

RESIDENTIAL TREATMENT OF CHILDREN
THE UTILIZATION OF TRANSFERENCE BEHAVIOR

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THE UTILIZATION OF TRANSFERENCE BEHAVIOR

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A unique therapeutic condition of residential psychiatric treatment of emotionally disturbed children lies in the transference potential which the institution provides. The child who is separated from his family and from the original partners in conflict re-experiences and re-enacts these conflicts within the institution. As the conflicts emerge in the new setting, the child tends to seek transference figures within the institution with whom to re-enact the old conflicts. He relives the past with this new cast of characters—the staff of the residential treatment center.

Intensive study of certain cases within our hospital demonstrates that the recorded events of the daily life of a child in residential treatment can be constructed as a narrative; reading such data carefully, with meticulous attention to detail, reveals the history of the disorder, the major conflictual figures in the illness, and the specific meanings of the child's pathological behavior and defense.

In these respects, the transference behavior of the child toward institutional figures as well as to the psychotherapist provides a diagnostic key to the nature and origins of the emotional disorder as well as the therapeutic instrument for effecting change in the personality through insight and corrective emotional experience. In order to

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utilize the full therapeutic potential of the milieu, the psychotherapist, the child careworkers, and other specialists who constitute the child's treatment team must collaborate closely in the exchange of daily clinical observations and in the development of mutually reinforcing therapeutic methods. This is not to say that the child care worker or the teacher should act as psychotherapists. The responsibility for the conduct of the child's psychotherapy remains in the hands of his individual therapist, but in all those ways in which child care and educational personnel support and reinforce the therapeutic aims for each child, they are regarded as collaborators and members of the clinical team.

In this paper we shall present a case illustration which describes one model of our clinical team approach and some of the typical problems which arise in the effective utilization of this approach.

BACKGROUND

A number of writers have commented on the relationship between psychotherapy and milieu management in a residential treatment center. The literature reports considerable diversity of opinion on the subject, which is in itself a healthy and fertile condition in a field that is still new and must engage in experimentation.

Noshpitz (1962) has reviewed the history of the early residential centers when psychotherapy was secret, special, different, and apart from the milieu. The residence held onto the youngsters while they were in therapy in such a way as to promote the course of therapy. Benign, uninformed common-sense handling by staff was all that was asked. Robinson (1947) recommended that the problems of psychotherapy be removed somewhat from the practical realities, involvements, and consequences of the child's daily behavior. He also commented on the dilution of psychotherapeutic effectiveness if the child invested his main interests and drive in vicarious achievement, such as school or outside group activities. He noted similar effects if the management of problem behavior in the daily living experience became the main focus of attention.

On the other hand, Redl and Wineman (1957) emphasized the problems of utilizing psychiatric interview techniques with "children who hate." They felt that a certain minimum of ego functioning

was a prerequisite, as well as the readiness of the child to relate at all. They observed that the volume of restlessness, aggression, and excitement forced the therapist into acts of interference. Thus, the therapist either became personally entangled in the child's pathology and his war with the world around him, or was put safely where he could do no harm, into the role of the "friend without influence." Redl and Wineman described a new design for treatment for these children who were so skilled at producing a never-ending chain of symbolic substitute figures in life situations. In addition, they felt that in an open treatment setting, when treatment began to take hold, the spillover into the life space of the child was so great that no ordinary psychotherapeutic arrangements could be expected to cope with it.

Bettelheim and Sylvester (1948) also utilized a fusion of psychotherapy and milieu management in one process. They spoke of a continuously maintained one-to-one relationship within a therapeutic milieu. Their milieu psychotherapy transposed features of individual psychotherapy (recapitulating the illness within the benign setting of the psychotherapeutic relationship) to a general milieu function. They felt that insight could thus be translated into uninterrupted action over twenty-four hours a day.

The issues involved in handling multiple transference reaction in severely disturbed children were discussed with clarity by August Aichhorn (1925). He said that the worker must act toward the child in such a way as to prevent a repetition with the worker of the situation with the parents which led to the conflict. In psychoanalysis, on the other hand, he noted that it was of greatest importance to let this situation repeat itself. (However, Aichhorn was referring to the neurotic child with dissocial features only. For the delinquent acting-out child he suggested taking the child's side in order to establish a "positive transference.") Lourie and Schulman (1952) stated that the disturbed child sees every adult in some distorted fashion derived from attitudes toward his parents, and that this is not only inevitable but desirable in the residence. They felt that the child could not be successfully treated if he were insulated from the disturbing aspects of his interpersonal relations.

More recently, Alt (1960) has discussed the therapeutic problems involved in children's "transfer to the institution itself," pro-

jected onto many different figures within it. He recommended that these elements of relationships with other adults be brought into the interview situation rather than concentrated on those with the therapist alone. Thus, he felt that environmental treatment and psychotherapy must be unified in a total treatment approach.

Anna Freud (1946), envisioning what would happen with children treated in a residential setting, stated that the children would group their "abnormal reactions around new personages," thereby experiencing transference in relation to the residential treatment staff.

We cite these remarks to bring our own discussion of transference into focus and to help us study transference behavior in residential treatment. One might consider the first condition which facilitates transference repetition in the residential treatment center to be separation from the original objects. The second, then, would derive from the individual therapy when such a therapy follows analytic lines of investigation and makes use of transference repetitions in the psychotherapist-patient relationship *as well as* the transference to other figures within the institution. By examining the transference manifestations with the child patient, the therapist makes it possible for the conflictual areas of the child's past to emerge, and both active and repressed conflicts which were formerly locked in characterological problems or mutually reinforcing pathology of child and parents, to dissolve into components that can be analyzed.

This is not to say that every piece of a child's everyday life in the institution must be labeled transference. We are only addressing ourselves to certain forms of repetition which are clinically demonstrable as transference, that is, tested by psychoanalytic criteria in the course of individual psychotherapy. While Freud addressed himself mainly to the psychotherapeutic transference (the revival of the repressed past in the analytic situation), he explicitly regarded transference as a manifestation of repression and the repetition compulsion, in which case, as he indicates in the passages that follow, the tendency to transfer is not confined to the psychotherapeutic situation alone.

Freud (1914) says: "we may say that the patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats*

it, without, of course, knowing that he is repeating it. . . . We soon perceive that the transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past not only on to the doctor but also on to all the other aspects of the current situation. . . . We may now ask what it is that he in fact repeats or acts out. The answer is that he repeats everything that has already made its way from the sources of the repressed into his manifest personality—his inhibitions and unserviceable attitudes and pathological character-traits. He also repeats all his symptoms in the course of the treatment" (p. 150f.).

In this report we present some material from the residential treatment of an eleven-year-old boy in which we see that the forgotten past is relived and re-experienced in the transference to the psychotherapist and to other figures in the institutional setting. It is part of a larger study of the factor of transference in residential treatment of children which was initiated in 1963 by the authors. We will not attempt in this short essay to take up some of the complex theoretical problems in transference which have emerged from the larger study. These will be the subject of a future publication. For purposes of this presentation we feel able to say that our use of the term "transference"—embracing the repetition of the past in the psychotherapist-patient relationship as well as repetitions with other therapeutic staff in the hospital—appears to us to be consistent with psychoanalytic usage.

CHILDREN'S PSYCHIATRIC HOSPITAL

As a background for the problems and methods described in the illustrative case material we shall briefly describe the institutional setting and its structure.

Children's Psychiatric Hospital is a training facility within the University of Michigan Medical Center. It operates an inpatient, outpatient, and day care facility serving the state of Michigan. The inpatient service is composed of three wards, each a separate unit housing sixteen to eighteen children, varying in age, sex, and pathology, who are hospitalized for an average of one and a half years. Each ward is under the direct supervision of a head nurse, two staff nurses, and four or five child care workers during the day. There is com-

parable staff coverage in the evening. A school and recreational program involving additional specialized staff is conducted within the hospital.

The child care workers, who have the largest amount of individual contact with the children, are for the most part college students in their early twenties who are unfortunately too transient in their stay, averaging one year at the hospital. (Only one out of seven is a career worker. They are high school graduates who average thirty-five years of age and have had about ten years of experience.) The child care staff begin with little or no formal experience dealing with children. Their inservice training consists of supervision from the psychiatric nurses and more experienced child care staff. In addition, they attend an ongoing orientation course in milieu management as well as regularly scheduled team meetings and case conferences on the ward. A large part of their understanding of individual psychopathology is acquired through their informal individual contacts with therapists who have patients on the ward.

Each child has a primary therapeutic team composed of his psychotherapist, a senior psychiatric staff supervisor who acts as a consultant, the social caseworker who works with the child's parents, a key child care person, a teacher, an occupational therapist, and a recreational therapist. While most of the psychotherapists are resident psychiatrists in their third or fourth year of training, senior staff members in psychiatry, psychology, and social work also function as psychotherapists. The therapist, who carries one to four inpatients, is the captain of the team, and formulates, organizes, and coordinates goals and approaches.

The core of the program has been built around individual psychotherapy which averages three sessions per week for each child. Casework treatment of the parents is typically on a once weekly basis conducted by the social worker. The children have regularly scheduled appointments with their therapists. The ward staff have considerable overall authority in the handling of the child's daily life as reflected in the setting up and management of certain requirements of social living on the ward, the child's home base. Overall administrative policy is decided by the psychiatric director of the inpatient service and the nursing supervisor and their respective assistants on each ward. Although the therapist supports the realities of daily liv-

ing as defined by the ward staff, he is also involved, as a member of the hospital staff, in modifications and redefinitions of policy and management problems in the total milieu on behalf of his patient.

The child is aware from the beginning of his treatment that his therapist and the rest of his staff need to communicate with each other in order to help him with his problems and help him get well. He is also aware that his therapist has considerable authority in making certain decisions on his behalf such as home visits, community privileges for shopping, movies, etc., and that the decisions are made on his therapist's estimate of his ability to cope with such experiences.

While this investment of authority in the psychotherapist must be taken into account in the transference relationship, it is our observation that it need not be an impediment to treatment—in fact, we can envision no better alternatives in light of the realities of hospital treatment of the child with severe ego disturbances. Since the psychotherapist must have ultimate responsibility for all aspects of case management and has the advantage of the most intimate knowledge of the child on which to base such decisions, a tactical evasion of this issue would serve no therapeutic purpose. Further, the absence of candor would in itself be more detrimental to the therapeutic relationship.

In order to maintain the integrity of psychotherapy and of milieu therapy, daily communication between therapist and ward staff is required. This is achieved through a variety of means: each therapist makes daily ward rounds, to read the detailed notes by ward staff maintained around the clock and to be available for informal consultation with ward staff. Scheduled team meetings or formal progress conferences for individual cases are held twice a week on each ward so that each child is formally presented in conference about every two months. In addition, there is a third ward conference each week which is an open discussion of policy and general clinical issues. Monthly meetings are held by the therapist with the evening staff, after the children are in bed. Informal, unscheduled team meetings are frequently set up by the therapists or any other member of the staff, as often as they are needed, especially during a difficult period in the child's hospitalization. Finally, the therapists meet weekly with their supervisors for consultation and/or supervision.

EXCERPTS FROM THE INPATIENT TREATMENT OF AN ELEVEN-YEAR-OLD
Boy

In order to illustrate some problems in communication between psychotherapists and milieu staff we have abstracted the treatment of eleven-year-old Tom, focusing on certain aspects of transference and the collaborative relationship between the therapist and the ward staff. Tom, in many respects, is a representative of the children with behavior problems admitted for inpatient treatment.

Tom was admitted to Children's Psychiatric Hospital following numerous school exclusions. Typically, he ran around the classroom in a giddy fashion, crawled on the floor making animal noises, clowned exhibitionistically in a driven, joyless way, thereby provoking his teacher until Tom was forcibly removed from the classroom. In spite of above average intelligence he was unable to work or to learn. At home he had goaded his parents relentlessly, leading to beatings from his father. Tom's impulsive, erratic behavior had exhausted his parents and the entire community. Frequently he disappeared for hours and wandered around the streets of the city.

Psychiatric and psychological evaluations had demonstrated serious defects in impulse control, shallow object relationships, tendencies toward withdrawal, isolation, and depression. It was noted that when Tom became flooded with anxiety, which occurred several times daily, there were periods of complete ego dissolution.

Almost as soon as Tom was admitted to the hospital he displayed the full repertory of his behavior. There was no "honeymoon period" to give us an opportunity to establish a relationship with him and to employ this relationship in influencing his behavior. He was immediately defiant and provocative and upon learning the few simple rules governing ward life, he took pains to break all of them. There appeared to be little or no discrimination in his antagonism toward all adults. Tom viewed none of his behavior as a "problem." When the therapist attempted to focus on the kind of difficulties which Tom was experiencing on the ward, he was indifferent or defensive, exhibiting no remorse and certainly no evidence of "the observing part of the ego" which we consider indispensable in psychotherapy. Like most of our patients, he was not reflective, he was not concerned with causes, and he had almost no vocabulary for putting feelings into words. When he experienced something, he translated

it into action. The private sessions with a doctor with whom he was invited to find *reasons* for his behavior must have been one of the most extraordinary experiences of his life.

This need to transfer, almost indiscriminately, without regard for the objective characteristics of the persons in this new environment was certainly one of the first indications of the extent of the ego disturbance in this child. There was a driven, urgent quality in his global acting out that we have seen in many of our borderline patients. It was as if an interior drama sought a theater and a cast of characters for interminable re-enactment.

During the first days the meaning of this behavior was a mystery. As long as we did not know its meaning, we were unable to handle it therapeutically and we could not effectively influence the behavior on the ward and in the classroom. Even our experienced ward staff found the antics of this child exhausting. The question was asked at a workshop at which this case was presented (we are paraphrasing the question now): "What sustained the staff during the period when Tom's behavior made no sense and when there were no measures to bring about effective control?" As we thought about it, it struck us that the sense of alliance with the therapist was probably one of the strongest supports for the child care staff during this period. The therapist and the staff of this ward had worked together as a team for some time. There had been successes in their collaborative work together and reasonable confidence that once the meaning of the behavior was revealed there would be more effective means of bringing about some measure of control.

Soon we began to see certain patterns in Tom's acting as they appeared in therapeutic sessions and on the ward. The relentless goading and challenging were accompanied by mounting excitement; clearly he wanted to induce anger in the adults and was longing for punishment. There was, of course, no direct physical punishment from the staff. However, when Tom was out of control he was taken, often bodily, to the seclusion room until he calmed down. When the adults failed to provide gratification for Tom's apparent wish for a beating, he turned to his peers. He needled and goaded the other boys into attacks upon him, and the longing to be beaten was finally gratified by several boys on the ward. All of this added its own weight to problems of management in a ward for severely dis-

turbed boys. We were also attentive to Tom's choice of partners in these invitations to attack. His partners were boys with strong homosexual conflicts.

As the provocative behavior became manifest in therapeutic sessions, the therapist began to draw Tom's attention to the patterns. He pointed out to Tom how he seemed to use every means to try to bring about anger and punishment both in treatment sessions and on the ward and added that there must be some reason for it. Meantime, too, ward staff began to show Tom how he provoked the other boys into attacks upon him and to reinforce the current work in therapy which was focused on isolating the behavior and helping the child to observe himself.

Gradually, in therapeutic sessions, Tom began to reveal in play his fear of attack and body injury and his longing for attack. In play acting Tom was in great danger of attack by men who were trying to capture him. There was much talk about doctors, about shots, about blood and death. And now for the first time, the therapist could begin to approach Tom on the basis of his fears. While listening sympathetically to Tom's fears of attack and injury, the therapist began to show Tom how his out-of-control behavior was connected with anxiety; when he became afraid and felt helpless, he lost control.

Within the next two weeks there were a number of occasions in which Tom himself began to see the connections between anxiety and acting out. On one occasion Tom created a disturbance in the classroom by clowning and running around the room, following which he was found hiding at the top of the hospital. He had climbed up and was hanging on to the screened grating atop the stairwell. When Tom talked with the therapist shortly afterward, he himself made the connection between fear of punishment and his flight to the highest part of the hospital. He was afraid that he would be put in the seclusion room, but guessed that the greatest fear might be of having nothing to do there—and as he spoke Tom's hand went automatically to his genitals.

In the therapeutic sessions that followed, the episode of the classroom crisis and the flight to the top of the building were examined with Tom in some detail. From this material certain vital links with the past became available. Tom mentioned battles with his father

over schoolwork. Tom's father had forced him to stay in his room until his schoolwork was done. As threats of expulsion from school for erratic behavior and academic failure were renewed each year, school had become the theater for conflict between father and son. It was already known that the father's rage had reduced him to acts of brutality against the child. Alone in his room, Tom told the therapist, he could not face the schoolwork and his fear of his father's rage would mount. There was one means of escape. By climbing out his window at home to the branches of a tree that overhung the roof, he could reach a low roof and jump down or shinny down the tree and take off. He would then lose himself in the city streets for hours or climb a nearby hill to hide and brood.

What was he afraid of if he stayed in the room? He didn't know and the therapist suggest a "spanking." (Spanking was a euphemism for the father's attacks upon Tom which were acknowledged by both parents to be beatings.) As the therapist uttered the word "spanking," Tom had a look of near panic on his face and began to move away from the therapist. He ran to the window, and began to jab at the window with a pencil in a frenzied fashion.

It was in this way that Tom's sadomasochistic relationship with his father came into the treatment. The fear of father's beatings and later the excitement in being beaten were gradually brought into the treatment and eventually provided access to the homosexual conflicts which proved to be central to this child's disturbance.

At this point, then, we obtained insight into one aspect of Tom's impulsive acting. Through careful observation and reporting on the part of ward staff we were able to follow the narrative of the critical events. By pursuing the elements in the classroom drama and the flight to the top of the building in therapy we discovered the repetitious features of this acting. The classroom disturbance led back to the conflicts with father over "doing the work." Then followed panic and fear of punishment in close correspondence with the pattern at home, and finally the flight to the top of the building in which he re-enacted the flight from father. We think that here for the first time when Tom made these links he began to understand that his apparently irrational behavior had meaning, that something that couldn't be put into words was translated into action. From this point on the

therapist was able to use Tom's behavior as "a way of talking" and there was progressively more cooperation from Tom in searching out the meaning of his acting.

And now, too, as we began to understand the meaning of this impulsive acting, we could share the diagnostic insight with the staff to provide them with the kind of understanding that could sustain them in dealing with an erratic child and to give them tools for working with the child in his periods of panic. Tom himself understood that not only the therapist but the ward staff were there to help him, that the therapist communicated with the ward staff in order to help them understand Tom, and that the staff talked to the therapist in order to give him a picture of Tom in his everyday life.

The therapist suggested to the staff that they could make use of the diagnostic information in preventing panic in Tom by spotting the moment when anxiety was about to trigger acting and encouraging verbalization of anxiety. One of the nurses who had the most influence upon Tom (if anyone did in those days) now approached Tom directly and told him that when he got frightened after leaving the classroom or at any other time, he did not have to panic but he could come directly to any of the staff and ask for help. She told him that they all understood that he was scared at times and would try to help him. On the following day Tom came to Don, one of the attendants, and told him that he was scared and that he had the feeling again of wanting to run off. Don then sat down with Tom and encouraged him to talk. And, of course, Tom did not act out.

In this sequence the ward staff and the therapist collaborated in the diagnostic process, sifting and organizing details of the child's behavior until the data tell their own story. In the process of examining the child's behavior the ward staff needed to be fully aware of the meaning of transference behavior even when they could not know what, in fact, the child was transferring. When we consider that the ward staff were also in the position of being the people who needed to manage this erratic behavior, we can fully appreciate the complexity of their job. It was not expected, of course, that the ward staff would behave with analytic remove and evenly hovering attention when Tom began his antics. All that can be reasonably asked of a good person is that so far as possible he understand that when a child behaves as if an adult were a dangerous attacker when in fact

he is not, the child is repeating something from the past. And while he as one of the caretaking persons must handle this behavior, he must handle it in such a way that he does not reinforce the transference image; he must not become the dangerous person. If, in fact, the staff had allowed themselves to be seduced into the role of threatening and "dangerous" people, the therapist would not have been able to uncover the meaning of this erratic behavior and we would have been plagued with an interminable re-enactment of Tom's internal drama or been impelled to "beat" Tom into submission.

In the sample cited the insight achieved in the therapeutic session was shared with staff and the staff was encouraged to make use of it in handling Tom in the moments of panic that initiated wild behavior and flight. By getting Tom to verbalize his fears before the panic cycle began, they achieved a means of control that became increasingly effective. There were no further episodes of "flights to the roof," although this by no means ended Tom's acting out in a variety of other ways.

Gradually during the first months of hospitalization we began to see a diminution of acting out and very significant changes in Tom's communications to the therapist. Tom himself began to see that as he talked about his anxieties and communicated his fears through play, he found relief and acquired a means of control. Like so many children with severe conduct disorders, Tom feared his own loss of control. The feeling of disintegration, of "craziness" which accompanied these episodes was terrifying to him. At those moments, he later told the therapist, he had the feelings that he was "not Tom," "somebody else," and from his descriptions it was very clear that the child meant that there was a dissolution of the sense of identity. Many times the therapist reassured Tom that by working on the fear problems, the "not Tom" feelings would go away and he would keep himself together. Increasingly, Tom began to regard the therapist as an ally against danger. He needed him and he valued him. It was striking that later, even when Tom was sometimes hostile toward the therapist or terrified of his own homosexual feelings toward the therapist, he never took flight from treatment to the extent that he allowed the stability of the therapeutic alliance to be completely undermined.

Yet for a long time the classroom remained the central theater of conflict. Even when Tom improved in other areas and became increasingly accessible to all those who worked for him, special difficulties persisted in school, which will be described in some detail. It was not only that Tom had selected the classroom as the focus of conflict long before we knew him. We felt that we did not have access to the classroom conflicts even in our hospital school because the transference aspects of this acting out remained obscured. Tom's teacher was new to our staff. As an educator he had understandable ambitions to educate. Even in a classroom of five severely disturbed boys, Tom distinguished himself as a provocateur, an agitator, and an inciter to chaos. If the teacher succeeded in getting these five disordered children to attend and to work on any aspect of the schoolwork, Tom could be depended upon to begin a cycle of acting that followed a predetermined course ending with the removal of Tom from the classroom. Over a period of months we pieced together the classroom pattern, and it looked something like this:

Typically, Tom would give his attention to work for fifteen minutes or half an hour. Then signs of restlessness and agitation would appear. He would begin girlish clowning or call out obscene words. His classmates, welcoming the diversion, offered him warm encouragement. The teacher would intervene with appropriate but futile remonstrances or warnings which Tom ignored. At the point of no return the teacher would ask Tom to leave the class and return to the ward until he could quiet down. Tom would refuse to leave. The teacher would now approach Tom, intending to lead him firmly out of the room. Tom would drop to the floor and firmly wind himself around the leg of a piece of furniture so that he could not be moved. In a variation of this scene, he would sometimes crawl around on the floor, making animal noises or imitating stereotyped phrases of one of the autistic children of the ward. All of this brought vast appreciation from his four classmates, and the spectacle of the teacher trying to detach Tom from the furniture or elevate him from the floor added special entertainment for the class. The final act of this classroom performance was preordained. The teacher called for two male staff to come down and bring Tom back to the ward. It was clear from the mounting excitement of Tom that this was the climax he longed for. As the two staff approached him and each took an arm

to lead him off or carry him off he struggled, with mixed excitement and panic, then kicking and cursing, allowed himself to be taken out of the classroom.

The girlish clowning in the classroom, the obscene words, the invitation for a struggle with a man, told us exactly what was being acted out in these scenes. Yet for several months we were helpless to bring about anything more than antiseptic interventions in these acting cycles. We knew that Tom found these scenes exciting, and the climax in which he needed to be carried off represented for him a homosexual surrender that was both longed for and dreaded. But the homosexual conflicts were not yet available to us in treatment and we knew that we needed to go slowly here because this was the dangerous territory for Tom, the area where the sexual conflicts and the ego disorder were united. The supreme danger was surrender in the ego sense as well as in the sexual sense. The danger of a psychotic break was always present in our thinking. Since we had to move with extreme care in this area and follow the child's own leads in examining the homosexual conflicts, we could not handle the classroom acting by focusing on its homosexual content which, theoretically, would have diminished the acting.

We spent many hours together and with our ward staff and the teacher trying to find ways in which the classroom problem could be handled. We wanted to avoid the situation in which Tom would have to be removed from the classroom. We tried various approaches. The therapist suggested to Tom (with the consent of the teacher) that when he felt he was about to lose control, he simply ask to leave the classroom and return to the ward himself. The teacher tried to intervene earlier, at the first signs of agitation, to help Tom maintain control. But, for reasons that may already be apparent, Tom did not want to be prevented from pursuing this drama from the beginning to the end. The pleasure gain was too great. In the absence of any effective intervention during this period, we could only handle the removal of Tom as antiseptically as possible. The therapist discussed with the teacher and with ward staff members the nature of Tom's excitement. The staff was helped to see how Tom seemed to be seeking some kind of gratification in being held and in struggling and that at this time the most important contribution the staff could make to Tom's treatment was handling Tom's removal from the

classroom in ways that would not feed into his fantasies: by holding him only when necessary and through voice and manner getting across to Tom that nobody wanted to be a partner in such a situation. To a large measure the ward staff succeeded in communicating this message.

Meantime, the therapist dealt with the acting out in school by repeatedly bringing Tom's attention to the provocative aspects of this acting and to his wish to be restrained. Without suggesting the homosexual nature of the motive, the therapist focused on the gain aspects of this behavior and invited the child to join the therapist in trying to unravel why Tom needed to get himself into this situation again and again. When Tom provided good samples of his classroom antics in the therapeutic sessions, the therapist was able to bring Tom's attention to the sequence of events which led to acting.

Certain patterns began to emerge in therapeutic sessions. A fantasy in which the therapist would attack Tom or kill him would be translated in a few moments to wild antics in the office and mounting excitement to see what the therapist would do. The therapist could then use this behavior to show Tom what he was doing in the classroom; how he turned the exciting fantasy into acting with the expectation that somebody should restrain him. Sometimes the threads led back to the father and Tom's fear of his father's beatings. But the erotic component of the struggle with father was not readily accessible. On several occasions, the therapist had made a mental note to himself that Tom appeared to have an erection just before the period of acting, bringing the diagnostic picture into better focus. We hypothesized that the wild acting in the classroom was initiated by an erection and that the drama that ensued represented the enactment of a masturbatory fantasy. Of course, none of this was communicated to Tom at this point.

As we were wondering to ourselves how we were to gain access to the homosexual conflicts that underlay the classroom disorder, Tom himself provided the means. As might be expected, he did it through acting. His classroom clowning was becoming more and more explicit. He would play the coy girl for the entertainment of his peers, swinging his hips, pulling his T-shirt down to his knees, patting his hair into place. And on more than one occasion as he was removed from the room by ward staff, he screeched in a high-pitched girlish

voice. Then, feigning surrender he waved a handkerchief toward his peers in a comic rendering of the scene of the abduction of the maiden. In variations of this scene he waved his handkerchief to his teacher and turned his buttocks to him in an exit gesture. The child care workers reported to the therapist that as Tom was brought out of the classroom on these occasions he was at a high pitch of excitement and showed signs of erection, not only of his penis but of his entire body.

It was now felt that the erotic component of this acting was explicit enough to invite handling in therapy. The therapist began to raise sober questions regarding "playing girl" on the ward, in school, in the therapeutic sessions. In order not to create intolerable anxiety, the therapist laid a careful groundwork in the treatment by pointing out to Tom that since he himself did not know why he did these things, the acting must be telling something that could not be put into words. Perhaps, the therapist suggested, it was a way of remembering something that was frightening; and as Tom already knew, he sometimes tried to get rid of scary daydreams or memories by acting them over and over again. In telling Tom this, we did not know, of course, whether this referred to the acting out of a masturbatory fantasy or a memory of a seduction or both, or whether in fact the content was repressed. Tom was struck by this interpretation. Then gradually in the course of many sessions a story began to emerge.

Memories of his father's beatings came back with details that added new dimensions. The details appeared in fragments over many sessions. Tom remembered with an ambiguous smile how, when he was small, he used to wiggle his hips in order to make his father miss with his belt. He remembered, too, that when he was sent to his room by his father he would dress up with a towel around his waist and another around his head, pretending to be dressed like his sister, his father's favorite. When he was dressed like a girl, he felt safe from his father. And it was also fun, he acknowledged. Later he remembered being held between his father's legs, struggling and wriggling, while his father beat his buttocks with a belt. These memories emerged with feelings of panic and barely contained erotic excitement. But there was relief in the telling and Tom began to understand how even these most terrible and shameful memories could

be told to the therapist and that afterward he no longer needed to feel as helpless. Now the therapist could help Tom see how "playing girl" was a defense against certain dangers. And as "playing girl" brought forth its own even greater anxieties, the therapist was able to show Tom that there would be other ways and better ways of dealing with his fears of attack.

As some of the seductive behavior began to come into therapeutic sessions and the signs of excitement were unmistakable, the therapist began to draw Tom's attention to the pleasure aspects in playing girl as another problem that needed to be understood. In many months of work Tom was able to reveal more and more of his homosexual fantasies and fears and his dread of becoming a "queer." Memories of homosexuals in a quarter of his hometown appeared. One distorted memory of an old man led us to suspect that Tom might, in fact, have experienced a homosexual seduction on at least one occasion. But when this material was traced in the course of treatment, the threads led back to the father again and we were left with uncertainty as to whether there had been an actual seduction or whether the memory of the old man was, in fact, a screen memory for the father who excited homosexual longings.

As the homosexual conflicts entered treatment and became accessible to investigation, Tom's acting began to diminish in the classroom. There were longer periods of time in which Tom was not only manageable in the classroom but was making progress in his schoolwork. But the relation to Mr. L., Tom's teacher, was never completely free of feeling on both sides and it was not until later when Mr. L. left and Tom was transferred to another teacher that the symbol "teacher" no longer conjured up old ghosts. Then, for the first time in his life, Tom achieved a constructive positive relationship with a teacher and when conflicting feelings emerged he could be helped to see them as transference reactions. With this bridge to education, Tom began to take pleasure in learning and eventually made such rapid progress that he was transferred to a public school in the community during the third and last year of his stay in the hospital. That year, he achieved good grades and some distinction in his work in science. There were no episodes of acting out and his behavior was regarded as unexceptional and entirely normal by his teachers.

In this sequence again we see that the collaborative work of therapist and institutional staff provides extraordinary opportunities for the diagnostic assessment of transference behavior and the exploitation of the transference in therapy. The examples show, too, that clinical neutrality is a very difficult condition to achieve in residential treatment. Nor can it be required. It seems to us that those child care personnel who understood something of the nature of transference had the means with which to manage their own reactions and thereby contribute greatly to our therapeutic work on behalf of Tom. The child care workers who knew that the child found excitement in his bizarre antics and who did not themselves play into the erotic cycle made it possible for us to show the child that he was transferring from the past. The teacher who, with the best will in the world, could not see the transference implications of this acting made it very difficult for the therapist to demonstrate to the child that his reactions to the teacher were transference reactions. And because the teacher had the double problem of teaching Tom as well as managing his behavior, he deserves our sympathy too. An experienced teacher in our hospital would probably have modified his educational objectives in certain ways and would not have taken Tom's antics as a reflection upon himself.

Much of the success of Tom's hospital treatment can be attributed to the flexible collaborative relationship between psychotherapist and child care staff. As we reviewed Tom's voluminous record, we were impressed by how many avenues were opened up in therapy through staff observations and sound clinical handling. When at one period Tom began a strange kind of midnight wandering and an elaborate spying on the night staff, this was reported to the therapist as clinical material by the staff. Exploration in psychotherapy revealed that Tom was convinced that after the children went to bed, the male and female night staff engaged in secret sexual activities. When he accused certain staff members of sexual adventures, he was evidently put out by their attitude of clinical remove in the face of such scandal. (As a commentary on the powerful nature of transference belief, it should be noted that during this same period Tom and several boys in his group were on a supervised nature walk in the local arboretum and while pursuing botanical specimens, they surprised a couple in coitus. This actual en-

counter with coitus was reported by Tom with considerably less interest than the concurrent sexual fantasies about the staff.)

The transference fantasies were handled by the therapist as "a way of telling us something"; something that Tom may have seen or heard that disturbed him. It was in this way that another part of the past was unfolded. Tom remembered with particular vividness a time when he had disturbed his parents at night. He did not observe coitus on that occasion, but clearly had interrupted a point in his parents' lovemaking. His father, enraged, chased him out of the room. The father's pajamas were open and Tom saw his erect penis which he remembered at first as "bloody" and then as "big and red." Now we could put into place another piece of the puzzle.

The excitement and dread that Tom associated with the erect male penis led further into exploration of his homosexual fantasies and his passive identification with the woman. Fascination with the erect male penis came into the picture for considerable therapeutic scrutiny and cast light not only upon a crucial point in Tom's homosexual fixation but the meaning of some psychotic mechanisms which had eluded us in our earlier work soon after Tom's admission to the hospital.

All of this derived from a piece of acting—the midnight prowling in the hospital which was handled by staff not just as a piece of mischief but also as a clinical communication and a story that needed to be reported to the therapist.

Working closely with the therapist the staff acquired an attitude of clinical attention to minutiae. When Tom refused for weeks to tie his shoes or fasten his belt during the first months in the hospital, the staff at first tried to handle this realistically, quietly insisting that he dress himself like all the other boys. But soon the staff began to sense something else beyond this apparent negligence. Tom became anxious when he tied his shoes and he behaved as if wearing a belt was a form of torture. Again the staff urged Tom to take this up with his doctor as "a problem" and temporarily relaxed their insistence upon conformity.

As this material came into psychotherapy, it led into the most extraordinary and unexpected paths: Tom's fantasy was that tying his shoes and fastening his belt "cut off circulation" and would make his body numb. This led him in turn to another dread. We knew from

the history and from observations during the first months of hospitalization that for a long time Tom had a curious writing inhibition in the classroom and would avoid any exercises that required writing. He told his therapist that writing made his hand "numb" and that when his hand became numb he felt as if it had gone dead. Numbness, deadness, panic at loss of sensation now crowded into the therapeutic picture and led in the course of weeks into the ultimate horror—the fear of loss of sensation in the penis, the fear that the penis would "go dead." (This was, of course, a basis for his compulsive masturbation—the need to revive the dead penis and reassure himself.) It also spoke eloquently for a more profound dread, we knew, the fear of the death of ego functioning itself. When the fear of the "dead feelings" was explored during this period in relation to the penis, the handwriting, the shoe tying, the belt fastening, we saw an impressive symptomatic improvement. The shoes were tied and the belt fastened as a matter of course. But much more important, Tom began to complete written work in the classroom for the first time in his school history and writing dropped out as a problem thereafter.

In this kind of collaborative work between the therapist and child care staff, the problem of confidentiality must receive sober consideration. We know that respect for confidential communications is as important for the work of child therapy as work with the adult. The kind of sharing of information which we employ entails certain risks even when the child himself understands the reasons for communication between therapist and staff. The child can tolerate this kind of sharing only when he himself experiences the benefits of his therapist and staff working together. Tom, for example, understood very well that when the ward staff understood the kind of anxiety that precipitated his wild acting out, they could help him with his anxiety at critical moments. But there are times when the child may feel that certain kinds of information should not be transmitted to others from the therapeutic sessions. And he may be right. The following example from Tom's case is illuminating in this respect:

There was a period in Tom's treatment when much of his homosexual longing and dread centered on Charles, a Negro child care worker. He was afraid of Charles and had disturbing thoughts that Charles would like to kill him. He had fantasies that Charles would come into his room at night and stab him or "change skins" with him.

During this period, Tom had difficulty in falling asleep. Charles, sensing the fear and hostility in Tom, tried to "make friends" with Tom in order to dissipate some of the irrational hatred the child directed toward him. And, of course, the friendliness of Charles only created more anxiety on Tom's part. As the feelings toward Charles came into psychotherapy and were linked to other material in the therapeutic transference, Tom began to see how fear of Charles was connected with his own homosexual fantasies and with some dimly remembered past experiences with Negroes in the days when he wandered around the city streets and found excitement in the Negro quarter of the city.

Now, almost abruptly, Tom closed off further exploration of his feelings toward Charles and toward Negroes. Was it his fear of the homosexual transference in therapy? Was it the fear of remembering a homosexual experience in the past? We could not be certain and waited to see what forms this resistance would take. Soon we began to see a pattern. For the first time in Tom's hospitalization, he began to complain that he could not trust the therapist. He complained that the therapist was in league with the staff against him. He began to prowl around the door of the conference room when he knew that the therapist and staff were having their regular meetings. He claimed that he overheard the therapist talking with the ward staff about sex and that now everyone on the ward was looking for sex play whenever Tom was horsing around with other boys.

Apart from the transference implications in the fantasy of the therapist "plotting against" the patient, we felt that Tom had a legitimate grievance. We had begun to explore in therapy some very painful material in the area of homosexual conflict. Shameful memories had begun to emerge and there were self-accusations "you are a queer." It is painful enough to talk of such things in the privacy of therapeutic sessions. If one knew that such shameful things had to be communicated to the entire ward staff, including Charles, perhaps, why should one speak of these things at all?

At this point the therapist did two things. First he presented the problem to the ward staff in general terms. He explained that Tom was working on some very difficult problems in therapy, problems generally in the sexual area, and that Tom appeared to be afraid to have others know about them, even the staff who had been trusted

with all kinds of confidential information. The therapist frankly confided his dilemma to the staff and asked their advice. The staff immediately expressed sympathy for Tom. After all, who would want to discuss embarrassing sexual thoughts or experiences if everyone in the hospital were listening in? They suggested that Tom be given assurance of confidentiality for certain information.

Now the therapist asked Tom if he felt that he could trust the therapist if something very private came up not to discuss it with others. Tom said that he could and that he had been worried that his hatred for Negroes would be communicated to the ward and that this would make life harder for him there. Subsequently, the flow of material resumed, and acting out diminished. No complications were noted in the triangular communication between the therapist, patient, and staff. It was our impression that such complications occur only when staff are told arbitrarily that certain information is withheld because it is part of the doctor-patient relationship and is excluded without staff understanding of the reasons.

CONCLUSION

These fragments from the hospital treatment of Tom do not in themselves tell the story of Tom's treatment. (A detailed report of the therapy is planned for another publication.) We should mention, however, that Tom's hospital treatment was brought to a successful conclusion toward the end of the third year. During the last year of hospitalization when Tom was fourteen years old, he was attending a public high school and, as already mentioned, his schoolwork was regarded as very good (he was functioning at the top of his high average capacity) and his classroom behavior was unexceptional. The homosexual conflicts seemed to have achieved favorable resolution in therapy and Tom demonstrated at fourteen a healthy interest in girls and an appreciation of his own masculinity. In all areas of ego functioning there were significant changes, but most important of all were those seen in the capacity for human attachments. This child, who had only mourned his dog when he first entered our hospital, made his farewells to the therapist and certain staff members with tears in his eyes and he was not ashamed of his tears.

Tom, we reflect, could never have been treated on an outpatient basis. We are also convinced that we could never have obtained

access to the conflictual material that underlay this grave ego disturbance if we did not have in our hands the transference potential of the institution. Through the collaborative work of therapist and ward staff that we have described above, we found the paths that led from the present to the past; and as we saw how memories were revived and transformed into bizarre actions, we were able to construct a therapeutic approach along analytic lines in which the analysis of the transference led the way.

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UTILIZATION OF TRANSFERENCE BEHAVIOR IN
RESIDENTIAL TREATMENT OF THE CHILD

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A unique therapeutic condition of residential psychiatric treatment lies in the transference potential which the institution provides. The child who is separated from his family and from the original partners in conflict will re-experience and re-enact these conflicts within the institution. As the conflicts emerge in the new setting, the child tends to seek transference figures within the institution, to repeat the old conflicts with the new figures and to relive the past with this new cast of characters.

In our intensive study of certain cases within our own hospital we have seen how the recorded events of the daily life of a child in residence can be constructed as a narrative; if they are read carefully, with meticulous attention to detail, they reveal the history of the disorder, the major conflictual figures in the illness, and the specific meaning of pathological behavior and defense.

In these respects, the transference behavior of the child toward institutional figures as well as to the therapist provides a diagnostic key to the disorder and its origins and the instrument for

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effecting change in the personality through insight and corrective emotional experience. In order to utilize the full therapeutic potential of the milieu, the psychotherapist, the child-care workers and other specialists who constitute the child's milieu team must collaborate closely in the exchange of daily clinical observations and in the development of mutually reinforcing therapeutic methods. This is not to say, that the child-care worker or the teacher act as psychotherapists in our setting. The responsibility for the conduct of the child's therapy remains with his individual therapist, but in all those ways in which child-care and educational personnel support and reinforce the therapeutic aims for each child, they are regarded as collaborators and members of the clinical team.

In this paper we will present some brief case illustrations which describe our clinical team approach and some of the typical problems which arise in the effective utilization of this approach.

Historical Background

A number of writers have commented on the place of psychotherapy within a residential center. The literature shows a considerable diversity of opinion on the subject which is, in itself, a healthy and fertile condition in a field that is still new and must engage in experimentation.

Noshpitz (1962) reviews the history of the early residential centers when psychotherapy was secret and special, different and apart from the milieu. The residence held onto the youngster while they were in therapy in such a way as to promote the course of therapy. Benign, common sense handling by staff was all that was asked. Robinson (May, 1947; July, 1947) recommended that the

problems of psychotherapy be removed somewhat from the practical realities, involvements, and consequences of the child's daily behavior. He also commented on the dilution of psychotherapeutic effectiveness if the child invested his main interests and drive in vicarious achievement, as for example in school or in outside group activities, and if managing problem behaviors in the daily living experience became the main focus of attention.

On the other hand, Redl (1957) emphasizes the problems of utilizing psychiatric interview techniques with "children who hate." He feels that a certain minimum of ego functioning is a prerequisite, as well as the readiness of the child to relate at all. He felt that the volume of restlessness and aggression and amount of excitement these youngsters produce, forces the therapist into acts of interference. Thus the therapist either becomes personally entangled in the child's pathology and his war with the world around him, or is put safely where he can do no harm, into the role of the "friend without influence." Redl described a new design for treatment for these children who are so skilled at producing a never-ending chain of symbolic substitute figures in life situations. In addition, he felt that in an open treatment setting, when treatment begins to take hold, the spillover into the life space of the child will be so great that no ordinary arrangements can be expected to take care of it.

Bettelheim (1949) also utilizes a fusion of psychotherapy and milieu therapy in one process. He speaks of a continuously maintained one-to-one relationship within a therapeutic milieu. His milieu psychotherapy transposes features of individual psychotherapy

(recapitulating the illness within the benign setting of the psychotherapeutic relationship) to a general milieu function. He feels that insight can thus be translated into uninterrupted action over twenty-four hours a day.

The issues involved in handling multiple transference reaction in severely disturbed children were discussed with clarity by August Aichorn (1935). He said that the worker must act toward the child in such a way as to prevent a repetition with the worker of the situation with the parents which led to the conflict. In psychoanalysis, on the other hand, he noted that it was of greatest importance to let this situation repeat itself. (However, Aichorn was referring to the neurotic child with dissocial features only; for the delinquent acting out child he suggested taking the child's side in order to get a "positive transference.") Lourie (1952) states that the disturbed child sees every adult in some distorted fashion derived from attitudes toward his parents and that this is not only inevitable but desirable in the residence. He feels that the child cannot be successfully treated if he is insulated from the disturbing aspects of his interpersonal relations.

More recently, Ait (1960) discusses the therapeutic problems involved in children's "transfer to the institution itself", projected onto many different figures within it. He recommends that these elements of relationships with other adults must be brought into the interview situation rather than concentrating on those with the therapist alone. Thus he feels that environmental treatment and psychotherapy must be unified in a total treatment approach.

Children's Psychiatric Hospital

As a background for the problems and methods described in the illustrative material that follows we will briefly describe the institutional setting and its structure.

Children's Psychiatric Hospital is a training facility within the University of Michigan Medical Center. It operates an in-patient, out-patient, and day care facility serving the state of Michigan. The in-patient service is composed of three wards, each a separate unit housing sixteen to eighteen children, varying in age, sex and pathology, who are hospitalized for an average of one and one-half years. Each ward is under the direct supervision of a head nurse, two staff nurses and four or five child-care workers during the day. There is comparable staff coverage in the evening. A school and recreational program is conducted within the hospital.

Each child has a primary therapeutic team composed of his psychotherapist, a senior psychiatric staff supervisor who acts as a consultant, the social caseworker who works with the child's parents, a key child-care person, a teacher, occupational therapist and recreational therapist. While most of the psychotherapists are resident psychiatrists in their third or fourth year of training, senior staff members in psychiatry, psychology and social work also function as psychotherapists. The therapist, who carries one to four in-patients is the captain of the team, and formulates, organizes and coordinates goals and approaches.

The core of our program has been built around individual psychotherapy with an average of three sessions per week for each child, and casework treatment of the parents on a once weekly basis

conducted by the caseworker. The children have regularly scheduled appointments with their therapists. Ward staff have considerable over-all authority in the handling of the child's daily life and in setting up and managing certain requirements of social living on the ward. Over-all administrative policy is decided by the nursing supervisor, in-patient director and their assistants. The therapist supports the realities of daily living as handled by ward staff, but he is also involved in modifications and redefinitions of policy and management problems on behalf of his patient and the therapeutic requirements of the case.

The child is aware from the beginning of his treatment that his therapist and his ward staff need to communicate with each other in order to help him with his problems and help him get well. He is also aware that his therapist has considerable authority in making certain decisions on his behalf such as home visits, community privileges for shopping, movie-going, etc., and that the decisions are made on his therapists' estimate of his ability to handle such experiences. And while this investment of authority in the therapist must be taken into account in the transference relationship, we have learned that it need not be an impediment to treatment and in fact, we can envision no better alternatives when we consider the realities of hospital treatment of the child with severe ego disturbances. Since the therapist must have ultimate responsibility for all aspects of case management and has the most intimate knowledge of the child on which to base certain decisions, a tactical evasion of this issue would serve no therapeutic purpose and absence of candor would, in itself, be more detrimental to the therapeutic relationship.

In order to maintain the integrity of psychotherapy and milieu

therapy, daily communication between therapist and ward staff is required. This is achieved through a variety of means: each therapist makes daily ward rounds, to read the detailed notes by ward staff maintained around the clock and to be available for informal consultation with ward staff. Scheduled team meetings or formal progress conferences are scheduled every one to two months for the day staff and monthly meetings are held by the therapist with the evening staff. Informal, unscheduled team meetings are frequently set up by the therapists or any other member of the staff, as often as they are needed, especially during difficult periods in the child's hospitalization. Finally, the therapists meet with their supervisors once a week for case consultation.

Excerpts from the In-patient Treatment of an Eleven Year Old Boy

We have drawn a group of problems from the treatment of eleven year old Tom to examine certain aspects of transference behavior and the collaborative relationship between the therapist and the ward staff. Tom, is in many respects a fairly representative case among children admitted for in-patient treatment.

Tom was admitted to our hospital following numerous school exclusions. Typically he ran around the classroom in giddy fashion, or crawled on the floor making animal noises. He clowning exhibitionistically in a driven, joyless way, and goaded his teacher until he was forcibly removed from the room. In spite of good average intelligence he was unable to work or to learn. At home he goaded his parents relentlessly, and provoked beatings from his father. His impulsive, erratic behavior had exhausted his parents and the entire community. Frequently he disappeared for hours and

wandered around the streets of the city. Psychiatric and psychological evaluations had demonstrated serious defects in impulse control, shallow object relationships, tendencies toward withdrawal, isolation and depression. It was noted that when Tom became flooded with anxiety (which happened several times daily) there were periods of complete ego dissolution.

Almost as soon as Tom was admitted to the hospital he displayed the full repertory of his behavior. There was no "honeymoon period" to give us an opportunity to establish a relationship with him and to employ this relationship in influencing his behavior. He was immediately defiant and provocative and upon learning the few simple rules which govern ward life, he took pains to break all of them. There appeared to be little or no discrimination in his antagonism toward all adults. Nor did he see any of his behavior as a "problem." When the therapist attempted to focus on the kinds of difficulties which Tom was experiencing on the ward he was indifferent or defensive but there was no remorse and certainly no evidence of "the observing part of the ego" which we consider indispensable in psychotherapy. Like most of our patients, he was not reflective, he was not concerned with causes, and he had almost no vocabulary for putting feelings into words. When he experienced something he translated it into an action, and the private sessions with a doctor with whom he was invited to find reasons for his behavior must have been one of the most extraordinary experiences of his life.

This need to transfer, almost indiscriminately, without regard for the objective characteristics of the persons in this new environment was certainly one of the first indications of the extent

of the ego disturbance in this child. There was a driven, urgent quality in his global acting out that we have seen in many of our borderline patients. It was as if an interior drama sought a theater and a cast of characters for interminable reenactment.

But during the first days we did not yet know the meaning of this behavior. As long as we did not know its meaning we were not able to handle it therapeutically and we could not effectively influence the behavior on the ward and in the classroom. Even our experienced ward staff found the antics of this child exhausting. The question was asked at a workshop for which this case was presented (we are paraphrasing the question now) "What sustained the staff during the period when Tom's behavior made no sense and when there were no measures to bring about effective control?". As we thought about it, it struck us that the sense of alliance with the therapist was probably one of the strongest supports during this period. The therapist and the staff of this ward had worked together as a team for some time. There had been successes in their collaborative work together and reasonable confidence that once the meaning of the behavior was revealed there would be more effective means of bringing about some measure of control.

Soon we began to see certain patterns in Tom's acting as they appeared in therapeutic sessions and on the ward. The relentless goading and challenging was accompanied by mounting excitement; clearly he wanted to induce anger in the adults and was longing for punishment. There was, of course, no physical punishment from our staff and when Tom was out of control he was taken to the seclusion room until he calmed down. When the adults failed to provide

gratification Tom turned to his peers. He needled and goaded the other boys into attacks upon him, and the longing to be beaten was finally gratified by several boys on his ward. All of this added its own weight to problems of management in a ward for severely disturbed boys. We were also attentive to Tom's choice of partners in these invitations to attack. His partners were boys with strong homosexual conflicts.

As the provocative behavior manifested itself in therapeutic sessions, the therapist began to draw Tom's attention to the patterns. He pointed out to Tom how he seemed to use every means to try to bring about anger and punishment both in treatment sessions and on the ward and that there must be some reason for it. Meantime, too, ward staff began to show Tom how he provoked the other boys into attacks upon him and to reinforce the current work in therapy which was focused on isolating the behavior and helping the child to observe himself.

Gradually, in therapeutic sessions, Tom began to reveal in play his fear of attack and body injury and his longing for attack. In play acting, Tom was in great danger of attack by men who were trying to capture him. There was much talk about doctors, about shots, about blood and death. And now for the first time, the therapist could begin to approach Tom on the basis of his fears. While listening sympathetically to Tom's fears of attack and injury, the therapist began to show Tom how his out-of-control behavior was connected with anxiety, that when he became afraid and felt helpless he lost control.

Within the next two weeks there were a number of occasions in which Tom, himself, began to see the connections between anxiety

and acting out. On one occasion Tom created a disturbance in the classroom, clowning and running around the room, then was found hiding at the top of the hospital. He had climbed up and was hanging on to the screened grating atop the stairwell. When Tom talked with the therapist shortly afterwards, he, himself, made the connection between fear of punishment and his flight to the highest part of the hospital. He was afraid that he would be put in the seclusion room, afraid, he guessed, of having nothing to do there - and as he spoke Tom's hand went automatically to his genital.

In the therapeutic sessions that followed, the episode of the classroom crisis and the flight to the top of the building were examined with Tom in some detail. From this material we began to obtain certain vital links with the past. Tom began to talk about battles with his father over school work. At home, Tom's father forced him to stay in his room until his school work was done. And as threats of expulsion from school for erratic behavior and academic failure were renewed each year, school had become the theater for conflict between father and son. The father's rage, we already knew, had reduced him to acts of brutality against the child. Alone in his room, Tom told the therapist, he could not face the school work and he would begin to fear his father's rage. There was one means of escape. By climbing out his window at home to the branches of a tree that overhung the roof, he could reach a low roof and jump down or shimmy down the tree and take off. He would then lose himself in the city streets for hours.

What was he afraid of if he stayed in the room? He could not tell the therapist and the therapist suggested a "spanking?".

(Spanking, was a euphemism for the father's attacks upon Tom, which were acknowledged by both parents to be beatings.) As the therapist uttered the word "spanking" Tom had a look of near panic on his face and began to move away from the therapist. He ran to the window, and began to jab at the window with a pencil in a frenzied fashion.

It was in this way that Tom's sado-masochistic relationship with his father came into the treatment. The fear of father's beatings, and later the excitement in being beaten were gradually brought into the treatment and eventually provided access to the homosexual conflicts which were central to this child's disturbance.

At this point, then, we obtained insight into one aspect of Tom's impulsive acting. Through careful observation and reporting on the part of ward staff we were able to follow the narrative of the critical events. By pursuing the elements in the classroom drama and the flight to the top of the building in therapy we discovered the repetitious features of this acting. The classroom disturbance led back to the conflicts with father over "doing the work." Then followed panic and fear of punishment, in close correspondence with the pattern at home, and finally the flight to the top of the building in which he reenacted the flight from father. We think that here, for the first time, when Tom made these links, he began to understand that his apparently irrational behavior had meaning, that something that couldn't be put into words was translated into action. From this point on the therapist was able to use Tom's behavior as "a way of talking" and there was progressively more cooperation from Tom in searching out the meaning of his acting.

And now, too, as we began to understand the meaning of this impulsive acting, we could share the diagnostic insight with the staff and provide them with the kind of understanding that could sustain them in dealing with an erratic child and give them tools for working with the child in his periods of panic. Tom, himself, understood that not only the therapist but the ward staff were there to help him and that the therapist communicated with the ward staff in order to help them understand Tom, and that the staff talked to the therapist to give him a picture of Tom in his everyday life.

The therapist now suggested in his meeting with the staff that they could make use of the diagnostic information in preventing panic in Tom, by spotting the moment when anxiety was about to trigger acting and encourage verbalization of anxiety. One of the nurses who had the most influence upon Tom (if anyone did in those days) now approached Tom directly and told him that when he got frightened after leaving the classroom or at any other time, he did not have to panic, but he could come directly to any of the staff members and ask for help. She told him that they all understood that he was scared at times and would try to help him. On the following day, Tom came to Don, one of the attendants and told him that he was scared and that he had the feeling again of wanting to run off. Don then sat down with Tom and encouraged him to talk. And, of course, Tom did not act out.

In this sequence, the ward staff and the therapist collaborate in the diagnostic process, sifting and organizing details of the child's behavior until the data tell their own story. In the process of examining the child's behavior, the ward staff needed to

be fully aware of the meaning of transference behavior even when they could not know what, in fact, the child was transferring. When we consider that the ward staff were also in the position of being the people who needed to manage this erratic behavior, we can fully appreciate the complexity of their job. It was not expected, of course, that the ward staff should behave with analytic remove and evenly hovering attention when Tom began his antics. All that can be reasonably asked of a good person is that so far as possible he understand that when a child behaves as if an adult were a dangerous attacker when in fact he is not, that the child is repeating something from the past. And while he as one of the care-taking persons, must handle this behavior, he must handle it in such a way that he does not re-inforce the transference image; he must not become the dangerous person. If, in fact, the staff had allowed themselves to be seduced into the role of threatening and "dangerous" people, the therapist would not have been able to uncover the meaning of this erratic behavior and we would have had interminable re-enactment of Tom's internal drama.

In the sample cited, the insight achieved in the therapeutic session was shared with staff and the staff was encouraged to make use of it in handling Tom in the moments of panic that initiated wild behavior and flight. By getting Tom to verbalize his fears before the panic cycle began, they now had a means of control that became increasingly effective. There were no further episodes of "flights to the roof," although this by no means ended Tom's acting out in a variety of other ways.

Gradually, during the first months of hospitalization, we

began to see a diminution of acting out and very significant changes in Tom's communications to the therapist. Tom, himself, began to see that as he talked about his anxieties and communicated his fears through play, he found relief and acquired a means of control. Like many children with severe conduct disorders, he feared his own loss of control; the feeling of disintegration, of "craziness" which accompanied these episodes was terrifying to him. At those moments, he later told the therapist, he had feelings that he was "not Tom", "somebody else" and from his descriptions it was very clear that the child meant that there was a dissolution of the sense of identity. Many times, the therapist reassured Tom that by working on the fear problems the "not Tom" feelings would go away and he would keep himself together. Tom, himself, began to regard the therapist as an ally against danger. He needed him and he valued him. It was striking that later, even when Tom was sometimes hostile toward the therapist or feared his own homosexual feelings toward the therapist, he never took flight from treatment and never allowed the stability of the positive transference to be undermined.

Yet, for a long time, the classroom remained the theater of conflict, even when Tom improved in other areas and became increasingly accessible to all those who worked for him. And here we had special difficulties, which we should describe in some detail. It was not only that Tom had selected the classroom as the focus of conflict long before we knew him. We felt that we did not have access to the classroom conflicts even in our hospital school because the transference aspects of this acting out were obscured. Tom's teacher was new to our school. As an educator he had under-

standable ambitions to educate. Even in a classroom of five severely disturbed boys, Tom distinguished himself as a provocateur, an agitator and an inciter to chaos. If the teacher succeeded in getting these five disordered children to attend and to work on any aspect of the school work, he could depend upon Tom to begin the cycle of acting that followed a predetermined course and ended with the removal of Tom from the classroom. Over a period of months we pieced together the classroom pattern, and it looked something like this:

Typically, Tom would give his attention to work for fifteen minutes or a half hour, but sometimes longer. Then signs of restlessness and agitation would appear. He would begin girlish clowning or calling out obscene words. His classmates, welcoming the diversion, offered him warm encouragement. The teacher would now intervene with futile remonstrances or warnings which Tom ignored. At the point of no return, the teacher would ask Tom to leave the class and return to the ward until he could quiet down. Tom refused to leave. The teacher would now approach Tom, intending to firmly lead him out of the room. Tom would drop to the floor and firmly wind himself around the leg of a piece of furniture so that he could not be moved. In variations of this scene, he would sometimes crawl around on the floor, making animal noises or imitating the stereotyped phrases of one of the autistic children of the ward. All of this brought vast appreciation from the four other class members, and the spectacle of the teacher trying to detach Tom from the furniture or elevate him from the floor added its own entertainment for the class. The final act of this classroom performance was pre-ordained. The teacher called for two ward staff members to come

down and bring Tom back to the ward. It was clear from the mounting excitement of Tom, that this was the climax he longed for. As the two attendants approached him and each took an arm to lead him off or carry him off he struggled, with mixed excitement and panic, then kicking and cursing, allowed himself to be taken out of the room.

The girlish clowning in the classroom, the obscene words, the invitation for a struggle with a man, told us exactly what was being acted out in these scenes. Yet, for several months, we were helpless to bring about anything more than antiseptic interventions in these acting cycles. We knew that Tom found these scenes exciting, and the climax in which he needed to be carried off represented for him a homosexual surrender that was both longed for and dreaded. But the homosexual conflicts were not yet available to us in treatment and we knew that we needed to go slowly here because this was the dangerous territory for Tom, the area where the sexual conflicts and the ego disorder were united. The danger was surrender in the ego sense as well as in the sexual sense. The danger of a psychotic break was always present in our thinking. Since we had to move with extreme care in this area and follow the child's own leads in examining the homosexual conflicts, we could not handle the classroom acting by focusing on its homosexual content which, theoretically, would have diminished the acting.

We spent many hours together and with our staff and the teacher trying to find ways in which the classroom problem could be handled. We did not want the situation in which Tom would have to be removed from the classroom. We tried various approaches. The therapist

suggested to Tom (with the consent of the teacher) that when he felt he was about to lose control he simply ask to leave the classroom and return to the ward himself. The teacher tried to intervene earlier, at the first signs of agitation, to help Tom keep under control. But, for reasons that may already be apparent, Tom did not want to be prevented from pursuing this drama from the beginning to the end. The pleasure gain was too great. In the absence of any effective intervention during this period, we could only handle the removal of Tom as antiseptically as possible. The therapist discussed with the teacher and with ward staff members the excitement that everyone was aware of in Tom. The staff was helped to see how Tom seemed to be seeking some kind of gratification in being held and in struggling and that at this time the most important contribution the staff could make to Tom's treatment was handling Tom's removal from the classroom in ways that would not feed him into his fantasies, that is, holding him only when necessary and through voice and manner getting across to Tom that nobody wanted to be a partner in such a situation. To a large measure the ward staff succeeded in getting this across to Tom.

Meantime, the therapist dealt with the acting out in school by bringing Tom's attention repeatedly to the provocative aspects of this acting and the wish to be restrained. Without suggesting, of course, the homosexual motive the therapist could still focus on the gain aspects of this behavior and invite the child to try to work out with the therapist why he needed to get himself into this situation again and again. And sometimes, when Tom provided good samples of his classroom antics in the therapeutic sessions,

the therapist brought his attention to the sequence of events which led to acting.

Certain patterns began to emerge in therapeutic sessions. A fantasy in which the therapist would attack him or kill him would be translated in a few moments to wild antics in the office and mounting excitement to see what the therapist would do. The therapist could then use this behavior to show Tom what he was doing in the classroom and how he turned the exciting fantasy into acting with the expectation that somebody should restrain him. Sometimes the threads led back to Tom's father and the fear of father's beatings. But the erotic component of the struggle with father was not easily accessible. On several occasions, the therapist made a mental note to himself that Tom appeared to have an erection just before the period of acting and our diagnostic picture began to come into focus. We were now fairly certain that the wild acting in the classroom was initiated by an erection and that the drama that ensued represented the enactment of a masturbatory fantasy. Of course, none of this could be communicated to Tom at this point.

As we were wondering to ourselves how we were to gain access to the homosexual conflicts that underlay the classroom disorder, Tom, himself, provided the means, once again through acting. His classroom clowning had become more and more explicit. He would play the coy girl for the entertainment of his peers, swinging his hips, pulling his T-shirt down to his knees, patting his hair into place. And on more than one occasion as he was removed from the room by ward aides, he screeched in a high pitched girlish voice, then feigning surrender he waved a handkerchief toward his peers in a

comic rendering of the scene of the abduction of the maiden. In variations of this scene he waved his handkerchief to his teacher and turned his buttocks to him in an exit gesture. Staff aides reported to the therapist, that as Tom was brought out of the classroom on these occasions, he was at a high pitch of excitement and showed signs of erection.

We felt, now, that the erotic component of this acting was explicit enough to invite handling in therapy. The therapist now began to raise sober questions regarding "playing girl" on the ward, in school, in the therapeutic sessions. In order not to create intolerable anxiety, the therapist laid a careful groundwork in the treatment by pointing out to Tom that since he, himself, did not know why he did these things, the acting must be telling something that could not be put into words. Perhaps, the therapist, suggested, it was a way of remembering something that was frightening; and as Tom already knew he sometimes tried to get rid of scary daydreams or memories by acting them out over and over again. In telling Tom this, we did not know of course, whether this was the acting out of a masturbatory fantasy or a memory of a seduction or whether in fact the content was repressed. Tom, himself, was struck by this interpretation. Then, gradually, in the course of many sessions, a story began to emerge.

Memories of his father's beatings came back with details that added new dimensions. The details appeared in fragments over many sessions. Tom remembered with an ambiguous smile, how, when he was small, he used to wiggle his hips in order to make his father miss with the belt. He remembered, too, that when he was sent to his room by

his father, he would dress up with a towel around his waist and another around his head, pretending to be dressed like his sister, the father's favorite. When he was dressed like a girl, he felt safe from his father. (And it was also fun, he acknowledged.) And later, too, he remembered being held between his father's legs, struggling and wriggling, while his father beat his buttocks with a belt. These memories emerged with feelings of panic and barely contained erotic excitement. But there was relief in the telling and Tom began to understand how even these most terrible and shameful memories could be told to the therapist and that afterwards he no longer needed to feel helpless. Now the therapist could help Tom see how "playing girl" was a defense against certain dangers. And as "playing girl" brought forth even greater anxiety, the therapist was able to show Tom that there would be other ways and better ways of dealing with his fears of attack.

As some of the seductive behavior began to come into therapeutic sessions and the signs of excitement were unmistakable, the therapist began to draw Tom's attention to the pleasure aspects in playing girl as another problem that needed to be understood. In many months of work Tom was able to reveal more and more of his homosexual fantasies and fears and his dread of becoming a "queer". Memories of homosexuals in a quarter of his native city appeared. One distorted memory of an old man led us to suspect that Tom might, in fact, have experienced a homosexual seduction on at least one occasion. But when this material was traced in the course of treatment, the threads led back to the father again and we were left with uncertainty as to whether there had been an actual seduction

or whether the memory of the old man was, in fact, a screen memory for the father who excited homosexual longings.

As the homosexual conflicts entered treatment and were capable of investigation, Tom's acting began to diminish in the classroom. There were whole periods of time in which Tom was not only manageable in the classroom but was making excellent progress in his school work. But the relationship to Mr. L., Tom's teacher, was never completely free of feeling on both sides and it was not until later when Tom was transferred to another teacher that the symbol "teacher" no longer conjured up old ghosts. Then, for the first time in his life, Tom achieved a strong positive relationship with a teacher and when conflicting feelings emerged he could be helped to see them as transference reactions. With this bridge to education, Tom began to take pleasure in learning and made such rapid progress that he was transferred to a public school during the third and last year of his stay in the hospital. That year, he achieved good grades and some distinction in his work in science. There were no episodes of acting out and his behavior was regarded as unexceptional and entirely normal by his teachers.

In this sequence, again we see that the collaborative work of therapist and institutional staff provides extraordinary opportunities for the diagnostic assessment of transference behavior and the exploitation of the transference in therapy. The examples show, too, that clinical neutrality is a very difficult condition to achieve in residential treatment. Nor, can we require it. It seems to us that those staff members who understood something of the nature of transference and who then had the means to manage their

own reactions contributed greatly to our therapeutic work on behalf of Tom. The aides who knew that the child found excitement in his bizarre antics and who did not themselves play into the erotic cycle made it possible for us to show the child that he was transferring from the past. The teacher who, with the best will in the world, could not see the transference implications of this acting, made it very difficult for the therapist to demonstrate to the child that his reactions to the teacher were transference reactions. And because the teacher had the double problem of teaching a Tom as well as managing his behavior he needs our sympathy too. The experienced teacher in our hospital would probably have modified his educational objectives in certain ways and would not, certainly, have taken Tom's antics as a reflection upon himself.

Much of the success of Tom's hospital treatment can be attributed to this flexible collaborative relationship between therapist and staff. As we reviewed Tom's voluminous record, we were impressed to see how many avenues were opened up in therapy through staff observations and good clinical handling. When, at one period Tom began a strange kind of midnight wandering and an elaborate spying on the night staff, this was reported to us as clinical material by the staff. Tom was convinced that after the children went to bed, the male and female night staff engaged in secret sexual goings on. When he accused certain staff members of sexual adventures, he was evidently put out by their attitude of clinical remove in the face of such scandal. (As a commentary on the nature of transference belief we might add that during this same period Tom and several

boys in his group were on a nature walk in the local arboretum and while pursuing botanical specimens surprised a couple in coitus. This actual encounter with coitus (verified by the child-care worker) was reported by Tom with considerably less interest than the fantasies about the staff that were running concurrently.

The transference fantasies were handled by the therapist as "a way of telling us something", something that Tom may have seen or heard about that disturbed him. It was in this way that another part of the past was unfolded. Tom remembered with particular vividness a time when he had disturbed his parents at night. He did not observe coitus on that occasion, but certainly had interrupted a point in his parents' love making. His father, enraged, chased him out of the room. The father's pajamas were open and Tom saw his erect penis which he remembered at first as "bloody" and then as "big and red". And now we could put into place another piece of the puzzle.

The excitement and dread that Tom associated with the erect male penis led us further into the exploration of his homosexual fantasies and his passive identification with the woman. Fascination with the erect male penis came into the picture for considerable therapeutic work and threw light not only upon a crucial point in Tom's homosexual fixation but the meaning of some psychotic mechanisms which had eluded us in our earlier work soon after Tom's admission to the hospital.

All of this derived from a piece of acting - the midnight prowling - which was handled by staff not as a piece of mischief but a clinical communication and a story that needed to be reported to the therapist.

Working closely with the therapist, the staff acquired an attitude of clinical attention to minutiae. When Tom refused for weeks to tie his shoes or fasten his belt during the first months in the hospital, the staff at first tried to handle this realistically, quietly insisting that he get himself dressed like all the other boys. But soon they began to sense something else beyond this apparent negligence. He became anxious when he tied his shoes and behaved as if wearing a belt was a form of torture. Again they urged Tom to take this up with his doctor as "a problem" and temporarily relaxed their insistence upon conforming. As this material came into treatment, it led into the most extraordinary and unexpected paths. Tom's fantasy was that tying his shoes and fastening his belt "cut off circulation" and would make his body numb. This led him in turn to another dread. We knew during the first months of hospitalization, that Tom had a curious writing inhibition in the classroom and would avoid any exercises that required writing. He told his therapist that writing made his hand "numb" and that when his hand became numb he felt as if it had gone dead. Numbness, deadness, panic at loss of sensation now crowded into the therapeutic picture and led in the course of weeks into the ultimate horror - the fear of loss of sensation in the penis, the fear that the penis would "go dead." (This was, of course, the basis for his compulsive masturbation - the need to revive the dead penis and reassure himself.) It also spoke eloquently for a more profound dread, we knew, the fear of the death of the ego itself. When the fear of the "dead feelings" were worked over during this period in relation to the penis, the hand writing, the shoe tying, the belt fastening,

we saw an impressive symptomatic improvement. The shoes were tied and the belt fastened as a matter of course. But much more important, Tom began to do written work in the classroom for the first time in his school history and writing dropped out as a problem thereafter.

In this kind of collaborative work between the therapist and child-care staff, the problem of confidentiality must receive sober consideration. We know that respect for confidential communications is as important for the work of child therapy as work with the adult. The kind of sharing of information which we employ entails certain risks even when the child himself understands the reasons for this communication between therapist and staff. The child can only tolerate this kind of sharing when he, himself, experiences the benefits of his therapist and staff working together. Tom, for example, understood very well that when his ward staff understood the kind of anxiety that precipitated his wild acting out that the staff could help him with his anxiety at critical moments. But there are times when the child may feel that certain kinds of information should not be transmitted to others from the therapeutic sessions. And he may be right. The following example from Tom's case is illuminating in this respect:

There was a period in Tom's treatment when much of his homosexual longing and dread centered on Charles, a Negro staff aide. He was afraid of Charles and had disturbing thoughts that Charles would like to kill him. He had fantasies that Charles would come into his room at night and stab him or "change skins" with him, and during this period, Tom had difficulty in falling asleep. Charles, sensing the fear and hostility in Tom, tried to "make friends" with

Tom in order to dissipate some of the irrational hatred the child felt toward him. And, of course, the friendliness of Charles only created more anxiety on Tom's part. As the feelings toward Charles came into treatment and were linked to other material in the therapeutic transference, Tom began to see how fear of Charles was connected with his own homosexual fantasies and with some dimly remembered experiences with Negroes in the past, in the days when he wandered around the city streets and found excitement in the Negro quarter of the city.

And now, almost abruptly, Tom closed off further exploration of his feelings toward Tom and toward Negroes. Was it his fear of the homosexual transference in therapy? Was it the fear of remembering a homosexual experience in the past? We could not be certain and waited to see what forms this resistance would take. Soon we began to see a pattern. For the first time in Tom's hospitalization, he began to complain that he could not trust the therapist. He complained that the therapist was in league with the staff against him. He began to prowl around the door of the conference room when he knew that the therapist and staff were having their regular ward conference. He claimed that he overheard the therapist talking with the ward staff about sex and that now everyone on the ward was looking for sex-play whenever Tom was horsing around with other boys.

Apart from the transference implications in the fantasy of the therapist "plotting against" the patient, we felt that Tom had a legitimate grievance. We had begun to explore in therapy some very painful material in the area of homosexual conflict. Shameful

memories had begun to emerge and self accusations "you are a queer." It is painful enough to talk of such things in the privacy of therapeutic sessions. If one knew that such shameful things had to be communicated to the entire ward staff, including Charles, perhaps, why should one speak of these things at all?

At this point the therapist did two things. First he presented the problem to the ward staff in general terms. He explained that Tom was working on some very difficult problems in therapy, problems in generally the sexual area, and that he appeared to be afraid to have others know about them, even the staff who had been trusted with all kinds of confidential information. The therapist frankly confided his dilemma to the staff and asked their advice. The staff immediately expressed sympathy for Tom. Who, they felt, would want to discuss embarrassing sexual thoughts or experiences if everyone in the hospital were listening in? They suggested that Tom be given assurance of confidentiality for certain information.

Now the therapist asked Tom if he felt that he could trust the therapist if something very private came up not to discuss it with others. Tom said that he could and that he had been worried that his hatred for Negroes would be communicated to the ward and that this would make life harder for him there. Subsequently, the flow of material resumed, and acting out diminished. No complications were noted in the triangular communication between the therapist, patient and staff. Such complications only occur, we feel, when staff are told arbitrarily that certain information is withheld because it is part of the doctor-patient relationship and is excluded without staff understanding of the reasons.

These fragments from the hospital treatment of Tom do not, in themselves, tell the story of Tom's treatment. (A detailed report of the therapy is planned for another publication.) We should mention, however, that Tom's hospital treatment was brought to a successful conclusion toward the end of the third year. During the last year of hospitalization, when Tom was fourteen years old, he was attending a public high school and, as already mentioned, his school work was regarded as very good (he was functioning at the top of his high average capacity) and his classroom behavior was unexceptional. The homosexual conflicts achieved very favorable resolution in therapy and Tom demonstrated at fourteen a healthy interest in girls and an appreciation of his own masculinity. In all areas of ego functioning there were significant changes, but most important of all were those seen in the capacity for human attachments. This child, who had only mourned his dog when he first entered our hospital, made his farewells to the therapist and certain staff members with tears in his eyes and he was not ashamed of his tears.

Tom, we reflect, could never have been treated on an out-patient basis. We are also convinced that we could never have obtained access to the conflictual material that underlay this grave ego disturbance if we did not have in our hands the transference potential of the institution. Through the collaborative work of therapist and ward staff that we have described, we found the paths that led from the present to the past and as we saw how memories were revived and transformed into bizarre actions, we were able to construct a therapeutic approach along analytic lines in which the analysis of the transference led the way.

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