HELPING A MOTHER FACE MEDICAL CRISIS IN A CHILD*

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IN casework practice, our focus is essentially two-fold — the individual's inner personality equipment and the environmental factors inherent in his situation. The problem in treatment is to assess the reality of each and to attempt to help bring about as harmonious and life-giving an interplay as possible. In this discussion we are concerned with the helping process in a situation in which there exists an acute, realistic environmental crisis; in this instance that of the effect upon a parent of the sudden, incapacitating, and fatal illness of a young and previously healthy child. Several aspects of this situation characterize its particular treatment problems. One such factor is the time element. The crisis is sudden, affording an acute change in the situation of the patient and those concerned. The need for help is imminent and pressing, limiting the therapist's flexibility in terms of time. Despite the pressure for prompt relief, however, there are barriers to the patient's amenability to treatment.

In the setting here concerned, that of a hospital** medical ward, the family member enters treatment motivated solely for alleviation of the medical trauma, rather than out of direct interest in his own emotional adjustment. In addition, his readiness for help is limited by the strong need for defense in the face of tragedy. The individual's entire interest is in a catastrophic event which would be taxing even to the most resilient of personality structures. It remains the case worker's problem in such cases to guard against being likewise overwhelmed by the outer trauma, and to retain a focus to the total individual and total situation. Though our direct treatment goal, in a medical social work setting, may be of help with an immediate situation, this cannot be achieved except through a focus to the whole.

It is in the life crisis that the emotional resources are most acutely taxed. Our awareness of the psychic interplay is critically essential and at the same time critically challenged in these cases. Regardless of the particular make-up of the individual, a situation of acute

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trauma inevitably calls for the erection of defense. The individual strives in his moment of crisis to preserve his identity. Defense in the threat of danger and loss is natural and helpful. It is in the quality of the defense that we receive our clues into the psychic structure of the individual and our guides into the treatment process. It is the degree to which the defense appears appropriately related to the outer problem and the degree to which it promotes or hinders healing which help us determine the need for help. Regardless of its effectiveness, however, the defense in itself is a protective device and cannot be relinquished unless a more effective support is substituted. This support can best be provided through the treatment relationship.

We shall attempt to illustrate such a treatment situation with a case illustration: We shall call the child Diane—an 11-year-old girl who entered our hospital with post-measles ascending myelitis. On admission she was completely paralyzed from the neck down; was placed in an artificial respirator. Her paralysis followed a case of the measles, prior to which she had been in excellent health. The diagnosis was established quickly and prognosis was felt to be poor. No hope was held for improvement and ultimate fatality was considered inevitable.

It was noted that the mother, Mrs. Mason, was a high strung woman with personality difficulties of her own which were complicating her adjustment to an innately traumatic situation. Referral for casework was initiated by the disturbing nature of her response and was for the purpose of helping her adjust to the limits of Diane's situation. It is at this initial point that we first glimpse Mrs. Mason's responses and receive clues as to the nature of her inner equipment for meeting the problem. Mrs. Mason's outstanding reaction was one of an attempt to control the entire situation from diagnosis on through ward routine and treatment of the child. She refused to accept the medical diagnosis and prognosis when this was realistically presented to her. She insisted that Diane would get well; exerted pressure on the child and the staff to take measures which would hasten recovery. She herself made unrealistic living plans regarding Diane's rehabilitation and pressed the child to strive for improvement. This pressure increased tension in the child and aggravated her problem in adjustment to the trauma. She became increasingly anxious, irritable and resistant. The liaison psychiatrist attached to the ward observed the inter-relation between the child's behavior and the mother's influence. Mrs. Mason was referred for casework treatment, was seen two times weekly for ten weeks. The social worker had no direct treatment function with the child, who was seen regularly by the liaison psychiatrist.

Before discussing treatment, a brief summary of the family background: Mrs. Mason, a 39-year-old woman, had been divorced from her husband for five years. Mr. Mason was a business man, who lived alone, supported her with alimony. There was one other child, a girl, aged 10. Mrs. Mason lived with the two children in a six-room private home owned by Mr. Mason. She lived on a high economic scale in an upper-middle class suburban neighborhood. She supplemented her income through private sale of antiques. There was little contact between Mrs. Mason and her former husband except in business matters. Mrs. Mason herself describes an emotionally deprived background. She was the youngest of eight children, isolated from her siblings because of age difference. The emotional milieu was cold. Her mother was a self-sufficient woman who devoted little time or feeling to Mrs. Mason. Her father was described as a weak, dependent man whose role in the family was subdued by his wife. Mrs. Mason's attitude toward him was one of contempt. She stated that she never felt loved, always felt the need to be self-reliant, for there was no one to whom she could turn for help. Mrs. Mason carried into her adult life her need to conceive of herself as self-sufficient; a "doer rather than a leaner," in her words. She married, at a young age, a man whom she described with contempt as a weakling. She spoke of having married for position rather than love. She prided herself on the degree of emotional control she could exert upon herself; expressed no regret at her broken marriage, in which she initiated the request for severance, after fourteen years of marriage. Though she maintained relationships with other men, she admitted to no interest in remarriage, described a coldness and emotional sterility in most of her relationships.

Mrs. Mason was an attractive, youthful looking woman. She was meticulously groomed; dressed fashionably. Her manner was self-

contained; aloof; and somewhat dramatic. She was intelligent and tended to intellectualize. People responded to her with an awesome deference. The significant point in diagnosis is that her outer facade was well controlled and retained throughout the crisis she passed through. Her attention to her wardrobe, for example, was something she clung to tenaciously and appeared to increase when anxiety mounted.

The degree of this superficially effective control gave us initial insight into the general nature of her defense mechanism. It is the extent to which this defense interfered with optimum adjustment that it became a destructive element which necessitated treatment. It was on the basis of this destructiveness that Mrs. Mason was originally referred for case work help. Her awe-inspiring personality had succeeded in virtually dominating ward routine and was interfering with treatment of the child. Mrs. Mason closely supervised Diane's care, spending most of her waking hours on the ward and allowing little help from her husband or other family members. She literally took over nursing duties, causing near-rebellion on part of nursing staff. Her anxious pressure for improvement was causing mounting tension in the child, herself and all others concerned. Any suggestion for change met with hostile resistance.

Upon her referral to the case worker, Mrs. Mason could in no way openly accept this situation as one for help with her own adjustment, but rather conceived of it as an additional instrument through which she could exert pressure for improved care of Diane. At onset of treatment, Mrs. Mason's need for control was strongly evidenced in her resistance to the interview situation per se. She attempted, at first, to control time, setting, subject matter. She tried to evolve the relationship into a friendly, social one; attempted to induce worker to conduct interviews informally over lunch. Throughout, we were uncritical but firm in setting certain limits with which we were consistent. We feel that this uncritical but firm consistency was crucial in treatment of Mrs. Mason. It is at this initial point that the milieu of treatment is established. If we had been moved by the pressure of her tragedy and the rigidity of her defenses to yield to her seeming need for a more relaxed, social milieu, we would have automatically blocked the establishment of the kind of rapport which would be most therapeutic to Mrs. Mason. If Mrs. Mason had been allowed to control this situation as she had all previous ones, this would have confirmed her conviction that there is no helping agent strong enough to cope with her problem; her insecurity and need for rigid defensive controls would have been perpetuated.

After much initial testing, Mrs. Mason began to yield to the limits for the treatment relationship. When she met with acceptance within these limits, she allowed herself freer expression of feeling and exposure of problems.

Mrs. Mason's progress in her adaptation to Diane's illness was gradual. At first she was openly fearful that we would pressure her into giving up hope for improvement. In her first interview she warned us that if this was our purpose in seeing her, she wished no further contact. She expressed resentment of the medical staff who she felt were trying to impose upon her acceptance of their hopeless attitude. We didn't directly challenge her defensive resistance to the prognosis; instead, we geared discussion to the present rather than the future and encouraged her to include, in her concept of the present, her life as a whole. There was discussion of her own practical needs; of her relationship with her husband, and, in particular, of her relationship with her younger daughter. Mrs. Mason revealed a negating attitude toward this younger child whom she had always identified with her guilt-ridden self, as opposed to Diane, whom she had idealized as representing her own frustrated strivings for perfection. When Diane was stricken, Mrs. Mason rejected her own welfare and that of the other child as being unworthy.

In discussion of this guilt and self-rejection, Mrs. Mason was able, with increasing freedom, to examine herself more objectively in terms of her past background and current functioning. She began to use interviews frankly for treatment and to give open expression to personality problems which had existed prior to the present crisis and which were continuing to impede her adjustment. The chief theme of these discussions was the unrealistic pressure she had always, in all areas, exerted upon herself for superlative and all-controlling performance; her inability to accept herself for herself; her lack of belief that others could be strong enough to help her. Mrs. Mason was able to make connections with her familial background: i.e., her development in an emotionally starved milieu, in which she was thrust upon her own resources for survival and had contempt for her father and resentment of a rejecting mother. Mrs. Mason exposed more completely the degree to which she had guarded against deep attachment in her adult relationships. She admitted that though she had

attracted attention and admiration from both men and women, she had never been able to respond with deep love-feeling. She was able to express guilt over the degree of her emotional detachment in all her close relationships. Of prime significance here is the extent of her self-recrimination over her prior handling of the sick child. Though she had idealized Diane's potentialities and fostered their fulfillment, Mrs. Mason condemned herself for some inner awareness of inadequacy as a mother and a woman. The interview situation offered Mrs. Mason an opportunity to expose these feelings and to view her behavior in the framework of her total life perspective. This somewhat relieved her self-blame. She began to identify with the worker's accepting attitude and to modify her own self-rejection. She was able to increasingly include concern over her own total welfare and that of her younger child. There gradually evolved a marked change in her daily adjustment to Diane's ward routine. She became less anxious; released some control over Diane's care; spent less time on the ward; allowed more help from her husband and family members. There was improvement in her relationship with the nursing staff and lessened tension in Diane herself. In general, Mrs. Mason became more realistic in her attitude toward Diane's illness. She expressed realization that she had needed to deny the prognosis in order to save herself from breakdown. With time, she was able to state that despite Diane's minimal signs of improvement, she recognized the possibility of limited recovery if any.

After ten weeks of treatment, Diane died without immediate forewarning. Mrs. Mason's response was controlled but not rigidly so. We feel that Mrs. Mason's response to Diane's death was cushioned by the preparation she had received in the previous weeks of treatment. Of chief significance was the relief of guilt and her resultant ability to value life apart from, or in addition to, Diane. In the moment of Diane's death, her energy thus remained more attached to existing life than it would have without preparation.

Following the child's death, there was a pause in treatment of about four weeks during which Mrs. Mason did not visit the hospital. The worker suggested that Mrs. Mason contact us should she wish an interview. She did so and we had two interviews with her, both initiated at her request. In these interviews she was able to express grief and emotion. She was profoundly depressed but able to reach out for help. She expressed awareness that she had emotional problems which had always hindered her adjustment and were continuing to do so. Her expression of this awareness led to discussion of referral for psychiatric treatment. She had at various times considered this, but had never been able to follow through. Mrs. Mason continued to express some resistance to yielding to treatment for herself, chiefly in her feeling of guilt about focusing to her own need now that Diane was gone. With the worker, she was able to work this through to the extent of seeking private psychiatric help. Our treatment function was necessarily terminated at this point. Despite the fact that Mrs. Mason's total needs were considered in treatment, our focus remained throughout, somewhat tied to the crisis which had initiated contact. With the passing of the crisis, it was important for Mrs. Mason to relinquish her ties connected with it, and to move on to further help. This could best be provided by a therapist in a new setting whose function would be directly related to her personal adjustment. The referral to a psychiatrist rather than another casework agency was determined by the purely intra-psychic nature of her problem at this point. Mrs. Mason's ability to seek such help reflects some carry-over of the treatment experience per se into her total life functioning.

The differentiating factor in the treatment problem illustrated is the advent of a crisis which, in itself, is highly traumatic. The ability to adjust to such a trauma is largely determined by the individual psychic makeup. Regardless of individual differences, however, several significant elements emerge for discussion. One such element is the natural need for defense in the face of threat. This defensiveness may be immobilizing and destructive, but it is necessary for self-preservation. The defense cannot be relinquished unless substitute support is offered. Such support can be provided through a treatment relationship which is sensitively adapted to the needs of the individual. Through this relationship *per se*, a modification of defenses can be worked through, resulting in improved adaptation to the problem at hand. In the case illustrated, Mrs. Mason's denial of the reality situa-

tion was a strengthening of her usual defense patterns, in an attempt to control the tragedy with which she was faced. Her defensive reaction added to the strain of the situation, but temporarily protected her from collapse. Any attempt to immediately deprive her of her defenses directly related to the child would have met with failure. However, this rigid need for defense was indirectly handled through the treatment relationship *per se*. As Mrs. Mason allowed herself to loosen controls within this relationship, and found herself supported and accepted, she was able to modify her reactions to the traumatic event. Ultimately, her lessened need for self-defense enabled her to seek further personal help.

In addition to a rigid strengthening of defenses, there are several factors in this situation which limit accessibility. The individual's focus at the point of contact is to an outer event affecting another individual rather than to his own need. The ability to focus to his own adaptation to the problem is hindered by the overwhelming nature of the crisis and by the tendency toward self-denial when a family member is stricken. This tendency varies with the individual and depends largely on the extent of his guilt-feeling. It is only through relief of such self-condemnation that the person can be helped to view life as a whole rather than binding himself completely to the stricken one. Mrs. Mason, for example, could allow herself interest in her own life only after expressing her self-blame and realizing that she couldn't rightfully hold herself fully responsible for all that had happened in her own life. The roots of such guilt as she suffered stem from deeper origin than the immediate trauma and can be approached only superficially in brief contact. However, even limited handling can result in relief and improved adaptation. In particular, the ability to face fatality is aided to the extent to which remaining life has retained its meaning. This meaning can be retained only if the individual allows himself to leave the departed one and focus to other life needs.

The experience of crisis inevitably causes some stirring up of psychic patterns. This emotional stirring can, if sensitively handled, often result in growth and movement which otherwise would not have been stimulated. Though our direct treatment goal may be limited to help with the presenting crisis, such help can be provided only through a focus to the whole. A hoped-for result of effective treatment is a carry-over into the strengthening of the total personality.