A MULTIPLE APPROACH TO CHILD GUIDANCE[1]

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Child guidance as practiced at the Alfred Adler Consultation Center and Mental Hygiene Clinic is a continuation and further development of the work of the child guidance centers which were started in Vienna by Alfred Adler soon after the first World War. These centers and their work have been described by numerous writers (among others: 1, pp. 392-398; 3, pp. 109-175; 5; 6; 7).

The original procedure took place in the presence of a small group of teachers, parents, and other interested persons. Since the center was connected with the public schools, it was a teacher who presented the problem of one particular child. From this presentation, Adler analyzed the background and possible reasons for the child's problems. Then the mother was called in to present her side of the story, and after that the child, to tell how he felt about the situation. In an encouraging, often humorous way the child was given hints for changing his attitudes, and was asked to return in a week or so. Then the mother was called in again; the understanding gained so far was conveyed to her in a tactful manner, and possibilities of improvement were dwelled on rather than criticism. As additional clinics were set up, these were conducted by therapists trained by Adler, and, indeed, the original purpose of this kind of group procedure was to serve as a training device.

Today, such centers continuing the Adlerian tradition are operating in Vienna, Chicago (2, pp. 180-197) and Los Angeles, as well as New York. They conduct child guidance sessions, including the mother as well as other key individuals, thus providing understanding of the social setting and using the "group" procedure for encouragement and insight.

If the complaints deal with school problems—peer behavior, or learning difficulties—contact is also sought with the teacher or guidance counselor. In most cases, full cooperation can be elicited and progress more quickly achieved.

In our present work, child and mother, after an initial interview with the psychiatric social worker, are assigned for psychiatric diagnosis. The psychiatrist, in the tradition of Adler just described, con-

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ducts these interviews in the presence of a group of staff members with whom plans for further treatment are made. A multiple approach is then applied in the following way.

APPROACH TO THE MOTHER

The mothers are assigned to group discussions, while the children are observed and involved in art therapy and/or play therapy, individually at first and subsequently in groups. Fathers occasionally are drawn into the counseling process, siblings regularly, and even grandparents, if available, because we have found that problem children can best be helped if a change in the relationship of the whole family is brought about.

Most mothers are at first afraid that they will be unable to speak up in the presence of strangers. But they soon realize the benefits to be gained from listening to other mothers who are faced with similar problems. They become so deeply involved that their discussions branch out from educational into other intra- and interpersonal spheres. Many a mother is encouraged by the progress report of other mothers and also learns to be patient and accepting of temporary regressions. Retrospectively, we realize that we have been practicing with mothers for many years what has since been called *didactic group therapy*. These groups are open; strengthened by the confidence gained in themselves and others, the members do not feel disturbed by newcomers, or by professional persons who are invited for observation. The mothers also become used to occasional visits to the group by their own children who, in the beginning of their treatment may feel the need to reassure themselves of their mothers' presence. The children's visits are welcomed by the group leader because they offer an opportunity for object lessons, i.e., for interpreting the mother's reaction to the child's behavior, and vice versa, and for demonstrating how to set limits without enforcement.

APPROACH TO THE CHILD

While the mothers are in their group, the children are selected by the therapists for either play or art therapy. They are assigned to play therapy for the free expression of their emotions. The play therapist observes and draws conclusions from the choice of toys, the use made of them, and the accompanying verbalizations. She encourages the expression of feelings, positive as well as negative. Occasionally, she interprets such feelings to the children. In group play, the children

may experience the consequences of anti-social behavior, and are guided by the therapist toward fair play. This is especially valuable when siblings participate in the same group, both for the conclusions that can be drawn about their life style and basic relationships as well as for the therapeutic effect.

In the art group, which is also made available to all the children, they project their feelings in their activities and drawings, and communicate their emotions by their attitudes and the intensity with which they go about their tasks. Their drawings mirror their biased apperception of their bodies, family, and social relationships. They reveal their fears, their way of aggression, and their kind of defenses. Just as every person has his style of life, he has his style of graphic presentation. The art therapist uses the verbal and non-verbal communications of the child for therapeutic purposes (4).

This multiple approach with its teamwork is helpful in arriving at an integrated understanding of the dynamics of a given case. The therapists of the mothers' group, the play group, and the art group meet before and after their sessions to coordinate procedures and exchange observations.

Two Brief Case Histories

Case I. A widowed mother came with her 8-year old boy who used vile language, was ill-tempered, had nightmares and suffered from enuresis. In the *mothers' group*, it soon became evident that the mother was extremely sensitive to the boy's behavior and reacted strongly to it because she felt that she had to take over the father's role too and thus felt doubly responsible. She was always getting involved in long discussions with her son because she herself was insecure as to what extent her demands were justified. Only slowly did she learn that mothers, too, have a right to make mistakes, and that she should not expect perfection either of herself or of the boy.

Meanwhile, Mike experienced in the *art group* that he had to share the therapist with other children. He often started fights, but, by being protected from older aggressive boys, he gained more and more confidence in the therapist, who became for him, temporarily, a substitute for his father. His temper and demanding attitude were discussed with him.

Gradually, Mike learned to accept limits and could now take part in the *play group* without getting involved in fights. But there were many fluctuations in his behavior. There were weeks when his mother

reported that their relationship had improved and the home atmosphere was calmer, but the bed-wetting remained a barometer for Mike's ups and downs. Whenever there was a challenging situation, e.g., when his mother lost patience with him, he went into a temper and wet the bed. With the passing of time, these incidents became scarcer and, after 15 months of weekly and bi-weekly visits to the Center, the summer months excluded, the mother felt secure enough to handle occasional flareups on her own, in a more effective manner.

Case II. Mrs. T. was referred to the Center because her 8-year old daughter had been vomiting for the past two years every morning before going to school, and her 10-year old boy was a bed-wetter. Both children were from her first marriage which had ended in divorce when the children were very young. Mrs. T. had re-married four years previously, and the children were reported to have a very good relationship with her second husband, whom they call "father." No reference had ever been made to their real father. Mrs. T. was tense and seemed over-anxious about the problems her children presented.

The children seemed well developed and intelligent. The girl was pretty but somewhat overweight and presented the picture of a child who wants to please. The boy was rather thin, lively, and seemed more intelligent than his sister. Both displayed normal sibling rivalry. Time and again, the mother questioned whether the children were not abnormal, and she could not be reassured either by the play or the art therapist. At her request, a second psychiatric interview was arranged. The diagnosis confirmed that her children did not show any signs of mental disturbance. It was only then that the mother revealed her apprehension: Her divorced husband had been hospitalized three times for schizophrenic episodes, and she was afraid that the children might have inherited some of the father's mental derangement. That was the reason why she had not talked to the children about their father, and she was afraid that if he were to appear some day, she would not know what to tell them.

From here on, the group became particularly helpful to Mrs. T. There were two other divorced women in the group; by learning about their experiences and comparing them with hers, Mrs. T. gained insight into her own guilt feelings about having divorced a sick man and having married a second time. Gradually, she became more self-assertive and secure in dealing with the children. She was able to discuss the situation with them freely and could now face the possibility of her first husband re-appearing some day.

The children, meanwhile, in art therapy, learned to express their feelings in painting, drawing, and clay work. The art therapist reported discussions of somatic symptoms, sibling relationships, and cooperation in the home, and the giving of sex information. As the children became more self-reliant, the symptoms disappeared and a much more relaxed atmosphere in the family developed.

SUMMARY

After an initial interview and psychiatric diagnosis, the mothers who come for help at the Alfred Adler Consultation Center and Mental Hygiene Clinic participate in group discussion, while their children are observed and involved in art and/or in play therapy, at first individually and subsequently in groups. At the end of the session, the therapists of the three groups meet for the pooling of their findings and discussion of further steps to be taken. Fathers appear occasionally, siblings regularly, and even grandparents participate when available. The cooperation of teachers is also elicited. Our experience proves that "problem children" can best be helped in the shortest time if their families, and even the school, are simultaneously involved in the counseling process.

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