PSYCHIATRY

Treatment of a Child with Spontaneously Arrested Hydrocephalus

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> "Psychotherapy can be a vital adjunct to any program for brain damaged children, and may be very necessary before educational and management technics can prove effective."

PSYCHOTHERAPY for children with diagnosed organic brain damage is often regarded as not only useless but unwise. Many psychiatrists think that psychotherapy may loosen such a child's already tenuous controls, and rarely make recommendations for further professional attention to his emotional problems. Reliance is then placed on special education and structuring technics.

Our orientation at Children's Psychiatric Hospital leads us to examine the emotional aspects of the child's total personality, which must include his—and his family's—reaction to his brain damage. Along with the history and description of the physical insult, which allow some baseline understanding of the limitations and assets of the patient, the psychiatric history and evaluation give an understanding of his psychologic development, the alterations in personality development due to the organic damage, and his current emotional reactions to his handicap. Since precise measurements of the changes in behavior and feeling caused directly by a brain injury are difficult to separate from the emotional reactions to it which exist in the patient and in his environment, efforts directed toward improvement of his emotional state would seem to be a prime source of optimism.

Obviously there should be some coordination between the therapy and the education of these children. Psychotherapy may be necessary before efforts to train and educate the "organic" child can be fruitful. Psychotherapy should initially be supportive, with attention to both the child's intrapsychic functioning and his interactions with family and environment.

Some of the reactions these children must deal with are feelings of inadequacy, based upon their recognition of their basic limitations, their deep concern over lack of impulse control, and their recognition of the rejection they often experience. The child with brain damage has as many or even more opportunities for disturbed life experiences as any other child who comes to a psychiatric clinic. Jerry's case, here traced, illustrates some of these points and will serve as a basis for discussion.

Jerry was eight years old when he was referred to the Children's Psychiatric Hospital because of difficulty in certain academic areas and slowness in acquiring motor skills. He was reading at his grade level or better, but had never been able to master arithmetic or handwriting. At age eight, he was still unable to tie his shoes or ride a bike. His family was aware that he had an unusual tiptoe gait and held his right arm in a somewhat peculiar way. Jerry was a good boy, almost too good, but showed tendencies toward sensitivity, fearfulness, and daydreaming.

His mother's pregnancy had been uneventful and the delivery normal. He had spoken words at 12 months, and sentences at 18 to 20 months. His walking, however, had begun more slowly, at about 21 months.

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When he was two years old, he had been hospitalizd for acute catarrhal laryngitis. During this hospitalization it was first recognized that his head was enlarged; it measured 59.2 cm. in circumference. No unusual neurologic signs were noted.

Jerry's family situation posed a number of problems. He was the only male living with his mother and four sisters. His father had died of advanced hepatic cirrhosis caused by alcoholism when Jerry was two and one-half years old. Since that time his mother had raised the family alone, and had developed a peptic ulcer two or three years prior to the evaluation date. She was a resentful woman, who felt wronged by fate in general and men in particular. Jerry was receiving the brunt of this resentment, since he was not only a male but was presenting her with problems. She did not conceal her irritation with Jerry and his condition, and talked at times about sending him to a special school.

Jerry's neurologic examination at the initial evaluation revealed a significantly enlarged head (60 cm.) and the following findings: he could not hop well, especially on the right leg; heel-to-toe gait was quite difficult; fine coordination was impaired; he had difficulty bilaterally with rapid alternating movements; the reflexes in the lower extremities were increased markedly, especially on the right; and there was a positive Babinski response on the right side. Later examinations have revealed intention tremor bilaterally on finger-to-nose tests.

Psychologic testing uncovered some motor deficits. On the WISC, Jerry attained a Verbal I.Q. of 121, a Performance I.Q. of 80, resulting in a Full Scale I.Q. of 107. Projective testing indicated strengths in being able to develop good relationships with others, creative self-expression, and a capacity for self-control and reality testing. It was suggested that he was trying to deal with his organic impairments by slipping off into fantasy.

Because few behavior problems were clinically evident and because the problems in school were felt to be directly related to his physical deficit, psychotherapy was not advised. It was recommended that Jerry's school utilize available educational technics to help him overcome his motor deficits. This meant entry into specialized recreational programs and being taught motor skills in the classroom. The school was also encouraged to help Jerry make use of his obvious verbal skills.

This approach did not prove fruitful. One year later, from a subsequent evaluation, a reading therapy program was begun with Jerry at Children's Psychiatric Hospital—a program designed to help him develop his skill in reading and give him some focus of success. In spite of this, Jerry failed the 6th grade. Psychologic testing indicated only minimal change in his intellectual functioning, but he appeared more constricted and was developing extensive compulsivity. Clearly the technics used up to this point had been insufficient to alleviate Jerry's academic problems. It was apparent also that his difficulty in functioning was related to his psychic conflicts. Hence psychotherapy seemed indicated.

For the next three and one-half years and continuing through the present, Jerry has been seen in psychotherapy once a week. His mother has been treated by the same therapist, but at a different hour. The focus of therapy has been directed to the areas of feelings of inadequacy, concern over loss of impulse control, feelings of rejection, and other conflicts unrelated to his organic disorder. The aim has been to develop an understanding of these problems which would enable Jerry to make fuller use of his assets, to overcome any of his physical limitations which are surmountable, and to adapt comfortably to those which are not.

Jerry's therapy went slowly at first and his performance in school remained about the same. The therapist felt that Jerry, like most other organically damaged children, viewed himself as weak and inadequate and that these feelings prevented his progress. He, therefore, initiated an almost frontal attack upon his problem. Jerry had made allusions to his inability to keep up with other boys in his class and had also recognized some of his motor handicaps. However, it wasn't until seven months of therapy had passed that Jerry could reveal with all the anger and sadness he felt his great concern over being "retarded" due to his brain injury. This had come out in a discussion of the difficulty he was having with arithmetic and handwriting. He had twice been asked why he thought he was having this trouble and he burst out with, "You know why. I'm retarded. That's why I'm here. Something happened to my brain. I put two and two together and I can figure it out." He

was subsequently able to talk about his resentment over this. Then, with some explanation of the problem as it really existed, Jerry seemed more convinced of his own capabilities. Shortly after this his work at school improved and in time his handwriting became legible. He was also more willing to attempt to improve his motor skills in skating and bicycling.

Jerry's concern over any display of emotion, most specifically anger, and the control of that emotion came out in reference to his mother. He had a tremendous fear of this anger, especially toward her, which caused a good deal of overcontrol and constriction. As mentioned earlier, his mother had an ulcer and Jerry was quite concerned that any upsetting scene might cause her to become acutely ill and die. He had already had the experience of losing his father. It did not take much interpretation to point out that his inability to be aggressive at home, with his peers, or in school was provoked by this preconscious concern over causing his mother's death through any impulsive show of anger. After this insight developed, he became somewhat more boisterous and lost some of the "inert" quality he had had previously.

Jerry, like many similar children, was rejected by his mother. This could be seen in her overprotection of him, as well as in her threats to have him schooled away from home. Jerry and she came to a mutual confrontation of this within a joint therapy hour. (They were seen jointly for several weeks in an attempt to get at problems such as this.) His mother had begun to talk about previous ideas of sending him away to school and Jerry interpreted it as though she were talking about the present. He accused her of not wanting him around because he wasn't as bright as the girls. In this hour his mother was able to see her rejection and with the therapist's help was able to reassure Jerry that she would not send him away, though with the reservation that if the doctor felt it necessary she and he would discuss it before a final decision was made. This, of course, was not the final resolution of the hurt Jerry felt over his rejection but certainly was a step in that direction. Jerry subsequently talked more about his feelings of rejection and actually improved in his relationships around the home, acting a bit more in the role of the man of the house.

Jerry's problem in competing in an all-female household illustrates family and environmental problems which are relatively unrelated to the child's organicity or reactions to it. He had become convinced that the only way to gain his mother's attention, or any other person's attention, was to outdo his sisters. He unfortunately chose to do this on the girls' terms and was in serious difficulty in relation to his sexual identification. Both the judicious use of male companionship and interpretation of his attempts to compete with his sisters provided the needed impetus to start him on the masculine path once again.

In summary, this child's history has illustrated how psychotherapy can be incorporated and prove helpful in the treatment of brain damaged children. Jerry, at 15, is currently in the 10th grade. He has a good concept of his future plans, having chosen to obtain a vocation in a field where he can use his verbal capabilities. His ability to relate to others, both in and outside of his family, has improved. He appears the typical adolescent. There are no evidences of any further neurologic problems. Psychologic testing shows his intellectual functioning to remain the same, with a lessening of the areas of difficulty noted in the second testing. The alleviation of the conflicts this child had built up around his organicity seems to have made him more amenable to attempts to further his education and his social adjustment. This gives hopeful support to the concept that psychotherapy can be a vital adjunct to any program for brain damaged children, and may be very necessary before educational and management technics can prove effective.