelings of the parents that have prevented the parents from personally expressing these impulses. The child here acts as a messenger for the parents, who stealthily relish the exploits of their offspring and then heap blame on the child.

Under the best of circumstances the adolescent period is a chaotic one and is characterized by a recrudescence of problems that had their origin in childhood and were never adequately resolved. Often parents have not been aware of these problems, and they are dismayed and frightened by the eruption of severe behavioral disturbances in a previously exemplary child. The early adolescent (12 to 15 years) is plagued by regressive thrusts that conflict with the new growth demands of this stage. The child ambivalently veers between submission and rebellion, sociability and isolation, friendships and enmities, overactivity and retreat, depression and overexcitement. Delinquency and acting-out are common. The

struggle in this period is a process of resolution of sexual identity, object ambivalence, and needs for separation and individuation. In middle adolescence (14 to 17 years) there is some resolution of sexual conflicts with greater ability to relate. Narcissistic defenses alternate with more mature coping mechanisms. Homosexual episodes, depersonalization, anxiety, and runaway tendencies may occur. In late adolescence (17 to 21 years) separation-individuation accelerates, object choice solidifies, identifications strengthen. Identity crises, depression, and adjustment difficulties continue, however, often encouraged by available peer groups involved in sexual and deviant exploits.

In summary, *adjustment reactions* to growing up are a normal byproduct of socialization. They occur in all children. The reactions become exaggerated in those who are subjected to extraordinary stress, or whose developmental needs are not being met by parents, or who are being grossly mismanaged, improperly disciplined, or subjected to cruel and abusive treatment. The constitutional makeup of the child will influence the severity of reactions and the ability to cope with the stress being experienced. The responses of the parents to the child's reactions will also influence the outcome. If they are kindly and caring adults, capable of maintaining control of the situation and their own emotions, the child may be helped through the critical adjustment years. If they are not so equipped, minor maladjustment reactions may explode into severe behavior disorders that can persist and influence adversely later stages of the child's development. The ultimate outcome may be a pathological neurotic or psychotic reaction for which treatment will be needed.

General Principles of Child and Adolescent Therapy

Choice of techniques in child therapy is complicated by a wide variety of available interventions. These are usually determined more by predilections of the clinician than by precise diagnostic assessments. This, in the words of Harrison (1979), has produced a state of "undisciplined chaos'' in the field. Experience is the mother of compromise and the great leveler of differences in therapeutic operation. For example, whereas in past years there was a tendency to segregate behavioral from psychodynamic

approaches, a fusion of these methodologies has more and more dominated the practices of many child therapists. Family therapy, with its transactional system orientation, has become an indispensable mode and is often executed coordinately with behavioral-psychodynamic-medicinal approaches and environmental therapy. It seems obvious that therapists cannot neglect any links in the behavioral chain among children any more than they can neglect them in adults, and this will necessitate the use of interventions designed to influence different zones of pathology. With the present knowledge, therapists can match a number of syndromes with appropriate interventions provided a proper diagnosis can be made.

The basic rule in treating disorders in childhood is providing an adequate climate in which developmental needs are met, opportunities for impulse gratification supplied, and proper discipline and restraints imposed. Alterations of the milieu are usually required and the cooperation of the parents and family may be essential even to the point of exposing them to individual or family therapy. Unless this is done, work with the child alone may prove to be fruitless, the parents and other family members sabotaging the child's efforts at adjustment. Indeed a sick child may be the vehicle for holding a family together.

Therapeutic interventions will accord with the accepted theoretical model. Thus, if deviant behavior is regarded as originating through reinforcement of unhealthy patterns by the family, treatment tactics will be organized around modifying the consequences of such patterns through behavior therapy (Ross, A, 1972). Should a psychoanalytic family interaction model be adopted, a search for pathogenic conflicts and their resolution through insight and working-through in the patient-family-therapist relationships will be embarked on. If constitutional organic neurological factors are considered most significant, developmental and language lags that interfere with the normal timetable in the evolution of essential functions will be looked for. Prescription of medications and the institution of adequate training routines will follow.

The existence in childhood of relatively undeveloped personality functions, strivings for independence and mastery that inevitably conflict with dependency yearnings, heightened motor activity and fantasy life, lowered frustration tolerance, greater needs for discipline, and extraordinary plasticity of the developing ego will require innovations in therapy technique. Environmental manipulation, crisis intervention (q.v.), family therapy (q.v.), drawings (q.v. art therapy), the use of play materials (q.v. play therapy), and the employment of greater activity and supportiveness with efforts at symptom control are more or less standard aspects of child treatment. The key to management is a proper diagnosis with assessment of the potential of the child as well as the role the mother and family will play in organizing a therapeutic milieu.

The majority of child therapy clinics use therapeutic methods that stress the interpersonal therapeutic relationship, focus on the presenting problems, and encourage therapist activities of a friendly, active, and supporting nature to provide a corrective experience for the child. Psychotherapy is considered a new and unique growth experience that is family centered with the focus of concern on the child (F. H. Allen, 1962, 1963).

In mental health clinics for children that emphasize careful evaluation, diagnosis, and treatment planning, both the child and parent are given attention. Thus at the beginning of therapy, parents require help in expressing their feelings about the plans being made for therapy. Prior to bringing their children into a treatment situation, parents are aided in ventilating their hopes, doubts, and fears. Discussions consider the part they can play in preparing their offspring for treatment. In these early interviews the role distortions of the parents with each other and their children usually become apparent. It is essential to involve both parents, when possible, in the planning to avoid distorting the family drama further. The beginning phase of treatment with children is diagnostic for the therapist. The therapist witnesses how the children react to a unique experience of acceptance and empathy, their degree of accessibility, the content and manner of their communications, and the ways that they express or conceal feeling. At the start,

children will probably perceive the therapist as they do other adults—hostile, dogmatic, overprotective, or omnipotent. Expectations, fears, and desires for magical cure are sooner or later projected onto the therapist. Recognizing this the therapist encourages the child to express and then to test out misconceptions in the hope of inspiring a more realistic life orientation. Dealing with the child's need to transform the therapist into a good or bad parent, steady maintenance of one's identity helps to provide for the child a truly differentiating experience. But even in the first interview a therapeutic process may begin. Winnicott (1969), using the child's drawings, has demonstrated that therapists can score a significant imprint on the child and increase their understanding in just one interview.

Emerging from this diagnostic phase is a therapeutic plan determined by the children's physical condition, the evaluative studies of the psychologist, the ability of the children to form a relationship with the therapists, and the cooperation of the parents. A definite schedule is set up, usually once weekly, the children and parents having separate and sometimes concurrent appointments. In a team plan different team members may see the parents and the children.

Changing paradigms of therapy have placed an accent on *child behavior therapy*. Its briefness, ease of administration, and effectiveness in behavior and habit disorders have enabled therapists to help some children, particularly those who because of deficiencies in motivation, cooperation, intelligence, and verbal skills have not been able to use traditional interview and play techniques. The focus is on altering the environmental circumstances that initiate and support deviant patterns. No effort is made to probe for conflicts or to promote insight. There is little emphasis on the importance of the child-therapist relationship except to establish sufficient rapport to enhance the acceptance of social reinforcement. The traditional diagnostic categories are not considered of great importance.

Initially, a behavioral assessment is made of the problem, consisting of an exact description of its nature, its history, its frequency, the circumstances under which symptoms occur, the reactions of the parents or teachers, and the consequences to the children. Many pertinent techniques on behavior therapy

are delineated in Chapter 51. The selective method used with particular children will depend on the specific behavior to be altered. Bijou and Redd (1975) have outlined some useful methods. Monitoring procedures are set up to provide data about progress, and parents are trained in proper responses, and at home to act as accessory behavior therapists.

Thus, in children who have tendencies that are upsetting to others (such as pushing, fighting, hitting), a program may be organized that grants rewards (candy, a token or points exchangeable for something the children like to receive or do, praise) for each instance of desirable social behavior. Coordinately, an aversive contingency may be employed whenever the obnoxious behavior occurs, for example, removal of the children from the room for a period and placement in a room without toys. Or the children may be penalized for conduct by taking away some tokens or points.

If children are psychologically withdrawn or show shy or phobic behavior, they are rewarded with praise and attention when they manifest sociable and non-phobic behavior. They are ignored when they do not. Reinforcements are gradually spaced and delayed, and requirements for reinforcement gradually are made more stringent to shape behavior. Modeling appropriate behavior may be utilized both for the children and the parents, the latter observing how the therapist responds through a one-way mirror if one is available. Systematic desensitization may also be employed. Thus, a school phobia is treated by gradual introduction to the school environment for slowly increasing periods, each success being rewarded.

The acquisition of new and desirable behavior repertoires will call for contingent positive reinforcement for initial improvements then for increasing intensities of the new behavior. Inappropriate normal responses (e.g., of speech, conduct) may gradually be extinguished and displaced to suitable situations by adequate reinforcements.

These operant techniques are also applicable to hospitalized adolescent patients. Their effectiveness is illustrated by the experience in the Adolescent Service of the Boston State Hospital (Lehrer et al., 1971). A

token economy is tailored to individual needs or problems. Patients are given points that can be redeemed for money, school attendance, and participation in various activities. Points buy food (hot dogs, pizza, hamburgers, soda, or ice cream). Then patients are permitted to play a jukebox, games (pinball, table tennis, board games) as well as purchase various items in a special teenage lounge that has a soda fountain and grill. Points are also exchangeable for parties, dances, camping expeditions, and so on. Points are taken away for infraction of the rules. Serious violations, such as assaultiveness and abuse of property, lead to restriction of all activities until the patients have worked out with a psychologist strategies for controlling their behavior and proper point payment for any damages that they have done to property.

Some therapists use the findings of dynamic psychology to conceptualize the development and problems of children. The therapeutic focus of *child psychoanalysis* follows this model and brings to the children's awareness the anxieties, unconscious wishes, and defenses that produce their difficulties. Since children do not respond to therapy as adults do, classical technique must be modified taking into account the children's tendencies to project problems onto the environment and the lack of motivation for therapy. The parents and other important members of the family also have to be brought into the therapeutic situation through parent guidance, family therapy, or individual therapy in accordance with what is required in each individual case. Because children express themselves most readily in play, play therapy is seen as an important tool for probing conflicts and for interaction with therapists. The analysis of children's problems was originally explicated by Sigmund Freud in his "Analysis of a Phobia in a Five-Year-Old Boy." The two main orientations that emerged were those of Anna Freud (1928, 1945, 1946) and Melanie Klein (1932, 1961). According to Anna Freud, children as young as three years of age may be analyzed. Free association and the couch position, however, cannot be employed. Instead the children's activities in movement, play, and random talk are used for interpretation, as are stories, dreams, and the children's reactions to the therapist. Caution in making interpretations is essential since the egos of children are not as firmly developed as those of adults. Generally children do not develop a transference

neurosis, instead reflecting more of the immediate situation than the past. The cooperation of the parents should be enlisted as an adjunct to their children's treatment but no attempt is made to offer direct advice. In Melanie Klein's technique, children as young as two may be treated. Unlike Anna Freud's method, the deepest interpretations to fantasies revealed by children in play are given, starting with the first interview. These are concerned with Oedipal wishes, awareness of parental intercourse, the desire to destroy the mother's body, and the desire to incorporate the father's penis. Since the reality situation is not considered significant, the cooperation of the parents is not sought; indeed, it is considered an unnecessary inconvenience. In recent years the formulations of self-psychology (Kernberg, 1980; Kohut, 1977; Mahler, 1968) have been applied to work with the more seriously disturbed children and adolescents (Marohn et al., 1980). Interesting descriptions of the psychoanalytic process in children may be found in the writings of Aichorn (1936), Bios (1962, 1970), Bornstein (1949), Erikson (1963), Fraiberg (1965), Gyomroi (1963), Isaacs (1930), and Winnicott (1958). There is some disagreement among analysts regarding how thoroughly the unconscious should be probed.

Instead of an expressive-exploratory approach it may be decided to employ a supportive-educative-suppressive type of therapy to bolster repression of offensive conflicts and active promotion of more constructive behaviors. Here combinations of therapies are commonly used such as environmental manipulation, promotion of emotional release, family therapy, educational techniques, behavior therapy, and play therapy as means of maintaining communication and releasing fantasies that may be explored. Examples of play therapy are Winnicott's (1977) squiggle game and Gardner's (1971) storytelling methods detailed in a number of books published by Creative Therapeutics of Craskill, N.J. In play therapy, psychotherapists may employ psychodynamic concepts and in essence integrate psychoanalytic with behavioral, educational, family, and environmental-manipulative approaches, an integration which is probably for the majority of cases the most rational mode of operation.

Children and adolescents are less motivated for therapy than adults and a good part of the time may have to be spent by therapists developing a relationship with the recalcitrant youngsters. Children are more likely than adults to project their difficulties onto the environment, acting out their needs and conflicts while avoiding inner exploration and self-observation and inhibiting the constructive use by the therapist of transference as a therapeutic tool. On the other hand, the children's natural use of play as a form of communication enables trained therapists to harness some of the bubbling energies that seem so chaotic. Working with the material elicited during play therapy calls for a great deal of skill, particularly in knowing how and when to interpret defenses, conflicts, and the underlying impulses (Harrison et al., 1984; Fraiberg, 1965). In adolescents the capacity for self-observation is somewhat more developed than in children. This is balanced by the ambivalence and confusion of identity that are hallmarks of this developmental period. Because adolescents tend to project their conflicts and to act out explosively at times, therapists may have to abandon their preferred roles as participant observers and intervene when the acting-out assumes dangerous proportions.

Technical modifications are necessary in adolescents that take into account the identity struggles going on within them (Esman, 1983). Because adolescents are so resistive to receiving help of any kind, an empathic, active, non-challenging approach is more effective than a confrontational one, which inexperienced therapists are tempted to employ, especially when the adolescents test them by acting-out. Periodically, therapists may have to substitute game playing for interviewing. Patients may find it difficult during puberty or early adolescence to discuss sexual concerns, and to lessen anxiety, therapists of the same sex may be preferable. Between 15 to 17, adolescents are somewhat less in a tumult and become more amenable to an exploratory approach, but here the relationship with therapists must be sufficiently firm to support this effort and to handle the adolescents' inevitable countertransference reactions. Therapists who have had difficulties in their own adolescence are likely to adopt an anti-therapeutic stance in working with patients exhibiting defiance, or resistance. Short-term psychotherapy may be especially

suited to adolescents (Proskauer, 1971; Rosenthal and Levine, 1971) focused on certain problems that patients choose to handle. Because children's and adolescents' pathology occurs before the maturational cycle is complete, because dependency on parents and family is still high and economically necessary, involvement of the parents and/or family is, as has been mentioned before, essential for good therapy. Family therapy is especially of value when dysfunctional transactional family processes exist, when scapegoating of patients is suspected, when the patients' difficulties are related to a pathological family structure, and when urgent intervention is required as a consequence of a family crisis (Berlin, 1970; Williams, 1973). Adolescents with borderline problems may require a special approach using some of the insights from object relations theory (Masterson, 1972).

Attempts to use more formal psychoanalytic therapy in late adolescence are more successful than in earlier years. A search is made for fixations and problems in the infantile period and in early childhood that reappear in direct or disguised forms as well as the defenses against regression, castration anxieties, and superego guilt. From these therapists may better understand how hitherto adjusted children become converted into disorganized, willful, or violent adolescents. Youthful patients are, however, usually resisting participants in probing noxious early experiences and reactions, not seeing the connection with what is happening in the present.

Gladstone (1964) describes three major groupings of adolescents for whom different treatment approaches are applicable. The first group consists of acting-out character problems and offenders who will require extreme therapist activity to promote a relationship, a firm setting of limits, and a constant emphasis on human values and their communication in the relationship. In another study, Gladstone points out how this may be done. The second group includes neurotic disorders and dependency problems. Here observant and interested objectivity is offered patients, emotional catharsis is encouraged, there is a probing of underlying conflicts toward insight, and there is a minimum of interference from therapists in working out the conflicts. Illustrations of such tactics are provided by Josselyn (1952, 1957). The third

group is composed of withdrawn schizoid reactions. With such patients are best employed supportive techniques, experience sharing, continuous correction of distorted perceptions with efforts at reality testing, and educational correction and filling in of learning deficits. Silber (1962) gives examples of these procedures.

Group therapy (q.v.) with children has been described by Slavson (1949, 1952) and has become an accepted way of dealing with problems in childhood, both as a principal therapy and as an adjunct to individual therapy. Of note, too, are Moreno's methods of using psychodramatic play with groups of children (Moreno, 1965).

The size of children's groups must be kept below that of adult groups (Geller, 1962). For instance, in the age group six years and under, three children constitute the total. Both boys and girls can be included. Single-sex groups are those (1) from 6 to 8 years, which optimally consist of 3 to 5 members; (2) from 8 to 12 years, which may have 4 to 6 members; and (3) from 12 to 14 years, which also have 4 to 6 members. Mixed-sex groups at the oldest age level are sometimes possible. Play therapy is the communicative device up to 12 years, the focus being on feelings and conflicts. It is obvious that the ability to communicate is a prerequisite here. Beyond 12, discussions rather than play constitute the best therapeutic medium. Techniques include confrontation, analysis of behavior in the group, and dream and transference interpretation. Both activity (during which acting-out may be observed) and discussions are encouraged at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. Ideally, individual therapy is carried on jointly with group therapy, particularly at the beginning.

Group therapy may be helpful for adolescents even though resistance is prominent. Identity crises and confusion respond better to group treatment than to any other approach (Rachman, AW, 1972a & b). The therapist must function in roles other than that of psychotherapist—for example, as guide counselor and

teacher (Slavson, 1965). A behavioral group approach is often helpful, for example, with disturbed adolescents in a hospital, such as was previously described, as well as in a residential setting (Carlin and Armstrong, 1968). The introduction of several young adults of ages 21 to 24 helps foster healthier transference reactions and provides identification models. The therapist amid the impulsive behavior in the group (which is spontaneous among adolescents) cautiously introduces interpretations.

Some therapists find a cotherapist (preferably of the opposite sex) useful (Evans, 1965; Godenne, 1965). Countertransference phenomena that often occur in cotherapy include excessive attraction to young patients of the opposite sex, fear of "liking too much" certain patients of the same sex (due to homosexual fears), projection of feelings and frustrated impulses in relation to the therapists' own mates onto the cotherapists or patients of the opposite sex, competition with the patients of the opposite sex for the cotherapists, competition with the cotherapists for the group's admiration and support, and transfer of emotions originally felt for children of the therapists onto members of the group.

The *drug therapy* of children with behavior disorders, schizophrenia, and chronic brain syndromes has included the use of a number of substances (Fish, 1963, 1965, 1966). The most important drug influence has been registered on psychomotor excitement, a control of which reduces other symptoms, such as perceptual and thought disorders. As a result of being calmed down, the children may become amenable to group activities, educational offerings, and psychotherapy (Fish, 1960a & b).

Generally no drug is given until it is proven that environmental manipulation and psychotherapy have had no effect on the prevailing symptoms. Diphenhydramine (Benadryl 12.5-25 mg 3 or 4 times daily; average dose 100-200 mg daily, maximum dose 300 mg) is valuable in behavior disorders with hyperactivity in children over 20 pounds of weight and in anxiety reactions in children under 10 years of age. Since it produces drowsiness, it may be employed as a bedtime sedative. Other drugs that can be used are chlordiazepoxide (Librium) for children over 6 years of age, 5 mg 2 to 4 times daily, increased if necessary to as much as 10 mg 2 to 3 times daily; and diazepam (Valium), 1 to 2.5 mg 3 or 4 times daily,

increased gradually as needed and tolerated for anxiety. Promethazine (Phenergan) for severely disturbed children (Bender and Nichtern, 1956) acts as a sedative when 25 mg is given at bedtime or 6.25 mg to 12.5 mg is given three times daily. Phenothiazines may be tried for primary behavior disorders, as well as schizophrenia and organic brain disease where milder therapies are ineffective. Chlorpromazine (Thorazine, 1 mg per pound of body weight daily, or 50-100 mg daily) is used in excited states; should an emergency necessitate intramuscular injection, 0.25 mg per pound of body weight every 6 to 8 hours as needed are given. Trifluoperazine (Stelazine, 0.15 mg per pound of body weight daily, or 1-15 mg daily) is used sometimes in apathetic, withdrawn children. Taractan (in children over 6 years of age) in dosage of 10 to 100 mg daily, Navane (in adolescents) in dosage of one to 40 mg daily, Haldol (in adolescents) 0.5 to 6 mg daily, and Moban (in adolescents) in dosage of 10-50 mg daily may be tried, in that order, where phenothiazines are ineffective. Haldol may be effective also in tic disorders and Tourette's disease. The employment of Ritalin and Dexedrine will be described later in drug therapy for attention-deficit disorders. Barbiturates should not be given to children. Should hypnotics become necessary, Benadryl or chloral hydrate may be used. The latter is prescribed as Noctec syrup (each teaspoon equals 500 mg) in a single dose depending on body weight up to a total of 750 mg. In depressive disorders in adolescents where psychosocial treatments have failed, imipramine (25-75 mg daily) may be tried, recognizing that cardiovascular symptoms may occur. MAO inhibitors are not recommended. Antidepressants have also been found useful in separation-anxiety disorder, attention-deficit disorder with hyperactivity, enuresis, and obsessive-compulsive disorder (Rancurello, 1986). The use and dosage of imipramine (Tofranil) in enuresis is described in the section on habit disorders. The use of stimulant drugs in attention-deficit disorders is detailed later in this chapter.

The Management of Aggression

The management of aggression constitutes an important aspect of working with children. Methods of

handling aggression range from extreme permissiveness—even to the undesirable extent of allowing physical attacks on the therapist—to rigid disciplinary measures and physical restraint.

Aggression is representative of many diverse conditions. It may be a reaction to frustration of a fundamental need or impulse. It may be a means of coping with overwhelming inner fears stirred up by terror of a menacing world. In the detached child it may signify an averting of close relationships with people; in the child with power strivings, a way of gaining control; and in the masochistic youngster, a technique of provoking others to a point where they retaliate in kind. In some children it is the only form of relationship to another human being that they know, and it constitutes a frenzied appeal for companionship or help. Aggression may be a camouflage for a deep feeling of inner helplessness, and as such it is motivated by the conviction that the only way to escape hurt is to overwhelm others. It may be a manifestation in compulsively dependent children of disappointment in the adults to whom they cling, on the basis that the children's whims are not being satisfactorily gratified or because more favors are being shown to others than to themselves. Before adequate therapy can be instituted, it is essential to know the symbolic significance of aggression to the children and the situations under which it is most likely to appear.

A number of children who exhibit behavior problems in the form of direct or subversive aggression never seem to have developed an inner system of moral restraint or the ability to tolerate an average amount of frustration. Neglected children—those reared without proper guidance or discipline or those brought up by parents who themselves fear aggression and are consequently unable to take a stand with the child—frequently develop a defective repressive mechanism that is incapable of inhibiting rage or of directing it into socially approved channels. Such children usually have no fear of, or respect for, authority. They are narcissistically oriented and use aggression as a coercive tool to force others to yield to their will. There is little contrition or guilt associated with their destructive acts, and the children usually

take the attitude that people or objects on which they vent their rage are worthy of its consequences. Retaliatory measures have little deterrent influence and actually may incite the children to further bouts of aggression.

In treating children showing this form of aggression, a permissive environment is worse than useless. This is because a sympathetic tolerance of the children's rage plays into the children's contemptuous attitudes toward authority. Actually, the children themselves see no necessity for change, and a permissive atmosphere merely perpetuates aggressive strivings.

The ideal objective in these children is to build up a superego capable of exercising control of their inner impulses. Much as growing infants develop a conscience from external restraints and prohibitions, so the children with diminutive superegos need discipline to nourish this impoverished portion of their personality. A kindly but firm expression of disapproval, and even irritation in response to destructive behavior, are much more rational approaches than its sanction or tolerance. The children must be taught that there are limits to their conduct beyond which they cannot go, that they have responsibilities for their daily acts that they must face, that definite things are expected of them, and that they have to live up to these expectations. When, in the therapeutic setting, limits to the children's conduct are first established, the children are apt to react violently; but as firm discipline continues, they will themselves discover that they are much more comfortable knowing that there are boundaries beyond which they cannot go. This is not to say that they yield themselves readily to such circumscription of their freedom. The usual reaction is to engage in a prolonged struggle with the therapists to break down the limits imposed on behavior.

The therapeutic situation differs from any previous atmosphere because the children soon begin to feel in it a warmth and expectation such as they have never before experienced. Indeed, while in the realistic world their impulses have brought them a measure of gratification they have also isolated them from people. They gradually begin to understand that therapists are adults who are not threatened by their aggression and do not yield to it or withdraw love even in the face of the most provoking tantrum.

As the children continue therapy, affection for the therapist gradually increases. Eventually, the children seem to go through a stage in development similar to that of the normal evolution of the conscience, namely, they feel it essential to win the therapists' approval and love. Whereas punishment and threats of abandonment have had little influence on the children's aggression, the fear of losing the approval of the only adults who have become significant to them has an extremely potent effect on the ability to inhibit rage. Needless to say, the process during which the children reintegrate themselves with authority, in which they identify themselves with loving adults and seek to win the latter's love and approval, is a long and tedious one. But the conscience, even in normal children, never develops precipitously; rather it extends over a period of years. One must not get too discouraged if the youthful patients have temporary setbacks in relationships with authority, including therapists.

There is another type of aggression in the form of a power striving that resembles the aggression in children with an undeveloped superego, but it has an entirely different dynamic significance and calls for a radically different kind of approach. The superego, instead of being diminutive, is hypertrophied and takes on a terrifying and punitive aspect. The image of authority is that of a fearful and destructive force that can overpower and mutilate the children if they yield to its control. The way that the children cope with their helplessness is by overwhelming others with their power drive and aggression.

The object in therapy here is not so much to reinforce and solidify the superego, but rather to undermine it and replace it with one that does not threaten the children for the exercise of their impulses or functions. It is consequently necessary to tolerate aggression as much as is possible within reasonable limits of safety and decorum. Unlike the case of the first type of aggression, a permissive environment is essential. The permissive atmosphere at first often incites power-driven children to exaggerated acts of aggression. These seem to be defensive techniques by such children to avoid yielding their vigilance against authority.

Power-driven children often have difficulty in expressing softness, love, or tenderness. These emotions conflict with their self-ideals, and this is especially the case in children reared in environments where toughness and strength are the only admirable qualities in life. During therapy in a permissive situation, such children gradually begin to let down their guard. One sees them working cautiously with creative materials, and there often emerges from deep within the children a great deal of esthetic feeling that has been buried previously under a crust of hardness. The amount of anxiety that accompanies the expression of tender emotions is amazing. As the attitude toward authority gradually undergoes a change, the children usually find it more permissible to enjoy softer impulses. In a hospital ward, for example, many children who have been egocentric and destructive may be seen, after a while, making active attempts to help the crippled and defenseless children in dressing, in their habit training, and in other routines. During the period when I was in charge of a boys' ward in a large mental hospital that housed violent and intractable boys who had not been able to get along in any other setting, I noticed this phenomenon repeatedly.

Another form of aggression frequently encountered is that in dependent children, who cling to the therapist or to other children in a submissive and ingratiating way. The aggression is stimulated by a feeling in the children that they have not received a sufficient amount of attention or love. The demands of dependent children are often so inordinate that it is impossible to live up to their expectations. There is involved an element of magical wish fulfillment, and rage occurs when wishes are not automatically granted. There is another important reason for aggression in the dependent child, and this emerges from their conviction that independence is being crushed by the people upon whom they lean. As long as dependency remains the keynote of living, assertiveness, activity, and creative self-fulfillment are constantly subdued. Great hostility may be underneath the outer core of submissiveness and ingratiation, and the children may regard the adults who care for them as overpowering beings who prevent them from attaining to self-sufficiency. This is one reason why aggression is precipitated without any apparent cause

in those children who receive unlimited privileges and favors. It is essential for personnel who deal with children to understand this, because the eagerness of adults to overprotect dependent children may actually rob the children of the necessity of participating actively in their own growth.

Dependent children may burn up their energy cajoling or forcing others to carry them, because they feel too helpless to accomplish things through their own efforts. Therefore, a program must be instituted in which the children learn to accept responsibility for daily routines of living. Self-growth is attained primarily through achievement. It is understandable that the children will exhibit episodes of aggression when they sense that others insist that they stand on their own feet. It is important not to yield to the children's aggression when it is obvious that the children are trying to force the therapist to care for them.

Finally, it is necessary to consider the aggression exhibited by shy and detached children. Such children are usually referred to a clinic or to a hospital because of neurotic symptomatology, psychosomatic complaints, or severe psychoses. Aggression, here, is at first not expressed, and the outward behavior of the children is usually of a compliant and innocuous nature. Detached children are threatened constantly by life and by people. They maintain their safety either by submitting to others or by building a defensive chasm that separates them from the world. In individual play therapy they will sit quietly awaiting instructions with little show of spontaneity. In a group of other children they will isolate themselves and play alone. They possess an enlarged and punishing superego as well as a great undermining of self-esteem. Beneath the shell of compliance are great quantities of hostility that they fear expressing openly. The object in treatment is to get them to mingle intimately with other children, to engage in competitive activities freely, and to express their aggression without counteraggression on the part of surrounding adults. This necessitates an extremely permissive environment.

Detached children are driven by a spontaneous force to assert themselves with other children and with adults, but their efforts in a normal environment are usually frustrated. In the permissive environment of the clinic or hospital these children gradually experiment with self-expressiveness. In play therapy they

may reach a point where they break through their reserve and begin working with pliable materials that they can manipulate or destroy. Later on, they may begin to penetrate from the periphery of the group to its center, participating in activities that bring them into contact with others.

As the children realize that they will not be hurt in closer relationships with others, they may engage gradually in mild competitive activities. Later, they may actually take a stand in life, defending their own rights and demands. At this point a tremendous amount of aggression is released, and they may become very destructive or assaultive. The aggression frequently is in the nature of a test to provoke adults around them into acts of retaliation in order to prove to themselves that their previous concepts of the world as menacing were justified. Furthermore, as the permissive environment begins eating away at their repressive images of authority, they may begin experiencing feelings of love toward the therapist. They may become so overwhelmed with terror out of fear of getting close to anyone they may direct their aggression at the therapist with little external provocation. Therefore, some tolerance of the children's aggression is therapeutically indicated.

Aggressive acting-out children have been helped by behavioral reinforcement programs. Rewarding desired behaviors with complete ignoring of unacceptable behavior has resulted in significant improvement. Working with parents and teachers to educate them regarding the meaning of the disturbed behavior is indispensable as a way of helping the children retain their gains. If behavior therapy does not help the problem, a program of psychotherapy (which may be a long-term one) with the children and parents will be required.

The Hyperkinetic Child (Attention-Deficit Hyperactivity Disorder DSM-III-R Code 314.01)

Whenever therapists encounter an aggressively hyperkinetic child, it is important to rule out organic syndromes that may manifest themselves purely as a behavior disorder (Wender, P, 1971). Symptoms of aggression, frustration intolerance, hyperactivity, and disturbed behavior occurring prior to 6 years and

even 10 years of age may be a consequence of damage to the brain brought about by such etiological factors as a high forceps delivery, severe infantile infectious illness (e.g., whooping cough, measles), and frequent spells of high fever without apparent cause (Levy, S, 1966). Before making a diagnosis, however, it will be necessary to rule out ordinary physiologic hyperactivity, reactive and neurotic behavior disorders, childhood schizophrenia, and mental retardation. Childhood depression also may mask itself in hyperactive and psychosomatic reactions (headache, abdominal pain). A rule of thumb has been applied to the effect that if children do not have enough control over themselves to sit still while watching their favorite television programs, an organic brain problem should be suspected. In true hyperactivity of organic origin there is a limited attention and concentration span, emotional lability along with impulsiveness, an inability to delay gratification, and poor frustration tolerance. Minor neurological signs and an abnormal electroencephalogram may be present. Often a learning disability is the reason children are referred for treatment. Because of sadistic, uncontrollable behavior, the children may be ostracized by other children and may be excluded from school. This undermines self-esteem and sponsors paranoidal ideas and more violent behavior.

Therapy is difficult and prolonged and is best administered by child therapists, preferably those who have had experience with hyperactive children. Work with both children and parents is essential. The latter must be counseled and educated regarding the nature of the problem and the need to refrain from applying the labels of “good” and “bad” to the children. It is often difficult for parents to accept the diagnosis of organicity and to control their desperate fears and guilt feelings. The cooperation of a neurologist may be helpful. Tutoring for special learning difficulties may be essential, as may exercise programs to improve motor skills. A comprehensive treatment approach is thus best. Feighner and Feighner (1974) describe one such program consisting of a complete evaluation of the child, pharmacotherapy, behavior modification, curriculum counseling, training for parents and teachers,

parent-child interaction videotaping, and feedback sessions while coordinating the treatment of the children with the family.

Drug therapy is usually symptomatically effective, the object being to stimulate the braking mechanisms of the brain to inhibit the motor overactivity. The drug that is most popular is methylphenidate (Ritalin), which is used in children over six years of age. Before breakfast and before lunch, 5 mg is given, gradually increasing by increments of 5 to 10 mg weekly up to a total of 60 mg if necessary. Usually 20 to 40 mg will be effective. If there is no improvement in one month, the drug should be discontinued. Other drugs that may be employed are the amphetamines. Dextroamphetamine (Dexedrine) may be given to children over three years of age as tablets or elixir. In children of 3 to 5 years, 2.5 mg is given daily, increased at weekly intervals by 2.5 mg until an optimal response occurs. In children over six years of age, 5 mg is given once or twice daily, raised weekly in increments of 5 mg until the best response is obtained, which is usually below 40 mg. Pemoline (Cylert) is an alternative drug and is given in dosages of 37.5-112.5 mg. All of these medications may be reduced or discontinued over weekends or during school vacations. After the patients reach puberty, the drugs may not be needed at all. Hyperactive children in a classroom setting may be helped by the stimulant drugs Dexedrine and Ritalin to control their behavior by improving attention and completion of classroom assignments. Behavior therapy is also effective in reducing fighting and quarrelsomeness, improving frustration tolerance, and controlling temper outbursts. Much of the behavior therapy can be done at home, the parents being trained in operant-reinforcement techniques. Target behaviors to be controlled are listed, their frequency and provocative stimuli charted, and contingent positive reinforcements of appropriate conduct and negative reinforcements of misbehaviors consistently applied (Safer and Allen, 1976). Self-instructional, self-control training may also be possible in some children (Meichenbaum and Goodman, 1971).

Coordinately, other adjunctive modalities previously mentioned should be employed. Parent groups meeting in six weekly sessions have proven beneficial. Reading materials should be assigned to parents,

such as the article by M. A. Stewart (1970). Teacher groups also have their use. Play therapy, contact with teachers, videotape sessions with the parents to play back interactions, remedial tutoring, and special exercises are other useful techniques.

In the medium of their relationship with their therapists, the children are encouraged to explore their feelings and attitudes. The poor impulse control and the motor incoordination of the children during treatment may stir up countertransference reactions in the therapist, at home in the parents, and at school in the teachers. A passive neutral attitude will create insecurity in the children. On the other hand, counteraggression will add fuel to the fire. A firm, kindly attitude is best. Should the children become violent, they should physically be removed from the disturbing situation so as not to perpetuate their behavior. Slowly, with proper management, mastery of behavior may be established, and there will be an ability to cope with increasingly challenging situations.

Hyperactive reactions may occur in situations other than in minimal brain dysfunction and present the same symptoms as the latter—for example, in children with unsocialized aggressive behavior, anxiety disorder, sociopathic personality disorder, and psychosis. In such cases stimulant drugs may not be effective or may actually exaggerate the symptoms. Appropriate diagnosis is essential in treatment planning. Individual, family, group, and behavioral approaches are productively employed in these conditions, but stimulant medications are definitely contraindicated.

Residual-attention-deficit disorder in adults, characterized by emotional lability, restlessness, and impulsive outbursts that are not due to schizotypal or borderline personality disorders also respond to methylphenidate (Ritalin) and pemoline (Cylert) (Wender et al., 1985).

Juvenile Delinquency (Childhood or Adolescent Antisocial Behavior, DSM-III-R Code Y 71.0)

A famous writer presented the problem of juvenile delinquency in these words: “Our youth now love luxury. They have bad manners, contempt for authority, disrespect for older people. Children nowadays

are tyrants. They no longer rise when their elders enter the room. They contradict their parents, chatter before company, gobble their food, and tyrannize their teachers." These are the words of Socrates, written in the fifth century B.C. In the thousands of years that have passed since Socrates, we are not only still grappling with how to control youth's defiance of convention, but also with serious infractions of law that are represented by offenses of violence, stealing, fire setting, vandalism, dangerous drug use, rape, and other crimes.

Delinquency among children who belong to asocial gangs is common in economically depressed areas. Here a cultural-transmission theory has been posited by such authorities as Tannenbaum (1938) and Topping (1943). Other authorities insist that the quality of family life is what is of greater etiological significance. Susceptible children are those from families in which there is no cohesiveness, no clear-cut authoritative model with which to identify, and little or no constructive supervision and discipline (Glueck and Glueck, 1950). Delinquent groups are powered by forces in opposition to the social world. (Cohen, AK, 1955). Collective solutions are evolved that, though antisocial, gain mutual support and identification. Work with delinquents, therefore, must take into account both the disruptive family organization and the deprived environment from which they come. Therapeutic directions are milieu oriented. These focus on a broad community approach, enlisting the aid of religious leaders, social agencies, and police groups. Economic help, counseling, and casework for the delinquents' families and rehabilitative group work with the delinquents themselves are given within the strictures of the available personnel and budgetary restraints of the involved community. Individual psychotherapy generally fails unless comprehensive environmental approaches are employed. A peer group can be the treatment of choice. Nevertheless, the need for individual therapy with a therapist who can act as a role model should not be minimized. Therapists directing adolescent groups require training and experience in working with adolescents.

Delinquency does not confine itself to children from deprived and lower socioeconomic families. It affects upper- and middle-class groups as well. A. M. Johnson and S. A. Szurek (1952) have shown that the inability of parents to set limits due to poorly integrated impulses and "superego lacunae" (Johnson, AM, 1949), and the goading of children to act out unconscious perverse and hostile parental strivings that were unresolved in the parents' own relationships with parental figures, produced delinquent behavior. "It is possible, in every case adequately studied, to trace the specific conscience defect in the child to a mirror image of similar type and emotional charge in the parent" (Johnson AM, 1959). A specific superego defect may thus be created in the children that reflects the parental flaw. Szurek (1942) insists that many cases of psychopathic personality are products of unconsciously determined promptings from both mothers and fathers that encourage amoral and antisocial behavior. The child "victims" chosen are the recipients of subtle insinuations and suggestions that may often, even though the parents are not aware of their presence or implications, be detected by a good clinician during an interview. Indeed, psychotherapy with delinquents may have to be focused on the parents rather than the children since they will tend to undermine the children's treatment should the children stop responding to their messages.

Modifications of technique are obviously very much in order in working with a family neurosis, and this was years ago pointed out by Aichhorn (1936). Aichhorn's methods, employed during the residential treatment of delinquent adolescents, inspired the founding of special residential units organized around providing emotionally corrective experiences (Brady S, 1963; Redl, 1959). Bettelheim (1950), E. Glover (1956), Noshpitz (1957), Szurek (1949), and Szurek, Johnson, and Falstein (1942), among others, have introduced methods that have proven of value in dealing with the problems of delinquent children and their families.

The treatment of delinquency is eminently unsuccessful, however, no matter what strategies are utilized. This is in large part due to the effect on the people handling the children. The children's expectation of rejection and punishment promote rampancy and rowdyism, to which the human targets of

this turbulence respond with retreat, outrage, and often brutality. The self-fulfilling prophecy of the children that they will be hurt creates a feeling of hopelessness and distrust. They move from one situation to another with the same result. Ultimately, the children may be placed in a *residential treatment unit* organized around the philosophy of a structured therapeutic community (Alt, 1960; Balbernie, 1966, Noshpitz, 1975). Various orientations exist among different centers. Thus, a center may operate as a school, casework agency, or hospital with appropriate personnel such as teachers, caseworkers, nurses, and physicians. Psychotherapy of a group and behavioral nature is usually available in such units depending on the philosophies and skills of the therapists.

Residential centers have increased in numbers, but unfortunately not in quality. An exception is the unit in England known as Finchen Manor described by Langdell (1967), which was organized for selected multiproblem families. An effective unit requires a special design. (*Roche Report*, 1966). Most present-day units are not well organized or operated effectively for ideal management of delinquent children. Moreover, residency is too short term, less than the minimum of two years usually required for any change to register. In addition, there is a lack of coordinated services (provision for educational and vocational opportunities, outlets for aggression, need for privacy, and an absence of well-trained staff and other personnel who are both caring and capable of maintaining adequate control. Too often the aggression of the children leads to remedies of isolation, punishment, and drug treatment, which, while temporarily effective, do not alter the existing difficulty. A pertinent problem in some settings is the insistence in retaining the medical model in the institution, which is an inappropriate one for children (Linton, 1973). Here the responsible psychiatrists, clinical psychologists, and psychiatric caseworkers are not in as intimate contact with the children as would be childcare workers, teachers, and other people who can be intimately related to the children's daily life and behavior. A reeducational model that involves total milieu planning is more appropriate than a medical model. It has been recommended that a different type of professional is needed for residential units, one who has received comprehensive training designed

for the tasks that he or she will pursue. In France, Denmark, and the Netherlands, for example, a new discipline is evolving concerned with mediating child problems ("education orthopedagogue").

A great deal of the failure in treatment is also due to the paucity of aftercare services once the children leave the residential unit. Little continuity usually exists between the residential center and the environment to which the children are returned, which continues to impose on them the original traumas and deprivations. *Intensive home therapy* by medical and non-medical personnel has been employed with some success (Dornberg et al., 1968). Therapist activities will vary from guidance and support to formal marital or family therapy depending on the needs of the family. The home therapists usually work under the supervision of the child therapists who are in charge of the program. Among the conditions for which home therapy is especially indicated are the presence of a psychotic parent at home, refusal of children or parents to accept office treatment, the dealing with double and multiple binds, adverse reactions of a mother to a baby or her pregnancy, and projective mechanisms in parents that activate the children's disturbed behavior.

A *day care center* constitutes a useful modality for some children, particularly those who manifest such problems as severe withdrawal, lack of object relationships, impulse control, and blocked language use (Westman, 1979). Reinforcements are provided for constructive conduct (North, 1967). Day-care treatment often avoids prolonged hospitalization, providing the children with a therapeutic environment for many hours a week while remaining a part of their families. A disadvantage is the low therapist-to-child ratio, which is ideally one to one. One way of meeting this dilemma is to train ancillary workers, some of whom can be recruited as part of a corps of volunteers.

Learning and Reading Developmental Disorders

A host of academic skill disorders exist under the umbrella of specific developmental disorders that have distinctive DSM-III-R Codes. These include *developmental arithmetic disorders (315.10),*

developmental expressive writing disorders (315.80), developmental reading disorder (315.00), developmental expressive language disorder (315.31), developmental receptive language disorder (315.31), and developmental articulation disorder (315.39).

Learning and reading disabilities are the commonest single immediate causes for the referral of children to guidance clinics (Rabinovitch, 1959, Silver, 1975). In prescribing appropriate treatment, psychological tests are in order to ascertain the general intelligence and to assess the potential, achievement level, developmental readiness, and degree of emotional disturbance; neurological examinations are recommended to rule out brain injury and aphasic disorders. Generally there is a close relationship between learning disabilities and emotional disturbance, but the presence of emotional illness itself does not presuppose that there will be failure in school work. A psychological inability to learn or to read is often a symptom that serves a specific purpose, such as to punish the parents, to defy authority, to refuse to grow up, to avoid competition, or to punish oneself. Anxiety that emerges from the children's school failures adds to their inability to attend and to concentrate on work. Even when the problem is organically determined, as when there is damage to the associational patterns controlling visual-motor functioning, such anxiety may act as a prime disorganizing factor. The treatment of learning and reading difficulties will depend upon their cause. Problems rooted in organic brain disorders will require retraining, using visual, auditory, and kinesthetic approaches (Kephart, 1955; Strauss, AA and Lehtinen, 1947; Strauss, AA and Vernon, 1957). Disabilities provoked by emotional factors will call for psychotherapy, aided, if necessary, by special tutoring and remedial reading.

School Phobias (Separation-Anxiety Disorder, DSM-III-R Code 309.21)

A school phobia is really a family problem and usually involves an immature, indulgent, or highly controlling mother who has been unwilling to separate herself from the child. A pre-phobic conditioning occurs prior to the school years. Children who have been reared with the idea that the world is an unsafe place, and that a mother is necessary to protect them and make things safe, are particularly vulnerable

when thrust into the strange environment of a school. Often the mothers are unaware of their own dependent needs and of their ambivalence toward their own mothers, which they are projecting onto the children.

Once realistic causes for fear have been ruled out, such as stressful situations within the school itself, juvenile terrorists who threaten or attack the child, a disturbed teacher, identifiable handicaps such as reading disabilities and other cognitive dysfunctions, or childhood depression, treatment may be started. The first step is to insist that the parents be firm with the children to the effect that school must be attended. Sometimes the children will have developed a host of somatic complaints (headaches, "stomach trouble," intestinal cramps) to reinforce the stay-at-home position. After a physical examination has revealed no organic problem, the parents will have to handle their fear that they will damage their children by insisting on school attendance. They must be persuaded of the fact that the longer the children stay away from class the more difficult it will be for the children to return. The school personnel may have to be brought into treatment planning to bolster the parents' resolve that the children must go to school even if the children complain and act ill in class.

Some family therapy with the parents is usually necessary to apprise them of their own involvement in the situation (in terms of their personal history and problems) and to give them support in the handling of the children's recalcitrance. The parents have to bring the children to school at first, and therapists should be available on the telephone to render assistance to these flagging parents who are wilting under the children's intransigence. Occasionally, behavioral desensitization is helpful as an adjunct (Eysenck, 1960a).

If the children's fear is associated with children who terrorize or threaten, this will have to be handled with the school authorities. Should the problem be the children's classroom teachers who are disturbed, the children may do better in another class. Coordinately, psychotherapy may be needed for the children, as well as the parents, and sometimes they may all be seen together. If the children have a serious

emotional problem, such as depression, intensive therapy may be required and perhaps some antidepressant medications. The parents may have to continue in long-term therapy after the children's symptoms have come under control to work through their own dependency problems.

Psychotic Children

Apart from *autistic* disorder (DSM-III-R Code 299.00) no generally recognized subtypes are classified in the existent group of "pervasive developmental disorders". In the past they have been loosely lumped in the categories of Atypical Development, Symbiotic Psychosis, Childhood Schizophrenia, and Childhood Psychosis.

The treatment of psychotic children is organized around a design that takes into consideration "the severity of the psychological impairment, the creation of a therapeutic relationship, the formulation of realistic expectations, and the maintenance of therapeutic agility" (Shafii, 1979). Psychoanalytic approaches are of greater use in exploring the dynamics than in contributing to practical management. This will necessitate flexible combinations of pharmacology, behavioral techniques, family therapy, and milieu therapy. Drug treatment has many drawbacks but in active psychotic states it may be essential. What has to be kept in mind is that children require relatively higher doses of psychoactive medication in relation to their weight than do adults and adolescents, that low dosage exposes children to risk with little chance of benefit, and that medications may result in unforeseeable long-term complications. When deemed necessary, neuroleptics such as chlorpromazine (Thorazine) and haloperidol (Haldol) may be employed with overactive children. Haldol is especially valuable in children with tics and Tourette's disease. Operant conditioning techniques may be indispensable in psychotic children, and especially with autistic children, in whom they may establish some measure of social conformity and reality-based behavior.

Residential treatment of children and adolescents is sometimes essential in youngsters who are out of control and who constitute a danger to themselves or others (Wolberg, LR, 1959). Psychotic children particularly will need hospitalization (Gralnick, 1966) as may severe cases of anaclitic depression (Spitz, RA, 1946), certain delinquencies (Aichhorn, 1936), and severe psychosomatic and organic conditions (Rapaport, HG, 1957).

Childhood schizophrenia (Bender, 1947; Despert, 1948), early infantile autism (Kanner, 1959), and the "symbiotic psychosis syndrome" (Mahler, 1952) are characterized by profound disturbances of behavior on every level of functioning—physiological, psychological, and interpersonal. Withdrawal tendencies and problems in communication make treatment extremely difficult. Therapy aims at establishing a better integrity of body image, a sense of entity and identity, a consolidation of object relationships, and a restoration of defective developmental ego functions (Mahler et al., 1959). Therapists provide for the patients auxiliary egos and encourage a living through of those developmental phases that were thwarted in the patients' actual growth experience. An interesting account of such a working-through with a schizophrenic in an intensive relationship is described by Sechehaye (1956). Due to the primary process nature of the children's behavior and communication, it may be difficult to comprehend the meaning of their verbalizations and actions. Here therapists may have to serve an educational function.

Emergencies

Sometimes emergencies arise in children that the psychotherapist may be called on to resolve. Usually they are the climax of a long preceding period of maladjustment to which the parents may have been oblivious or indifferent. They are differentiated from the normal developmental crises that call for minimal interventions since they may be the means to conflict resolution. Acute disturbances in adolescents may occur as a result of identity crises. Here a quiet youngster may suddenly become aggressive and destructive. Often we find this among adolescents who have been forced to be "good." As they enter into the turmoil of adolescence they break through their passivity by outbursts of

aggressiveness. On the other hand, aggressive and violent behavior, as toward people, may be the result of a psychosis, which will call for entirely different management. To put a youngster with an identity crisis into a psychiatric institution as a result of the crisis will only contribute to the identity confusion.

True emergencies will call for accurate assessment of underlying causes. A detailed history of the children's development and interviews with the parents and perhaps teachers and other significant adults is in order. The therapeutic plan will then be discussed with these people. The plan may follow a crisis interventional model.

One of the most common emergencies is *running away* from home (Jenkins RL, 1973). It is estimated that there are 600,000 to 1 million runaway children yearly in the United States. Often the elopement is to communes of peers who encourage drug and promiscuous sexual indulgence. Some runaways are normal children escaping from a situation of intolerable stress or complete rejection. Some seek constructively to effectuate separation-individuation, which is impossible in a home that continues to infantilize them.

The effect of this gesture may be disturbing to the families, but it calls for an examination of their role in blocking the children's personality growth. Since over 90 percent of cult members leave the group within two years, patience, understanding, and resumption of communication with the children are essential.

Some schizophrenic children resort to disorganized runaway tendencies and may be accepted in a group that seeks to protect them, though they in fact offer little. Commonly, running away is a delinquent response, all the more dangerous since the children may be attracted to delinquent gangs that wreak havoc in the community. Diagnosis is important since *why* the children run away will determine the kind of treatment that must be instituted. In all runaway problems, work with the families as well as the children is mandatory.

Another emergency is a *suicidal attempt*, which most frequently occurs in teenagers between 15 to 19 years of age. These are often impulsive in nature, precipitated by disproportionately minor provocative incidents that, for the youths, are interpreted as of major importance. What is behind the attempt (conflict over sexual impulses, self-punishment for forbidden impulses or thoughts, projected aggression against a parent or sibling, frustrated dependency, persecutory delusions, toxic drug reaction, hopelessness, depression) will require persistent probing. Whether or not hospitalization will be needed must be assessed. At any rate, environmental rearrangements may be required along with therapy for the children and at least counseling for the parents.

The easy accessibility of *drugs* during period of school attendance or during leisure hours has, particularly in adolescents, produced emergencies brought on both by the discovery of the indulgence by parents and by an overdose of the intoxicating substance. Although casual temporary experimentation with such drugs as marijuana may not be too significant, substances such as amphetamines, barbiturates, codeine, and heroin can lead to serious emergencies and addiction. The use of mind-expanding drugs, such as LSD, substances in glue (glue sniffing), and gasoline is also fraught with dangerous consequences. Usually, combinations of drugs have been taken, and their exact identification is difficult when the children are admitted to a detoxification center, since they themselves usually will not know what they have imbibed. Behind the taking of such destructive drugs may be efforts to escape from depression, boredom, stresses of separation-individuation, and impulses of aggression. Often the only signs that these youngsters exhibit are anxiety, excitement, and overactivity. The temptation for clinicians is immediately to use sedatives. Without knowing whether or not drugs have been taken, and their nature, it is dangerous to contribute to the drug toxicity by adding other substances to an already overloaded nervous system. In recent years there has been a shift from hallucinogenic and tranquilizing drugs to alcohol, and it may be anticipated that cases of acute alcoholic toxicity will be increasing among adolescents. After successful detoxification, a psychotherapeutic program, often prolonged, will be required.

In *car crash cases* where one youngster is killed and another survives with minor injuries, it is often helpful in the emergency room for the doctor or nurse to communicate to the survivor that it is common in such cases to feel guilty and, if this happens, to recognize that it will eventually be gotten over. Allowing the youth to verbalize feelings while listening sympathetically may be important. Sedatives should not be offered since refuge may henceforth be found in drugs. The parents should also be informed regarding the turmoil the child is likely to experience and to anticipate it.

In the event of *death of a parent* the surviving parent should be encouraged to talk about the departed member openly with the children and not to cover the matter up by denying the validity of the pain that the children are bound to suffer. A great area of prevention can be instituted in the emergency room when an adult with a coronary attack is brought dead on arrival. The surviving parent may have no opportunity to see any other professional people than the personnel in the emergency room, who should try to explain how best to guide the children through their grief. A few minutes spent with the parent explaining the need not to cover matters over with a pall of silence may prevent a great deal of misery, particularly among adolescents.

Other emergencies include school phobias, anorexia nervosa, parental beating of the child (the battered child), sexual and other violent assaults, and deaths in the family. These will call for special handling and perhaps extended treatment (Morrison, 1975).

In the U.S., where the divorce rate is almost 50 percent and father absence (due to separation, abandonment, or divorce) is approaching a national epidemic, the breakup of the family may be considered another crisis in child development. Recent studies (Mallerstein and Kelly, 1982) indicate that the effects of divorce are persistent and pervasive for children as well as their parents, with stress, anxiety, and depression lasting as long as five years after the event. Particularly vulnerable are children under six years of age, when the presence of the father during the Oedipal phase plays a critical role in healthy development. Both mothers and children need special support to weather this crisis. The stress provoked

by separation and divorce may need to be dealt with through special counseling, crisis intervention, divorce mediation, and psychotherapy.

PSYCHOTHERAPY IN OLD AGE

As people mature they are confronted with ravages of aging that make a mockery of the advertised joys of the golden years. Eyes, ears, teeth, joints, heart, and other organs gradually deteriorate and physical energies slowly give way. These burdens are increased by the death of loved ones, as well as the detachment of children who insist on leading overly independent lives. Loss of the great ego supports of job and professional position, along with disillusionment with the false promises of retirement, add to the strains of loneliness and devalued self-esteem. The elderly are subject to multiple personal losses due to their longevity (Goodstein, 1985). As medical advances add years to peoples' lives, diseases of aging (arthritis, cardiac ailments, kidney disease, arteriosclerosis, cataracts, cancer) and associated infirmities complicate the existence of the elderly person. But even more devastating are the ravages of fear and insecurity. Little wonder, then, that depression and growing old are so often inseparable.

Women experience such consequences of aging somewhat later than men do. They must, however, endure the disabling illnesses of their aging mates, whose enhanced dependency needs and importunate demands for attention may make them difficult to manage. For the spouse of a depressed, phobic, hypochondriacal, paranoidal, or mentally deteriorating partner, individual or group psychotherapy may be vital to the couple's welfare.

The loss of a mate through death or divorce during the elderly years is especially traumatic, and bereavement reactions not too uncommonly terminate in suicide. Therapeutic help is often focused on crisis intervention followed by continuing psychotherapy of a combined counseling and supportive nature. The ideal philosophy on which bereavement therapy should be based is that although, in the words of

Nemiah (1984), humans do "have a built-in-clock, and are programmed to a destiny to which we all must yield," a happy and fulfilling existence can still be enjoyed in the years remaining.

The assumption that the elderly cannot benefit by psychotherapy, that their dulled cognition and blunted memory are permanently gone, has been proven false (Cath, 1982). Therapy will require an empathic immersion by therapists into the relationship and the ability to deal with countertransference that often involves the therapists' own terror of growing old. There is resistance also on the part of therapists to being viewed as objects of idealized identification.

The employment of environmental support systems is vital as an adjunct to psychiatry. Unfortunately, our culture fails to provide adequate roles for the many old people who retire or who, because of their age, are pushed aside by younger and more energetic citizens. In making efforts at facilitating adjustment, counseling and casework methods may help resolve problems of housing, finances, health, occupation, socialization, and recreation. Proper information and guidance may be all that an older person requires to continue to maintain self-respect and to shore up feelings of self-sufficiency. In many cases more will be needed. Community health centers for the aged are increasingly being demanded that consider the common problems of medical care, housing, transportation, finances, nutrition, job training, recreation, and hospitalization. Preparation for retirement is urgent, and some enlightened industrial groups have taken responsibility for development of educational and social-action programs to ready their executives and employees for termination of their jobs. The economic burden of medical care has for many been lightened by Medicare, but the rising costs of delivery of health-care services are creating many budgetary problems. The economic, legislative, and administrative bodies of government are accordingly constantly being reminded of the growing problems of dealing with the aged.

A shift in living arrangements alone may eliminate a host of difficulties. Any changes must obviously take into account both the person's desire to live in familiar surroundings and the practical needs of one's

situation. Dwelling units especially designed for the elderly have become increasingly popular, and retirement villages containing medical, recreational, and rehabilitative services are available.

Many aged people are needlessly condemned to the wretchedness of nursing homes or the segregation of poorly run retirement communities. In some cases private-home placement may be a more suitable solution, supplemented with the facilities of community centers that have programs for the aged. On the other hand, if individuals are unable to care for themselves, a hospital or old-age nursing or convalescent home may be what is required.

Finding suitable work for an active older person may restore vitality, interest, and self-esteem. It is totally unrealistic to assume that leisure alone can bring contentment to those who have been occupied productively all of their lives. Nor is it sensible for the community to turn people out to pasture who have acquired skills and knowledge that cannot easily be duplicated.

The problems of retirement make preretirement counseling an important preventive measure. New adaptations will be required. Spouses should be prepared for irritation at being with each other full time. Role playing is helpful in preparing the retirees for what is inevitable—time on their hands, a feeling that they are out of the mainstream of life and "has beens." A search for new meanings to existence will be needed.

Education in an aging society is an important aspect of a comprehensive program. Properly implemented, it supplies information to the older person regarding the physical changes in the body and new emotional requirements that take place with ongoing years. It clarifies confusion about sexuality. It furnishes guidelines for continued creativity and vocational usefulness. It encourages enjoyment of positive assets and minimization of liabilities. Programs of adult education to prepare individuals for aging and to help develop new leisure-time interests must include instruction for people working with older people about various phases of geriatrics. The booklet, *Planning for the Later Years*, issued by the

U.S. Department of Health, Education and Welfare (Washington, D.C., U.S. Government Printing Office) contains some excellent suggestions for health maintenance, nutrition, emotional adjustment, housing and living arrangements, retirement income, work, and legal problems. It may be profitably read by the aging person. Other reading materials for the aged or their relatives are given elsewhere in this volume (see the section on old age in the Addenda, Selected Texts). For professional persons the writings of Weinberg (1975), Butler and Lewis (1973), Rossman (1971), and Simon and Epstein (1968) and the publications *Medical World News*, *Geriatrics* (1973) and *Psychiatric Annals*, (vol. 2, no. 10 and 11, 1972) are recommended.

Among the most useful measures are the development of appropriate recreational facilities in churches, schools, community centers, and the various old-age institutions that encourage hobbies, handicrafts, dancing, lectures, and discussions. Social participation increases morale and counteracts withdrawal and deterioration.

The above measures designed to meet the diversified needs of older people may avert or delay the development of untoward senile reactions. The most common of these are confusional syndromes that come on suddenly, particularly when individuals are moved to unfamiliar surroundings or subjected to situations to which they cannot adjust. Old people have a tendency to prowl around at night and during the day to wander away from home. Providing them with activities to occupy their minds tends to keep them more focused on reality.

Perhaps the most difficult problem in providing a solution to the elderly in family settings is the inability of children to accept the inevitable change in role that will be demanded of them as their parents become more helpless and dependent. The psychotherapists consulted by the families will usually have to involve the entire families in the treatment plan, helping children to face the physical and emotional changes in their parents, and educating them about the need for becoming substitute parents for their own parents in response to the latter's developing dependency needs. What the aged person often requires is "a

surrogate-protector in much the same way that he approached a parent as a child.…It is possible for the therapist to use this delegated authority to foster and maintain an illusion that the patient has found a protector and one who will satisfy many psychological needs" (Goldfarb Al, 1964).

Mental disorders in elderly people are characterized by a superimposition of psychological reactions (usually depression and paranoidal projections) on an organic substrate. Assessment of the degree of organic involvement is essential in outlining an appropriate program of therapy. This will require clinical observation, laboratory tests, and an electroencephalogram. Once the degree of affective and organic components implicated is estimated, a comprehensive treatment plan includes physical care, rehabilitation, drugs, and psychotherapy. With good supervision the vast majority of unstable older people may be treated outside of a hospital. Geriatric day treatment is both therapeutic and cost effective (Roche Report—March 15, 1982). Transfer to a mental institution causes great anxiety and agitation and may shorten life. If home conditions are unsuitable or upsetting, institutionalization may be inevitable, and, if proper facilities can be found, the last years of life may be made tolerable if not enjoyable.

Depression is the most common symptom in the elderly. Frequently it is misdiagnosed as dementia, memory loss, or other presumed organic conditions, which disappear when the depression clears up. Depression in the elderly is accompanied by frequent somatic concerns, memory or cognitive defects, and occasionally, paranoidal ideas that may expand into delusions. The treatment of depression in old age differs in some respects from that in younger years (Charatan, 1975). Modest treatment goals are pointed toward symptom relief employing a directive, supportive approach with frequent brief sessions rather then infrequent long ones.

If drugs are needed, it must be remembered that elderly people are extraordinarily sensitive to psychotropic medications, which may produce untoward and sometimes dangerous side effects even with lowered dosage. Pressure to prescribe medications is brought to bear by relatives because of disturbing symptoms such as confusion, somatic complaints, insomnia, nocturnal wandering, behavior disturbance,

and especially, depression. Adverse side effects are common especially when cardiovascular, kidney, and other ailments exist, and when various drugs employed to control these ailments interact with the psychotropic substances. Yet psychotropics properly employed can be useful. For example, depression may be the basis of an elderly person's confusion, impaired memory, and personality change. A misdiagnosis of organic brain disease fosters hopelessness and "giving up" by the patient. Here antidepressants may be valuable, with selection of those drugs that produce a minimum of sedation and cardiotoxic and anticholinergic effects, such as trazodone (Desyrel) nortriptyline (Pamelor), desipramine (Norpramin), and monoamine oxidase inhibitors (e.g., Nardil). Neuroleptics like thioridazine (Mellaril) or chlorpromazine (Thorazine) should be used with awareness of their anticholinergic side effects. If sedation must be avoided, haloperidol (Haldol) or fluphenazine (Prolixin) may be selected. The anticholinergic effects of antidepressants and antipsychotics (constipation, blurred vision, dry mouth, difficulty urinating) may be very annoying and can be minimized by choosing the least anticholinergic agents available. A good antianxiety drug is alprazolam (Xanax), which has a half-life of eight hours; it may also be used as a hypnotic and mild antidepressant. Oxazepam (Serax) and Lorazepam (Ativan) are preferred to diazepam (Valium). Other good hypnotics for elderly insomniacs are temazepam (Restoril) with a half-life of about nine hours and triazolam (Halcion), whose half-life is very short (3 to 4 hours). Temazepam has been shown to mix Well with other drugs used by the elderly. Since low blood pressure and ataxia, which lead to falls and disabling injuries and fractures, are often caused by psychotropic drugs, patients must be warned to take special precautions in footwear and walking. Absorption of drugs is delayed when taken with food. Medications should, therefore, be given on an empty stomach at least 30 to 60 minutes before retiring. In treating depression in the elderly, it should be kept in mind that depression can be produced or exaggerated by medications taken for cardiovascular disease, such as reserpine (Serpasil), methyldopa (Aldomet), and beta blockers, e.g., propranolol (Inderal). Substitutes for such medications may have to be found. Severe depressions may require electroconvulsive therapy (ECT) after

a thorough physical examination, blood count, urinalysis, electrocardiogram, and x-ray of the chest and spine show no contravening abnormalities. A total of 8 to 10 biweekly treatments is best.

Insomnia may require chloral hydrate (Noctec), Dalmane, Restoril, or Halcion. Barbiturates should be given sparingly, if at all, and central analeptics should never be given in confusional states. There are many other substances in use whose virtues are mixed (Hollister, 1975). These include the cerebral dilators Pavabid, Cyclospasmol, Vasodilan, and Riniacol, the ergot alkaloids (Hydergine), and procaine (Gerovital), although the latter can produce a mild antidepressant effect. Small doses of stimulants such as Ritalin sometimes help fatigue and mild depression. Vitamin supplements are often used, but a balanced diet should eliminate the need for heavy vitamin intake.

The conditions requiring psychotherapy in geriatric patients include all of those in younger groups as well as syndromes arising with the deteriorative, metabolic and systemic disturbances of old age. Relationship and interpretative therapies are employed in combination as needed (Goldfarb Al, 1955, 1959; Meerloo, 1955). The question arises as to whether reconstructive changes in the elderly can be achieved through alteration of the basic character structure and development of new potentialities. Or must therapists be content with a holding operation, with symptom relief and better adaptation in areas of living in which the patients are failing, with at best a reorganization of attitudes and value? Elderly people with a basically good ego structure and in whom organic brain damage is minimal may, if sufficiently motivated, be brought to some reconstructive change (Yesarage and Karasu, 1982). Generally, however, significant alterations in character structure are not to be anticipated. Psychotherapy serves to alleviate the anxieties of aging individuals, providing a means for emotional catharsis, reassuring them about their physical condition, helping them deal with depression, grief, and the death of family members and friends, assuaging frustrated sexual feelings, correcting misinformation, managing problems of retirement and difficulties in living alone, mollifying paranoidal projections, and convincing them that their basic needs will be met because somebody cares. Chronically ill patients who live in fear of death appreciate friends

and counselors. In psychotic states, psychotherapy may be coordinated with drug therapy even in those with brain damage (Hader, 1964). Short sessions (10 to 15 minutes weekly or bimonthly) may be all that is required. This usually suffices to support dependency needs and to give patients a feeling of being protected.

Group therapy and group discussions are ideally suited to the needs of elderly people, fostering group belongingness, reducing the sense of isolation, and enabling people to deal with feelings of separation and fears of loss and death (Cooper, 1984). The goals in group methods are to support existing personality strengths, inculcate knowledge of human behavior, expand tolerance and flexibility toward individual differences, accept a changing role in life, deal with personal prejudices, facilitate group cooperation, and promote better interpersonal relationships (Burnside, 1970; Goldfarb Al and Wolk, 1966; Klein WH et al., 1966).

One of the problems, however, is getting older people to break through their isolation and join a group. Often individuals will come to an outpatient clinic in search of help for somatic complaints and will resent being referred to a psychiatrist. A well-explained referral, however, will often be accepted, such as that physical problems and suffering always give rise to tensions that make it difficult or impossible for a physical problem to heal and that group therapy often will help resolve tensions and aid the healing process. Most patients experience great relief as a result of group therapy. This may ameliorate somatic complaints as well as mollify problems of living. Through group interactions the virtues of continuing work, sexual, and exercise activities are discussed and encouraged and social isolation is reduced. Many "organ deficits" vanish when personal life interests and social activities are restored (Levenson, 1982).