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AUTHOR Stein, Myron; And Others
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ABSTRACT

This report describes a 4-year project at the Sarah Lawrence Nursery School in which the teacher's role was expanded to include extensive work with parents. Nursery school teachers, after conferring with psychiatric consultants about children's problems, had frequent meetings with parents in which observational and childrearing information was shared, and effective strategies for dealing with individual children were worked out. Eleven case studies are presented, representing families who worked closely with the nursery school teacher and were helped to handle difficult situations with their children. Implications of the project for preventive psychiatry and mental health services for preschool children are discussed. (DP)

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BEYOND BENEVOLENCE—THE MENTAL HEALTH ROLE OF THE PRESCHOOL TEACHER*

By Myron Stein, M.D.
Evelyn Beyer**
Doris Ronald**

The material in this report derives from a four year experience at the Sarah Lawrence College Nursery School. This is a school for normal children, supported by the College to give the college students an opportunity to observe nursery school age children in action, as well as to observe the functions of a nursery school and of nursery school teachers. The teachers are highly competent, and from their ranks come many of the leaders in nursery education in this area. In addition to teaching the children, they meet with and teach the college girls who have participated in the nursery classroom as assistants and as observers. Other observers include members of the Psychology and Child Development Faculty and their students who are there to learn about child development.

Our project was not a complex one. It involved an attempt to assess and enlarge the role of the nursery school teacher in facilitating optimum child development. It began with the Psychiatric Consultant meeting on a weekly basis with the teachers and other faculty members involved in the nursery school. At first, these sessions involved presenting material about a child to the psychiatrist, who attempted to clarify the psychological issues and ways of working with both the child and his parents. After a

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**Dr. Stein was Psychiatric Consultant to the Sarah Lawrence College Nursery School and is currently Associate Director of the Center for Preventive Psychiatry in White Plains, New York.

Miss Beyer was Director of the Sarah Lawrence Nursery School and is now a faculty member Emeritus of that college.

Mrs. Ronald was a teacher and faculty member of the Sarah Lawrence College Nursery School and is now Educational Director of the Center for Preventive Psychiatry in White Plains, New York.

time, it became obvious to the consultant that he was doing "flying consultations," handing down dicta for the teachers to carry out. Frequently the children were discussed in these sessions when they were out of hand and the psychiatrist was expected to take over. Often there followed a short meeting between parents and the psychiatrist in which he recommended, often to no avail, that they seek a more complete psychiatric evaluation.

In trying to understand this unsatisfactory situation, we realized that the teacher, who had a longer and more intimate relationship with the parents and the child, somehow did not use this relationship to work very much with the parents on some of the normal emotional difficulties which are part of child development. Instead the parents were turned over to the authority, the psychiatrist, who could not make his recommendations stick on such short notice and with so very little real contact with the parents.

From this situation we came to realize that the teachers should try to do more with the parents. We felt that the teacher was in more intimate contact with the parent-child community, and that this contact should be taken advantage of just as indigenous therapists have taken advantage of their greater community contacts in work in their communities.[1, 2]

The issue was raised then and many times since about the appropriateness of the teacher's attempting to function in the mental health role. Was this not more the function of the psychiatrist, social worker, general physician, pediatrician, or even minister. In answer to this we refer both to the literature on statistics of available child help and to our own clinical experience.

Professionals in this field are impressed with how little is done for the mental health of children, despite a great deal of talk about it.[3]

In a 1968 study of child therapy in Westchester County, it was found that the largest neglect of mental health help for

children occurred in the preschool child. In our affluent and child-oriented community, we found that, of a child population aged two to five of 64,000, only forty-six of these children were receiving any kind of treatment by professionals. Older age children fared better, but not appreciably so in view of the various estimates of the urgent need for treatment of children. This ranges from two to twelve per cent and higher with a much higher estimate of less severe psychological and developmental problems which also could use help.[5, 6, 7, 8]

With a startling shortage of child psychiatrists (700 board certified, 300 additional trained child psychiatrists in this country), coupled with the disinclination of psychiatrists, child psychiatrists, and other therapists to work with the preschool child, there is really very little actual treatment of this age child going on.

The busy physician is usually too busy, or for other reasons reluctant, to become involved in a great deal of guidance of parents, so that in the end it seems that there is very little preventive work being done with parents and children in the preschool years. Referrals increase greatly when the children get into school and when their disturbances become more interfering with the school routine.

The question arises as to whether there is any such thing as meaningful preventive work to be done with the preschool child. For those of us in this field, it is an absurd question, but there are many people who do not feel so. Adult psychiatrists often have said to the parents that children cannot be treated prior to the age of adolescence, and will counsel that children should be left alone. Anna Freud refers to the benefits to be gained from parent education in situations where the parents' pathological needs are not so great as to make this educational guidance ineffective.

Impressions of children in a normal population in regular, non-therapeutic nursery schools, seem to indicate a much higher

incidence of transient emotional and developmental disturbances, than the usual estimates of psychiatric illness. Some of these disturbances and symptoms disappear spontaneously without any apparent subsequent ill effects on the child's functioning; some give way to other minor disturbances or symptomatology; and some act as significant blocks to development. We have come, in recent years, to think in terms of preventive work with children and their parents in times of crisis. These situations include divorce, bereavement, sexual assault, etc.[9, 10] We have even come to realize the preventive function of education in helping the parents to help the child, by our familiarizing the parent with the norms of childhood, and reassuring them so that they can work less anxiously with the child.[11, 12, 13, 14] It is in the in-between area, the area of the transient developmental difficulty of the child that we have fallen down—somewhere between the excellent literature on child rearing and the sometimes excellent although numerically insufficient treatment of children with fixed disturbances. What about the child of preschool age with some difficulties, some signs that something is wrong? What about the perplexed parent who doesn't function appropriately with the child and doesn't know what to do?

The Nursery School Teacher:[13]

The nursery school teacher has, at her best, tried to fill this gap. Some of the better nursery school directors and teachers over the years have conferenced with their staff and their psychiatric or psychological consultants. They have tried to understand puzzling children and parents, in order to help them in and outside of the classroom. Despite the shortage of psychological and psychiatric consultation time, it is our experience that when schools really want this they can manage to get it.

Conferences between teachers and parents are a fixture of the nursery school routine, as they are in many of the higher grades. Unfortunately, as in the higher grades, these conferences are too infrequent, too superficial, and hampered by the

teacher's reticence to share her trained observations with the parents. It is our conviction, as it is that of others in this field, that the preschool teacher is pre-eminent in her knowledge of children, and that from her prolonged and intimate observations of children comes unique knowledge of their functioning. It is this experience and this knowledge of children on which we seek to draw in enlarging the scope of the nursery school teacher. By taking advantage of this experience and knowledge, we feel that an important preventive mental health function can be carried out which otherwise will not be done by anyone.

What is a Nursery School Teacher?

From the psychological point of view, we see the nursery school process as involving the facilitation of the separation from the mother and home, and moving towards the teacher and subsequently to peers; the support of the ego in its many functions involving learning, reality testing, handling of impulses both external and internal; and the chance to work through the concerns and crises and issues of normal development. This is done through the use of fantasy in play, identification with the appropriately friendly but also appropriately gently limiting teacher, with consequent growth and a feeling of well-being and competence in living.

What does the community and what do the parents think of nursery school teachers? They like them. Nursery school teachers are usually nice people. One parent once described the nursery school teacher as someone who does not yell at children. Hopefully, she was right, although this definition hardly encompasses the functions of the nursery school teacher. Some parents and communities look upon the nursery school teacher as a glorified baby sitter, who, however, is not so glorified that she need be decently paid. Some parents resent the nursery school teacher for not "teaching" the child more. They do not realize that the good nursery school teacher teaches things which are more important than reading, writing and arithmetic, namely an

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ability to function and get along without which meaningful learning can be impossible, now, and meaningful living can be impossible in later years.

What Does the Nursery School Teacher Think of Herself?

Although the nursery school teacher will bridle and object when told about her baby sitting function, too often she seems to view herself in this light. The more professional teachers and directors such as those at Sarah Lawrence Nursery School have always gone beyond the baby sitting role to a search for understanding and implementation of ways of facilitating growth in children. Despite this, there is still a lingering sense, among many teachers, and among our society as a whole, of the triviality of being engaged in working with children.[3]

It is then not surprising that teachers tend not to sufficiently credit the value of their knowledge and observations about children, and to be very tentative in communicating these matters to parents. They are concerned lest they seem to be trying to be therapists, lest they hurt the parents' feelings and insult the parents and endanger the good feeling between teacher and parents, if they talk about their concerns about the observed functioning of a child in the class, or if they are too "nosy" about what happens at home. Indeed they are often reluctant, and understandably so, to face parental displeasure if they talk about a child's difficulties.

This is understandable in view of the feeling on the part of many parents that we send our children to school to participate in the school process, and not to be psychoanalyzed on the spot by a teacher functioning as an amateur psychiatrist. This attitude of parents is fostered by many things including the defensive narcissism which we have in regard to our children, as well as the sometimes over-eager and over-ambitious psychologizing of the occasional teacher, director, camp counselor, or anyone else who is eager to utilize his incomplete knowledge about psychology.

How then do we go about utilizing the unique knowledge of the teacher in regard to preschool children, and the unique opportunities to observe in great depth and great detail the functioning of the child in this transitional time of leaving the family and moving into the world—nursery school years.

The Project:

As a starting point, it was decided that we would work to have more frequent interviews between the parents and the teachers. This seemed a natural step which could be easily accepted by the teachers and the parents. Initially, we found a great deal of reluctance on the part of teachers to build a continuing close relationship with the parents through frequent parent-teacher conferences. Part of this seemed to be due to the lack of experience the teachers have in conferencing and interviewing techniques. This is certainly a lack which should be made up in teachers' training. Along with this went the above-mentioned uncertainty as to the worthwhileness of the teacher's role, and consequent uncertainty about the right of the teacher to bring the parent in for these interviews, and about whether the teacher had anything worthwhile to tell the parent.

Along with this go certain needs shared by all people in dealing with children. These include the natural competition with the parents and the need to have the child exclusively to oneself, and thus to exclude the parent from the nursery school process. This is a need which, hopefully, we deal with, so that we can include parents and help to enrich the parent-child relationship. Sometimes, in counteracting and denying the need, professionals avoid real closeness with children and parents. Also there is the element of putting oneself under closer parental scrutiny when one has frequent interviews. One then has to question more carefully what one is doing, and why one is doing it. Actually all these issues need not realistically have worried our excellent group of teachers, but they do crop up with teachers in such situations, and some of these issues did emerge with us.

There was the expectation that some parents would object to these frequent interviews, feeling that they were being subjected to excessive psychological scrutiny, an issue that was mentioned earlier. Some parents did object to this initially, but not very many, and not for very long. When the teachers were comfortable about what they were doing, they could state simply and directly to the parents that a closer liaison between the parents and the teacher with the sharing of home and school observations could help the school process, and aid the parents in the child rearing process. Then the parents were usually able to accept the more frequent interviews and, in fact, were eager for them. For a time we found the reluctance of the teachers caused them to miss signals from the parents asking for the next interview. So, several times, the teachers would end an interview and leave the timing of the next meeting in vague form, rather than set a definite appointment. They would justify this in terms of not wanting to push the parents. Later they realized that actually the parents had made a clear request for further conferencing with the teacher, which the teacher had sometimes ignored because of her counter-transference feelings.

The project consisted of, at first, the more frequent interviews with parents to share the observational and child rearing materials. Secondly the working out of modes of coping with the child and helping the child help himself both in school and at home, and the assaying of this work with the child. By sharing the teacher's mode of coping with the parents, often the parent gains immeasurably and is able to identify with some of the teacher's methods. Sometimes the anxious parent gets enough support from the teacher, to be able to handle the child rearing in a much less frantic fashion. The review of the teacher-parent and teacher-child contacts was done on a weekly basis involving a meeting of the teachers, school director, psychiatrist, psychologist and sociologists teaching the child development courses at Sarah Lawrence College.

The role with the child comprised the traditional ego

building, object relations building methods of the teacher. In addition, we sought to observe where the child's fantasies and play communications could be verbalized back to the child, without delving in the fashion of dynamic psychotherapy. We sought to see where confrontation of the child with maladaptive coping measures could be helpful to the child, along with the support, reassurance and acceptance which is the standard stock in trade of the nursery school teacher. We sought to understand the child's defensive measures as they evoked counter-transference feelings in the teacher so that the teacher could function with greater facility in helping the child, rather than only in responding to the defensive measure. In this last regard there was one child who "turned the teacher off." This was a child who sabotaged every effort by the teacher to be warm, giving, or related. When the teacher was able to discuss in the conference what she felt when this child would "turn her off," it was then possible to go back and understand the situation in view of our knowledge of the family and of the child's experience so far in school. It was then clear the child used this backwards language of turning the teacher off, attempting to confirm for herself that the world was a rejecting place, if here again she could succeed in creating a rejecting environment.

In working with the teachers to understand the parent-child units, we were faced, as all workers with children are, with the very difficult problem of assessing the status of the child's development. We were not concerned particularly with diagnosis, or with labeling as to normality or abnormality, but with a developmental understanding of where the child was, what was happening between the parent and child, so that we could know what the teacher could do in facilitating development and the child rearing process. In this regard we found that we could make simple and regular use of a modification of the Profile by Anna Freud[15, 16, 17, 18] basing our "profiling" on the interviews with the parents held by the teachers, and on the very great volume of observation done by the teachers in the course of the school day. By organizing our thinking in terms of the lines of development

of a child in his object relations, his ego functioning, his super ego functioning, as well as having some idea of the typical modes of defenses and coping, and some of the other issues in the Profile, it facilitated our thinking about and work with the children and parents. It also provided a worthwhile reminder of the limitations of the teacher in mental health functioning where there was significantly aberrent functioning. Often the profiling pointed towards the need for more intensive psychiatric involvement. The work of the Child Development Center under Dr. Peter Neubauer in New York City on The Assessment of the Criteria as to Normality and Abnormality in Children,[19] was helpful to us. Using it we learned to assess the difficulties which come up between children, and between the child and the parent without too quickly deciding that we were dealing with a fixed pathological entity.

The types of situations we review here are divided roughly into situations of normal development and transient difficulties; crisis situations; and psychological disorders. Needless to say, the children and parents whom we saw did not fit neatly into these categoris, nor did we think of them in these categories, but we have so divided them to facilitate an orderly presentation of samples of the massive amount of data which we accumulated in the four years of our project. Since the situations which we present do not fit at all neatly into these categories, the reader will find qualities of the other categories in many of the children who are presented.

Guiding the Mother and Father in Regard to Normal Child Rearing:

Child growth can be characterized as going from problem to problem or stage to stage, or as overcoming one bit of concern, quandary or issue after another. It is the sense of confidence and fulfillment in overcoming these issues which give rise to a sense of confidence and well-being in the child. To achieve these multiple overcomings involved in growth, the child must have help from his parents and environment including support, reassurance, understanding, love and limits in something

like appropriate amounts. Particularly for parents of first children, the dilemma of child rearing can be great. Here we have a most important role for preschool teachers to fulfill—that is the sharing of their knowledge of the vicissitudes of child development with the parents, and helping to apply this knowledge to the particular child and the particular child rearing situation.

The method we have used is basically a sharing with the parents of observations of the child's functioning in school. This serves to elicit sharing by the parent of her observations of the child's functioning at home. In addition, it facilitates the closer observation by the parent of the child's functioning, and a lessening of the sense of futility which parents so often feel in child rearing problems. This, once again, has involved a greater activity by the teacher in fulfilling this role, and a giving up of the relatively passive role which has for so long been a part of so many nursery school teachers' functioning. Dr. Josselyn points out some of the fallacies in viewing many areas of life as appropriately passive.[20] She refers to the greater activity inherent in appropriate nursing by the infant; the activity that we have come to recognize in stages of sleep; as well as some of the errors in the old view of women's function as passive. Similarly, we have come to view the role of the nursery school teacher as a much more active one than has previously been thought to be the case in working with parents and children. We have been supported in establishing this pattern by the president of Sarah Lawrence College at that time, Mrs. Esther Raushenbush, who responded to our report about parental objections to the expanded role of the teacher by saying, "We are a college where students come to learn. The nursery school, as part of the college, also has a teaching function which the parents must recognize and accept." This teaching function is easier to explain in a college setting, but is nonetheless there in any setting according to our view of the needs of the children and the special competence of the teachers.

There are many issues which must be solved by the parents, not only in terms of what to do but how to do it and how to handle the conflicting parental feelings. These involve such areas as concerns about food, sleep time and circumstances, elimination, the setting of limits, and the role of the parent in these issues. Helping the parents to understand the developmental issues in these dilemmas usually stimulates widespread ripples in parental thinking and helps out far beyond the immediate issue, for example, of sleep. The problem of separation, of being used to being away from the parents at night, staying in one's room, feeling secure there—all come up. These are related frequently to the problems of separation from the mother with the initial school experience—nursery school. The feelings of the parents in wanting to give up or not wanting to give up the children comes up routinely along with ways to facilitate a child's sense of competence either to go to school, or to go to sleep at a relatively definite time.

To ameliorate the frequent "eyeball to eyeball" escalating confrontations between parent and child, it is helpful for a parent to see how a child reacts in another setting with a different adult. Sometimes the parent can then identify with the teacher's mode of handling these situations in a less anxious, less involved fashion so that the exciting, stimulating, and guilt provoking confrontations need not occur. Other such issues involve sibling rivalry and the handling of this, sharing, the questions of privacy or nudity, and the special problems that come up such as in raising twins.

In order to preserve the privacy of the Sarah Lawrence families, many of the examples here are from other nursery school settings where programs similar to the Sarah Lawrence one are going on. Names are fictitious.

The following is a report of a situation which arose in nursery school and involved a set of twins. It is included not only because it illuminates similar problems which occur in non-twin children as well as the teacher's role in parent guidance.

Family No. 1: George and Samuel are four years old identical twin boys from South America. These boys were in school throughout the year in the same class. The parents were reported by the teacher to have been interested, appropriately concerned and competent in the handling of their children. In several meetings with the teacher, a great deal of mutually helpful sharing of the information about the twins went on. Consequently, towards the end of the year, when the family was planning a trip back to their South American home, it was natural for the mother to discuss this with the teacher.

During the year there had been some participation by the twins in activities with other children, but they were primarily related to one another. On a few occasions, when one or the other twin was absent, there was some play with other children by the remaining twin, but this twin who attended school was obviously handicapped by the absence of his counterpart. We find that this delay in relating to children outside the twinship is a frequent and normal part of a twin's development.

Earlier in the year there was a period when the father had to go to South America on business and the mother had to be gone on an emergency for a few weeks. At that time one twin was hurt over the eye in a fall. He lay for a couple of days in a fairly unresponsive fashion, somewhat withdrawn and evidently quite shocked by the injury. There was evidently no physical reason for this, and this must be presumed to be a reaction to the injury's occurrence in the absence of the mother. After this period he showed no subsequent reaction to the injury. Incidentally, the other twin shortly thereafter hurt himself over the same eye.

Then the issue of the forthcoming trip involving the whole family's going to South America that summer came up. The parents were planning to leave the children for two weeks, in South America. Each of the twins was to be with a separate relative whom the children had not met previously. The rationale of these parents was that the children were too dependent on one another

and that this would be a good time to start to facilitate their separating.

The teacher's handling of this issue involved discussing with the mother the fact of the great interdependence of these twins, as of twins in general,[21] and the importance of careful timing in facilitating the children's separation and individuation. She pointed out to the mother that in a foreign country, away from the parents, with relatives whom they did not know, it was important to keep such young children together. In fact, she suggested that not only should the twins be kept together but the other sibling should stay with them also, in order that the children might provide support for one another and to limit the possibly deleterious effects of the parental separation. The teacher understood that, with the original plan, there would probably be considerable regression in these young children, and possibly also symptom formation and other difficulties for some months afterwards. This might well result in a delay of the progression to greater separation and a delay in their movement towards trust in people outside the twinship. The teacher mentioned an earlier regression when the twins had been separated from the parents earlier in the year when father and mother were away, and again when George had such a profound reaction to what was a relatively minor injury above his eye. The apparent unconscious need of the other twin, Samuel, to have a similar injury shortly thereafter was also noted. At that time they were in their own safe home, with a trusted maid and with siblings, but still there was this difficulty. Happily there were no apparent reported subsequent sequelae.

Here we see healthy concerned parents who benefitted greatly from this educational guidance approach which was an example of primary prevention. This would probably not have been carried out by anyone else since the parents were not in the habit of discussing such issues of handling the children with anyone else.

A related issue involved the question of putting the twins in the same or separate classes in kindergarten the following

year. This was discussed at length and it was felt that an evaluation of their functioning should be made at the end of the summer and after the separation experience in South America. The teacher recognized, and shared this recognition with the parents, that it was important that separation of the twins be facilitated at some point by putting them in separate classes, but that it has to be done at the right point. Exactly when each set of twins needs the help of parentally induced separation from one another in school is something that must be evaluated in each situation. Too soon can cause difficulties, as in other premature measures involving expected maturity for which children may not be ready, and too late can cause missing a developmental opportunity for separate and individual growth. One possibility that was discussed was that the children might be put in simultaneous adjacent kindergarten classes, if these were available, as a step toward the separation.

Here the teach r helped the parents to see the pattern of the children's road toward separate identities in view of the many observations, such as the pattern of playing and not playing with other children, the reaction to the earlier separations, and our concerns about what further separations would do at this time. They could rely upon their knowledge of the normal lines of development involving the progression of object relations from mother to teacher to peers, and the special ways in which children can be helped to handle unavoidable separations by being buoyed up by the presence of other familiar children and siblings.[22] In addition, from experience with many twins, the teachers are familiar with the particularly intense closeness of twins, and the resultant particularly intense difficulties in separation which twins may experience. They know the special importance that separation, properly handled and fostered, has in helping the emotional development of twins.

I recall a set of adolescent twin girls who had never properly managed to separate and to move towards outside object relationships so that, in mid-adolescence, they still refused to

identify their clothing as belonging to one or the other but insisted that these be referred to as "ours." In addition, they would insist on pooling their allowance. This is an example of the fear with which they faced the simplest evidence of individual functioning. Such happenings can be prevented in children who are twins, often without psychotherapy. But it does usually involve very careful handling of the twinship. It is unlikely that anyone will help the parents in this, unless the nursery school teacher assumes this responsibility.

Another set of twins comprised one preschool child with a physical defect, and his twin who seemed more emotionally damaged by his brother's defect than was the physically impaired child himself. This is very reminiscent of Samuel's having to hurt himself when George injured himself over the eye.

We see many extremes of parental behavior and attitudes in regard to twins which were, happily, not seen in this situation involving the parents of George and Samuel. One parent who stated in a joking but poignant fashion that she refused to accept the burden of twins, another who stated, "I don't believe in twins. Luckily they are not identical. If they were I would have to have two houses." We will not go into the effects of such attitudes on the children, but we have found that the prolonged support, communication and educational process that goes on in the meetings with the teacher can have important effects in ameliorating the difficulties of being the parents of twins. Sometimes, the teachers find that a point is reached where other professional involvement is required. This issue will be discussed under a subsequent group of children (with psychological problems).

With the twins themselves the teachers do many things within the previously mentioned framework of support and warmth. Once again, she is there as an accepting, reality oriented person who comes up with alternative ways for the child to cope, who listens to the child's ventilation, and who accepts communications, sometimes verbalizing them when they come through play. Other

more specific examples of the teachers' functioning with children in the nursery school will follow.

Crisis Situations:

It is amazing how adept adults are at denying, avoiding and repressing the recognition of the many crises in life, particularly as they face children. We would not need to interfere with this sort of popular illusion were it not that the maintenance by parents and mental health helpers of these illusions deprives children and their parents of one of the most helpful modes of handling crises, namely communication. The child whose greatest fear is that of separation from and lack of ability to make contact with a parent, frequently has his fears realized when the well meaning parent completely cuts off communication in a crisis under the unfortunate and misled idea of protecting the child by not talking about something. So children have often not been told of the death of a family member or grandparent or friend of the family, while at the same time they have had to deal with the fact of the parental grief and withdrawal. At the same time they are frequently bombarded with very clear indications of what has happened, while the parents maintain the pretense that nothing has happened and that the children don't know. So the parents will talk about the tragedies over the phone, thinking somehow that children don't hear and don't see.

Whereas a person, for instance a seriously ill person, may sometimes need to and want to maintain denial of the reality situation, and this is certainly his privilege, it is rarely appropriate or helpful for professionals to permit themselves this indulgence of avoiding and denying to themselves the real situation in dealing with patients.[9, 10, 23, 24] Similarly we will refer later to the effects of other parental ambiguities in parent-child communications.[25]

Even professionals at the Center for Preventive Psyciatry who are used to dealing with crisis situations will often experience the tendency to employ such defensive mechanisms—a tendency

which they must constantly guard themselves against. When Dr. Stein was asked several years ago if he had ever treated a bereaved child (a child who has lost mother or father through death), he initially said that he had not. Then for months afterwards, as he began to work in this area, he kept remembering such children whom he had treated and whose bereavement he had managed to repress. Adults are constantly shocked by the figure of two per cent which describes the percentage of children in our country who have been bereaved by the time they reach kindergarten.

Crisis situations are endemic in the life of a child and his parents, and the positive handling of these situations is crucial in the prevention of mental illness. In a study in 1966, by Oleinick et al, the authors summarize that what "did discriminate patients from controls in the study of a sample of our clinical population was the experience of separation from parents by illness, death or desertion and the occurrence of marital distress," —not such variables as age and manner of weaning, toilet training, sexual education, etc. We still place considerable importance upon the latter, but we must not continue to avoid the significance of the occurrence and the handling of crisis situations as they effect the development of children.[26]

Situations Involving Death:

Although investigators such as Piaget do not feel that children can definitely grasp the concept of irreversibility as in death until the age of nine, the profound effect of death upon the development of children is generally accepted. In a very large percentage of disturbances of adulthood, we find a history of childhood bereavement. It is a very significant factor statistically.[27, 28, 29] The previously mentioned concerns about separation, isolation, lack of ability to communicate, or even to breathe, have been shown to relate to children's concerns about death. Yet, with millions of dollars being spent on sex education in our enlightened society, we maintain a comprehensive taboo in discussing such matters as death with children.

Family No. 2: Kevin was four years seven months of age when his father died after an illness of three months. The mother had known beforehand of the father's impending death and had told Kevin and his three older sisters about it ten days before he died. When he did die, she went right to them and told them about it. Despite her openness and her communicated willingness to talk, there was little immediate overt grieving.

When Kevin came into the classroom the next day, he appeared pale with bags under his eyes. He told the teacher that the father had a flashlight, that the father would not come back and that his father loved them very much. The teacher reported that there was no sadness evident in his voice, just a matter of factness.

His behavior that day was not unusual except for one incident. He got a scratch on his face and refused to hold a wet cloth to it or to put a Bandaid on it. Instead, he wept and moaned, in a totally uncharacteristic fashion for him, saying, "My blood is dripping down from my face." It was not. When the teacher suggested he look in the mirror he said, "No, I can't," and instead covered his face with his jacket. The teacher reassured him, held him, and comforted him. A few days later, the children were carving things in class for Halloween and were talking about the various things daddies could do including wield a big knife and carve things very well. Keven entered the conversation saying, "I have a big one, too." (pumpkin) Everybody took a piece of pumpkin to eat, but he refused. Later when the children were hearing a story about pumpkins, he covered his ears as though their excitement and laughter was too much for him to stand. That day he made a large enclosed block building with no entrance or exits. This looked to all observers like a mausoleum.

A few days later he was noted to point to his wrist and say to a little girl, "Your blood goes in there. My daddy is dead. He is out in heaven with God. He shouldn't have died. We went to church. He was a policeman." (He wasn't.) A few weeks later

Miss Beyer, the school director, reported that the mother called saying that she thought the children were doing well. Kevin was talking freely about the father being in heaven, happy, etc. The mother reported that the children were actually comforting her in that she feels their strength and their faith.

Summary: Here we have some brief excerpts of a situation of a familial tragedy which was handled by a mother with her four children in as open and matter of fact a fashion as possible. Mourning did not happen all at once, but mourning never happens all at once. There are workers in this field, in fact, who believe that anything approaching a thorough mourning reaction cannot really occur until adolescence.[30] It is our experience at the Center for Preventive Psychiatry that children can mourn, although often they require a great deal of help to facilitate this process.[9, 10] In the course of the weeks and months after Kevin's father's death, he spoke about and played out his fantasies about the father's death at great length. The school was able to accept this as was the mother, in contrast to other families we know where the older members of the family are angered and horrified at children dwelling upon the fact of a parent's death. In the course of these months, Kevin regressed, at times requiring comforting as in the episode of his feeling so vulnerable when he scratched himself after his father had died. He was preoccupied with blood, death and bloody deathly matters. But he was not ghoulishly preoccupied, nor did he only deal with these matters. It is our feeling that it was the help of the parent and the teachers in permitting him to talk about this tragedy which made his mourning task easier.

Family No. 3: Barbara is a four year old child whose father died of a stroke when she was two-and-a-half years of age. One day the teacher was reading a story in which daddies and what they did for a living were described. In hearing the story, Barbara did not react and appeared disinterested. Her play consisted primarily of four-sided block cubicles with a bridge and, at the top of the hill, stood an isolated male figure whom Barbara called

a farmer.

One day the father of our class's guinea pig died at his home in another nursery school. The children were told, when they asked, that the father had died and the teacher did not know of what. Barbara was holding a little baby guinea pig in her lap and was stroking it. On hearing of the death of the father guinea pig, she immediately put down the baby in the basket.

We were told that Barbara drew a picture of a little girl lying in bed in the night and holding her arms up as though reaching towards someone. Barbara had also been in the habit of dressing up in men's clothing in the dress-up corner, and then playing the role of the female counterpart to various characters. For instance, when playing a doctor game, she would be the nurse, etc., but wearing the men's clothing.

Discussion: As in all such situations, the teachers' function comes into question. We are all loathe to tread too energetically in such sad situations, because of our reluctance to add to a child's anguish, as well as because of our needs to protect ourselves. One teacher verbalized for all of us that when she hears of a small child whose parent has died, she always feels a pang in the middle of her stomach.

It is, however, our duty to help children with their grief. If we do not, the chances are overwhelming that nobody will. It has become our routine to discuss with the surviving parent the facts of the bereavement as well as the facts of the communication of the bereavement to the child. When this is known, we can help the parent to understand the need to undo distortions, and to further communications.

In the classroom we feel that we don't want to barge in with dynamic interpretations which are not the function of the teacher, and which are usually not founded on any certain dynamic knowledge. Still, to totally ignore a child's communication of his grief is to be obtuse and, we feel, rude. Another child was in the habit of putting his fingers in his ears whenever fathers were mentioned. His was a divorced father whom he rarely saw.

We considered his to be a communication to us which required picking up, noting, and verbalizing. Then in supportive discussions we can try to help him know that perhaps he can stand hearing about fathers and working out his feelings about fathers, without incurring an unacceptable burden of additional unhappiness.

With Barbara, we can expect with some certainty, that her putting down of the guinea pig was related to the fact of the guinea pig's father's death. We need not go further at that point, but with such a start we can certainly learn more about her reaction to the death of this father guinea pig. Perhaps she put it down because she wanted nothing to do with the whole subject of the death of a father. Perhaps, because of her own guilt feelings about her father's death, she felt that this baby girl guinea pig must be bad if her father has died. The only immediate role for the teacher had to do with comforting, attending to and supporting Barbara.

In regard to her picture of a child holding her arms up toward somebody, it might be well to talk to Barbara about this. In helping her to ventilate about the picture, we can perhaps also pick up what we can safely say about it, for instance, that sometimes children are lonely and do need a grownup, a mother or a daddy, more so at night before going to sleep. Thus, the displacement from her own situation would be maintained and she might be able to proceed with the ventilation in this displaced fashion. Certainly, the dressing as a man, despite any theories we might have, would be something to watch and try to understand without the teacher venturing to get directly involved with it.

In summary, then, the therapeutic function of the teacher here is not to make premature dynamic interpretations, but neither is she to ignore a child's fantasy communcations. Instead, her role is to recognize, reflect on, accept and put into words the child's play. Perhaps to universalize it and to maintain the displacement. If the child's own situation is directly alluded

to by the child, it would then be highly appropriate for the teacher to do the same thing in the framework of the child's own situation. For instance, if Barbara said it, the teacher might concur that, yes, Barbara must miss her father sometimes at night and wish he were there.

Family No. 4: Alice is a four year old whose mother had not told her about the death of her maternal grandfather. The child knew what had happened from the mother's grief and from the many conversations about the death in the house and on the phone. Alice asked her mother one day if Grandpa had been buried. She was told indignantly, "No, he was not buried, he is in heaven." The mother was so upset about the death of her father that she had great difficulty communicating to Alice the fact of the death. She was doubly upset that the child knew about the death, feeling that she had inadequately "protected" the child from knowledge of this grievous event. Alice subsequently told her mother that, of course, she had seen many cowboys and Indians killed and buried on TV.

When Alice was taken to the cemetery by her mother and widowed grandmother, she was told that this was a place of flowers and rocks. She had not been told about the grave. She urgently asked her mother where Grandpa was buried only to be told, "He wasn't buried, although perhaps sometime his things might be buried."

Thereafter, in school, the child repetitively and obsessively built crypt-like structures, defended them from the other children and spoke about their proximity to churches. The mother passing through the school, insisted on identifying these as bath houses.

Discussion: It was certainly within the realm of the teacher's functioning to point out that the child knew about the death and the burial and was only being confused by the mother's denial of them. She suggested that the child would probably be greatly relieved when mother could talk realistically to her about the grandfather's death.

The group felt that the mother could be helped to realize that she was not being altruistic and sparing the child, as she thought. Instead, she was only protecting herself from the unpleasant job of affirming both to herself and to the child that her father really was dead. In other words, rather than altruism, she was indulging in understandable but nevertheless inappropriate selfishness. Some parents are not able to face the reality of a death and to help the child to face it. The teacher has to use her judgment in knowing when to desist and to leave parents to their own timetable even though the timetable may add to the child's burden.

Family No. 5: Steven is a four year old boy whose brother, Anthony, was killed in an automobile accident when Steven was fourteen months of age. Arthur, age six at the time of his death, had darted out into the street and was run over by a car. Steven was shipped off to his grandparents whom he did not know very well and who, in addition, were withdrawn and highly upset because of Arthur's death. Steven did not see his parents for two weeks except at the funeral of his brother. There they were able to show very little emotion, smiling at friends when telling them about the death of their son. When Steven returned home his parents were somehow different, changed by their bereavement.

Steven came to our attention because of difficulties in school. He showed an emotional flatness, did not seem to hear, listen or meet the eye. In addition, he had to be everybody's friend, and he was taken up with a great deal of excessively violent fantasy. Visited at home, he only played a game of crashing cars together. In addition, he was noticed to be accident prone, particularly at home.

Because of his lack of participation in class, his undue altruism, his excessive fantasy life and his uninvolvement, the teacher was concerned about this boy. When she began to focus upon him, paying more attention to him, being more interested in him because of her concern about his functioning, he began to change. The parents at first insisted that nothing was wrong;

then the mother began to see that actually a great deal was wrong. Slowly, with the greater involvement and individual attention from the teacher, Steven began to respond.

One day he related a story of a good witch which turned into a bad witch, who then was going to eat up children. He immediately changed this horrible fantasy by bringing Batman to the rescue. In telling the story, it is interesting that when talking about a good witch "turning" into a bad witch, he switched it by saying that "I turned the rope round and round." By using the word, "turn," in an active fashion he turned passive into active and was able to avoid the sense of vulnerability when the dangerous witch played out her part. Instead, she was just an inactive character in his drama. This is one of the defense mechanisms involved in his accident proness. It is either the counter-phobic taking of many, many chances to prove his inevitable survivability, or his recapitulation in his play of catastrophes from which, however, he survives. Other determinants no doubt would have to do with guilt about having lived while his brother died.

The next day, following the witch story, he came in very much involved in a violent Batman fantasy. He would not let go of this fantasy to go on to quieter and less obstructed play despite the teacher's persistent attempts to help him, and despite her staying with him through it. Finally, she said that she knew he wanted to play this by himself, but nevertheless she was going to help him to go inside and to play with the other children. Removing him from the repetitively violent fantasy play was because it seemed to be a non-productive play, which did not ease but rather escalated his anxiety. At this point he turned to the teacher and for the first time said to her, "My brother, Arthur, was killed."

Our understanding of this incident is that her insistence on involvement with him, as well as her assurance that she was strong enough not to let him down, permitted him to let go of

the saving fantasy of Batman and to relax. With this lessening of the anxiety, he was able to ventilate and share with her his reason for the repetitive, anxiety laden and violent play—the death of his brother. This support must have been something he did not adequately experience at the age of fourteen months when his brother died and he was left with relative strangers (the grandparents), away from his parents, in other words, without adequate support. It is our understanding that the car play has continued these many years in the same violent unproductive fashion without surcease and without moving towards resolution of concerns about the brother's death, because there has not been a sufficient opportunity for ventilation of his anxieties in a supportive atmosphere. Otherwise, a continuous and gradual mourning process would probably have occurred, permitting his own development to progress.

Recently, with the teacher's greater involvement, he has not had to be everybody's friend and he has received reassurance from her about this. He has also not had as much involvement with fixed and unproductive fantasy and so his play begins to be more successful. The mother, since talking to the teacher and sharing in the evolution of her son's behavior at school, is trying to help him to communicate more. A communications gap must always have been there, but it was undoubtedly exacerbated by the need not to communicate the parents' anguish about the brother's death.

In summary: Here the teacher has questioned the maladaptive defenses and has shown the boy that it is possible to handle the anxiety and the fears more directly through communicating, rather than through the unsatisfactory defensive maneuvers of stereotyped fantasy and the defenses of denial, reaction formation and turning passive into active. These defenses led nowhere. The teacher has also assured him that he has rights and need not be so altruistic. He need not be the good son (lest he incur his father's or mother's anger and not be loved anymore) following the death of his brother.

We note also that the fantasy of the witches eating children is a sign of a certain degree of fixation on the oral aggressive stage, no doubt related to the timing of the brother's death. Similarly, another area of developmental immaturity is seen in his prolonged descriptions of himself as "he" rather than having progressed to the first person pronoun, "I."

Illnesses:

S. Freud quoted a poet in saying, "Concentrated is the poet's soul in his tooth's aching hole"—or in other words, with illness there is regression. This is true of adults, and it is true with children that with illness they have a greater need for parental support, loving and closeness. When a child is ill, the teacher can be helpful in aiding the parent to understand the developmental issues involved in helping the child. The ill child may be more demanding, may regress to earlier modes of functioning, may need the parent much more. This behavior is usually accepted by the parent. What is sometimes harder for a parent to handle is the management of a chronic illness. Here the parent is faced with an ongoing bodily illness, often requiring special care of the child by the parent. Here, it is important for the parent to differentiate between appropriate parental support and inappropriate infantilization.

With chronically ill children we commonly see situations involving such excessive infantilization of the child by the parent. With diabetic children, many parents have chosen to sleep in the same room with the child ostensibly to catch any vacillation in the child's sugar balance which realistically can be a serious matter. These emergency measures, however, go on too long, and if not controlled, can lead to severe blocking of development because of excessive infantilization. Similarly, in other situations involving cardiac conditions in children, birth defects or other injuries, the teacher has an important role to play in helping the parent to understand the underlying issues. It is important to achieve a balance between realistic protection and support to allow the child to express his independence by

doing for himself and not needing quite so much babying, particularly after the first stage of an illness has passed. The issues discussed under "Deaths" certainly apply in regard to the need for honesty by parents with ill children, and the importance of not pretending that children do not hear or do not understand merely because they are young. A precocious five year old once indignantly verbalized the issue for her mother by saying, "I may be only five, but that doesn't mean I'm stupid."

A common effect of illness is an after-reaction. The "good" placid child often will have a delayed reaction of transient behavior difficulty after illness or after operations or hospitalization. In this way he copes with the anxiety in an active fashion which he could not express directly during the enforced passivity of the sickness.

Surgery of the Young Child:

Children should be prepared for crisis situations, if at all possible. Certainly we believe that children should be honestly dealt and communicated with at the time of and after crisis situations, so that the lines of communication be left open and children do not have to avoid, deny and repress, with the great potential damage to future development which these mechanisms can pose.[29]

If a child is to have any hospitalization for any medical or surgical procedure, he is entitled to be told about this. This is the case if the child is two years old or twenty. The teacher's role is to help the parents to understand the importance of informing the child in as much appropriate detail as possible about what will happen. It is urged that the child be given a chance to ask questions, and to communicate with both surgeons and anesthetists about the imminent procedure. In describing the procedure to the child we should acknowledge that we cannot foresee every part of the procedure, but we can do our best to describe it. Dr. Augusta Alpert has said that we always

forget something in these situations.[31] So, with one child, the parents did not foresee to tell him that, in the suturing of a simple laceration of his face, he would have to lie back. This became the fearsome issue for him. For another child, it was having to have a drape put over his eyes. In these situations the children went through a period of time after the simple suturings when one of the children was afraid to lie down at night, had nightmares, etc., and the other was afraid, for a considerable periof time, to play blind man's bluff or be in the dark. Still, the preparation that one does do is well worthwhile in preventing more extreme and long lasting disorders.

Without preparation, children usually know what is happening by inadvertent overhearing of conversations, etc., but they are left to their own primitive fantasies and deprived of the opportunity of discussing the forthcoming frightening event with the people they love and trust. The teachers have a very important role to play in this area.[29]

It is startling how many physicians are annoyed and resentful about the parents' wish to follow these relatively few small mental health principles in dealing with children who are to undergo an operation or go into a hospital. Most pediatricians will give lip service to these principles, but we have been startled by the lack of psychological orientation both in hospital set ups and in private practice. A study done by the Child Psychiatry Committee of Westchester County, with a presumably progressive and modern population showed startling lacks of even such simple measures as having facilities available to enable a mother to stay with the child in the hospital.[32] It is very hard for a parent to deal with doctors who say that the mental health issues are not important, and yet this is exactly what parents must do. The teachers can be helpful in backing up the parents who have difficulty in insisting upon some of the simple mental health principles such as the need to communicate with the child about what is going to happen. They often need support in being allowed to stay with preschool children during

at least the first part of a hospitalization. It is hard for the parent who is depending upon the doctor's expertise to separate out the expert medical opinions from the unconcern about psychological issues of some, but thankfully not all of our physicians. One parent who was himself a psychiatrist had told his two-and-a-half year old daughter that he would stay with her and hold her hand during a simple suturing after she had fallen and lacerated her cheek. The plastic surgeon was very angry about this, complained that he was babying the child and that "she would have to face the music sometime." The father told the surgeon that he would see to it that she learned to face the music, but he thought perhaps this could wait until she was a little older than two-and-a-half. Even with the support of the teachers, it is very hard for parents to insist on having things done in such a way that these difficult situations will be least pathogenic for the child. It is also hard for the teachers to insist upon such things against the will of the medical authorities. The physician is an authority, and the teacher, as mentioned above, has not been in the habit of considering herself as an authority in her own field, whose expertise is very much akin to that of the physician. This may be a situation in which the presence of the psychiatric consultant is crucial to back up the teachers in their expanded mental health roles.

Family No. 6: Peter was a four-and-a-half year old boy with an inguinal hernia. One day the mother mentioned to the teacher in passing that Peter was soon to have an operation. She had taken him to the doctor on the advice of her pediatrician without telling him why he was going. In fact, the pediatrician had said not to tell him, because the surgeon would examine his whole body. Since he wouldn't have any special attention called to the area of the hernia, why should he be worried by being told about the hernia? The mother followed this advice, and, not surprisingly, the surgeon concentrated exclusively upon the child's inguinal and genital area.

Shortly thereafter, Peter began to have trouble sleeping, became apathetic in school, and withdrew from friends in and out of school. He had nightmares of a minor sort. His previously excellent functioning seemed to have slipped, and the mother did not know why. The mother was herself uncertain about the medical reasons for an immediate operation. She had not directly confronted the physicians about her doubts. She was uncomfortable about the whole situation, and due to this discomfort, she was passive and childishly obedient with the doctors. This is a frequent reaction of parents in dealing with a medical authority. It is likely that in bringing this to the teacher a month ahead of the operation, the mother was communicating her concerns and her wish for advice. The teacher helped the mother by calmly asking the appropriate questions. The mother was not able to answer the questions about why the operation should be done now, what were the potentials for difficulty if the operation were not done now, etc. The asking of the questions helped the mother to go back and ask them of the physicians. She was then able to lessen her own doubts and anxieties, which helped her to be more direct with the child. In addition, the mother, who had known about the importance of preparatory measures, was helped by the teacher's concurrence to insist upon them with the medical people. She had already insisted on rooming in and had gotten reluctant acceptance of this from the surgeon and the hospital. It is interesting that a large modern hospital in an area of many medical universities had only one rooming in set-up—showing a lack of commitment to this obvious preventive mental health measure. Nevertheless, she insisted on waiting for an available rooming in space. She had not requested preparation of the child for anesthetic or for the details of the operation. There had been no arrangement made for the surgeon or anesthetist to talk to the child, and, in fact, the pediatrician had given the mother a book to read to the child the night before the operation. This mechanical way of handling the preparation is, we think, not unusual. Such handling avoids the necessity of careful preparation of the child

through this mechanical and belated gesture. Despite some disagreement among our group about timing of preparation of children for operations, it is our feeling that we would rather tell the child too early than too late. We would rather give ample notice, let the child react with symptomatology and other evidences of anxiety beforehand so that he can communicate this, rather than be stuck with it after the operation when such ventilation is much harder to accomplish. In this case it was obvious that the child knew a month prior to the operation when he was carefully examined by the surgeon, so that there was no real choice about the timing.

In this situation the teacher could help the mother greatly. In turn the mother was able to help the child whose symptoms decreased prior to the operation and disappeared afterwards. This is in marked contrast to the severe prolonged reactions which we believe are related to the absence of careful parental handling and communication.

The aftermath of this situation found the mother angry at the teacher and the school about a relatively minor point in which our information about hernias was at variance with the surgeon's statements. This occurred despite the teacher's having urged the mother to check with the surgeon herself about it rather than leaving herself in doubt. In other words, the active involvement of the mother was fostered. It was important that there be psychiatric supervision for this process, not because the teacher did not know what to do. She did know what to do and did do it. It was in handling the backlash and its reverberations, in dealing with the mother's anger at the helping teacher, over a trivial displaced point. The transference reactions of parents are an important factor which will be discussed later.

Other related issues involve a surgeon's occasional decision to perform a second unrelated operation while the child is under anesthesia. We recall a child who was to have a simple mouth operation, and surgeon's decision to do a simple genital procedure at the same time without any preparation of the child. Some children subjected to such surprise multiple procedures have shown

great confusion post-operatively as well as difficult to remedy symptomatology.

Operations and Illnesses of Other Family Members:

As mentioned in the discussion of twins, it is often the other child who has the greater anxiety when his twin is ill or injured. In response to this, in Family No. 1, a twin injured himself in a fashion very similar to that of his brother. We also have seen the extreme debilitating anxiety of another twin related to his brother's chronic orthopedic difficulty, which the physically afflicted child was able to emotionally resolve and overcome, whereas his brother was not. It reminds us of the impression that there is less mental illness during wartime than during peace time, presumably because the dangers are real, finite, and can be coped with, rather than the unlimited fantasied dangers of the mind.[22] Similarly, the person who must cope with his own limiting physical illness can usually manage to do so, but the effects upon children of the ill person or siblings are often much more far-reaching. The realization of the vulnerability of a sick father who has seemed so omnipotent and invulnerable can be shocking, and very difficult for a child to handle at any age. With help this can be an important step in a realistic viewing of fathers and their omnipotence, particularly if the illness has a happy outcome. If not handled, we frequently see important and far-reaching sequelae.

Unfortunately, in situations of real physical illness, everybody's attention turns to the physical illness, with a resultant shunting aside of the non-physically ill persons. This is not a matter of the necessary attention to lifesaving measures, but to the human tendency in crises to concern ourselves with material things in concrete ways, rather than to face our own anxiety and grief, and, consequently, to help a physically healthy child to face his.

Family No. 7: Chris, a four year old, was shortly to have open heart surgery. His brother Ned age three was also in school. The boys' mother, Mrs. Reese, spent the first conference in the teacher's office in tears about Chris' forthcoming surgery. It was not certain when the surgery would occur. The mother insisted that no one in the family knew of Chris' impending surgery. The mother catered greatly to Chris.

The teacher had noticed no unusual behavior in either child in school, except that Ned was cautious. He did, however, move toward the group, make friends and was related. The parents had been attempting to make up for Chris' small size, so they tended to delay Ned's mastering developmental tasks to allow his older brother to do them first. Ned was much more agile, much larger than Chris. In fact, he referred to Chris as his little brother. Chris was always verbalizing doubts about his maturity in relation to his brother, but was very proud of one fact, that he was able to fall asleep alone, while Ned required the presence of a parent at bedtime.

There was so much denial in this family and so much avoidance of the implications of this child's illness, that we felt that eventually psychotherapeutic intervention would be needed for the emotional health of the whole family. In the meantime, the teacher used her knowledge of the intricate details of the children's lives in school to help the mother to understand the different individual burdens upon each of these children because of Chris' illness. The teacher also tried to help the mother see more clearly the deviousness of the situation, and the fact that in many ways, Chris was betraying that he really knew that something was wrong, and that there was a reason for the multiple examinations and cardiac catheterizations. We felt that adequate preparation of a child for this sort of operation was crucial, and might perhaps be lifesaving. We also felt that the mother would probably feel a great sense of relief if she could finally be honest with the child about the operation. The child, in turn, would likely feel relief at his renewed ability to communi-

cate with the parents about his concerns.

A psychiatrist friend of the family had told the mother to tell Chris that he needed an operation to make him big like Ned, but to go no further. A pediatrician had counseled the mother to tell Chris that he was going on a plane ride, and nothing more. The teacher functioned here to facilitate the handling of Chris' preparation. She tried to help the intelligent parents to question the validity of the medical advice which had been given in that they were told to partially or fully avoid what was happening, under the misconception that this was helping Chris. The teacher was supported here by our group in going beyond the dicta of the medical authorities who wanted to continue to avoid the psychological necessities in this situation.

In subsequent observations of Ned, we noted that he was most concerned about any injury, fantasied or real. One day he picked up a little rubber doll with a bandage on its arm and cried, "Get if off! Get it off!" On closer observation he was seen as a child who, to a considerable degree, stood by. He performed, but did not take the initiative, was not active and would not rebel. When other children hit him, he did not react physically. He spoke a great deal about his "baby brother, Chris."

It is obvious that this child was confused in terms of the difference in sizes. A simple explanation to him and to his brother about the effects of heart disease upon size, would probably have helped him considerably with this dilemma. Similarly, it is hard for the sibling of any afflicted child to be open, active, assertive, rebellious and aggressive, other than in a counter-phobic fashion (to deny the effects of the sibling's affliction upon himself). It was doubly hard where there was no chance to communicate, ventilate, and hopefully resolve these issues in one's mind, including the issue of his guilt related to Chris' illness. The teachers worked a great deal with this family on just these issues, with an uncertain result. It was not clear what was accomplished. For all intents and purposes there did not seem to be any shift in the parental attitudes.

The father was adamant about not sharing this material with the children, and was furious with the school for suggesting otherwise. This fury of parents towards someone when a child is very ill is something which we find to be typical and for which we must be prepared. For instance, one can routinely see parents of a very sick child in a hospital, being furious about some trivial bit of malfunction in the hospital routine, such as the child's cereal being cold, etc. This is a displacement of the strong feelings about the child's illness onto something concrete.

This was a hard situation for the teachers. Here, once again, it was clear how necessary it is for the teachers to have sustained weekly supervision if they are to carry out the mental health functions which we are suggesting for them. With the supervision, and with an attempt to help them to understand the parental feelings involved and their own reactions (including rage at the mother, the father, etc.), it was possible for them to function quite well in such situations.

Separations as in Divorce:

Changes in the family makeup are confusing to children, and we find that the teacher can guide parents in helping children through such changes. With the tension, resentments and high feelings in separations and divorce, children are often lost or shunted aside. This may seem surprising when a lot of the manifest content of parental concerns and conversations relate to children, their needs and reactions. Despite this outward concern about the children, the situation is similar to that in which the parents of a seriously ill child pay attention to the temperature of the cereal but emotionally abandon the child. They then leave the child to stumble through his unrealistic fears and fantasies.

One unusual mother whom I saw for several sessions in a very different situation verbalized this issue very well. She was a woman whose husband was dying and who was intent on gradually preparing the children for this catastrophe. She insisted that her young children (four, five and ten) attend the funeral

despite objections of all adult members of the family (grandparents, aunts, cousins). She said, "I want them to see the funeral and the burial so that they'll know very clearly that their father is dead and will be able to deal with it realistically. I'm afraid at that time I will be tempted to pretend it didn't happen and pretend it isn't real. At least this will help them to know what is really happening."

The following is a situation involving a father who had gone off with another woman and whose whereabouts and activities were kept a secret from this nursery school age child.

Family No. 8: William was a four year old boy with an older sister. The grandmother assumed the contact with our school, and it was she who told us that William's parents separated when he was eight months of age. The whole family was furious at the father who had accepted money from the family while starting a business, only to run off with another woman whom they felt was socially inferior.

William did not like the dress-up neckties at school. He avoided them and refused to put them on at first, then picked a certain tie which he wore exclusively. The teacher once asked him if his grandfather wore such a tie and he said no and pointed out a tie resembling his grandfather's. William showed it to the teacher and said, "You put it on." The teacher explained that women don't wear ties and William said, "I don't have a daddy." When the teacher told this to the grandmother, the grandmother was embarrassed about it and insisted on avoiding the subject.

This is a family where the maternal grandparents are very much involved, paying part of the housekeeping monies, living in the same building. The maternal grandmother did much of the housework and child rearing. The mother seemed both very involved with her own mother and at the same time wanting to work, which she did, to "get my independence." William functioned fairly

well in school except for his concern about not having a father, and an air of depression about him. He frequently said, "I can't," when being shown something new. One day he was playing with blocks and kicked apart what he was building, scattering the blocks all over the room. We felt that he was saying, "I can't do anything good—because I don't have a father."

Realizing that at this age fathers are very important to children, we felt it was important to understand where the father was, what had happened to him and what the boy knew about his father. After the teacher discussed this with the mother who finally was willing to come in, the mother went back and spoke to William and his sister about this. When she started to tell them where their father was, William said that he knew, "in China." (His grandmother had said it would be better if the father were in China.) The mother gratefully accepted this reprieve—deciding that the child did not want to know where the father was, and let it go. Prior to this time the child had frequently asked the mother and grandparents about his father's whereabouts and had been given one vague conflicting answer after another. So angry was everyone at this father, that they could not even accept the necessity of letting the child know where his father lived. They justified this by saying that he had been asked if he wanted to visit the child but had said that he did not. It is possible that this father genuinely did not want to visit his children, or that it was put to him in such a way as if to say, "You didn't care enough about your children to stay with them. You went off and married another woman. Now do you want to visit them?", to which he may well have reacted by staying away. The attitude around the house is that all men are good-for-nothing. It is not surprising, then, that in response to the anti-male attitude of the women in the house, and with the relative unavailability of his maternal grandfather, William shows deficient masculine identifications and limits his playing of masculine roles as though to say—"I had best not identify with men; they are not

so popular around here." It is interesting that on the day he told the teacher that he didn't have a father, he seemed relieved. His behavior the rest of the day was phallic and aggressive while playing outside with a shovel. The grandmother was surprised when she watched him for a time, because he was suddenly not the charming little boy whom they so prized. Shortly thereafter, he was again the charming little boy.

The teachers felt that they were limited in what they could do with this parent. They could not insist that the mother and grandmother seek out the father to help the child's development. They could only point out to them again and again what they saw in their observations. The teachers hoped that the family's concern about the child would eventually be great enough to lead them to rethink some of their attitudes and some of the decisions they had made about paternal visiting, etc. Here this did not work. The teacher could not get them to change. Perhaps sometime later the family could permit themselves to remember some of this guidance work and begin to make use of it. Right now, the teachers could only try to persist in the guidance and to help the child in the classroom, and to encourage his development by showing that at least in school there were women who thought highly of men.

Psychological Problems:

We have spoken of statistics about the prevalence of psychological difficulties in preschool children. We will now discuss briefly the relationship of schools and teachers with families having psychological problems. Some form of screening of children usually occurs prior to their being accepted into nursery school. However, unless a child is floridly and garishly disturbed, he is usually accepted in nursery school. And yet we would not suggest an extensive psychological examination for children applying to nursery school. The answer of what to do lies in various areas. First, nursery school directors should have training in spotting

the more severe forms of emotional disturbance in children because this expertise could forestall many later difficulties.

What then happens to the children who are not accepted? Are there special schools for children of preschool age with emotional problems? There are a few, such as the Child Development Center in New York City, the Cornerstone Nursery School in White Plains, the Hannah Perkins School in Cleveland, and several other famous therapeutic nurseries scattered throughout the country. But these are very few indeed. Hopefully, sometime, there will be enough of an outcry about the paucity of therapeutic nursery schools so that something will be done about it.

Unfortunately, some nursery school directors who are more psychologically oriented, become somewhat grandiose in what they attempt to do to help children psychologically. Children with considerable disturbances are frequently taken into these schools. Such schools then become exercises in containing one or a few such children and protecting the others from them, rather than providing regular nursery school living and learning situations.

Perhaps the answer lies in a trial period for children in nursery school. The idea of separating out a child who is not getting what he should from the school, or who is disrupting the school experience for all of the other children is often verbalized but rarely used. Directors are reluctant to be punitive, and view the removing of a child from school as being punitive, particularly if there is no appropriate place to refer the child. Parents often will view it that way also, and this makes it very hard for the directors to do this. Perhaps area schools might band together to form special classes with fewer children and more teachers, into which they could feed the children from the various schools who were not functioning in the regular classes.

The problem arises as to when the emotional difficulties are severe enough to warrant separation of the child from the school. Some understanding of the differences between transient and fixed pathology using the Profile method of developmental classification

is helpful for this, once again under the supervision of the psychiatric consultant. Beyond this, a thoroughly pragmatic approach is helpful.

First, one would rule out children who were obviously so disturbed, withdrawn, isolated or autistic as to obviously need more attention than can be given by the regular nursery school. Beyond this the criteria could be, as at Sarah Lawrence, to ascertain which children are so disruptive as to greatly interfere with the school's functioning. It is not necessary for a school to bear a hyperactive child as their cross and in so doing to distort and disturb the nursery school experience of the rest of the children. The question arises as to why some societies have more tolerance for pathology than others, and this can be a philosophical question. We find that there has been a tendency to go along with too much pathology for the purpose of not separating out the pathological child.

Another example of a pathological classroom situation involves children who desperately want to be babies. This does not mean the child who intermittently will try out the role of baby in the doll corner. It refers instead to the deprived child who has not had enough babying and who insists on being a baby. One such child, when asked by her father what she did all day replied, "I play baby all day, every day." This child had suffered considerable maternal deprivation and had a great deal of playing baby to do along with a great deal of needing to be mothered. When a Corrective Object Relations type treatment[33] as outlined by Dr. Augusta Alpert is not possible, sometimes a one-to-one relationship with a frequently present student has been helpful. It can sometimes give the child enough support to permit some participation in the growth promoting possibilities of the nursery school.

Family No. 9: Bobby was a four year old boy in his second year at nursery school. In the previous year he was described as unable to relate except in the most fleeting fashion. This

year he showed no significant change. He was unhappy and destructive in a group situation. He could not sustain his interest and became angry. He needed constant reassurance from the teacher who would spend her time just supervising Bobby. He seemed to constantly go to every activity everywhere in the room. He liked to play with the guinea pig and would let no one else go near it when he was playing with it. He made what he described as ugly and angry faces in the play dough. His rough facade caused the other children to be in awe of him.

His mother was described as a beautiful woman who seemed to see her children as an extension of herself. When playing with her son she played as a child instead of an adult.

As the year progressed he became more aggressive and terrorized the children. He would throw blocks at children and teachers. He grabbed another child, banged his head against the wall, then would dive into his mother's lap or the teacher's lap and would begin sobbing.

Discussion: This was a child who was in his second year at school without having made any progress. The process of working his way into nursery school and getting used to things had not evolved. The feeling his way and becoming acclimatized, which is often accompanied by aggressiveness of a counterphobic sort, had not occurred. There was a fixed unchanging quality to his relationships.

The mother, who was called in, showed concern about this child. However, she showed an inability to accept the teacher's observations of the child's disturbed behavior. The father, called in at our insistence over the mother's objection, could understand a bit more. Incidentally, here the mother was positive as is so often the case, that the father would not be interested or willing to come, whereas actually he was most willing and interested.

The parents were not willing to have this child psychologically evaluated. As his hyper-excitability and hyper-aggressivity became worse, it was finally decided that whether he was sick or merely a very active child wasn't the point. He was disruptive and

preventing the regular functioning of the school. It was decided to try his having a shortened day, or having fewer days of attendance in a week. The parents met this plan with rage, but accepted it. Eventually they did go for a psychological evaluation for the child which resulted in his going into therapy. After a short time they removed him from therapy, claiming that all was well, although it was not.

We must wonder about the slow reflexes of the nursery school which permitted this to go on for a year and a half before deciding that they had enough and that something should be done about it. Another parent in a similar situation complained about the fact that the school had not suggested that something be done sooner, and that the school should have. The parent was right.

Too often, in fact in most cases, schools do not come right out and suggest an evaluation on the basis of observed difficulties would make sense.

The extent of this mother's pathology was considerable, going beyond what has been mentioned. It was not likely that she would accept the recommendation of treatment. Although she did, it was a very short-lived effort. Nevertheless, we believe that it is important to tell the parents what we see, using the method of shared observations rather than presuming to give diagnoses or involved psychological formulations. Even though the parents can avoid doing anything about it, it becomes harder each succeeding time for them to continue their avoidance, as the same message is repeated in succeeding grades. We consider our role to be that of underlining for the parents our observational impressions in the hope that if they cannot listen now, at least the stage will be set for them to listen next time.

Sometimes we feel like insisting that the parents and children go for evaluations. It is one of the more frustrating lessons for the teachers to realize that parents do not have to go along with our recommendations. On the other hand, the school need not put up with disruptive pathology, and indeed probably should not as much as they usually do. Even if families do take

children for evaluation and treatment, it is often not doing the child or his family any favor to try to keep him in a normal school when his needs are not normal and he cannot get the sort of attention he needs.

The teacher's role with parents comprises the sharing of the school's observations, as mentioned above. These sharings are conducted over a period of time, and usually give a rich picture of the child's functioning.

Family No. 10: Nathan L., age four-and-a-half, was a small thin whiny boy who talked in a babyish manner and had tantrums in the class. He could not wait his turn. He withdrew when he didn't get what he wanted. During each morning he would usually lie on the grass sucking his thumb and saying he wanted to go home. He was constantly masturbating. He lost no opportunity to torture the guinea pig with nails. He constantly provoked others to attack him which they in turn did. He did not enjoy any materials but sometimes he listened to stories. He could not be part of any group and was easily distracted.

He was noted by several observers to spend a lot of time caressing his own body, moving his hands over his own buttocks in a loving fashion. In addition, he was seen to caress the bodies of the college student helpers and the teachers, stroking their thighs or their abdomens in an unobtrusive way so that it usually took several moments before the adults noted what he was doing and would stop him. Sometimes this innocent wide-eyed child was not stopped because of the unwillingness of the observer to believe what was happening in such a practiced fashion.

He would say that tears are magic. He would get what he wanted when he cried. He took the role of the baby when playing in the doll corner. Once, his teacher, seeing his block structure, told him enthusiastically, "Let's go over to the mirror and look at the big boy who made the block structure." He replied, "Where is the big boy?" His passivity was felt to be extreme

even to the point of his taping nails to boards rather than hammering them.

Discussion: In hearing of these observations, the mother and father were noted to be distressed about Nathan's behavior. These parents were able to respond by sharing with the teacher similar home behavior. Some alleviating suggestions for some of the difficulties at home were made. At one point the mother said, "Maybe we should see somebody professional like a psychiatrist." The teacher agreed that this would be a good idea.

We note that in almost every situation the parent will come up with some suggestion either in seriousness, or jocularly or derisively. Our teachers have learned to hear these suggestions and respond positively to them regardless of how they seem to have been given. This gives an opening to begin to help parents to move toward psychological help.

Frequently, after a time, the parents are resentful about this suggestion and claim that it came strictly from the teacher which it usually had not. The teachers have learned to accept the shocking fact that they cannot expect gratitude when pointing out a child's pathology to parents. In this as in other issues, the psychological supervision has been most important.

In the case of Nathan, it is interesting to note that in the psychiatric evaluation, the parents managed to avoid telling the significant material to the psychiatrist. They presented a perfectly normal happy picture at home and at school, so that the psychiatrist was unable from their description to see signs of pathology. Similarly, in the one session in which he saw the child, no pathological signs came out. The child played in a friendly conversational fashion with this experienced and expert doctor who saw him only as a charming boy.

When the parents reported back that no difficulty had been found, the teachers asked for parental permission to share their observations with the psychiatrist. With this additional background the psychiatrist delved further, and began to hear from the parents about the many trouble areas. Subsequently, the family was treated and both child and parents did well.

Less frequently there are less cooperative physicians who make referrals difficult. Psychiatrist, pediatrician or other professional friends of parents who know the children sometimes insist that no child therapy is ever warranted before teenage. This archaic view of things is unfortunately not rare.

Sometimes physicians will "pooh pooh" psychiatry entirely making it very hard for the parents to push on, and to insist upon an evaluation.

Sometimes parents have insisted that a child was having therapy when he was not, or refused to permit the school to share its observations with the therapist. These are unfortunate situations which sometimes cannot be overcome. In these cases the teachers must learn to live with the difficulties, unless, as mentioned above, there is extreme disruption of the class.

We have primarily talked about working with parents in regard to child pathology. The work with children involves methods similar to those described in dealing with developmental difficulties or crisis situations. The teacher is not usually able to go much beyond this. The teacher can confront the child with his maladaptive functioning, and can support the child at the same time. Sometimes this helps a child to move on to more adaptive coping methods, but often the pathology is too great to allow this.

Family No. 11: Catherine was a four-and-a-half year old girl with an eight year old sister. The mother was artistic and constantly painted and played with the children, spending four to five hours each afternoon play-acting with them. Sometimes, in fact, she would come to school and refer to Catherine as King Richard, the Lion Hearted. Thus, she carried the fantasy world even into the real world of school.

The mother was obese, artistic looking and wore dramatic clothes. The mother and father both favored Catherine's older sister. Catherine had the role of a deprived "step-daughter" whose older sister is admired for everything she does. Catherine

was withdrawn, apathetic and demeaned her work. She frequently tore things up, saying they were not good. When she brought things home from school, the older sister said that they were no good. The mother mildly proclaimed, "Well, why don't you pretend that they are nice and encourage Catherine." This was done within Catherine's hearing.

Some months of trying to get the mother into conferences, the teacher finally succeeded. During the time of no contact, the teacher had not pushed very hard to get beyond the mother's delays, choosing instead to respect them and not importune the mother.

The teacher did not know what to do with this woman, who seemed to need help, but who was not yet ready to go into any kind of guidance relationship.

In school, the teacher tried to provide a one-to-one relationship for Catherine as much as possible with many other children clamoring for the teacher's attention. One day the teacher was sitting with Catherine who had made a lovely paper figure. When the teacher went away, Catherine took a scissors and cut off the head of the figure. On returning, the teacher found Catherine with her hands tightly clenched as though furious and with the head of her puppet lying in front of her. The teacher responded that Catherine must have been very angry when left alone. The teacher said she was sorry that she <u>had</u> to go.

In retrospect, the teacher and her colleagues felt that this was presuming more than she knew. It was akin to jumping a step in therapy. She would have been more to the point had she sympathized with this having happened, while apologizing for the realistic necessity of having had to go. She might have told Catherine that she was so sorry that she cut the head off her beautiful puppet, just as she so often hurts the lovely things she makes.

This seems to be an attempt on Catherine's part to recapitulate the only way she has of relating to her mother, that is by being self-belittling and by denying her artistic capacities.

It was also felt that the teacher, who is put into the position of a mother by Catherine's mother, might have used this position better. She need not have accepted the mother's avoidance of teacher conferences. Instead, she could have insisted authoritatively that the mother and father come in to school because this was more important and urgent than anything else. With this sort of authority she might have involved the mother more. She might also have succeeded in involving the healthier father.

In this situation it was very hard to bring the mother to any sort of sober consideration of the child's difficulties. We do not know whether the parents ever followed up on the suggestion to have psychiatric guidance. The pathology in this family is so great as to make this not too hopeful a prospect.

The Need for Supervision:

There have been many mentions in this paper of the urgent need for continued supervision if we are to ask the teachers to expand their function into the mental health areas. Without continuous supervision, either the teachers withdraw from the anxieties inherent in their enlarged task, or they find themselves functioning in a wild fashion beyond their appropriate function and beyond their competence. In addition, the teaching of these functions in various teacher training courses over a period of years would seem to be crucial, as well as a most obvious priority.

Poverty Children:

This paper is about a middle-class nursery school. The authors have consulted at Headstart and day care centers dealing with socio-economically deprived children. The difficulties inherent in establishing communication with over-worked, overwhelmed parents in such a setting are greater but not impossible. We have seen motivated, ingenious teachers insist on reaching parents in such a way that they could be accepted. Because of the relatively greater difficulty in finding professional guidance or treatment for these groups, the teacher's role is even

more important. This expanded functioning could be carried out by carefully trained teachers supervised by consultants, and, in turn, supervising indigenous personnel who could work with the areas of child rearing and child crises. There have been systematic attempts to have teachers and mental health professionals work with poverty children and their families,[34] but to our knowledge teachers themselves have rarely been used in the way that we suggest.[35]

Summary:

This has been the description of a four year project at the Sarah Lawrence Nursery School in which teachers, under psychiatric supervision, have attempted to expand their functions with preschool children and their families. The expansion has utilized the teachers' expertise in child development, as well as their tremendous amount of child observational experience. The method has been one of building a close relationship with the parents and of sharing observations with the parents and encouraging them to share their observations and concerns with the teachers. The purpose has been to utilize these observations in helping parents to function more effectively in child rearing, and handling of child crises. Where there has been considerable pathology, this has been brought to the attention of the parents, once again through observations, and psychiatric evaluation has been suggested. In the classroom the usual nursery school methods have been used with the children, but with greater emphasis on understanding, dealing with and verbalizing the child's play communications or behavior communications. The purpose once again has been to support the child in his efforts to move to a more adaptive coping with the many issues to be faced in nursery school as in life.

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