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A study of maternal resistance to treatment in the Massachusetts Division of Mental Hygiene Child Guidance Clinics in cases closed as unimproved during fiscal year, July, 1948 to June, 1949.

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Boston University
BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF MATERNAL RESISTANCE TO TREATMENT IN THE
MASSACHUSETTS DIVISION OF MENTAL HYGIENE CHILD GUIDANCE CLINICS
IN CASES CLOSED AS UNIMPROVED DURING THE
FISCAL YEAR JULY, 1948, TO JUNE, 1949

A Thesis

Submitted by
William Leonard Williams
(B.S. in Ed., Kent State University, 1949)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
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CHAPTER I
INTRODUCTION

A close working relationship with the mother is inherent in all child guidance work. This is necessarily true because of our culture which, for the most part, deems it necessary for the father to concentrate most of his time and energy to providing for the family and the mother is responsible for maintaining the home and rearing the family. In child guidance the psychiatric aspects of the work seem to be threatening to many mothers. If the mother is resisting the clinician, consciously or unconsciously, and is unable, with the help of the therapist, to overcome the feeling of resistance which she has against the clinic, she will withdraw from the clinic setting.

The purpose of this study is to examine the treatment cases closed as unimproved because of maternal resistance during the fiscal year July, 1948, to June, 1949, from the Child Guidance Clinics of the Massachusetts Division of Mental Hygiene directed toward understanding some of the outstanding indications related to resistance and to attempt to answer such general questions as:

1. How was the mother's resistance expressed in the treatment setting?
2. How does the mother's resistance affect the progress of the treatment?
3. How was resistance used by the mother to terminate the treatment?

Scope of the Study

Resistance is a term used both in psychiatry and in case work which makes a definition, suitable to the understanding of both professions, a very difficult task. A broad and general definition of the term would be, any and all of a client's defenses expressed in the treatment setting. With such a flexible definition, it can be said that every mother in treatment is resistant; however, this study will be limited to those cases in which the mother rejected the treatment because of the factor of resistance. Every case used in this study had been accepted for intensive treatment on the recommendation of the psychiatrist and, despite repeated efforts of both the psychiatrist and the social worker, the mother rejected the treatment offered by the clinic, which seemed to be directly related to resistance. In each of the cases the psychiatrist and the social worker were active and had focused their treatment on the goal as determined by the psychiatrist. However, the material available for study, which was used in this thesis because of the natural limitations of the recording, and because of the nature of the treatment involved, does not lend itself to the more detailed and complete analysis that would reveal some of the more specific aspects of resistance. In each case, however, the mother's resistance was the major cause of the treatment.
being rejected. It must be remembered that this is not intended to be an intensive study of resistance factors but it is felt that the study will have value in pointing up some of the more important aspects of resistance in the unimproved treatment cases in the Massachusetts Division of Mental Hygiene Child Guidance Clinics.

Method

There was a total of 271 treatment cases closed from all clinics in the fiscal year July, 1948, to June, 1949. These figures were obtained from the research social worker at the Division of Mental Hygiene. Of these 271 cases, forty-eight were closed as unimproved. Twenty of these cases were closed because of the factors of resistance as found in the record. Ten cases, which were recorded in the fullest detail, will be presented in sufficient detail to answer the general questions listed above. The writer feels that the information found in these cases (Chapter IV) is fairly representative of the material to be found in the unimproved treatment cases related to resistance in any fiscal year.

The ten cases were studied and abstracted with the use of a schedule (see Appendix) formulated for this purpose. Significant information relating to the child and his problem, the mother and the father when available, was included for the study in each case. All expressions of maternal resistance toward the clinic and treatment, its effect on
the progress of the treatment, and the expression of resistance at the termination of treatment were studied carefully. In every case the judgment of the psychiatrist and the social worker was accepted as final.

Background of the Study

In Boston, in November, 1921, Doctor Douglas A. Thom was asked to make a private survey to determine the practicability of psychiatric clinics for young children. Doctor Thom became very enthusiastic about the possibilities that opened before him. Soon three clinics were put in operation under his direction by the Community Health Association (Visiting Nurses) and were called by the innocuous but descriptive name, "habit clinics." In 1922, Massachusetts was the first state to provide by legislation for a Division of Mental Hygiene, which was formulated as a part of the Department of Mental Health. Doctor Thom was appointed the first Director. The Division was charged with the responsibility for everything which affected the mental health of the citizens of the Commonwealth. The organization and operation of child guidance clinics was financed by state funds. In June, 1923, one year after the Division of Mental Hygiene had come into existence, the Habit Clinics for children were established under their direction. There were no age limits specified in the organization of the first clinics, but it soon became evident that more than half of the total number of cases consisted of children of grammar
school age. On January 1, 1939, the age range for admittance to the clinics was set from two to fourteen years inclusive, and the name was changed from Habit Clinics to Child Guidance Clinics. The clinics have accepted in the past, and still accept for treatment, any child who is not classified as feeble-minded (I.Q. below 70) and who is not so mentally ill as to be classified as psychotic.¹

The most important contribution to the clinics is rendered in the field of preventive work with children in whom is evidenced the tendency toward the gradual development of the potential neurotic, eccentric, delinquent, and psychotic adult.²

At present there are four Child Guidance Clinics in operation under the auspices of the Division, one at each of the following locations: Boston West End Health Unit, Lowell, Brockton and Quincy. The cases in the study are representative of the work done in each of these clinics.

The service of the Child Guidance Clinics consists of study, recommendations, referral, and treatment. The work is carried on by a specially trained group of experts, which includes psychiatrists, psychologists, and psychiatric social workers. In addition, there are reading tutors, speech therapists, and occupational therapists for cases requiring

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² Commonwealth of Massachusetts, Annual Report of the Commissioner of Mental Diseases for the Year Ending December, 1938, p. 52.
this special help, or in addition to other treatment. Cases are divided into full service and special service which is decided upon by the psychiatrist after study and consultation with other staff members.

Full service is given when intensive treatment is indicated. This may be because long-term therapy is indicated or because the problem is of a serious nature. In full service cases, the social worker obtains a social history from the parents, the school, and other agencies. The child's physical condition is determined from medical histories and reports from hospitals or private physicians. The psychologist gives the psychological examination and, on occasion, achievement tests. From these findings the treatment is decided and carried out by the staff. During treatment, the mother and the child usually have weekly clinic appointments with the psychiatrist and the social worker. The psychiatrist usually works with the child and the social worker with the mother. Occasionally, this procedure is reversed. In some cases, the psychiatrist sees both the child and the mother; or the child will see one social worker and the mother will see another. It is necessary to point out that in cases where the child and the mother are both being seen by social workers, the treatment is recommended and followed closely by the psychiatrist. In addition to clinic visits by the mother, the social worker may make one or several home visits as is felt necessary in the treatment process.
Special service cases are those which do not need intensive treatment and only enough information is needed to guide the clinic staff in making a diagnosis. Some of the special services are:

1. Services to children who are brought to the clinic for consultation and diagnostic service only.

2. Services to cases where the psychiatrist, after staff consultation, feels that full service is not warranted.

3. Services to children who can be treated at the clinic for a particular disability without full service, such as speech or reading.

4. Services to children who are referred to another agency which is qualified to meet their needs, such as school, another social agency, or the training classes of the Division of Mental Deficiency.

Another feature regarding the function of these clinics should be mentioned which is that case loads cannot be limited because the clinics are supported by the State and their services to the public are free. Because of the heavy case loads, it becomes necessary to give a more generalized treatment to many rather than intensive treatment to a few.
CHAPTER II
THEORETICAL DISCUSSION OF MATERNAL RESISTANCE

Whatever the form of resistance of the mother, it is present in every case and must be reckoned with from the beginning of treatment. It is openly expressed, and it comes in cleverly disguised forms that vary from complete rejection to an eager spirit of cooperation, but it is always present.

Resistance is a highly complex term as used by the analyst. Resistance involves the entire concept of the unconscious; the repression by the ego of painful, disagreeable, or obnoxious impulses and their conscious associations into the unconscious; the resultant neurotic symptom formation as these impulses remain active and express themselves in altered undesirable form; and finally the opposition by the ego, through a variety of psychological defense mechanisms, to the efforts of both the analyst and the individual to make these impulses again conscious. If the repressed impulses should reach the conscious level, suffering would result because the impulses were originally repressed because of the pain they were causing. The symptom formation represents an adjustment, though undesirable, to these impulses; and the ego strives against the consciousness which would make a readjustment necessary and possible.

Freud says, "...the whole psychoanalytic theory is in fact built upon the perception of the resistance exerted by the patient when we try to make him conscious of his uncon-
When we undertake to cure a patient of his symptoms, he opposes against us a vigorous and tenacious resistance throughout the entire course of the treatment. The patient exhibits all the manifestations of his resistance without recognizing it. The resistance is not a part of the unconscious but of the ego, which cooperates with the therapist. 

Psychoanalysis differs from other forms of psychotherapy in that it deals with a sign of unconscious resistance. An understanding of the basic psychology involved in the psychoanalytic method is essential to understanding the factors of resistance; however, this thesis will only deal with some of the gross forms of resistance.

In social work, resistance "...covers any and all of a client's defenses against treatment, which requires understanding in order that the case will not be lost to treatment." Resistance in case work is based on the same dynamic psychological concepts as is used in psychoanalysis, but the social worker's use of resistance factors vary in aim and purpose as the two professions vary in their work. The social worker makes no attempt to interpret to the patient the unconscious

3 Ibid., p. 379
motivations of his resistance. He is more concerned with preventing resistance from interfering with the case work process and inhibiting the treatment goal. The resistive client uses energy for resisting which can be used in therapy if it is released. A long-standing resistance pattern apparently gives the client a growing confidence that he has his problems in personal check and is invulnerable. The success of the treatment will depend upon the patient's conscientious effort to cooperate and overcome his resistance in whatever manner expressed. Resistance is shown in a number of ways—by refusing to give history which is frequently encountered in any clinic setting. The mother will concentrate on the present situation and avoid the past by vagueness or by saying she doesn't remember.

Resistance is frequently expressed by the mother's attempt to control the interview. She will frequently do this by her conversation, discussing only material which she wants to discuss and at such a rapid pace that the worker is unable to participate in the discussion. Oftentimes after a brief period of treatment the mother will insist that the child is well or that things are going better so there is nothing to talk about. Frequently the mother takes the stand that the clinic is not equipped to handle the problem and she prefers to take her child elsewhere. This is generally an attempt to withdraw from the treatment and mother has no intention of going to another clinic.
One of the most prevalent expressions in a child guidance clinic is mothers' unwillingness to participate in the treatment plan. They feel it is not their responsibility and the social worker has some magic formula that can be applied to bring an end to all difficulties. When the necessity of their participation in the treatment plan is pointed out, the reaction is that they did not come for help for themselves and will not enter into the treatment plan. When this plan is outlined, the mother withdraws from the treatment.

The opening interviews are the most crucial periods and the time when most mothers express their resistance in some manner. Success or failure many times depends on the first several interviews and can be classed as the first phase of the treatment. Resistance automatically develops as soon as the transference is established, when the defenses are laid aside and the therapist approaches the center of the emotional conflict.5

Also, in the course of treatment, resistance varies in intensity continually; it always increases as a new topic is approached and is another crucial point when a case may be lost to treatment. The mother must be made aware of the direction of treatment and know that it is aimed at her own personality difficulties.

Jealousy is another reason for resistance. Some mothers feel that the therapist may get a stronger emotional hold on the child, thereby estranging him from them. This fear is particularly intense in cases where the parents themselves are emotionally too bound up with the child, and resent any loosening of this emotional tie. 6

Resistive mothers have so mobilized their fears and anxiety that they are unable to relax enough to benefit by treatment. They often develop a strong feeling of guilt that complicates the problem. They feel somehow responsible for the difficulty of the child, either because of his constitution, or because of mistakes that they have made in his education. The thought that the child may be disturbed not only activates a sense of guilt, but also deals a deadly blow to the pride of many parents. Sometimes the parents unconsciously feel that the child's disturbance is only a part of the whole disturbed situation at home, and that any change in the child would affect themselves. In that case, they defend their own neurosis along with that of the child. They meet with distrust the person who tries to rid them of the disturbance. Their resistance is rarely open and conscious, usually it is unconscious and well rationalized. 7

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7 Ibid., p. 639-640.
If the parents' participation is lacking, the entire treatment process is seriously handicapped. As soon as the child is in treatment, resistance in the mothers tends to develop—either to the child's treatment or to any expression of her own involvement in his problem. Asking for help for the child without assuming responsibility in any way usually means that the parent will create a conflict for the child which will sooner or later prevent his coming to the agency. A little child cannot relate himself to the worker unless his mother can also relate herself to the treatment process, and even an older child, if he feels parental disapproval, may break off. Time given to the parent before seeing the child may be well spent. 8

The child guidance clinics deal with problem environments and problem parents rather than problem children. Most of the problems of childhood are conditioned by the behavior of adults, the children's behavior being but a response to the stimuli they received from their home setting.

For treatment, the problem is how to reach these mothers and make them accept the fact that they have problems of their own which should be treated and, at the same time, minimize the factors of resistance. It is related to the mother's insecurity, a condition in parenthood not uncommon in our culture. It is also related to the immediate circumstances

8 Hamilton, op. cit., p. 175.
in the family which is threatening to the mother. The anxiety of visiting the clinic coupled with the tense home environment is more than the mother can accept, and so she takes the most obvious means of escaping a portion of the frustrating circumstances—that of withdrawal. It is the underlying fears and conflicts of the mother, making for insecurity in parenthood which has created this maternal anxiety which led to the mother's decision.

**Summary**

In child guidance work, all mothers display some degree of resistance which is shown in a variety of ways. It is necessary to understand the close relationship that exists between the mother and the child, and the importance of the far-reaching effects of the unconscious attitudes that are a result of the mother's own human relationships during the years of her childhood. Specific emotions such as anxiety, guilt, jealousy and pride will arise during treatment and play an important part and find varied means of expression in the mother's behavior in treatment. Occasionally, some of these emotions are well organized and expressed at the beginning of the treatment which prohibits any progress in the case following the initial clinic contact. They refuse the treatment to protect their own neurosis. Many of the prevalent American attitudes and beliefs, which are not peculiar to our culture alone, regarding psychiatry and mental abnormalities play an important part in maternal resistance.
CHAPTER III
DESCRIPTION OF THE GROUP

The tables presented in this chapter are intended only to give the reader a better understanding of the material in the case studies and in no way lend any significance to the understanding of maternal resistance. The most outstanding feature of Table I (below) is the portion of males to females; however, the number of cases studied is too small to be significant.

TABLE I
AGE AND SEX DISTRIBUTION

<table>
<thead>
<tr>
<th>Age at Opening</th>
<th>Male</th>
<th>Female</th>
<th>No. of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

The mother's resistance to seek treatment for the child is emphasized in Table II which indicates a lack of initiative in coming to the agency. The sources of referral are significant because in only three of the ten cases did the mother
take the initiative in coming to the clinic. This may also be significant in terms of the effect of community pressure.

TABLE II

SOURCES OF REFERRAL OF THE TEN CASES

<table>
<thead>
<tr>
<th>Source</th>
<th>No. Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>4</td>
</tr>
<tr>
<td>Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Social Agency</td>
<td>2</td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Tables III, IV, and V give additional material concerning the type of group studied emphasizing several factors which will give the reader pertinent facts regarding the cases studied.
### TABLE III
**DISTRIBUTION OF INITIAL PROBLEMS AT REFERRAL**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Male</th>
<th>Female</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor school work</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Enuresis</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nervousness</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Speech</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stealing</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fighting</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nailbiting</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Itching nose</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lying</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>School failure</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lonely</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Morose</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Soiling</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Head banging</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Poor school adjustment</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

### TABLE IV
**NUMBER OF SIBLINGS IN FAMILY**

<table>
<thead>
<tr>
<th>No. of Siblings (Including patient)</th>
<th>No. of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
TABLE V
RANGE OF I.Q. IN THE 10 CASES

<table>
<thead>
<tr>
<th>I.Q. Range</th>
<th>No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>80-84</td>
<td>1</td>
</tr>
<tr>
<td>85-89</td>
<td>1</td>
</tr>
<tr>
<td>90-94</td>
<td>0</td>
</tr>
<tr>
<td>95-99</td>
<td>2</td>
</tr>
<tr>
<td>100-104</td>
<td>1</td>
</tr>
<tr>
<td>105-109</td>
<td>0</td>
</tr>
<tr>
<td>110-114</td>
<td>1</td>
</tr>
<tr>
<td>115-119</td>
<td>3</td>
</tr>
<tr>
<td>120-124</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
CHAPTER IV
PRESENTATION OF TEN CASES

Maternal resistance to treatment is a highly complex problem which makes any type of classification difficult. The classification used in this study is based on three broad categories—rejection, ambivalence, and acceptance—relating to the mother's attitude to the child as found in the records of the cases studied. This classification is not a rigid one in any sense of the word and there may be some indication of overlapping with some cases fitting into more than one of the categories, but, because of the complexity of the case material and the difficulty involved at any attempt to cross reference, none will be used.

a. Four cases of mothers who reject their children:

Case #1

Edward was referred to the clinic by the school nurse because of nervousness in school. He was ten years old and an only child. He entered parochial school at six years of age but was later expelled because of truancy and behavior. He was uncooperative with the sisters and refused to attend Sunday mass. He transferred to Peter Fanueil School but his behavior pattern continued, although he was not truanting quite so often. At the clinic he appeared to be friendly and agreeable with an expression of physical exhaustion. His I.Q. was 103. After school he sold papers occasionally but was not interested in the work because the mother gave him money whenever he asked for it. He was a member of the Newsboys Foundation and attended the meetings regularly, although he did not participate in any of the activities. Because of the irremediable home situation and the mother's unwillingness to cooperate in a treat-
ment plan, it was felt a placement outside the home would be most helpful. He was committed to the Home of the Guardian Angel in 1949.

The mother was tall, heavy, poorly dressed and very untidy in appearance. Her background was very unsatisfactory. She was committed to the Girls Industrial School in 1935 following several complaints from the maternal grandmother of stubbornness. She was later paroled to the maternal grandparents but was returned because she was unmanageable. Following the second parole, she was promiscuous and became pregnant. The maternal grandmother refused at this time to care for the patient and he was placed under control of the Division of Child Guardianship for four years.

The mother made no attempt to find the patient's father although they were good friends for a long time before the mother's pregnancy. When the mother was preparing for marriage, she told her prospective husband about the patient and following the marriage they adopted Edward. After five years of marriage, they were divorced and mother went to work to support herself and the patient. Her working hours were from 5 p.m. to 1 a.m., which made it necessary for her to be away from the home when the patient needed the most supervision. She was possessive and defensive toward the child and expressed hostility toward the neighbors and the maternal grandmother for interfering in her home life. She felt she was the black sheep of the family and that maternal grandmother and step-father wanted to take the patient away from her. The step-father had offered to get the patient a job on several occasions. She often had drinking parties and kept male companions in her home.

The clinic made repeated attempts over a period of several months to get the mother into treatment. She not only refused to come to the clinic but would not consent to a home visit.

This mother felt guilty about her past life and expressed the belief that the workers at the clinic were also intent on punishing her because of her past. A treatment plan never
was put into effect because the mother would not cooperate. She would make appointments but never keep them. The case was closed because it was felt very little could be accomplished with the child as long as the mother resisted keeping her scheduled appointments. Her pattern seemed to be one of rejection toward the child and an acting out of the hostility which generated from her early childhood. Placement of the child was an indication that the mother did gain some insight and wanted to help the patient in spite of her expressed attitude toward the clinic.

Case #2

Sylvia was eight years old and the second of three girls. She was referred to the clinic by the family doctor because of nervousness. The parents were concerned about her loss of weight which the doctor felt was emotional and not physical. She was able to control the mother by her severe temper tantrums. In play she was shy and had very few friends because of her demanding attitude and insistence on having her own way. She seemed to be torn between her will to have her own way and her need to conform in order to get adult approval. She was very intolerant and would give up a friend rather than accept anything which she considered to be wrong on the friend's part. Her arguments with other children often ended in fights. She gave the impression of a child who had rebelled against too rigid demands with a lack of freedom for ordinary childish initiative. It was extremely important to her to be right and to have other people do and say things in which seemed to be the right way to her. She appeared to have a compulsion to have every small detail worked out as she thought it should be. If this was not done, she not only protested, but also took action. There was a question of a heart ailment but the family physician felt the child was in excellent physical condition. It was difficult for the parents to accept this diagnosis. Her I.Q. was 115. She was in the third grade and
her grades were satisfactory but her failure to socialize had its effect.

The mother was a great verbalist. She did a great deal of explaining to the children and had to work everything out for herself. She tried to justify herself and her attitude toward the clinic and attempted to explain everything in terms of the physical or obvious. It was difficult for her to accept emotional disorders and there was a strong attempt to associate the child's symptoms with her heart ailment in spite of the doctor's diagnosis. Her attitude seemed to be one of over-indulgence. The maternal grandparents died before the mother's third birthday and she was placed with a maternal aunt who had twelve children. The aunt was a semi-invalid and the mother had to care for herself much of the time; hence, deprived of the love and affection which is essential to every child's development. The aunt died when the mother was seventeen. The mother's deprivation in her own childhood seemed to be affecting the patient. She referred to Sylvia as, "the bane of my existence," but she still wanted to give the child so much because she was deprived as a youngster. The mother felt threatened by a neighboring family also visiting the same worker and expressed jealousy on her clinic visits. She wanted to be a good mother and had a tendency to minimize the patient's problems. She was unable to overcome her jealous feelings relating to the worker and her other patients and withdrew from treatment. In physical appearance, the mother was of average build, neat in appearance and well dressed. She spoke with a peculiar pitch to her voice and was very tense and anxious. She had a great need for affection of which she had been deprived all her life.

This mother was immature and her need for affection made it impossible for her to give any love to the patient. She expressed resistance in the treatment setting by constantly talking to control the interview and prevent the worker from discussing pertinent material. Her attempt to explain things in terms of the obvious is also an expression of resistance.
to protect her true feelings. Progress in the treatment was very slow to say the least. Her ability to control the interviews prevented the worker from reaching the true source of the conflict. It is quite evident that this relationship had a great deal of meaning to the mother which was expressed by her jealous behavior. This jealousy so manifested itself that the mother refused to keep her appointments.

Case #2

William was thirteen years old and the oldest of five children. He was referred to the clinic by his mother because of poor school adjustment. His I.Q. was 96. He attended a parochial school for the first five years and then transferred to a public school. He was in the seventh grade at the time of referral. He objected to homework and his grades were very poor. As for social adjustment, he had very few friends. This was partly due to the parents who would not allow him to go out in the evening. He felt he was not given enough freedom in the home and resented authority. The patient had a brother three years older than himself who was killed in a fall from a tree. William was three years old at the time. The patient was deprived as a means of punishment which he resented very much.

The mother appeared capable but very anxious, impatient and strict. She expected help from the clinic but could not see herself as an important factor in the clinic treatment process. She did not seem to be concerned about the patient's behavior and regularly broke appointments. She seemed to give the children an opportunity to express themselves before any disciplinary measures were enforced. On the other hand, she was very rigid and punishing in her attitude. She felt that treatment would only concern the patient but when she found she, too, would be involved and her regular attendance at the clinic was required, she refused to continue the treatment relationship.
The mother had no insight and was unwilling to relate to the clinic situation. She wanted help for her child but felt too threatened to participate in a treatment plan. A treatment plan was outlined but was never initiated because of the mother's refusal to accept it. This is frequently encountered in child guidance work. Parental fear of revealing their inadequacy in meeting the child's emotional needs creates too great a threat and their guilt feelings may find expression. To avoid this they refuse to participate in a treatment plan.

Case #4

Barbara was an attractive, very alert little four-year-old girl referred to the clinic by her mother because of head banging. She was the oldest of two children. Her I.Q. was 114. This little girl banged her head from the time of infancy. There was evidence of sibling rivalry as the parents openly preferred the younger child. Barbara knew her behavior annoyed the parents because they made such an issue of it. They felt this would make the patient feebleminded and, in an attempt to control it, admitted soaping the patient's mouth. Whenever the mother got angry at the patient, she would spank her. This was usually followed by a period of cuddling and asking forgiveness. The patient evidently controlled the household and would only obey the maternal grandmother who was also living in the home.

To add to the intensity of the situation, the mother employed a nursemaid five days a week to care for the children and help with the housework. The nursemaid was also dominated by the patient's behavior.

The mother was well educated, economically well off but very childlike in her behavior and admitted being dependent on the maternal grandmother. At times she felt immature and thought
she might be at fault as she did not know the latest findings on child care. She enjoyed the freedom from the family and attended classes in arts and ceramics. She expressed a fear that the patient would hurt herself and would have the child examined after a period of banging. When the father came in from work in the evening, Barbara would run to him and cry if he would not spend time with her.

At the clinic, the mother was overprotective of the patient. She was not able to allow the child to be tested out of her presence. She accompanied patient to the testing room and in the interview would only talk about the patient. She would break appointments and be too embarrassed to notify the clinic. When she was contacted by the clinic, she would ask for forgiveness. At every opportunity she emphasized the seriousness of the child's problem but was resistant to the treatment program.

The mother had no insight and was looking for a quick solution to her problems. Her idea of treatment was something that could be completed in a few interviews without her participation; however, her resistance to the clinic was expressed by her refusal to be separated from the patient even though the social worker explained several times that this was not the procedure at the clinic. This pattern of behavior rendered it practically impossible to initiate and carry out a treatment plan. After a very brief contact with the clinic, the mother would not return because she felt the clinic could not help the patient. It is quite obvious that the mother's behavior rendered any treatment plan impossible.

b. Three cases of mothers who are ambivalent toward their children.
Case #1

David, a boy of nine years with an I.Q. of 121, was referred by the school department because of infantile speech and enuresis. He is the youngest of two children. There was eight years difference in the boys' ages. The patient was very shy and cried easily. He likes sports and was reported to be a very good swimmer and was the only one in the family who could whistle. He mowed the lawn and cleaned his own room without being told. Mother said, "He is something like the girl I should have had."

The patient was in the third grade. He did well in everything but arithmetic; however, he received an "unsatisfactory" in conduct because he was so noisy. He enjoyed his school work. His teacher reported he was very sensitive and when he was hurt he drew into himself and whimpered.

Mother admitted favoring the older boy but did not think she showed it. She felt more like a sister to him. When the patient came into the house, mother tensed up and waited for something to happen. She sometimes allowed him to get into bed with her when she was reading.

The mother enjoyed writing but at this time she was unable to write because her typewriter was broken. She blamed the patient for this. Mother was very sociable, enjoyed many friends and often had small drinking parties in the home. She admitted being attracted to other men as she believed they all admired her. She wanted a divorce but was dependent on the father financially. If she could have found a man to marry, she would have left father. She admitted having boy friends and enjoyed dating. She had never been satisfied sexually by her husband but her boy friends excited her. At this time she said her marriage was compulsory. She attended a drinking party and became intoxicated and had intimate relations with the father. She was seventeen years old at the time. She did not love the father but wanted him because he was hard to get.

Mother felt superior to father in a social way. When they were married, father was making only twenty dollars a week. She had an inheritance
and they lived very well. During this period the mother and father traveled in many countries and flew from one part of the world to another. During the early years of their marriage, they employed a maid. The inheritance was soon spent and mother was dissatisfied because father could not supply her with spending money. In a fit of rage she sold the family automobile. Mother insisted on keeping ten dollars weekly for recreation.

Father was described as good looking, neat appearing, and attractive to other women. He was also shy and did not engage in discussion easily. Frequently he did not come home in the evening until late, preferring to spend his time with friends in a bar room. He had physically abused mother for having a boy friend and blamed her for poor management and the family's indebtedness.

The mother could not see herself as an important factor in the treatment process. She continually broke appointments saying she forgot about them. By her irregular attendance and careless attitude regarding the clinic an effective treatment plan could not be carried out. She felt threatened by the patient's visits to the psychiatrist, thinking certain material may have been revealed which she would not like discussed. It is evident that she was expressing a fear of the clinic and probably would not have come at all if it were not for the school department, the referring agency. Her attendance became more irregular until treatment was terminated, because the psychiatrist felt very little could be accomplished until the mother was more concerned and interested in the treatment program.

Case #2
John was five years old and the older of two children. He was referred by a newspaper because of poor social adjustment. He appeared as a very attractive, well poised and friendly youngster who was pleased with the clinic and especially enjoyed the toys while he was alone. When other children arrived, he became very excited, overactive, antagonistic and very possessive of all the toys. At home, he was jealous of his younger brother and would fight him when the mother was not with them. He was talkative, bossy and dominating and wanted his own way. His I.Q. was 119. He was enrolled in kindergarten but refused to go much of the time. When he did attend, his work was very poor. He seemed to have a need for punishment. He would provoke the mother into punishing him but he would not cry and told the mother she could not hurt him. He enjoyed the excitement. This behavior pattern was repeated only in the presence of the mother. The father had no difficulty in dealing with the patient.

The mother appeared as a nice, well dressed woman very much concerned about her child. She thought he was badly spoiled. She appeared to be very conscientious and tended to blame herself for all of the family's problems. She referred to the child as being beyond control and in need of discipline. She had read about the clinic in a newspaper and thought her case could be treated.

The mother was more interested in her own problems than those of the child. She had a reading problem and never finished high school. Her reading and spelling were very poor, and as a child was converted from left to right handedness. She had never associated with children until she began to rear her family. It was very depressing to her to have the patient disobey.

She admitted a great deal of anxiety when the patient asked about reproduction because she didn't think it was right for children to talk about such things. There were frequent quarrels among the neighbors because of the child's behavior. The mother thought all the neigh-
boring children engaged in sex play and the patient learned it from them.

The mother was very punishing and was easily excited and tense. She never could give love and affection to the patient and always had to fight with him before they could agree. She had very fixed ideas. She could accept things intellectually but not emotionally, and interpreted all suggestions literally which the clinic offered, and wanted a pat answer or formula for rearing a child. She was hostile to the clinic because it was not meeting her demands.

It would appear that this mother was quite bewildered in dealing with her family. She seemed to be able to see her mistakes but did not see how she could correct them. Resistance is frequently expressed by the mother's unwillingness to explore a particular area of feeling or experience and reject any interpretation of it. She was very suggestible but was hostile to the clinic if the suggestions did not meet with her approval. It was very difficult to carry out a treatment plan with this mother because of her attitude in the interviews and little movement was indicated. She was projecting her feelings onto the clinic and was openly hostile because her demands were not being met; as a result treatment was discontinued.

Case #3

This is the case of a fourteen-year-old-boy, with an I.Q. of 95, referred to the clinic in December, 1948, by the school nurse because of poor school adjustment and being lonely and morose.

The patient's father died seven years before and since that time the patient was said to
have a "nervous stomach." He had had difficulty in making friends at school. He often visited his classmates but never asked them into his own home which was quite disturbing to his mother. The mother wanted to send the patient to boarding school or a military academy but the patient threatened to run away if this was done saying he could make friends. The school was interested in the patient, but in spite of their attempts he remained withdrawn and seemed "to have a shell around him." His marks were quite low which could be understood since the patient was a picture of disinterest and apathy. He was the youngest of two children.

The patient seemed to be overconscious about his physical sexual development and got no help from his mother with these problems, which concerns the normal adolescent development of any child approaching maturity.

The mother, an attractive, youthful-looking woman, felt her trouble started after the death of the father as she felt the children did not care for her and helped out very little with the work around the home. Mother worked all day in the home owned market and felt the patient and his brother should have helped with the housework.

Mother was unable to have any male companions because of her strict family upbringing. She expressed a desire to have a male escort to a movie and visit a club occasionally. The family felt the mother should be married if she wanted "to keep company at night." The mother felt very guilty about this because, "I do want to go," but the strict upbringing prevented her from seeking out male companionship and felt guilty when she thought of ways in which she could meet men of her own age.

Mother was very defensive and had projected her own domination on the patient and thought of him as "mean and nasty." The mother recognized she had made the patient dependent as a little child but found it hard to believe
she was still doing this. The patient described his mother's interference as "nagging." Mother might have been able to accept the reality situation better if it was interpreted with other words; however, mother had a great need for attention and sympathy for her children and it would have been hard for her to give up domination of the patient.

Mother wanted the clinic to tell patient to be more grateful to her and was threatened by the idea of her own participation in the clinic treatment. When the treatment became too threatening to the mother, she rejected it.

c. Three cases of mothers who accept their children:

Case #1

Walter was nine years old and the second of three children. The youngest sibling was a half brother to the patient. He was referred by the Visiting Nurses Association because of enuresis, fighting, and soiling. He was an attractive, friendly little boy but appeared very tense and anxious. His I.Q. was 89. He attended kindergarten one year and continued in the first grade. He repeated both grades one and two. In school, he wanted to go to the toilet frequently and the teacher thought he was masturbating. The mother had observed this and had spanked the boy and dressed him as a girl. Occasionally she would shame him before his friends. His neurotic traits became more marked following the death of the stepfather. This seemed to be the onset of his soiling at school and during play. Prior to this, it was only done at home. He had also become negativistic toward his playmates at school. The mother often scolded him for this. The patient did not improve and he became hostile to his mother and threatened to kill her, although he had never assaulted her physically.
The mother was tense and anxious, medium build, poorly dressed and disheveled in appearance. It was difficult to discuss significant material with her because of her extreme vagueness. She was injured as a child and felt that was why she could not remember things very well. She was very emotional when speaking of the patient and the death of her second husband. Her eyes would fill with tears but she never cried openly. She divorced the patient's father because he was not true to her and would not provide for the family. She remarried about three years later. The patient's step-father was very fond of the children and they in turn liked him. He died in 1947 because of a heart condition and kidney trouble. Mother was having a conflict with the step-father's parents. The step-father had purchased some land from the paternal grandfather on which he had built a house. The paternal grandfather held the deed for the land and the mother could not prove the land was hers even though the step-father paid for it before his death.

She was unable to control the patient and he ordered her about. There were times when she made excessive demands on the patient but felt that children are obligated to their parents. At time of referral, she was receiving A.D.C. and devoting all of her time to the family. She felt the situation would become worse if she were away working. She was inconsistent in keeping appointments before the treatment was disbanded.

The mother was beset with her personal problems regarding her two marriages and the poor relationship with her in-laws. She had no insight and seemed unconcerned about the attitude of her family which was reflected, to some extent, in her personal appearance. Her method of handling the patient's symptoms indicated a complete lack of understanding. Her resistance was primarily expressed by her very irregular attendance pattern. There were also many reality factors
to be understood in this case. Certainly the personal problems presented are enough to overwhelm most people. In view of the reality factors presented the mother's resistance may be justified. This opinion was supported by the psychiatrist who felt that environmental influences were too great to expect any degree of movement with the case.

Case #2

Doris, a fifteen-year-old adopted girl, was referred to the clinic by the school adjustment service because of stealing, lying and school failure. She was the only child and had been living with her foster parents since the age of two. The adoption had been discussed freely with Doris since she was a little child but she had never been told that she had a brother. She had never seen her true parents since her adoption. She entered the first grade at five-and-a-half years and had one repetition. At the time of referral, she was in the ninth grade. Her I.Q. was 83. There was always an interest in music and the child showed some talent. She played the violin and piano in the school orchestra but the mother was disturbed because she would not practice her lessons. Doris was not defiant but refused to obey in a passive way. Most of her reactions to her mother were negativistic. She did not feel accepted or well treated at home. She had shown some curiosity in sex but the mother found it very difficult to discuss this with the patient. The mother would ignore most of the patient's questions and felt the child's attitude in regard to boys was foolish. The mother felt Doris had obtained most of her sex information from friends. The child stole money from the mother and took desserts from the refrigerator meant for family use. When she was questioned about this, she would always deny it. The mother seemed more concerned about the lying than about the stealing.

The mother was intelligent, well educated, and had a college degree. Also, the father had a
Master's Degree and had a good position. The family was economically secure and socially prominent. The mother dressed extremely well and was easily recognized at the clinic because of her very superior manner. She was ambivalent about the treatment because she suffered a loss of status by having to participate in the treatment. She had some insight and felt the problem was related to her poor methods of handling the child. She had always dreamed of the day when Doris would go to college because she could relive her experiences and study with the child. Her attitude was one of continuous pressure and a demand for achievement in school. She would frequently telephone the teacher to find out whether the patient had homework assignments rather than take her word for it.

The mother's failure to produce a child had real meaning to her. She adopted the patient after twelve years of marriage. She admitted being too demanding and that she pushed the patient too hard. Often the mother would remind the patient that she should be like her true mother who was a very good woman. The mother also admitted that she knew nothing about the child's true mother. The child reacted to this in an indifferent manner. At the time of the adoption, the mother was told of the child's below normal intelligence and was advised against adopting her. The mother could not accept this because the child had an unusual control of the language. In the early grades, Doris was interested in baton twirling but the mother would not permit her to do this because it was "not proper for a lady." The mother's attitude was one of concern about what her friends would think. The mother felt the clinic was for babies and it was humiliating for her to continue the treatment.

The mother could not accept the child's limitations. The psychologist felt the child was working to the limit of her capacity. The mother was more concerned about her social standing that she was about the welfare of the patient. She did not want to face the reality situation of her present position and sought an escape into the fantasy of her early
college days. The mother showed a great deal of anxiety and insecurity in her life but could not relate to the treatment situation. She felt she was suffering a loss of social prestige by coming to the clinic. Her intellectual acceptance of the responsibility for not rearing the child properly may have been an attempt to bring the treatment to a swift conclusion. She suffered from a feeling of deep humility when it was suggested that she should participate in the treatment plan. She was more concerned about her social prestige than she was about doing anything constructive for herself or the patient. She sought to escape by saying the clinic was for babies and it could be of no help to her.

Case #3

Robert, who was eight years old, was referred by the New England Home for Little Wanderers because of poor school adjustment, an itching of the nose and biting his nails. He was the oldest of two siblings. His I.Q. was 116. He was a nice looking mulatto boy, very mannerly, well behaved in school and his grades were satisfactory. He learned easily and was promoted two grades. He developed a tic and was put back to the first grade at the mother's request. His curiosity and active mind carried him away from his work and, as a result, he functioned in a haphazard and disorganized manner. He had little motivation to drive or succeed, played by himself and would not mix with the other children. The teacher seated him by himself in a corner of the room because he would not cooperate. She had tried reward, praise, punishment, threats and deprivation but all were unsuccessful.

The mother was neat, attractive, fair complexion
and medium build. She verbalized her problems with a great deal of anxiety. She felt her child was a genius and different from all other children. She felt queer trying to rear a gifted child and wanted to take all the credit for the child and the family's success. She said the patient was just like her. There was a great deal of hostility expressed toward the school because of the teacher's handling of Robert. The mother felt the teacher was prejudiced. She was entrenched in the protective fantasies of herself and the child and felt her neighbors were jealous of her family because of their achievements. They owned their home and had a new car which made them outstanding in their community. When the worker failed to support the mother's opinion regarding the school and its relation to her child and when it was pointed out to mother that perhaps her method of handling the patient's symptoms could be improved, she became very hostile to the worker and the clinic and broke treatment.

The father was in the rubber business and worked as a stationary engineer. He was also conscious of the family's social position. He had scoliosis and was in Metropolitan State Hospital for two months because of "nervous exhaustion." He thought someone was doing something to him. The mother was dissatisfied with the treatment and had him transferred to the New England Sanitorium for shock treatments for two weeks. He was discharged as recovered. The period of confinement followed a traumatic situation in which the family sustained loss of considerable property which represented a major portion of the family's savings.

This mother was very capable and proud of the family's social achievements and was compensating for a sense of racial inferiority and discrimination by an inordinate ambition for the patient who, she felt, was closely identified with her and was a genius in a class by himself. She was projecting all of the patient's difficulty onto the teacher. In spite of the mother's apparent intelligence, she seemed
to have little insight into the family's problems. She expressed hostility to the school and wanted support in her beliefs from the social worker. When this support was not forthcoming, she would not cooperate in a treatment plan. She felt her methods of handling the patient were the best and when it was suggested that perhaps her ideas were not the only correct ones, she felt too anxious to continue. This mother's motivation for treatment seems to be support for herself and not anything relating to a treatment plan for herself. She was resistant to everyone and everything that did not support her opinions.
CHAPTER V
SUMMARY AND CONCLUSIONS

In this study an effort has been made to review the treatment cases closed as unimproved because of maternal resistance during the fiscal year July, 1948, to June, 1949, from the Child Guidance Clinics of the Massachusetts Division of Mental Hygiene in an attempt to understand the implications and extent of maternal resistance which was met in these cases. Of the total of 271 treatment cases closed during this period, forty-eight were unimproved. The records indicated that twenty of these cases were closed because of maternal resistance. The ten cases used in this study seem to indicate quite well the many and varied ways in which resistance will manifest itself and find expression. These cases also are the basis of all findings and conclusions in this study. It seems necessary to state that no evidence is entirely conclusive. The cases have been discussed only in terms of maternal resistance. This study is not intensive enough to indicate any trend in maternal resistance.

The age and source of referral indicate that pressure was brought to bear on the mother, especially from the school where the child's behavior is particularly disturbing, to get her into treatment. In every case, the resistance factors were mobilized sufficiently to result in rejected treatment. Because resistance is so closely related to the unconscious, no one is held responsible for his resistance.
Every effort should be made to understand the mother in the treatment setting so that all possible help can be given her.

It can be concluded from this study that maternal resistance is a major problem in these child guidance clinics. Resistance was most often expressed by an unwillingness on the part of the mother to become actively involved in treatment for herself; by using her aggressiveness to control the interview, thereby preventing the worker from reaching the source of the emotional discomfort; an unwillingness to explore particular areas of feeling or experience by attempting to divert the attention of the social worker or by indicating an unwillingness to discuss it; by rejecting an interpretation, pointing out to the worker the fallacy of the interpretation; by attempting to relate everything to the physical or obvious; and by complaining about their loss of social status by attending the clinic. Irregular attendance at the clinic and an attempt to intellectualize the discussion thus protecting the emotions were also found in the cases studied.

By such an array of expressions of resistance, no treatment plan could be effective. The progress toward a treatment goal was very little in most cases. The resistant factors were of such a major importance in the behavior pattern of the mothers that the efforts of the clinic staff to reach any goal in treatment were blocked almost completely.
Whenever the mother became anxious to the extent that she felt threatened in the interviews, she rejected the treatment by saying the clinic was not helping her, it was for children and not adults, it was humiliating to visit the clinic, by expressing the opinion that her participation could not possibly help the child and by blaming the clinic staff for the lack of progress with her problem.

Every effort was made to keep these cases in treatment, and it was only after repeated unsuccessful efforts by the clinic team to keep the cases open that they were closed as unimproved.

Approved:

Richard K. Conant
Dean
BOOKS


Kanner, Leo, *Child Psychiatry.*


PAMPHLETS


## APPENDIX

### Schedule

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