PEDIATRIC MENTAL HEALTH UNIT REPORT FOR JULY, 1950

Statistical Analysis of Teaching Cases

Cases seen	No. of cases	No. of pts.	No. of 1 hour interviews with pts.	No. of interviews with referring phys.
1. New cases accepted for intake	8	16	12	10
2. Cases active in treatment	6	12	24	8
3. Cases active in counseling	1	2	2	2
4. Cases active in diagnostic study	1	2	2	2
5. Consultation on cases only - with referring physician	3	3	0	5
6. Cases inactive	0	0	0	0
Total	19	35	40	27
New cases accepted for intake				
1. Accepted for therapy	2	4	8	4
2. Accepted for counseling	3	6	6	3
3. Accepted for diagnostic study	1	2	2	1
4. Referred to another clinic	1	2	1	1
5. No help wanted	1	2	1	1
Total	8	16	18	10
In-Service training of rotating resident				
1. Cases carried in intake	3	3	5	3
2. Cases carried in treatment	2	2	5	2
3. Cases carried in counseling	1	1	2	1
4. Cases carried in diagnostic study -	0	0	0	0
5. Consultation oncases only	2	2	0	4
Total	8	8	12	10

REASON FOR REFERRAL FROM PEDIATRICS TO PEDIATRIC MENTAL HEALTH UNIT

CHIEF COMPLAINTS

	Sex	Age	Referring Physician	Treatment
Behavior problems without significant physical findings				
Attempted suicide, can't be trusted	M	12	Burnip	Therapy
Stealing, behavior problem	M	7	Schade	Counseling
Stealing, behavior problem	F	6	Bruyn	Therapy
Sexual precocity	F	7	Carr	Counseling
Physical and nervous symptoms with behavior problems				
Stuttering, enuresis, shyness	M	7	Cohen McLeod	Therapy
Enuresis, school problem	F	8	Burnip	Counseling
Enuresis, poor relationship with mother	M	14	Cohen	Therapy
Enuresis, "emotionally disturbed"	M	8	Grossman	Referral of father to Adult Psych.
Enuresis, abdominal pain, school problem	F	11	Burnip	Mother returned to Adult psychiatry
Overweight	F	9	Grossman	Felt no need for help now.
Can't sleep, nervousness, fearful	F	10	Louie	Pt. ret'd to mother - symptoms alleviated
Asthma, behavior problem	M	10	Cohen	Therapy
Retarded and/or emotionally disturbed, fearful	M	4	Burnip	Diagnostic study
Mental deficiency, nervousness	M	5	O'Gara	Counseling
Asthma, pyelonephritis, dependency	F	10	Burnip	Therapy
Migraine headaches, poor school adjustment	M	14	Pickering	Therapy

PEDIATRIC MENTAL HEALTH UNIT

TWO EXAMPLES OF CASES UNDER TREATMENT

The following two cases accepted this month for therapy, following intake study, illustrate (1) the problems for which these parents and children sought help; and (2) the help they received in the Pediatric Mental Health Unit.

Case illustrating behavior problems without physical findings

On 6/22/50, Dr. B. of Pediatric Clinic, discussed with one of our staff, referral of Joe, age 12, and his mother, Mrs. N., to our clinic. Dr. B. told us that Mrs. N. was very upset because Joe had made an attempt to commit suicide by slashing his wrists with a pocket knife, and has also been very difficult to manage at home recently. Joe has many problems at home, in that the father is chronically ill and bed ridden, and maintains a very strict discipline with the boy.

Dr. B. discussed the case with us, at which time Mrs. N.'s knowledge of our clinic's function and method of working with patients, as well as her wish for our help, was questioned. Dr. B. clarified these points with the mother and intake appointment was scheduled for 7/6/50.

From the intake interview, it seemed to the therapist that Mrs. N., a controlling, over-protective 44 year old mother, had reached a frustrating impasse in her relationship with her son, Joe, age 12, due to an unrecognized conflict in her feelings of wanting to keep him attached to herself and, at the same time, to be an independent, trustworthy, responsible individual.

At first, Mrs. N. did not acknowledge any responsibilities for the difficulties in their relationship, but angrily projected all the blame on (1) Joe's non-trustworthiness; and (2) her husband's inadequacies and long illness. She also expressed (1) an annoying similarity between husband and patient; (2) the patient to be a hard child to handle because he is stubborn and won't do as she tells him; (3) an unfavorable comparison with his sister; and again (4) what an inadequate person her husband is.

She was able to move in this interview to some realization that perhaps she may be overdoing her protection of the patient and holding the reins too tightly. She also became freer to express (1) her own need for a more satisfying life; (2) that she didn't want her two children to become as emotionally involved as she has been; and (3) that her own inability to express her feelings has been a handicap to her. She concluded that a good relationship with Joe was the most important thing to her now, and hoped that we would be able to see them in the clinic.

In the following three regular weekly therapeutic interviews that followed, Mrs. N. became aware that (1) Joe likes to do things, but he's always been interfered with; (2) she found it easier to give in, though now recognized this handling was good only for the day; (3) she no longer had to threaten to put Joe away in a reform school, feeling it would not help, since she now felt Joe needed more understanding rather than more punishment; (4) she now can be firm with Joe and expect him to follow through; (5) she had done too much for him - every little thing had been her problem, but she is now allowing Joe to be responsible for his actions. She gained this understanding in these three interviews following intake and because she had worked this out through the use of the therapeutic relationship, it had meaning and conviction for her and she was able to put it into practice in her relationship to Joe.

Through Joe's participation in regular weekly therapy sessions, he, too, changed from a dependent, demanding, irresponsible 12 year old boy to one who became able to assume initiative and responsibility for his actions. He, too, became freer to function constructively, especially in his relationship to his parents, where he had previously been experiencing much difficulty.

WILMA BUCKMAN,
Psychiatric Social Worker

PEDIATRIC MENTAL HEALTH UNIT REPORT FOR SEPTEMBER, 1950
Statistical Analysis of Teaching Cases

	No. of cases	No. of pts. (mother and child)	No. of 1-hour interviews with pts.	No. of interviews with referring physicians
A. Cases seen:				
1. New cases accepted for intake	6	12	14	8
2. Cases active in treatment	12	24	76	12
3. Cases active in counseling	8	8	22	8
4. Cases active in diagnostic study	2	2	6	1
5. Consultation on cases only with referring physician	8	8	0	11
TOTAL	36	54	118	40
B. Disposition of new cases seen in intake:				
1. Accepted for therapy	3	6	18	3
2. Accepted for counseling	2	2	7	2
3. Accepted for diagnostic study	0	0	0	0
4. Referred to another clinic	1	2	0	1
TOTAL	6	10	25	6
C. In-service training of rotating resident:				
1. Cases seen in intake	1	1	1	2
2. Cases carried in treatment	3	3	11	3
3. Cases carried in counseling	4	4	10	6
4. Cases carried in diagnostic study	1	1	3	2
5. Consultation on cases only	5	5	0	9
TOTAL	14	14	25	22

D. Chief complaints of patients referred from Pediatrics to Pediatric Mental Unit who are now in therapy.

	Sex	Age	Referring Physician
Behavior problems with physical symptoms			
1. Asthma, pyelonephritis, truancy	F	11	Burnip
2. Frontal headaches, stomach aches, many fears	M	7	Hahman
3. Constipation, fecal incontinence, negativistic	M	10	Cohen
4. Enuresis, poor relationship with mother	M	14	Cohen
5. Migraine headaches, irresponsible behavior	M	14	Pickering
6. Stuttering, enuresis, shyness	M	7	Cohen
7. Diaphragmatic spasm associated with menses	F	12	Simpson

D. (continued) Behavior problems, no physical symptoms	Sex	Age	Referring Physician
1. Sets fires, won't mind - - - - - - - - - - -	M	10	Cohen
2. Steals, lies, poor school adjustment - - -	F	7	Bruyn
3. Attempted suicide, can't be trusted- - - -	M	12	Burnip
4. Asthma, behavior problem - - - - - - - - -	M	11	Cohen
5. Lies, problem at home - - - - - - - - - - -	M	10	Smith

E. Reason for not continuing with patients referred from Pediatrics to Pediatric Mental Health Unit:

	Sex	Age
1. Referred because of obesity, refusal to follow diet, or allow Tbc and Schick tests to be done.	F	9

Mother did not return for second intake appointment, which in this case was necessary because she had been unable to clarify the problem with which she wanted help.

2. Referred because of "nervousness", difficulty in going to sleep at night after listening to radio programs.	F	10

Following intake interview, mother called to say that child had improved considerably in the past two weeks and they saw no need to return to the clinic at the present time.

3. Referred because the patient's mother feared he was seeking sexual relations with older women rather than with girls of his own age.	M	14

Following the intake interview where the mother seemed to gain some recognition of her inconsistent attitudes and discipline, she called to cancel their appointments, saying they both had colds. She agreed to notify us regarding future appointments, but did not follow through.

4. Referred because of blinking movements of eyes, shyness and timidity caused by "inherent small stature".	M	12

The mother did not feel this was a psychological problem. She felt that the use of testosterone to stimulate physical growth would solve the boy's problem.

E.(continued) Sex Age

5. Referred because of enuresis. It was the pediatrician's impression that the enuresis was on the basis of emotional disturbance. M 7

In the intake interview, the father expressed feelings of adequacy in dealing with his son's enuresis, which had improved since the child was in his custody. Since he focused the problem around his own anxieties in relation to his two marital failures and his need for help in this area, he was referred to Adult Psychiatry.

6. Referred because of frequent temper outbursts, many falls, soiling, wetting, and destructive behavior. M 8

Since there was evidence of convulsive susceptibility of considerable degree, patient was referred back to Pediatric Clinic for anticonvulsive regime. This family was also given the opportunity to return to our clinic for therapy should the problems persist following stabilization of patient's convulsive state.

7. Referred for evaluation of emotional difficulties in connection with enuresis. F 11

At time of the intake interview mother was being seen at Langley Porter Clinic for her own anxieties. She decided to complete her therapy there and return here later for help with her daughter.

8. Referred because of "nervousness", vomiting, and disruptive classroom behavior. M 8

Following intake interview when the mother was notified that they would be accepted for therapy, she stated that they now know what to do and that is "to pay more attention to their son".

9. Referred for psychiatric evaluation of an emotional problem between mother and child, which precipitates frequent attacks of asthma. M 7

After given opportunity to clarify her problem in intake interview, the mother decided her conflict with her husband was the primary difficulty. She was referred to Adult Psychiatry.

F. Follow-up treatment.

This case shows follow-up treatment, consisting of four interviews, one year later, of a mother and child who were previously seen in our clinic for nine interviews. In the first series of interviews the mother gained some understanding of why she found it difficult to accept her ten year old son as he is, i.e., difference in temperament and native intelligence, as well as the son's likeness to his father, described as an irresponsible alcoholic, whom she had divorced. She gained some recognition that in her attempts to control her son's growth and development, she was trying to force him to achieve goals beyond his capacity. The boy defied her attempts by anti-social behavior in school and in the neighborhood, which intensified the struggle going on between them.

As this boy experienced understanding and acceptance from his therapist and later, to some degree, from his mother, he became less defensive about his slowness.

One year later the mother telephoned to ask if she could return to the clinic for help in dealing with her son. She expressed being at wit's end regarding his lying and fascination with fire, and feared for other members pf the family and the house.

During the second period of treatment, consisting of three interviews, this mother gained further understanding of her "hollering, bickering, and nagging" behavior toward her son, how it came to be and how unhappy and disturbing it was both to herself and her ten year old son. Following this, she became more relaxed, less demanding, developed some satisfying outside interests (such as Red Cross work) as well as becoming able to see the positive traits in her son. She reported that they were now having a good time together going to the beach, the movies, and having her son's friends, as well as her own, to dinner. Also during this second period of therapy, this ten year old boy became better able to accept the limitations necessary for growth, independence and adjustment in his community through the use of therapeutic relationships.

WILMA BUCKMAN
Psychiatric Social Worker
Pediatric Mental Health Unit

PEDIATRIC MENTAL HEALTH UNIT REPORT FOR OCTOBER 1950

STATISTICAL ANALYSIS OF TEACHING CASES

	Number of Patients	Number of 1-hour interviews with patients	Number of consultations with referring physicians
A. Patients Seen:			
1. New patients accepted for intake	12	14	9
2. Patients active in treatment	26	97	16
3. Patients active in counseling	2	9	3
4. Patients active in diagnostic study	2	8	2
5. Consultation on patients	12	0	12
Total	54	128	42
B. Disposition of New Patients Seen in Intake:			
1. Accepted for therapy	4	12	2
2. Accepted for counseling	3	7	4
3. Accepted for diagnostic study	2	4	2
4. Referred to another clinic	0	0	0
Total	9	23	8
C. In-Service Training of Rotating Residents:			
1. Patients seen in intake	2	3	6
2. Patients carried in treatment	1	2	4
3. Patients carried in counseling	2	5	5
4. Consultation on patients	4	0	6
Total	9	10	21

PEDIATRIC MENTAL HEALTH UNIT REPORT FOR NOVEMBER 1950

STATISTICAL ANALYSIS OF TEACHING CASES

	Number of Patients	Number of 1-hour interviews with patients	Number of consultations with referring physicians
A. Patients Seen:			
1. New patients accepted for intake	32	22	18
2. Patients active in treatment	20	73	11
3. Patients active in counseling	4	4	2
4. Patients active in diagnostic study	2	6	1
5. Consultation on patients	10	0	7
Total	68	105	39
B. Disposition of New Patients Seen in Intake:			
1. Accepted for therapy	12	26	7
2. Accepted for counseling	10	11	5
3. Accepted for diagnostic study	4	5	2
4. Referred to another clinic	2	1	1
5. Parents saw no need for further help	4	2	2
Total	32	45	17
C. In-Service Training of Rotating Resident:			
1. Patients seen in intake	7	12	12
2. Patients carried in treatment	5	10	4
3. Patients carried in counseling	2	2	3
4. Consultation on patients	6	0	10
Total	20	24	29

PEDIATRIC MENTAL HEALTH UNIT REPORT FOR DECEMBER 1950

STATISTICAL ANALYSIS OF TEACHING CASES

	Number of Patients	Number of 1-hour interviews with patients	Number of consultations with referring physicians
A. Patients Seen:			
1. New patients accepted for intake	6	5	4
2. Patients active in treatment	24	82	6
3. Patients active in counseling	6	9	3
4. Patients active in diagnostic study	2	6	1
5. Consultation on patients	14	0	9
Total	52	102	23
B. Disposition of New Patients Seen in Intake:			
1. Accepted for therapy	4	4	2
2. Parents failed to keep appointments	2	0	1
Total	6	4	3
C. In-Service training of Rotating Resident:			
1. Patients seen in intake	3	4	7
2. Patients carried in treatment	7	18	6
3. Patients carried in counseling	3	9	8
4. Consultation on patients	6	0	7
Total	19	31	28

PEDIATRIC MENTAL HEALTH UNIT

CASE ILLUSTRATING THERAPY IN A DISTURBED STEPMOTHER-CHILD RELATIONSHIP

This is a case illustrating the results of therapy in the disturbed relationship between Timmy, a 10-year old boy, and his stepmother, who brought him to Pediatric Clinic with the following complaints: (1) frequent lying; (2) doing poorly in school; (3) being a problem in the family; (4) difficulty in managing him; and (5) fear that he will get more and more out of control.

Timmy has been known to U.C. Hospital since the age of 7, with the following diagnosis: bronchitis, gingivitis, dermatitis, and behavior problems. Psychometric tests revealed "normal intelligence" - I.Q. 102.

Timmy has lived with his father and stepmother in San Francisco for the past three years. Formerly he lived with his mother, father, and maternal grandmother. The father states that the grandmother took care of Timmy while the mother worked and that they had a good relationship. In his present family unit Timmy is the oldest of four children, having a stepbrother, age 6, and two half-brothers--one age 3, the other, 7 months old.

Timmy and his stepmother were seen in our clinic from October 12, 1950 to January 11, 1951 for eleven interviews. The father came to the Intake interview on September 5, 1950 with the stepmother, but found time for only one other appointment. Timmy was seen by Dr. Gofman, whose summary of the play therapy sessions will follow the summary of the interviews with the stepmother. I saw the stepmother and the results of our therapy sessions are as follows:

In the first four interviews, as I gave recognition and showed interest and understanding of the stepmother's problems and her feelings regarding these problems, she was able to express (1) her feelings of "aversion and resentment toward Timmy," feeling that he was "aggressive, impolite, pouty, and sulky," (2)"resentment" toward her husband's "smallness and meanness," (3) her inability to communicate with her husband, "I shut myself up like a clam," (4) how she "hates and dreads to have Timmy come home from school," (5) "feeling tense all the time," and (6) her rigid "control and demands" on Timmy. She also became free enough in our relationship to relate how Timmy felt (1) "imposed upon," (2) that "everyone was forcing him," (3) that "he wanted to strike out for himself" and (4) that "he had no time to play."

When I asked her to tell me the problem with which she wanted help she explained: "He feels my dislike. I'm putting my foot down too much. I would like to learn to get along with him, especially when he's irritating."

As she experienced these feelings in relation with me and I gave her acceptance and support by understanding her feelings of "resentment, inability to communicate," etc., and recognition of her strengths and readiness to do something about her problem, she became more tolerant of Timmy's need for development of his own capacities, recognized now by her as a need "to try on his own," and allow him "to learn at his own pace."

In the fifth interview she expressed a new awareness and perspective regarding a more constructive and satisfying use of herself. She brought

out how she used to feel,--"I didn't feel up to facing problems, they were too much for me, I used to let them ride. I had gotten into a rut, I wasn't aware of what I was doing except that I was continually exasperated and had become progressively more tired and exhausted, not only physically, but with the total situation." When I acknowledged her feeling, "I can understand how tired and exasperated you must feel using all your energy this way and getting very little satisfaction in return," she became freer and recognized, "I had never learned to think things out or to use myself. I really have been quite lazy and allowed things to drift." She now expressed "determination" and "to make some effort to work out the home situation."

Following her expression and my acceptance of these feelings and determination to make better use of herself, in the next interview she talked about the progress she had made and her change of feelings toward her stepson. She acknowledged, "I was trying to run every little thing and was too possessive." When I asked, in order to clarify, "And what were the results of this? What did you gain?", she said, "I just became a tyrant. Now I am letting him learn." When I called to her attention, "But you did make the effort and accomplished this," she told how recently she has allowed Timmy to assume some responsibility for his own behavior and with favorable results. She seemed quite proud to relate that she has not nagged him about practicing, saying to him,"It's going to be up to you to practice when you can and will." She added, "You know, he did without being reminded." I said, "Well, then, Timmy does seem capable of assuming some responsibility for his behavior." She agreed, saying," I have tried to live everything for him."

In the seventh interview this mother seemed very pleased with her success when in an animated manner she related, "My feeling toward Timmy is changing. It is so much better." When I asked in order to help clarify in her own mind, 'In what way', she said, "I feel more relaxed. I have the attitude now that he's pretty good and that I had expected too much." When I asked, "How about Timmy, what has he done and has he improved too?" she acknowledged, "Yes, he is happier, and he feels better about having his friends over. Also, you know he is doing better in reading." When I asked to what she attributed her change of feeling and Timmy's improvement she explained, "I expected perfection and really I used to work myself to death. Now it's different. I think I have a more relaxed attitude about Timmy." When I inquired about herself, for emphasis on the importance of her feelings, she admitted, "Oh, yes, about myself too, I'm not so worried about the housework being done exactly on time, as I used to be. I feel so much freer and can let Timmy be freer too."

Also, in this interview she talked about her own childhood, how every member of her family feared to show their feelings. When asked why the fear to show feelings she said, "My father was the cause of it. He was very stern. I never felt I could explain anything to my father and mother. However, my dad now realizes that was wrong and recently, when he has come to visit, he is more relaxed, like a human being. I now realize I was doing the same with my family."

She came to the eighth interview in exuberant spirits and announced, "I can stand up alone now." When I was interested in how she liked that and how it happened she said, "I feel more confident of myself. I feel better toward Timmy these days. We're both much more able to bring

things out in the open. I have been seeing things differently since talking it over with you." When I was interested, "How are things different?", she described her change in feeling toward Timmy and in herself. "Previously I was looking at Timmy as being a big person. Also I used to keep him in place and my thumb on him. I used to let people step over me. Now I assert myself, something I had not been able to do before. I used to keep things to myself and I did that an awful lot. I found myself brooding and making the situation terrible." She also felt free to acknowledge, "I was all set when I first came that Timmy was a delinquent. I used to hate kids and used to be afraid to tell other kids what to do and not do in the house. Now I'm no longer afraid."

In the ninth, and next to last interview, she talked about how much better she was getting along with her husband as well as with Timmy. "We had such a lovely Christmas. My husband and I felt so much better and it was so much more fun. Before coming here, I thought I would be happier if I let other people take over for me. I did not feel important." Also Timmy and she had discussed termination of therapy and together had decided that they would come one more time, since Timmy too, felt better, seemed to be doing well in school and they were getting along. Timmy now was "doing dishes without my nagging and bringing friends home" and she was able "to let them play alone without watching them and they did all right."

She opened the last interview with "Things are going along so much better between Timmy and myself." When I asked, to help her gain awareness of her own feelings and the important role they played in motivating her behavior, "To what do you attribute this?" she explained "I'm

better able to discuss my feelings. Before I couldn't admit a mistake. I felt the children would lose confidence in me as a mother. Now I want them to be able to admit their mistakes and be free about it, so I guess I have to set the example." She related how she did this. "You know, when I blow my top and later admit that I certainly was angry about a certain situation, I've noticed that Timmy does the same thing these days. He says to me, 'I guess I got pretty angry there', and things like that. I see now I show by example."

Also "Timmy has become much more respectful toward me these days. When I ask him to do something, he now says, 'Yes, mom. In a minute, mom', and really does it." To help her gain a clearer understanding I asked, "Haven't you become more respectful toward him too?" She said, "I sure have, but it's funny, this all didn't come at once."

When it was time to leave she said, "Oh, this isn't the end. I feel we are friends now." I agreed but also assured her that, like friends, should any problems arise they could return. As Timmy and she were leaving the clinic together, she said, "Doesn't he have nice dimples?" This was a very different attitude as contrasted to one three months ago when he was showing her a painting he had made in his play therapy session, and she gave him no acceptance or recognition whatsoever, but just dismissed him.

WILMA BUCKMAN

Psychiatric Social Worker
Pediatric Mental Health Unit

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THERAPY WITH CHILD

Timmy, aged ten, was referred to the Pediatric Mental Health Unit because of complaints of lying, doing poorly in school, and in general being a problem in the family.

Timmy is a nice looking, very pleasant, active ten year old who appeared very eager to please. During the first part of his eleven interviews he made a great effort to appear to me to be a very good boy with no faults.

Some comments he made which illustrate this are: "I used to get fifty cents a week but now I get only twenty-five cents. I broke a window." When asked how he felt about that he said "Oh, good. I like to pay for windows." In drawing "I can d o better. I'll show you what I can do"...."You know, me and Sammy are the best drawers at school."...."When the other kids see this, they'll think I'm a good artist but tell them I'm just beginning." He volunteered "I do dishes all the time--morning, afternoon and even at night." (?) "Oh I like to. I like to help. My mother needs help."

At first Tim had difficulty in accepting the idea of coming to the clinic. The first interview he denied that he knew why he was coming then said "Well, I guess it's to help out." ("To help out whom?") "To help out myself--I want to get A's at school instead of D's and I just can't catch on, but I want to." I explained to Tim that this was a place where perhaps he could get help with some of his problems and I was here to help him if and when he wanted it.

I think for the first three or four times he thought he was going to get specific help with his school work here, for he came back to the next four interviews saying he wasn't coming back--although he always eagerly

signed his name on the calendar for his next appointment. "I'm going some place else instead--I need other help in arithmetic and reading." I explained to him that I wasn't a teacher who could tutor him but that if he wanted extra help perhaps he could ask for it at school. He presented in the first six interviews many reasons why he couldn't get extra help--he had substitute teachers who thought he knew it, the teachers didn't want to stay after school--dental appointments interfered, etc. etc. He repeatedly hinted that he was missing a lot at school while he attended the clinic--art class, Indian lore, "Rudolph the Red-nosed Reindeer", etc.

Whenever he stated he wasn't coming back I said it was up to him and his mother to decide about this and he could talk this over with her if he wished. I suggested that perhaps he was confused as to why he was coming. He said "Yes, I am and I'm going to ask my mother." However, the next four interviews he still had not done this and offered the excuse that he was too busy or forgot. I think Tim wanted to put the responsibility on my shoulders--he said "You don't know what my problems are?" ("No I don't Tim, I'm here to try to help you with whatever <u>you</u> want help with.") He said, warmly, "Fine, Well I'm going to find out before next time." (Alright, you talk to your mother. You two are the ones who should know and I guess you have to know what you want help with before you can work on it, don't you?") Tim said "Yes."

In this interview I tried to help Tim understand that I couldn't tell him what his problems were that it was up to him to talk this over with his mother and then tell me when he could and wanted to. One of the

big problems between this boy and mother was their inability to talk with each other about their difficulties and to understand and accept each other's feelings. This Tim and his mother were able to do in the week following and with this discussion his attitude toward the clinic changed. He said, in the sixth interview, "I can do everything here we do at school!" He was then able to "let down" a little on his need to appear so perfect for also in the sixth interview he said "I'm going to a friend's tonight and oh boy! I won't have to do the dishes. I've been doing them every night for three years." I asked how he felt about this. He said "Well -- I don't get paid but it's fun -- it keeps me busy at night." He added "And I take the washing down every day too." ("What do you think about that?") "Oh, it makes me happy to do that." ("But I bet you can think of other things you'd like to do too?") He grinned and said "Yeah, play."

The seventh interview Tim came back saying "I got help from the teacher myself and I know my times tables now." ("Well, Tim, I guess you took care of that yourself.") "Yes, it took all my brains to do it, but I told her I wanted help and she gave it to me."

During this interview he was able to hint that he did have other difficulties than those at school. He said "My father says I'm supposed to come here." ("How do you feel about that yourself?") "Well, my father and mother say I'm supposed to come here for help and so I'll come."-- he paused, then added "And I need help and so I'll come."

In this interview, and those following, he was able to admit he

had fears and negative feelings in contrast to his former attitude. He told how mystery programs gave him bad dreams, how he was afraid at times kids might make fun of him in his guitar class. He also said "Sometimes I hate to come here but I must." Then for the first he stated one of the main reasons he and his mother were coming "I just must to get along better with my mother--that's why we both come and if we want to we can..it's hard but if we want to I guess we can." and added "There are three other naughty boys at home." ("Other?") "Well, sometimes I'm naughty too. I want to be good, I try, but I get bored and then blooie. But the other boys are naughty too....Why doesn't my family come?" ("You wonder why you're the one who comes?") He answered this himself saying with pride "Well, it's because I'm the biggest."

In the ninth interview Tim talked quite freely about why he was coming to the clinic. He said "You know I come here to get along better with my mother." ("How are things going, Tim?") "This morning she yelled at me because I spilled some cereal but when I explained about it, she apologized. If you explain, you can get along a lot better."

His mother reported at this time that Tim's grades had improved and that she was much happier with him at home.

In the tenth interview he showed that he was able to admit to himself and his parents his negative feelings when he said "I had to baby sit on Christmas and was I mad! I put up a big fuss but I had to anyway." ("How did you feel about that?" "I hated it. Now it's all over with, and I don't care but I sure was mad then and I don't want to have to do it again on

Christmas." After a pause he said "You know next week is going to be my last time--I think so. I'm going to find out this week how I get along at home. My mother says she's done but I'm not sure. I want to wait and see this week. Gee, I hope the hour goes fast today." ("Maybe you're really through here Tim.") "Maybe but I have to see this week." ("You seem to have trouble deciding.") "Yeah, I usually do--Do the other boys stop coming here?" He was assured they do.

He came back to his last interview saying "Well, this is my last time." ("I see you've decided. How do you feel about it?") "Well, kind of glad and kind of sad. I like it here so much." ("Kind of hard to decide to stop?") "In a way yes, in a way no."

At the end of the hour, he started to play marbles instead of leaving and I said "It seems you're kind of lingering today." He said, "I like this game." ("Maybe it's kind of hard to stop Tim.") He nodded his head then gathered up his coat and said "I must look at everything for the last time" and enumerated all the toys he had used in his play. "And now I have to get a list drink." As he did this, I explained that if in the future he and his mother had problems they wanted help with, they could always come back and see us. Tim looked quite interested and when he left he said "I might see you again some day." I said "Maybe you might Tim, and you know where we are."

It was my feeling that Tim had worked out his difficulty and was ready to stop therapy. He was able at times to talk about his shortcomings and was no longer the boy who used to tell how much he loved doing the dishes and working around home to help his mother, but could at times

admit there were other things he'd rather do.

One of his chief complaints when he was referred here was lying and I think that now with Tim able to admit his negative feelings and mistakes, lying is no longer necessary. He was greatly helped in achieving this by the progress his stepmother made in also accepting some of his limitations and negative feelings; and also herself being able to admit to Tim that she, too, is sometimes wrong and makes mistakes.

HELEN GOFMAN, M.D.

Pediatric Mental Health Unit

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