A Child with Compulsive Neurosis

Rudolf Dreikurs, M.D., *Chicago*

The development of a severe neurosis in young children is a rare occurrence. The case cited herein demonstrates that the severity of the symptoms in children does not have the same significance as similar symptoms have in adults whose treatment is generally very difficult and long.

During the first interview the following history was taken: Eight-year-old Sharon had been a "normal," healthy child until one month ago. She was a charming, obedient and kind little girl who performed equally well in school and at home. Suddenly, she developed fears of blindness, of infantile paralysis and of diphtheria. She could not breathe and was terrified of death. She repeatedly asked Mother whether she would die or become sick, demanding reassurance and sympathy. For the last four days she had been afraid her food was poisoned, and Mother had to taste all foods before she would eat them. She drooled because she could not swallow her saliva, fearing the germs in it. She lived in constant expectation of disaster. She had many compulsive symptoms, counted the steps or other objects when she walked on the streets and developed new symptoms each day. When she was not concerned about her symptoms she was impertinent, mocked her mother, if scolded, and demanded continual reassurance that she was loved. One day she pointed a knife at her mother and on another occasion threw a ball violently at her parents when they were together. The parents always carefully avoided any demonstration of affection between them in the child's presence. At school, however, Sharon behaved well, was exceptionally advanced for her age, was liked by the children and played with them.

Past history: Three years ago patient had a disturbing episode when she enrolled in school. She did not want to leave Mother, was afraid Mother would not be home when she came back from school. Mother had to go through a ritual of promising that she would be home, crossing her heart and repeating the same assurance many times. The child was taken to a psychiatrist who arranged play therapy for her once a week. She went for nine months and was completely well when discharged.

Her parents were divorced when the child was two and a half years old. Since then the patient has lived alone with her mother. They have been constantly together although the mother remarried three years ago. Her second husband has been in the service until two and a half months ago.

During the interview with the child, she maintained that she was happy, not at all sick and denied any fears. She said she did not need or want help. She denied ever having seen another doctor, but spoke of a play

room in a hospital, drawing pictures and eating candy. Upon further insistence she stated she did not want to talk, that she did not like the doctor and stalked from the room.

The following impression was related to the mother at the first interview. It seemed that Sharon had been completely dependent on her mother and wanted to possess her exclusively. Her first disturbance was directed against entering school and the mother's remarriage. Apparently the play therapy induced her to accept temporary separation from her mother and prepared her for school. The present episode seemed to be caused by the return of her step-father, and by her fear of losing her monopoly on her mother. Her symptoms were the expression of her rebellion and were her tools to occupy mother constantly, not only forcing uninterrupted attention, but also concern and worry. As she never was openly rebellious and seemingly wanted to please her mother and be a good girl, she could neither admit her rebellion and opposition to herself nor express them overtly. Furthermore, we suspected from her symptoms that the girl had been subjected to much pressure.

The mother was perplexed about this explanation. She stated that her husband had expressed similar ideas about Sharon's using her symptoms coercively, but she had not accepted his explanation. However, now she could see that our impression might be correct.

She was advised to ignore the girl's behavior though this treatment would probably increase Sharon's violence and symptoms. However, she should not permit herself to be intimidated or dominated by the child's behavior. On the other hand, she should not become angry or impatient, should not show annoyance, but should be affectionate and play with the child. As a first step, she would have to overcome her own apprehension and distress and would have to establish a new relationship with the child.

Three days later, the mother reported the following development. She was capable of maintaining an attitude of neutrality. The girl first pleaded, then raved, then attacked her with a pair of scissors and a knife. She wrote on the walls, "Mother is a stinker." She was destructive; cut mother's nylons and threw objects around. She begged mother to kiss her when she was in bed, to keep her, Sharon, from falling asleep as she was afraid of her dreams. Mother told her she was willing to kiss her because she loved her, but not after she had been bidden "good night." Last night, she wanted to get into her mother's bed because she had been alarmed by a fire siren, but mother refused and the girl went to sleep on the floor. When mother paid no attention to her, she arose in half an hour, asked for a phenobarbital, and retired to her own bed without any coaxing or persuasion.

Sharon had expressed her anger at us to her mother and had protested that we had changed mother's personality. She asked mother why she did not get angry when she was destructive. She said, "I don't know what

makes me so bad. God didn't make me like this. How can I be good?" Her mother advised her to talk it over with us.

We commended the mother for her attitude and for her ability to retain her composure in the face of the child's provocative behavior. She was advised to continue in the same way.

The mother came one week later to report that Sharon was recovering from a mild case of measles. Prior to her illness, her aggressiveness had subsided; now, in her convalescence, she again had become hostile, kicking her mother and others. Her compulsions also had increased; she counted steps and spat her retained saliva on the floor. She placed an ash-tray on mother's head when mother was seated; went into the parents' room after they had retired, turning on the lights; followed her mother everywhere about the house, wanting to hold her hand. Sharon was now afraid of contracting polio, and, if mother was not with her all the time, she was fearful lest she die in her mother's absence. She did not want to listen to the radio because she might acquire new fears. Her eating habits also changed. After our first consultation, Sharon had determined not to eat the same food as the parents but to have something special. Now she decided to take nothing but milk. On the other hand, she had asked mother to have me telephone her at home because she wanted help in overcoming worries.

At the next interview, Sharon was willing to talk about her problems. She was quiet, friendly, cooperative and attentive. An attempt was made to give her some understanding of the unconscious reasons behind her behavior—that she was accustomed to having mother to herself and had rebelled against her father's return because she did not want to share her mother with her father; that she used her fears to make her mother become concerned about her; that she was angry with her mother and annoyed both parents to punish them and to gain attention. Sharon listened attentively and responded several times with the "Recognition Reflex."

The next week the step-father accompanied Sharon to our office because her mother was sick. He reported much improvement. Sharon lost her temper only once a day. She continued, however, to swear at mother and father and to expectorate all over the house. She went for a ride with her girl friend, leaving the house without her parents for the first time. It was still difficult to get her out of the house to play with children; she generally followed her mother from room to room. She ate better and did not demand that her food be tasted. For the first time she went to bed by herself without fussing.

The next interview with the mother, a few days later, indicated additional progress. The mother had learned to let Sharon experience the consequences of her actions. If Sharon became angry, mother simply left the room; when she returned the girl generally was quiet and conformed to the

necessary rules of order. Previously the selection of the daily wardrobe had been a major problem. Now, after a short discussion between mother and Sharon, in which mother expressed her opinion but left the decision to Sharon, Sharon accepted mother's choice without remonstrance. When mother succumbed to a temptation to coax her, Sharon stopped her, saying, "That is none of your affair." Mother did not feel hurt, but smiled inwardly; she recognized now how much pressure she had exerted before. It was still difficult for her at times to restrain herself; but she accepted increasingly her new role and relationship, and no longer became upset by the child's coercive activity, which she now recognized as a reflection of the forcefulness she had previously exerted. When Sharon started to demand reassurance about her symptoms and fears, mother referred her to the doctor and encouraged Sharon to seek advice there. (The previous evening Sharon had telephoned us and asked what she could do about her fears. Our answer was a reference to their purpose,—that she wanted to absorb her mother's attention by demanding sympathy, consolation and reassurance. She was praised for her cleverness and told to continue her scheme.* The girl seemed to be satisfied with the answer and ended the call with friendly thanks.)

The principal remaining difficulty at the next interview was the girl's "inability" to swallow her saliva. The problem was discussed with Sharon. She volunteered the information during the discussion that she was bad and did not deserve to be happy. It was pointed out to her that one of the reasons for not swallowing the saliva was that she considered everything in herself to be bad, including her saliva, which she fancied was full of germs. She also was angry with her present situation, and expectorating was an emotional expression of her dissatisfaction and contempt for order and regulation, particularly since she no longer manifested her anger overtly through her temper tantrums.

During the discussion with the mother, a policy was established in regard to Sharon's expectorating. Mother was to tell her that she should go up to her own room if she wanted to expectorate on the floor instead of using the appropriate receptacle.

Two weeks later, the mother reported that the expectorating had stopped. Mother and daughter spent much time playing together and there was little disturbance in the home. Only once during this period had a relapse occurred, shortly after Sharon had visited her own father. After this visit, she berated her mother and struck at her several times. (Apparently the girl was unable to forgive her mother for having remarried instead of devoting the remainder of her life exclusively to her!) Sharon

*Such "anti-suggestion" is often very effective!

did not like to have her hair combed and sometimes became angry on such occasions. (The rebellion against being overpowered or handled).

During the next few weeks, the child occasionally became moody as an appeal to mother for special consideration. Occasionally, she struck her mother who managed to ignore the abuse composedly.

After three months of treatment the case was closed as "recovered." Sharon became "her old self" but on a different equilibrium. Several months later, during a casual encounter, mother reported that Sharon had continued well and happy without a recurrence of any difficulties.