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A study of the habit clinic for child guidance and its contacts with thirty mothers

Sidman, Marion S

Boston University

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Boston University
A STUDY OF
THE HABIT CLINIC FOR CHILD GUIDANCE
AND ITS CONTACTS WITH
THIRTY MOTHERS

A Thesis

Submitted by

Marion Shirley Sidman

(B.S. in Ed., Boston University, 1942)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1943
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PART I

INTRODUCTION

CHAPTER I

INTRODUCTION AND PURPOSE

This study was undertaken at the Habit Clinic for Child Guidance in Boston, Massachusetts, one of about 700 United States guidance clinics offering service to children. The author had completed a year of field work in that agency, eight months, three days a week. It was thought to be of value for future treatment to study mothers' feelings and attitudes and thoughts about the clinic, together with their recommendations for adjustments. Too often, changes are made solely from a theoretical viewpoint without the practical assistance of the client's views. This author is of the opinion that it is necessary to know the feelings and thoughts of a group to make constructive changes for that group.

This thesis aims:

(1) to determine the feelings of satisfaction and dissatisfaction toward the clinic of a group of thirty mothers of clinic children, after their formal contact with the clinic had been terminated;


2 In this thesis the terms feeling and attitude will be used interchangeably to denote the general set of the whole organism toward a situation or object that requires adjustment.
(2) to determine mothers' understanding of the function and purpose of the agency as it relates to treatment and to the larger picture of public relations; and

(3) to determine mothers' recommendations for changes and improvements at the Clinic.

These aims were carried out by a study of the Habit Clinic records of cases closed in March, September, and December 1942, and by personal interviews in the Spring of 1943 with the mothers of thirty-two of these cases.

Twelve of the total of forty-four closings during the three months considered were eliminated, two because they were second closings, four because the families had moved out-of-state, three because the family moved from the address last known by the Clinic, one because a parent had never attended the clinic but the child was brought by a social worker, one because the mother was known to be unstable and in the last months of pregnancy, and one because the case had been re-opened and was active at the time of the study.

The author felt that the two cases closed for a second time had proved their satisfaction with the Clinic in returning to it and because of two periods of treatment were in a different category than the cases closed for the first time. It was felt to be impractical to visit the four out-of-state families, impossible to visit the three families who could not be located, unnecessary to visit the mother of the one case who herself had never been in direct contact with the Clinic, and unwise to visit the unstable, neurotic mother in the late months of pregnancy, and the mother of the re-opened case because of the possible hindrance to present treatment.

In the total of thirty-two cases considered, there were two sets of siblings. Therefore, in discussing the children there will be a total of
thirty-two; in discussing mothers there will be a total of thirty.

The thirty-two children who compose the sample for this study comprise 18 per cent of the 182 closings made during 1942. Twelve of the closings were made in March, 1942; ten in September, 1942; and ten in December, 1942. A sample of 18 per cent is large enough to be valid. To study all the cases closed in 1942 would have been prohibitive.

In actual practice, in science, and in practical life, we rely on what may be called the Principle of Fair Samples, that is to say, the belief that, with reasonable care, it is possible to judge the character of a large group, or of the whole class of phenomena, by the aid of a sample or a selection from it.

After a study of the case records with emphasis on face sheet data and closing notes, mothers were contacted. In the twenty cases where there were phones, mothers were telephoned. In the ten instances where there was no phone number recorded in the record, mothers were contacted by letter on Clinic stationery. By both methods mothers were asked to participate in a Clinic study in an effort to help improve Clinic methods, and a definite appointment was made to avoid the antagonistic attitude which can be justly aroused by the attempt of anyone to "break in" to the home when the mother is engaged in other activity. A complete statement of the purpose of the study was not given either by phone or by letter, in an attempt to avoid too great preparation for the interview.

At the time of the home interview two purposes of the visit were explained:

(1) to find out how "our old children are coming along", and

---

3 Habit Clinic for Child Guidance Statistics, p. 3.

4 George A. Lundberg, Social Research, p. 134.
(2) to find ways to improve clinic procedure by mothers' feelings about certain phases of it.

Although it might be thought that mothers who ended their contact with the agency, and who did not send for the interviewer would be unwilling to spend the time with her and uncooperative about giving information, yet, the vast majority of the interviewees were most willing to participate in the study after the interviewer remarked that their participation was in no way required of them, but rather an act of generosity on their part. No mother refused to see the interviewer, though in two instances, after arrival at the home, the mothers expressed hostility and the fact that they "did not like this kind of thing." The basis of one mother's criticism was that she disliked social workers in general, disliked their "snooping". She explained that she did not trust them as she once knew one who divulged some personal data and soon it was public gossip. Though the interviewer twice agreed to leave without completing the interview, this mother insisted that she remain, "since you came way out here." The second mother who expressed hostility to the interview was of a higher economic level than the average Clinic clientele and stated that she disliked being picked to "represent the other ordinary people." Yet, both these mothers readily agreed over the phone to see interviewer and later insisted that the interview be completed. But the majority of feelings toward the study were expressed in such words as these: "It makes me feel good to feel you all think of us even after this long time"; "I feel quite honored that you should choose me to help you"; "I'm always glad to participate in studies"; "I'm flattered that you should ask me when you want to take stock"; "Just tickled to cooperate for all you did for me"; and "You're certainly moving ahead to be able to ask your clients
to help you correct certain things." Yes, a progressive agency wants to evaluate itself and to gain from its mistakes as well as from its successes.

Unlike the straight case work interview where the fundamental purpose is more to assist in adjustment, in this type of interview there is more an objective, scientific purpose, an impersonal interest, and the interviewee is more a member of the group than a case as such.

Yet, though scientific, more semi-scientific as feelings or attitudes are much concerned with the subjective side of human behavior, notes were not generally taken in the interview. Only in two interviews, where mothers had arranged for them and thought them a necessary part of a study, were some notes jotted down. In other cases it was thought to be too dangerous and inhibiting a factor, too threatening to the sensitive and self-conscious to make possible the securing of accurate feelings and comments.

The role of the personal interview may be questioned as a scientific approach, as being not the most objective method of research. However, it is the most penetrating of all methods in that it goes to the living source of the data, and it is a valuable supplementary tool to records, which in this instance were not formally recorded to indicate feelings and to gain the information sought by this study, i.e., to gain the mothers' own viewpoints. "It may be that a person is largely unable to analyze all aspects of his attitudes and opinions. But the analysis he does make is significant as psychiatrists and others well know."  

5 Pauline Young, Scientific Social Surveys and Research, pp. 183-185.

6 Lundberg, op. cit., p. 247.
CHAPTER II

THE CLINIC PROCEDURE

Throughout the Habit Clinic procedure the joint treatment of psychiatrist, psychologist, and social worker is accepted. Yet, each has a specific job in which he excels. During the period in which the cases here studied were active, there was an average of three psychiatrists, two social workers, and one psychologist on the staff. The final decision in a case rests with the psychiatrist. He (or she) proceeds on the basis of the social worker's and psychologist's information, together with information he gains from talks with the parents and child, information that helps him to gain insight into the emotional problems that are resulting in the child's problems. The psychologist measures and evaluates the child's capacity and specific achievements through the administration of standardized tests, and through her ability to recognize various phases of development as they relate to problems. The social worker analyzes the social situation and studies the home and school environment to determine underlying social factors in the environment, as well as the relationship between the child and his siblings and the adults of his immediate environment. Dr. Douglas Thom, director of the Clinic until his entry into the Army in the Spring of 1943, has referred to the social worker as the "clinic manager", for it is she who makes first contacts with individuals and organizations desiring clinic assistance, she who makes appointments and steers parents and children through
the routine clinic examinations and interviews.  

The functions of the child guidance clinics are threefold: they study and treat patients; they seek to interest other community agencies in the prevention of behavior and personality disorders in children and in promising methods of dealing with them when they occur; and they attempt to reveal to the community, through the first-hand study of individual children, the inmost needs of groups of children.  

Functionally, it is an agency for bettering the adjustment of children to their immediate environment, with special reference to their emotional and social relationships, to the end that they may be free to develop to the limit of their individual capacities for well-balanced maturity. 

Most clinics agree in aiming toward a more efficient, and more harmonious adulthood for the children under consideration by studying and treating these children who are handicapped by undesirable habits, personality developments, and delinquency trends. The clinic accepts for examination and treatment children who present any "problem" which has not responded to the ordinary type of management usually used by teachers, parents, relatives, or doctors.

What happens to parents and children in starting treatment at the Habit Clinic for Child Guidance? Usually, the mother telephones for an appointment and speaks to the secretary who answers the phone. Brief identifying information is asked by the secretary, sufficient to register the case and to clear with the Social Service Exchange, and sufficient to place the problem and to eliminate any cases very much outside the Clinic function as to age or problem. An appointment is next given the mother to see a Clinic social

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3 Ibid., p. 53.
4 Thom, op. cit., p. 4.
worker at a time convenient to both, and it is suggested that the mother come for her first history-taking interview without her child.

At the time of the first interview with the social worker, initiated by the mother's voluntarily keeping the appointment, the mother describes the complaint and problem she is having with her child, and is asked for considerable data relative to the child and the environmental situation, in order to see the child in his environment and to compile the social history to be used by the psychiatrist and psychologist. Reality is given to the nature of the Clinic by the social worker's explanation of the Clinic's way of having parents and children work with both the social worker and psychiatrist, and of the appointment and fee plans. The social worker may suggest that the child be given a physical examination if there is indication of a need for it or if a considerable period of time has elapsed since the last examination.

On the first visit of the mother and child to the Clinic, the child is given a series of psychometric tests. With the results computed and analyzed, they are given to the psychiatrist who is aware of them together with the social history before he interviews both parties. He talks with the mother alone for about one-half hour, and for the following half-hour he talks with the child alone. Thus, both parent and child participate in the process, in separate interviews so as to eliminate having each discussed in the presence of the other. On following visits, an appointment period of one-half hour rather than a full hour is provided for seeing both, and again the psychiatrist sees each person individually. The psychiatrist who interviews at the first visit continues to do so on following visits, which come at intervals as closely together as the psychiatrist desires and the Clinic
program permits. Quite often, next visits are pushed ahead further than desirable because of the pressure of cases. At best, cases are seen weekly or bi-weekly during first visits, and at periods of from four to six weeks as treatment continues and progresses. In the interim, the social worker carries out the recommendations of the psychiatrist.

The treatment of the Clinic, through which the function is exercised, consists essentially of psychotherapy with the child and his family through the interviews with the psychiatrist, and the environmental adjustments such as the uncovering and using of recreational facilities, the changing of schools, the regulations of regimes, made through the contact with the social worker. In all, it is a highly individualized helping process, and no two people can receive the same specific treatment. In various situations all of the four types of clinic treatment are undertaken.\(^5\) (1) Through direct advice and suggestion the Clinic findings are discussed and parents are advised on next steps. This is the most successful method with those individuals of sufficient maturity to accept advice or with those so seriously maladjusted that other kinds of treatment are impossible. (2) Through education, an effort is made to have the parents understand the meaning of the child's behavior. (3) Through insight therapy, an effort is made to help the parents gain emotional insight into family relationships and their own mechanisms and motivations. This method centers about the parent's understanding her own problems. (4) And finally, through attitude therapy the parent is helped to consciously recognize her need for help with her

personal problems and enters into the treatment relationship. Here the parent's problems are the focus of treatment for she recognizes herself as the patient. This is the most specialized procedure and the most time-consuming and is rarely employed.

The main treatment emphasis of the Clinic is on the inter-relatedness of the child and his parents.

The primary function is conceived to be the helping of a child in his emotional development so that he can realize more the capacities which he has for attaining an adequate adjustment within himself and to his environment. All this applies to the parent as well, with the added qualification that the help is directed toward his relationship with the child.6

Since parents are by far the most important influence in the child's environment, much emphasis must be placed on them. To center on the parent-child relationship, the worker is operating within the function of the agency.

The final step in the process from the beginning to the end of treatment is the closing of the case, the point at which it ceases to be active. The disappearance of the problems that originally brought the child to the Clinic may or may not in itself be an indication that the case should be closed, for other problems often are brought into focus as treatment progresses. Yet, no case can be carried to the imaginary point where all problems are solved.

The point at which active relationships are broken off is determined in part by the patient's or parents' own decision, in part by the Clinic's rule-of-thumb estimate of the degree of adjustment reached and the relative advantages and disadvantages - in terms of the patient's welfare and the Clinic's other responsibilities - of further efforts at treatment.7


Routine follow-up visits on all cases closed for a period of time are not conducted. However, occasionally, in the pursuit of a specific research study, a number of homes may be visited. Such follow-up studies are most profitable for they serve to lend reality to one's optimism or pessimism in regard to the work of the Clinic and the modifiability of people and situations.
CHAPTER III

THE GROUP STUDIED

In order to present a picture of the group of children and mothers studied, the following information is presented.

Age and Sex

TABLE I

AGE* AND SEX DISTRIBUTION OF CHILDREN STUDIED

<table>
<thead>
<tr>
<th>Ages (in years)</th>
<th>Boys</th>
<th>Girls</th>
<th>No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.9</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2-3.9</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>4-5.9</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>6-7.9</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>8-9.9</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>10-11.9</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>10</td>
<td>32</td>
</tr>
</tbody>
</table>

* Age at time of referral.

Table I indicates that, of the thirty-two children considered, twenty-two were boys and ten were girls. Interestingly, these are the exact percentages of boys and girls, 69 per cent and 31 per cent, of the cases referred to the Clinic in 1942. Of the total of 160 referrals, 111 were boys and forty-nine were girls.¹

The age range of children studied was from one year and seven months to

ten years and ten months. This follows the Clinic policy of accepting children through the age of ten that was in effect during the period when these cases were accepted for treatment. In December, 1942, the age limit was raised to twelve years in order for the Clinic to utilize its facilities in dealing with an anticipated increase of pre-delinquent and delinquent youths that are the result of the War situation. The median age of the group studied was 6.6 years. This corresponds significantly with the age distribution of all 1942 referrals where the median age was 6.4 years.

Mental Status

**TABLE II**

MENTAL STATUS OF CHILDREN STUDIED

<table>
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<th>Intelligence Quotients</th>
<th>(Rating)</th>
<th>No. of Children</th>
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<tbody>
<tr>
<td>115 - 134</td>
<td>(Superior)</td>
<td>6</td>
</tr>
<tr>
<td>105 - 114</td>
<td>(High average)</td>
<td>7</td>
</tr>
<tr>
<td>95 - 104</td>
<td>(Average)</td>
<td>10</td>
</tr>
<tr>
<td>85 - 94</td>
<td>(Low average)</td>
<td>2</td>
</tr>
<tr>
<td>65 - 84</td>
<td>(Borderline)</td>
<td>2</td>
</tr>
<tr>
<td>Undetermined</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

Table II indicates that, of the total of twenty-seven children tested, twenty-three, or 85 per cent, rated average normal or higher, leaving only 15 per cent to be in the low average and borderline groups.

Experience has shown that the child of decidedly subnormal mentality cannot profit as much by clinic treatments, and it is customary not to accept such children.²

---
² Fink, *op. cit.*, p. 146.
The mentally healthy child with potentialities for achievements cannot often be neglected because of the problems of the mentally retarded child.

Referral Problems

The kinds of problems which children are having and for which they are referred to the Clinic are in reality but symptomatic of underlying difficulties and so difficult to group under headings.

The various problems which arise in the relationship of parents and children usually fall, according to Dr. Lawson G. Lowry, into the following categories: Items of behavior which disturb the peace and comfort of the parents, reactions which defy or negate parental authority; acts and failures which reflect unfavorably upon the family or the parents' training of the child, or both; and behavior which shocks the parents' moral sensibilities. Among the behavior manifestations and personality traits which most frequently agitate and baffle parents untrained in the intricacies of personality development and in methods for the treatment of such disorders are the following: maladjustments in feeding and sleeping habits, enuresis, outbursts of temper and disobedience, stealing, lying, quarreling, truancy, swearing, nervousness, school retardation, speech defects, absorption in phantasies and day dreams, lack of consideration for others, blaming others for own actions, carelessness and procrastination, jealousy, fears or general bad manners and rebellious attitudes.

Though it is difficult to classify children as falling under one or another heading, difficult to categorize anything as dynamic as human behavior, an attempt has been made to classify each referral problem under either the heading of habit, personality, or behavior problem, by the emphasis of the referring source. Habit problems include such manifestations as thumb sucking, nail biting, enuresis; personality problems include shyness, fears, over-dependence; and behavior problems include stealing, truancy, sex activities.

3 Clara Bassett, Mental Hygiene in the Community, p. 165.
Of the thirty-two cases studied, eighteen were fundamentally problems of habit formation, eight were fundamentally personality problems, and six were behavior problems. Perhaps the large proportion of habit cases are referred because of the name of the Clinic and because of the comparative ease of recognizing habit difficulties as compared with personality and behavior problems. Too, it may be that habit problems are more easily recognized because of an easier acceptance of them as problems by parents.

Referral Source

Table III indicates that, of the thirty-two cases studied, twenty-one children were referred by their parents, twenty by mothers, and one by a father. Sixty-six per cent of these referrals came directly from parents; only 22 per cent from other social agencies, 9 per cent from doctors, 3 per cent from schools.

The vast majority of clinic referrals in recent years have come directly from parents. Dr. Douglas Thom has said that probably this is the most satisfactory referral in that by the referral the parent indicates that her child has a problem that she recognizes and with which she needs help.\(^4\) Too, it indicates that education in mental hygiene is becoming more general and parents are becoming more concerned with indications of maladjustment or inadequacy in their children.

The large number of referrals made by parents makes an interesting contrast to the first demonstration child guidance clinic initiated in St. Louis in 1922, where three-fourths of the cases came through the court. Not one of the group studied was a court referral.

---

\(^4\) Thom, op. cit., p. 13.
### TABLE III

**REFERRAL SOURCE OF CHILDREN STUDIED**

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>No. of Referrals</th>
<th>Per cent</th>
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<tbody>
<tr>
<td>Mother</td>
<td>20</td>
<td>63</td>
</tr>
<tr>
<td>Independently</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Suggestion of doctor</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Suggestion of clinic mother</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Suggestion of social agency</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Suggestion of school</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Suggestion of clinic mother</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Social Agency</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Health Association</td>
<td>4</td>
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<tr>
<td>Hospital</td>
<td>2</td>
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<tr>
<td>Family Welfare Society</td>
<td>1</td>
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</tr>
<tr>
<td>Doctor</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Private</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clinic psychiatrist</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Teacher</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Year by year the percentage of referrals from the juvenile court has been decreasing, while the referrals from persons acquainted with the Clinic have been increasing. This trend may mean that not only have the courts established their own clinics, but also that there is a growing recognition that the clinic is a preventive source and thus should be an antecedent to the court. Furthermore, the same trend indicates a growing awareness by non-correctional agencies that the clinic is an integral part of the social service organization of the community. It shows a broader acceptance of the child guidance clinic work.

The source of referral is always an important consideration in treatment, because of the proneness to identify the clinic with the referral source.

Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>12</td>
<td>38</td>
</tr>
<tr>
<td>Jewish</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>Protestant</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table IV indicates that, of the group studied, 50 per cent of the families and children were Jewish, 38 per cent Catholic, and 9 per cent Protestant. In one instance the religion was not recorded in the case record and

5 Fink, *op. cit.*, pp. 143-144.
in the course of the personal interview the mother refused to state the child's religion.

Speculation as to the reasons for the preponderance of Jewish cases leads to the question of the possible greater concern of Jewish parents for the best upbringing of their children and an awareness of the community facilities. Also, with the smaller Jewish families, which in twelve of the sixteen cases studied had only one child, there is more time available for attention to that child, more time for clinic visits. Too, the Clinic's location, close to the heavily populated Jewish sections of Brighton and Boston, may be an important factor.

Economic Status

Because of the necessity of having a reasonable degree of economic security in the family for good use of treatment, this factor was considered. As indications of economic status the number of telephones, Social Service Index reports, and the comments in the record throw light on the subject.

Sixty-seven per cent of the thirty families had telephones. Fifty-three per cent had no Index record, and another 26 per cent had less than three contacts with social agencies at the time treatment was begun. And the majority of references were to non-welfare agencies. In only six instances was the present or past economic status sufficiently serious to be listed as a social problem on the face sheet of the record. These comments indicated such factors as older brothers unemployed, compound home because of limited finances, and dependency on welfare.

It is, then, probably safe to say that the majority of the families of the group studied were in the middle class economic brackets.
Residence

Map I indicates the home localities of the families at the time of referral. It shows the communities from which the Clinic children come, and it shows the limited area one agency can serve for practical reasons of distance and accessibility. Few families lived beyond a six mile radius of the Clinic.
RESIDENCE OF THE GROUP STUDIED

THE COMMONWEALTH OF MASSACHUSETTS
STATE PLANNING BOARD

METROPOLITAN DISTRICT OF BOSTON
(43 CITIES AND TOWNS)

SCALE IN MILES

\[\text{\(\text{\(\text{\( \ast \)}\)}}\text{\(=\)}\text{\(\text{\(\text{C}\)}\})\text{\(=\)}\text{\(6\)-MILE RADIUS FROM CLINIC}\text{\(\)}\]
PART II

THE QUESTIONS ANSWERED

CHAPTER IV

MOTHERS' EVALUATION OF TREATMENT

In view of the fact that mothers' appraisals of the results of treatment would be likely to influence their positive or negative feelings about the Clinic, this was the basis of the first question in the personal interview. With a preface that mother and child were free to return to the Clinic if desired, though under no obligation to do so, interviewer asked how the child was getting along in relation to old and new problems. Mothers were asked to evaluate treatment by the child's present-adjustment on a three-point scale comparable to the scale used in the Clinic closing notes. In the closing notes results of treatment are evaluated in view of the problem or problems for which referral was made, and in view of other problems which became apparent as the treatment progressed. Evaluation is summed up as "adjustment satisfactory," "some improvement," or "no adjustment." "Adjustment satisfactory" implies that at the time of the closing the symptoms and problems for which the child was referred to the Clinic had disappeared, no new problems had developed, and the child appeared happy and functioning satisfactorily. "Some improvement" connotes that, though the referral problem had not entirely disappeared, there was an improvement and no new difficul-
ties had appeared. "No adjustment" means that at the time of closing the case there had been no improvement and that the symptoms and problems which were apparent when the child was referred had not disappeared or even may have become more severe; he may have had new difficulties develop during treatment that left him more poorly adjusted at the end of treatment than at the beginning.

The follow-up evaluations were based on the same categories as at the conclusion of treatment, but it should be noted that the evaluations made at the closing of the case were the judgments of the Clinic social worker and the later evaluations based on the appraisals of the group of thirty mothers. Too, a period of three, six, or twelve months elapsed between the two evaluations.

**TABLE V**

**COMPARISON OF MOTHERS' AND SOCIAL WORKERS' EVALUATION OF TREATMENT**

<table>
<thead>
<tr>
<th>MOTHERS' EVALUATION</th>
<th>SOCIAL WORKERS' EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Adjustment</td>
</tr>
<tr>
<td>Adjustment Satisfactory</td>
<td>1</td>
</tr>
<tr>
<td>Some Improvement</td>
<td>6</td>
</tr>
<tr>
<td>No Adjustment</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>
As Table V indicates, of the thirty-two cases, the social workers' closing notes evaluated nine as "adjustment satisfactory," thirteen as "some improvement," nine as "no adjustment," and one as unknown. Though the agreement of social worker and mother was not exact in each case, it is significant that nine mothers also evaluated results as "adjustment satisfactory." More satisfied than the workers, twenty mothers stated that there had been "some improvement," and only three mothers felt there was "no adjustment." One marked difference was in regard to the four children of borderline and low average intelligence. While the record evaluated these as showing no adjustment, mothers felt these children had improved with Clinic guidance, that mothers were helped to understand their children, to push them less, thus leaving them freer and happier and able to "grow older and learn."

In fourteen of the thirty-two cases, or 44 per cent of them, there was perfect correlation and agreement between the record evaluation and mothers' later evaluations. The correlation between the two judgments is .31. This is a positive correlation, indicating a degree of relationship.

A moment spent considering the length of treatment and the evaluation of its results should prove interesting. The length of treatment is computed from the first of the month in which the social history is taken and the case accepted to the end of the month in which the case is closed. The beginning point is based on the theory that treatment begins with the first personal contact of parents and the Clinic worker.

The range of the months of treatment of the cases studied was from one to fifty-four months, with the mode at the period from 4-7.9 months. Twenty-

---

1 By the mean square contingency method.
one cases or 66 per cent of them were carried for less than a year, with
only three or 9 per cent of the cases carried longer than two years. Eight
of the nine cases evaluated by the social worker as unsuccessful were under
treatment less than eight months, and all three of the cases evaluated so by
mothers were carried less than eight months.

Table VIII gives a quantitative picture of the degree of treatment dur-
ing the period before closing a case. "Psychiatric interviews" are those
occasions in which the child and parent are interviewed by the psychiatrist.
Social service interviews refer to the social worker's personal contacts
with other agencies relative to the child and his family, home visits, and
Clinic visits during which time the parent or child or both contact the so-
cial worker in more than a wholly social way, or in more than the social
worker's capacity as "clinic manager".

Fifty-nine per cent of the thirty-two children studied had only from
0-3 psychiatric interviews. Eighty-four per cent of the cases had only from
0-3 social service interviews. That the result of such brief treatment con-
tacts should be evaluated as indicating improvement and adjustment almost
seems impossible. Yet, many of the mothers and social workers did state
that improvement had occurred. With an average case load per social worker
of 159 in 1942, and an equally heavy load of the psychiatrist, it seems
unlikely that it is humanly possible to give more time to each case.

In the majority of cases the results are good. In some the improve-
ment is quick and very marked - in the mother's eyes a miracle. In
others the progress is slow and the condition is complicated and not
fully appreciated by the mother who takes the attitude either that
it is useless to come to the Clinic as the child is not improving,
or that the problem is too unimportant to bother with. In either

2 Habit Clinic for Child Guidance Statistics, p. 4.
case there must be frequent calls at the home in order to educate the mother and to insure the proper following out of the treatment. 3

A reduced case load would permit more intensive treatment, and the likely consequent greater improvement and adjustment in more cases, and so even more encouraging evaluations.

TABLE VI
LENGTH OF TREATMENT AND SOCIAL WORKERS' EVALUATIONS

<table>
<thead>
<tr>
<th>Length of Treatment (In months)</th>
<th>Adjustment Satisfactory</th>
<th>Some Improvement</th>
<th>No Adjustment</th>
<th>Unknown</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>0 - 3.9</td>
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<td>0</td>
<td>5</td>
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<tr>
<td>4 - 7.9</td>
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<td>6</td>
<td>3</td>
<td>0</td>
<td>10</td>
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<tr>
<td>8 - 11.9</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
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<td>12 - 17.9</td>
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<td>1</td>
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<td>5</td>
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<td>13</td>
<td>9</td>
<td>1</td>
<td>32</td>
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</table>

3 Thom, op. cit., p. 7.
TABLE VII
LENGTH OF TREATMENT AND MOTHERS' EVALUATIONS

<table>
<thead>
<tr>
<th>Length of Treatment (In months)</th>
<th>Adjustment Satisfactory</th>
<th>Some Improvement</th>
<th>No Adjustment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3.9</td>
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<td>3</td>
<td>1</td>
<td>5</td>
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<tr>
<td>4 - 7.9</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>10</td>
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<td>8 - 11.9</td>
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<td>6</td>
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<td>12 - 17.9</td>
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<td>3</td>
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<td>18 - 23.9</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
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<td>48 - 59.9</td>
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<td>20</td>
<td>3</td>
<td>32</td>
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TABLE VIII
PSYCHIATRIC AND SOCIAL SERVICE INTERVIEWS DURING TREATMENT

<table>
<thead>
<tr>
<th>Psychiatric Interviews</th>
<th>No. of Interviews</th>
<th>No. of Children</th>
<th>Social Service Interviews</th>
<th>No. of Interviews</th>
<th>No. of Children</th>
</tr>
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<td>0 - 3</td>
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<td>27</td>
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<td>4 - 7</td>
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<td>8 - 11</td>
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<td>4</td>
<td>8 - 11</td>
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<td>18 - 23</td>
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<td>18 - 23</td>
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<td>0</td>
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<td>Total</td>
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<td>32</td>
<td>Total</td>
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</table>
CHAPTER V

MOTHERS' REASONS FOR IMPROVEMENT

TABLE IX

REASONS FOR CHILD'S IMPROVEMENT

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Mothers'</th>
<th>Social Workers'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outgrew problems</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Mothers' changed attitude</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Child's relationship with staff</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Medical treatment</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Group activity</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Lessons</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>School change</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong>^a</td>
<td><strong>36</strong>^b</td>
</tr>
</tbody>
</table>

^a Based on 29 cases in which mothers saw improvement.
^b Based on 22 cases in which social workers saw improvement.

The mothers of twenty-nine of the children felt that there had been improvement since the start of the Clinic contact. The total number of reasons given for this growth, under the variety of headings, was fifty, thus giving an average number of reasons of 1.7 per mother for the twenty-nine mothers who saw improvement. The mothers of eight children gave but one reason for the change and in six of these cases the child's growing older was that reason. Two mothers gave as many as three contributing factors.

The closing notes of twenty-two of the thirty-two records studied evaluated treatment as showing either complete or partial improvement. The total number of reasons given for improvement by the social workers was
thirty-six, thus giving an average number of 1.6 reasons for each of the twenty-two cases. In ten cases only one reason was given; in two cases the social worker noted three factors combining to make for the change.

The reasons given for improvement will next be considered.

**Outgrew Problems**

Sixteen, or 56 per cent, of the twenty-nine mothers who stated that their child improved, gave as the reason that he grew older. Six mothers, or 21 per cent of them, considered this the sole reason for change. As the child grew older, he understood what he should do and what pleased his parents; he grew into conformity. Two of the ten mothers, who also saw other factors contributing to the change, stated that, though the child grew out of his old ways, they were not certain he would have done so without Clinic help. One mother stated that her child might have done so, "but it was not worth the gamble." Other mothers stated, "His stuttering was just a period he was going through;" "As she matured physically she grew up in other ways."

To say that the main factor in a child's improvement was his growing older seems to negate the influence of the Clinic. Yet, it is easier for mothers to believe their children outgrew their difficulties, that is, that they did not really need psychiatric help. Interestingly enough, in every one of these cases treatment was actually undertaken and suggestions made.

In one instance, considerable help was given to a mother in understanding a sibling rivalry situation and in understanding the ways to alleviate it, as well as carrying out a successful nursery school plan. In another case, a careful enuretic regime was established and considerable emphasis placed on
giving the child commendation for his efforts at overcoming his undesirable habit.

It seems likely, then, that other factors than time led to the alleviation of problems. It is more the way of human nature, that time more firmly fixes patterns of behavior rather than eliminating undesirable habits. At least, it is one theory of guidance clinics that merely with the passing of time one more firmly grows into a habit rather than growing out of it. As would be expected, then, this reason was not given by social workers in their reasons for improvement.

Mothers' Changed Attitude

Fourteen of the fifty reasons given by the twenty-nine mothers stated that the change in their own approach and attitude to the child helped to bring about the change in the child. Yet, in not one of the instances was this factor listed in itself. One mother expressed the thought in her statement, "C. changed by my realization that I had to change some in my approach to him to train him right." Another said, "I could see an almost immediate change in D. once I began to like him even without his being perfect." A number of mothers sensed that improvement in the child came as they became able to disregard a little misbehavior, to become less concerned with problems and better able to "do nothing".

Sixteen of the thirty-six reasons given by the social workers accounted for the positive change in terms of the mother's evident changed attitude toward the child and his problem. The improvement in ten cases was accounted for solely by this factor. So, to the social worker, the improvement in 45 per cent of the twenty-two cases was accounted for by a change in
the mother. This change was expressed in the records in these varying ways:

"Mother and family took the psychomotor hysterical episodes more easily and understood them as an attention-getting device;" "Mother learned to understand the rivalry situation and the norms for patient's age;" "Mother successfully tried a positive training regime;" "Mother accepted patient's aggressiveness as a normal reaction for constant contact with women;" "Mother relaxed her standards of perfect behavior and the tense atmosphere of the home."

It seems significant to note that, while in the record reasons for improvement this was given so often as the sole and main factor in improvement, it was not given in itself in any instance by the mothers.

Child's Relationship with Clinic Staff

Eight of the fifty reasons presented by mothers stated that the Clinic personnel was in large measure responsible for improvement in the child. One mother even stated that the "heart to heart" talks the child had with the psychiatrist were entirely responsible for "getting R. on to himself."

Only one mother coupled the social worker with the psychiatrist as being equally responsible for helping the child, and she also included other Clinic members, in a picturesque view of the Clinic and the importance of each worker in influencing him. "The doctor helped J. to see it was up to him; the social worker got the camp plan going and helped by talking to his school teacher; a younger worker in the playroom gave me a beginning in seeing how children can be helped to get acquainted and to play together; and even the secretary was wonderful in letting J. work her typewriter without the customary 'no' that I and most other grown folks burst forth with when a
child does something we think he shouldn't." Six other mothers noted the psychiatrist's relationship with the child as contributing to the improvement. "B. had to get going because he liked the doctor so well;" "Just the doctor's personality did it."

In five cases the social worker's evaluation of the case thought the child's relationship with the psychiatrist was an important enough factor to be noted as contributing to adjustment. One child profited from a strong relationship with a doctor of his own religion who helped him to accept his minority group. Another child with a high psychometric rating was thought to be sufficiently bright to profit from the contact with the psychiatrist whose hobby was similar to his own.

Perhaps it was undue modesty that made this factor be mentioned less frequently by the Clinic workers than by the mothers.

Medical Treatment

Five more of the contributing reasons given by mothers related to medical treatment. In four of these cases in which the Clinic recommended that a complete physical examination be undertaken, organic disease was discovered. With the subsequent treatment of the medical problem, mothers felt the child's emotional problems were in part solved. One mother thanked the Clinic for encouraging continued medical follow-ups, which in each instance relieved her.

In contrast to this, in only one instance was the alleviation of the child's physical difficulty felt to be of sufficient importance to the social worker to be mentioned as a factor in improved adjustment. Perhaps mothers are apt to over-emphasize the medical, while the Clinic social workers
underestimate it in favor of more abstract help.

**Group Activity**

The mothers of three children felt that group activity, i.e. club, camp, or nursery school, had contributed to their child's improvement. One mother stated that her bright child had benefitted from the enrichment of the B. club and the camp program. Another mother said her child profited from the "group outlets for his aggressiveness." Interestingly enough, these are very psychiatric statements; very likely in repetition of the psychiatrist's explanations.

In nine of the twenty-two case records, group activity was considered to be an important factor in improvement. Six of these cases involved bright children who profited by the enrichment of extra-curricular activity, by having an acceptable outlet for their energies.

**Lessons**

Three mothers felt that speech or reading lessons taken at the Clinic contributed to improvement in their children. One mother commented that speech lessons had helped give her child a firmer foundation in social life; another felt speech improved her child's whole social adjustment.

In the record evaluations, four children were thought to have profited by lessons, two by reading lessons, and two by speech help.

**School Change**

One mother felt that all the improvement in her child had resulted from the change from a public to a private school, where her child got more individual attention. This plan, however, did not result from a Clinic sugges-
tion; it was made by the child's parents.

In only one case was a change in school and grade thought to be an important factor to the worker's accounting for improvement. It was the case of a child over-graded for his age and subsequently demoted to a grade in another school.
CHAPTER VI

MOTHERS' RECALL OF CLINIC SUGGESTIONS

The number and kind of suggestions made by the Clinic personnel and recalled by mothers should be most encouraging to the Clinic staff, though some verbalizations may have indicated only an intellectual, rather than also an emotional grasp of the problem. The expressed understanding and discussion of a number of sibling rivalry situations were especially complete.

With only four exceptions, all concrete suggestions indicated in the record closing notes were recalled by mothers, i.e., medical examination, club or camp plan, nursery school, or use of constructive toys. More abstract and indefinite suggestions were less clearly and less easily verbalized by mothers, i.e., "treat the child as a younger child," "let him have more responsibility," "accept her confidence," "use self-control," "blend persistency and kindness." As might be expected, those mothers found best able to carry out these more abstract suggestions, were best able to recall them. Those suggestions which were not, or could not, be fulfilled were usually omitted.

The mothers of three children recalled no suggestions that had been given them. Yet, most markedly in one of these cases, the child had been given reading lessons, camp, and his mother had been given help in increasing the child's growing independence.
Time Suggestions Followed

The mothers of eighteen of the thirty-two children, or of 56 per cent of them, stated that they were still carrying out, at the time of the home visit, at least part of the Clinic suggestions. The majority of these mothers spoke of their long-continuing changed attitude and approach to their child: their ignoring little things, their trusting child more. One mother vividly stated that "as long as she lives she will never forget to employ the Clinic suggestion: "He'll be kept busy as long as I'm on this earth; he'll be enriched." Another mother humorously reported that the psychiatrist's explanation of her child's behavior was that it was typical of many an only child's behavior. As a result, she was expecting another child, "And the doctor was the main impetus!" Other recommendations were being continued in private reading and speech lessons, group activity, and medical treatment.

Three mothers in addition reported they had only recently begun to try recommendations, after a period had elapsed following the discontinuance of treatment. One mother began to try suggestions after her child's physical problems had been alleviated, and his behavior problem persisted. Another mother, who did not believe the suggestions would work, was beginning to grow desperate and hence "really ready to try anything," including following the Clinic suggestions. The third mother felt that only recently had her child grown old enough to profit by her ignoring his attention-getting behavior, and at the same time sufficiently old to leave her at ease that, if something very serious arose, the child would be able to express the real seriousness of it.

Five mothers reported that they carried out suggestions only during the period that they were under treatment at the Clinic. Three of these mothers
saw no immediate improvement, saw "nothing happen," and so discontinued the Clinic contact. "I tried the things for a couple of days and nothing happened, so I stopped following them and stopped coming to the Clinic." Two of these mothers felt that after the child had been discharged as improved there was nothing more for them to do.

And the three mothers who stated that no suggestions had been made to them naturally could recall no suggestions to follow.
CHAPTER VII

MOTHERS' FEELINGS, AND EXPECTATIONS AND DESIRES
AT THE FIRST CLINIC CONTACT

It is known that a mother's coming to a clinic may be accompanied by at least one of a number of feelings that may interfere with or may help treatment. Helpful and positive feelings for beginning treatment result from mothers' readiness for their new orientation, their ability to bear reality, their ability to allow the child to have a real part in the process and also to have themselves assume a part in the process.

That coming may have been preceded by long hesitation or by renewed determination to work out problems alone, or by a variety of other reactions roused by facing the necessity for seeking some kind of help.¹ That coming does not mean that either the parent or the child can or is ready to use help. Even though the parents may have known of the Clinic previously, it has no vital meaning to them until they seek to use its services for problems in their own lives. At this point the Clinic ceases to be simply an external, community force, and becomes a part of them. At this point it becomes a source of comfort or a threat, a cure-all or a passing fad, or a place where parents can expect to find real help in making changes in their relationship with their child.

The tabulation of the mothers' responses to the question on their feelings about coming to the Clinic in the first instance, as given in Table X, indicates five distinct reactions to this new experience. Each of these

¹ Frederick Allen, Psychotherapy with Children, p. 62.
The reactions will be considered.

TABLE X
MOTHERS' FEELINGS ABOUT FIRST COMING TO THE CLINIC

<table>
<thead>
<tr>
<th>Feeling of Mothers</th>
<th>No. Mothers</th>
<th>Per cent Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashamed</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Ready for help</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Desperate for help</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Fearful</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Dubious</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

Ashamed

The largest number of the thirty mothers, 33 per cent of the total, expressed a feeling of being ashamed to have to resort to clinic assistance. Mothers said, "I was ashamed that this should happen to me. No one else in my family ever needed to see a psychiatrist;" "I was just ashamed when I thought that there would be a public record of the fact that I had to go to a social worker, where bad children from courts go;" "I was ashamed and disgusted that I had to come to a place like an insane asylum;" "I found it hard and shameful to have to admit that I couldn't bring up my own child-I couldn't even tell J's father until I stopped coming." It is likely that these mothers were guilty about their relationship to their child, and that they felt a threat in their grasp for outside help.

Ready for Help

The next largest number of mothers expressed a readiness and willingness to contact the Clinic. Eight of the thirty mothers, 27 per cent of
them, recalled that they were glad to come to the Clinic and felt ready for help. In many instances this attitude resulted from adequate preparation by another social agency or by having heard of good results of Clinic treatment from other Clinic mothers.

Three mothers were as agreeable to contacting the Clinic as they would have been in contacting a medical doctor for a physical problem. One mother stated, "I felt no different about seeing a psychiatrist than a straight medical doctor; R. and I needed help and that was what I was after." A second mother said, "It was like seeing any good pediatrician; I wanted help with my difficulty and was ready for it." However, this acceptance of psychiatric help as in the same category as medical help may not be as desirable as at first thought. "Most parents are accustomed to taking a child to a physician and having no participation in what goes on except in so far as they subsequently carry out instructions given." Habit Clinic procedure expects mothers to take a more active part in the process by gaining insight into or education regarding the situation. Frequently there is a genuine relief in taking part in the process and not simply sitting impatiently while the child has his treatment. To compare psychiatric treatment with straight medical care may well indicate an attitude of desiring that the child be cured without the mother's expecting to participate.

Although a mother may verbalize her desire and readiness for treatment, she may nevertheless not yet be ready to accept the implications of treatment, nor to assume the most positive attitudes essential for her to work out her own difficulties. Only a complete study of the child and his family can

2 Allen, op. cit., p. 63.
make possible a diagnostic interpretation of the total situation, so to indi-
cate what treatment potentialities there are in the child, his family and
his environment.

Desperate for Help

Five mothers, 17 per cent of the total, expressed intense anxiety about
their requests for help in alleviating their problems. These mothers said
that they were desperate for help and ready to try anything suggested to
them. It is likely that this initial feeling so binds mothers in tenseness
and confusion that they cannot benefit from help in an objective manner.

Fearful

Four mothers of the thirty interviewed, 13 per cent of the group,
stated that their outstanding feeling about first coming to the Clinic was
one of fear. One mother dreaded that the psychiatrist would find, "I was
responsible for F's troubles." Two mothers who had little confidence in
"mental work" feared what would be done to them and their children. The
fourth mother was "scared silly" by the nurse's recommendation that, "I
should take P. to a place like that; I thought she thought he was a mental
case." Fear, too, is a negative beginning; it too often blocks objectivity.

Dubious

Three mothers, 10 per cent of the total interviewed, stated that they
had no feelings about contacting the Clinic other than to be dubious and
apathetic about it and the need for help. These mothers were not "sold on
coming," and came only because friends suggested that they try it. These
mothers wanted nothing from the Clinic; they simply came after referral by a
friend, although they saw no real need for assistance. In a study made by Mills and Ritterskampf at the Hartley-Salmon Child Guidance Clinic in Hartford, it was concluded that little or nothing could be accomplished in cases where parents were dubious about wanting and needing Clinic treatment. Of the three Habit Clinic mothers who expressed this feeling, in no instance did the Clinic evaluation indicate improvement.

Mothers' recall of the children's feelings about first coming to the Clinic was very sketchy. In the majority of cases no explanation was given to the child as to where he was going or why. He simply accompanied his mother, with no evident feeling reported. There was no evidence or mention of any child's struggling and resisting change because someone else wanted him to change. However, it would seem that the children did not have sufficient awareness of what was ahead to resist any part of it.

Mothers were more ready to speak of their children's complete readiness to return to the Clinic after the initial contact. Reference was made to the children's fondness for the playroom, and for the personnel of the Clinic, and of their delight in the trip to and from the Clinic. In a number of instances children had expressed a desire to visit since the termination of regular contacts. Only two mothers reported that their children were unwilling to return; in one instance because the child feared leaving his mother to see the psychologist, and in the other instance because the child was uncomfortable with the psychiatrist's "lectures". The child's unwillingness to continue visits and treatment then seems to be an almost negligible factor in the discontinuance of treatment that will be more fully considered

later.

* * * * * * *

In answer to the question as to what mothers expected and wanted, mainly, at the time of the first visit, all thirty mothers agreed that they wanted help of one kind or another. Two mothers were unable to develop this idea more fully. The responses grouped themselves under a number of categories. These will next be considered.

Quick Cure

TABLE XI

<table>
<thead>
<tr>
<th>Expectations and Desires</th>
<th>No. Mothers</th>
<th>Per cent Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick cure</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Assurance</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Analysis of problems</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Physical examination</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Lessons</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Consultation</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Punishment of child</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Just help*</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* These mothers could not explain this further.

Ten of the thirty mothers questioned, 33 per cent of them, had a desire for a quick cure as their main expectation and desire in approaching the Clinic. Varying responses in this category were: "I wanted a quick remedy for all of J's problems, a drastic cure for thumb sucking and sleepless nights," "a miraculous over-night cure, a little trick so B. wouldn't
bother me," — a rule to cure up everything, the touch of a magic wand, a miracle to undo immediately what did not occur suddenly. These mothers wanted their children to be made over so that all troublesome behavior would disappear. The Habit Clinic work was to them a kind of Aladdin's lamp, a kind of sleight of hand that had ever-ready-made explanations and sure-fire remedies.

Interestingly enough, this emphasis at the start of treatment seems to be a contradiction to the most often mentioned factor in improvement by the end of treatment, "He outgrew it." Even though the emphasis on outgrowing problems seems to negate the influence of the Clinic, it nevertheless indicates a growing realization that time is necessary for change, in contrast to the original desire for a quick remedy.

**Assurance**

Six of the thirty mothers, 20 per cent of them, stated that the kind of help they desired was that of assurance. They wanted to be told that their child was not low mentally although he had poor coordination; they wanted "those helpful words to help me carry on." In all but two of these cases, the child was found to be below average mentally.

**Analysis of Problems**

Five of the thirty mothers, 16 per cent of them, wanted a full analysis and explanation of the problems for which referral was made, as well as treatment to help alleviate these problems and causes. One mother wanted the roots of the trouble; another wanted causes fully explained to her so that she could explain them to the child's father who did not see a real need for Clinic help.
Physical Examination

Two mothers expected and wanted a complete physical examination. Both of these referrals were made by nurses and because of this the mothers expected further emphasis on medical aspects. One of these mothers thought the name, Habit Clinic, was simply "a disguise for the name, Hospital Clinic, which sounds so bad." Too, because of the association with a medical clinic, both mothers mentioned their expectation of long waiting and "interns poking at you."

Lessons

Two mothers' main expectations and desires at the time of beginning treatment were lessons for themselves. One mother was convinced that her case required that she have speech lessons with emphasis on care in enunciation, so that she would be a desirable model for her child who was beginning to stutter. The other mother wanted lessons and discussions on how the mind and emotions work so that she could then cure her child herself. These mothers gave indication of an incomplete acceptance of the agency as helping their children; they wanted that privilege reserved for themselves.

Consultation

Two mothers came to the Clinic with the purpose of consultation. One of these mothers wanted the general opinion of a neutral body who was accustomed to handling children's problems. The second mother wanted the advice of "someone better equipped than I, someone with a dispassionate view and someone outside my immediate family who would have no reason to be prejudiced."
Punishment of Child

One mother's main desire in approaching the Clinic was to have her son "get a good scolding and talking to, so that he would realize that his mother was right about things and he had to obey her, or else." It is very possible that this desire was even more prevalent than the one instance in which it was expressed.
CHAPTER VIII

MOTHERS' REASONS FOR DISCONTINUANCE OF CLINIC CONTACT

The mothers' reasons for the discontinuance of treatment is one way to evaluate the Clinic's work, to learn what is desired by those referred for its help and what is not always gained; and so to adjust Clinic procedures. While the closing notes of the records gave reasons for closing the case, they were rarely the main reasons given by mothers. In another thesis conducted at the Habit Clinic for Child Guidance, entirely on an analysis of reasons why children are withdrawn from treatment, as given in the records, the proportionment of facts was quite different from this author's results, as gathered directly from the mothers. Helen Barrington found that the majority of parents withdrew because they were not ready for help.¹ These parents feared that they would lose their self-esteem in asking for help and in following the Clinic recommendations. Many of these applications were made under pressure. The second largest group in that study were those parents who withdrew because of their dissatisfaction with the type of treatment suggested to them.² Individual case records may give as the reason for withdrawal that the child was unable to form a relationship, or his problems caused insufficient anxiety for his parents to continue treatment; but what do mothers say are their reasons for discontinuing treatment?


² Ibid., p. 47.
Of the total of thirty-two cases considered in this study, mothers gave a total of sixty reasons for the termination of formal treatment. Nineteen of the mothers gave only one reason, thus leaving forty-one reasons for the remaining cases. While the average number of factors stated was 1.9 per case, thirteen of the cases had an average of 3.3 contributing factors.

The reasons given by the mothers will next be considered. Difficult as it is to find a fundamental cause for withdrawal, the mothers' responses point out factors contributing to the discontinuance of treatment.

**TABLE XII**

**MOTHERS' REASONS FOR THE DISCONTINUANCE OF CLINIC CONTACT**

<table>
<thead>
<tr>
<th>Mothers' Reasons</th>
<th>No. of Times Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic discharge</td>
<td>7</td>
</tr>
<tr>
<td>Dissatisfaction with personnel</td>
<td>15</td>
</tr>
<tr>
<td>Fathers' insistence</td>
<td>9</td>
</tr>
<tr>
<td>Inconvenient clinic location</td>
<td>8</td>
</tr>
<tr>
<td>Considered child cured</td>
<td>6</td>
</tr>
<tr>
<td>Assured</td>
<td>6</td>
</tr>
<tr>
<td>Dissatisfaction with treatment</td>
<td>5</td>
</tr>
<tr>
<td>Not ready to accept help</td>
<td>3</td>
</tr>
<tr>
<td>Impossible to follow suggestions</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

* Based on the reports of the thirty mothers.

**Clinic Discharge**

Table XII indicates that in seven cases the child was discharged from treatment by the Clinic personnel. In six instances he was discharged by the psychiatrist as either improved, as considerably over the age limits of the Clinic, or because it was felt that the child could not profit by further Clinic assistance. One case was discharged by the speech teacher because
there had already been considerable improvement, and with the child's transfer to a more distant school Clinic visits were impractical. Two of these mothers added that they would not have terminated treatment even with the discharge if they did not know they could readily return if further difficulty arose.

**Dissatisfaction with Personnel**

Mothers' dissatisfaction with the personnel of the Clinic accounted for fifteen, or 25 per cent, of the total of sixty reasons given for withdrawal, though in only one instance was it the only cause for withdrawal. In this one case, there was an intense dislike of the psychiatrist. He was reported to have inhibited the mother, to have made her uncomfortable and so nervous that she was more tense on leaving him than on arrival. "So, when I received a card for the dentist at the same time as my Clinic appointment, I was glad to go to the dentist." In the remaining instances in which this was given as one of a number of causes for withdrawal, the psychiatrist was again the staff member mentioned. He, or she, was felt to be too distant and impersonal with the mother, and in some instances too friendly with her child. One mother commented that she heartily disliked having the psychiatrist know more of her child's intimacies than she did.

In six instances the dissatisfaction was with a woman psychiatrist, largely on the basis that she was a woman. Disregarding the more psychiatric reasons for their preferring a man psychiatrist, mothers stated that women lower professional standards, that their ideas "mean less than a man's."

It can reasonably be said that these mothers may have had definite feelings of rivalry with the psychiatrist; they were threatened in finding
an outsider who might be successful with their children where they had failed. To criticize the staff of the Clinic is often a projection of criticisms directed towards themselves.

**Fathers' Insistance**

In nine cases mothers mentioned fathers' part in the withdrawal of the child from treatment, though their reasons for insisting were not always recalled. In five of these cases it was the only cause mentioned. The bases of fathers' feelings seemed to have been that they feared that their children would really begin to feel themselves problems; or that they disliked a non-private psychiatrist. Two fathers were reported to have been unable to recognize any abnormality in their children's behavior.

**Inconvenient Clinic Location**

Eight mothers considered that the location of the Clinic was so inconvenient as to make Clinic visits too difficult to be practical. In three instances this was the only factor mothers mentioned as resulting in the termination of treatment. Most often it was the inaccessibility of the Clinic and the number of public vehicle changes required that were mentioned. Only one mother mentioned the carfare expense involved; this was a mother of a family dependent on public relief, and to her the Clinic trips did not warrant the expenditure.

In many instances the location of the Clinic is a real factor in discontinuing visits. From most areas of the community served it is an hour's ride by public transportation, and so is time consuming. If there are other children in the home, it is especially inconvenient, not only because of the expense of hiring someone to care for them, but also because of the
difficulty of finding such a person.

**Considered Child Cured**

Six mothers terminated the Clinic contact because either they considered the child already cured, or so close to being cured as to make further visits unnecessary. Three mothers thought this the only factor in the discontinuance of treatment. A typical response was, "The end was in sight so I didn't feel it necessary to trouble the doctor further." Yet, in none of these cases did the psychiatrist agree that the child and parent had reached the point for discharge.

Sometimes with a shift to another, or to a less undesirable symptom, the mother feels her child is cured. It happens quite frequently that after the mother's first interview with the social worker or the child's first Clinic visit, that there is an immediate shift in symptom. The child is then determined that, if any changes are to be made, he will make them. And of course, for the mother to deny the need for further Clinic visits is one way to avoid doing something that is unpleasant. For a mother to believe that her child is already cured allows her to maintain control of the situation.

**Assured**

The mothers of six children commented on their satisfaction in securing some ideas and assurance from the Clinic by which they could carry on by themselves without further Clinic help. One mother considered this the sole reason for discontinuing Clinic visits. The psychiatrist gave her assurance that, by overlooking little problems, her child would improve. Another mother commented that she quickly received the brief clues to carry on, readily
became aware of the generalizations that were important, so that more formal treatment was unnecessary. However, before a discharge by the Clinic staff it is necessary that the improvement be evident, and not simply that there be the likelihood of improvement.

Dissatisfaction with Treatment

In five instances the mothers partly blamed the treatment for the discontinuance of visits. In no case was it the only cause given. Complaints related to a too long period of treatment in which no miraculous changes occurred, and that no drastic cures were undertaken. Two mothers were dissatisfied that the treatment did not involve giving them the roots of the problem that they had wanted. One of these mothers considered that she had received no real help as she had not been given, "the big whip--the causes." Another mother reported that she discontinued visits when the psychiatrist would not give her a fuller explanation of "what was my fault." Two mothers thought their children's problems too unique and indefinite to profit from the Clinic procedure, that the kind of treatment did not meet their needs.

On occasion this dissatisfaction with treatment, or failure to understand it, is indicative of the parent's hostility. But on occasion, too, the cause is related to an omission on the part of the psychiatrist or social worker.

Not Ready to Accept Help

Three mothers reported that they were uncertain and dubious as to whether or not they even wanted Clinic assistance, and eventually decided that they did not. One mother, whose predominating thought was that she lost self-esteem in having to ask for help, considered this overwhelming feeling
responsible for her unreadiness to accept help, and responsible for her withdrawal from treatment. Other mothers resented their initial referral to the Clinic which was made under pressure. "It made me mad to be pushed in when I didn't know if I wanted to come or not."

It can readily be realized that, unless parents regard children's problems as problems, and voluntarily seek help, there is little hope of benefit from the Clinic contact.

**Impossible to Follow Suggestions**

One mother stated that a complicated home situation contributed to her discontinuance of treatment, though it was not the sole factor. This mother reported that, anxious as she was to follow suggestions made to her, it was impossible to do so because of a compound home made necessary for financial reasons, and because of relatives' failure to recognize the child as having any deviations from perfection.

* * * * * *

It is evident, then, that there are many reasons why mothers discontinue Clinic contacts. In some cases the Clinic is responsible, in others the environment, and in still others the parents and relatives. Apparently, instances in which the child is himself responsible for withdrawal from treatment are rare.

In all these categories, with the exception of those cases discharged by the Clinic personnel, or possibly those which discontinued treatment at fathers' insistence, it is probable that mothers' themselves resisted treatment, and that their reasons were in some cases defenses for their resistance. The reasons for resistance are many. Among them are the association of the
Clinic with a punitive agency and so something to draw away from; the satisfaction gained from illness and so a refusal to treat and cure that illness; the mother's being threatened by the child's relationship with an outside person as the psychiatrist or social worker; the mother's being so guilty because of her desire to punish her child that she cannot accept Clinic help because she recognizes that she wants punishment; mother's desire for only specific, concrete things from the Clinic and when these are obtained she feels no need to continue the contact. These are the more subtle, often less conscious reasons for withdrawal, and consequently are not readily verbalized.

Then as the change begins in the child and the parent, the latter may feel threatened with what is taking place in the child as well as within himself. Like the rest of us she is uncomfortable when change occurs. Frequently, these feelings are a putting out of blame—projection is the technical term—on to other people and things, such as on to the psychiatrist, the social worker, the inaccessibility of the clinic, the hour and day of the appointment, the fee, the noises in the street, the negroes in the waiting room, etc.

Yet, mothers come to the Clinic, in most instances, under their own power and ask for help with their children. They come voluntarily and are free to break the relationship and to leave voluntarily.

At no point is it the purpose of a child guidance clinic to order the life of a parent. Individuals come to the agency not to be turned inside out and upside down and remade, but rather for help in living with the kind of self he is. Mother asks for help in the areas she wants it, and she will resist any effort to go further.

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4 Fink, op. cit., p. 153.
5 Ibid., p. 152.
MOTHERS' UNDERSTANDING OF THE WORK OF THE CLINIC

Mothers' understanding of the Clinic at the time of the personal interview, after the termination of treatment, indicated a number of interesting differences from the expectations at the time of the initial contact. Many mothers had become educated in this phase of mental hygiene and social work. While the emphasis before beginning treatment was on treating the child, after treatment had been terminated eleven of the thirty mothers, 37 per cent of them, emphasized that the main work of the Clinic must be in working with mothers or with both parents. These mothers mentioned the necessity of working with the relationship of children and parents to help them to better understand each other as a part of the total problem. One mother expressed the main work of the Clinic to be "the brain behind mothers and children to get them both together harmoniously."

Still, the majority of the references were to work with the child, as the name, Habit Clinic for Child Guidance, implies. One mother saw the objective of the Clinic to be, "helping the younger generation to grow up sane and sound and happy, so that they will not need mental care in later life when it is really too late." Other mothers stressed the non-medical side of children's problems and the correction of habits. Many spoke of the work as helping children to adjust. One mother understood the main work of the Clinic to be the motivation of the child to realize that he has a responsibility in overcoming his problems.
A smaller number of mothers related the Clinic to its part in the larger community. One mother expressed this thought in, "The Clinic does certain intensive work with children sent in by other agencies less well equipped to deal with children." A few mothers remarked that the Clinic deals with mental problems of Greater Boston, the less serious problems than the mental hospitals.

**Referrals by Mothers**

Referrals by mothers not only indicate a certain satisfaction with the Clinic, but also the kind of problems for which they refer mothers and children indicates their understanding of the agency. The majority of the mothers referred problems similar to their own. In total the scope of the referral problems covered the majority of the kinds of problems dealt with at the Clinic.

Sixteen of the thirty mothers reported that they had already referred at least one friend or associate to the Clinic in the months since their case had been closed. They were not certain that all their referrals reached the Clinic, but at least they had recommended the Clinic highly when hearing of a child's difficulties. Interestingly, these mothers were delighted with their role of good will agent.

Seven mothers stated that as yet they had not had the opportunity to suggest the Clinic to anyone, though they would certainly do so on hearing of a situation in which they thought the child and mother would profit by the service.

Two mothers were unaware that they could make referrals; both of them were referred by other social agencies and so thought that all referrals came
about in that way.

Four mothers stated that they would not refer anyone because of the subsequent necessity of saying that they and their children had been under psychiatric treatment, "for not such nice things," as slow development or stealing. To admit these things would involve shame and disgrace on their part. One mother added that, though she had learned that mental and emotional illness are no worse than physical illness, most of her friends had not yet reached that point. As might be expected, these four mothers were among the ten who expressed feeling ashamed at the time of the first Clinic contact. Encouragingly, the other six mothers were now willing to make referrals without shame, and four had already done so.

Only one mother stated definitely that she would make no referrals under any circumstances; "None of my friends are so poor as to require Clinic service, and besides, I don't believe in all that foolishness."

The vast majority of the mothers either had already, or said that they would in the future, refer others to the Clinic. They were satisfied with the Clinic and were able to see and understand its constructive force, able to understand that it helps people with certain kinds of problems.
CHAPTER X

MOTHERS' FEELINGS ABOUT CHANGES IN WORKERS

TABLE XIII

NUMBER OF CHANGES IN SOCIAL WORKERS

<table>
<thead>
<tr>
<th>No. Social Workers</th>
<th>No. Cases</th>
<th>Per cent Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18</td>
<td>56.0</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>25.0</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The total of thirty-two cases had a total of fifty-four social workers, of course in a great many cases the same social workers. There was an average of 1.7 social workers per case. As indicated in Table XIII, in 56 per cent of the cases there was one worker, thus leaving the remaining 44 per cent of the cases to have as many as four workers. Undesirable as these changes may be to the client, in a Clinic which has as one of its main objectives its use as a training center for students this is not too unusual. In a few instances trained volunteer workers were available for comparatively short periods of time.

As with the psychiatrist, there was considered to be another worker in the case when more than one contact was made with the parent and child.

The total of thirty-two cases had a total of thirty-two psychiatrists,
an average of one each. However, three cases saw no psychiatrist, leaving three cases to have a change. Of the cases, 9.5 per cent had two psychiatrists. This was accounted for in one case by the request of a mother of a defective child that she see another psychiatrist, "in the hopes of getting a more favorable diagnosis." In the remaining two cases the psychiatrist left the Clinic for the armed forces.

**TABLE XIV**

**NUMBER OF CHANGES IN PSYCHIATRISTS**

<table>
<thead>
<tr>
<th>No. Psychiatrists</th>
<th>No. Cases</th>
<th>Per cent Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>9.5</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
<td>81.0</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

But how do mothers react to these changes? In not one of the fourteen cases involving different social workers was there any evident negative feeling about the changes! The majority of these mothers were of the feeling that to get the facts to the psychiatrist was the most important thing, and the number of social workers necessary to do this was very unimportant. One mother who had experienced three changes said, "I didn't mind; all the social workers knew M.; they were all like different nurses for the doctor." Another mother who had had two changes stated, "The number doesn't matter. It's like having different nurses; the doctor's the main one. No, I wouldn't say I was tossed around." The comments of the two mothers who experienced four social workers were these: "Yes, I guess I did have a number of pretty
young workers, but they were all nice. They all help the doctor, and as long as he gets the information, that's most important;" and, "I never felt anything bad about seeing different people. They all meant well. Anyone from the Clinic is good enough for me."

However, the three changes in psychiatrist brought a marked negative reaction! The mother who asked for a change in an attempt to get another diagnosis to relieve herself stated that she "felt awful" not to have been able to accept the opinion of the first reputable psychiatrist. The two instances in which the psychiatrist left the Clinic for the armed forces brought reactions of, "I suppose he was needed there, but I felt just left in the lurch. I was so fond of him that I found the change very hard. While he was so good, I found the other doctor just the reverse and very hard to talk to."

These comments emphasize the greater importance of the relationship with the psychiatrist and the lack of full understanding of the specific role of the social worker as a part of the Clinic team. It seems justified to say that the relationship of many mothers to the social worker was less meaningful as a part of treatment than the relationship with the psychiatrist. With a strong positive transference to one social worker, the termination of that contact and the transfer to another worker would be likely to be difficult in at least some of the cases.
CHAPTER XI

MOTHERS' RECOMMENDATIONS FOR THE IMPROVEMENT OF THE CLINIC

The number and kind of recommendations made by the thirty mothers for the improvement of the Clinic should be a valuable impetus to changes at the Clinic. These recommendations indicate the areas in which there is dissatisfaction and in which some adjustments can be made.

TABLE XV

MOTHERS' RECOMMENDATIONS TO THE CLINIC

<table>
<thead>
<tr>
<th>Area of Recommendation</th>
<th>No. References</th>
<th>Per cent Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td>Social worker</td>
<td>7</td>
<td>23</td>
</tr>
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<td>Psychologist</td>
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<td>Interpretation</td>
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<td>Fee</td>
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No mother was at a loss for at least one suggestion at the conclusion of the personal interview. Six mothers gave one suggestion, fourteen mothers gave two, seven mothers gave three, and two mothers gave four and one mother five. Thus, there is a mean of 2.3 recommendations in different areas for each mother. In total, sixty-eight recommendations were made.
And in the words of one mother, "May you grow on the emphasis on negative criticism, and may these suggestions be as helpful to the Clinic as the Clinic suggestions were to me." The recommendations will next be considered.

**Psychiatrist**

Twenty of the thirty mothers, 67 per cent of them, made suggestions pertaining to the psychiatrist. The largest number of the total of sixty-eight reasons were in relation to him.

**Sex**

Eight mothers referred to the sex of the psychiatrist. They requested that, if the Clinic needs have women as well as men psychiatrists, mothers should be given a choice in the selection of the sex of their doctor. These mothers, who had all had a woman psychiatrist, expressed marked feelings about her, on the basis of her womanliness. There was emphasis on the fact that a male psychiatrist "means more," that he "raises standards," that he is "the symbol of strong mind and strong will, in contrast to the kind and nice social worker." These mothers suggested that mothers be warned if they have to see a woman doctor, as they do not expect it and "just cannot speak to another woman when they expect a man."

**Different Psychiatrists for Mother and Child**

Eight recommendations suggested that the child and mother have different psychiatrists. Mothers saw this as a means of alleviating the "asking and wondering," the "painful curiosity," that they feel when their child sees the same psychiatrist they do. They wonder if he is on their side or on the child's, and consequently they become defensive during interviews. Probably much of this indicates the mothers' guilt feelings, their anxiety
about trusting their children to another person without the support of their presence; and it might not be alleviated simply by different psychiatrists.

Explanations

Five mothers made suggestions relative to the giving to them of fuller explanations by the psychiatrist. These mothers thought that there should be a greater emphasis on the removal of causes, which can be done by the giving to them of fuller explanations and analyses of the causative factors, as well as the possibility of modifying disturbing elements. The consensus of opinion was that fuller explanations were needed by "intelligent mothers who could actually utilize them; one expects deep causes from a psychiatrist."

A number of these mothers suggested that the psychiatrist discuss the prognosis in each situation, that he warn mothers of other problems that may appear, that he emphasize that just as no medical doctor prevents all illness through life by curing one disease, so people should not expect psychiatrists to prevent all future problems. One mother suggested that in the prognosis, given early in treatment, the psychiatrist state "for sure" if the child can be helped by him.

In other cases it was suggested that the psychiatrist help in planning next steps and in explaining the future in entirely practical terms. The mothers of the four children found to have below average intelligence were especially desirous that more help be given them in planning for the child's future, and though the advisability of taking time from more treatable children might be questioned, still, "The clinic cannot and should not refuse to study and treat a child simply because he is found to be of inferior intelligence. The condition by itself does not always lead to any maladjust-
A few mothers asked that fuller, more detailed reports of the psychological findings be given by the psychiatrist. Two mothers reported that they were never told anything of the results, though in both cases the child was of at least average intelligence, and they had been concerned about them ever since the tests were given.

It seems likely that at least some of the mothers would have profitted by fuller reports and explanations, in lay language, of the factors that determine the extent to which behavior and attitudes may be modified. Such items as these could be considered: the duration of the symptomatic behavior, the extent of the area of life affected by it, the rigidity of related attitudes, the emotional value that the behavior has to the individual, alternative sources of satisfaction, mobility of the environment, and the quality of relationship it is possible for the psychiatrist or social worker to develop with the child and his family. Treatment should be planned with parents and not dictated to them. They are entitled to know why certain recommendations are made.

**Personality**

Five mothers suggested that the psychiatrist treat mothers more like "human beings, that ladies be treated like ladies; for after all, we're not all paupers and there's no need for a doctor to be too harsh and brisk."

Many said that the psychiatrist should be more sociable, less formal, and

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1 Stevenson and Smith, *op. cit.*, p. 72.


less inhibiting. One mother commented on one psychiatrist, "He's grand in theory, but personal contacts are very poor; he made me feel as if I was talking to a blank wall."

There can be no therapy when the therapist assumes an impassive role and allows little evidence of being a human being himself, as the other participant in the relationship. The therapist who tries too hard to maintain an objective attitude may become an automaton in a relation with a child (or adult) who needs the unobtrusive warmth of a friendly human being who possesses the skill and strength to help him to come to grasp with his emotional turmoil.4

Yet, on the other hand, to have the psychiatrist too good and understanding may block treatment, as the child and parent can reveal nothing that might hurt the too good relationship. However, the psychiatric interview must be so conducted that the child and parent feel at ease and feel as if treated as responsible human beings.

A few mothers resented the arrogance of the psychiatrist to their faulty management of their children.

Constructive, detailed, and comprehensive advice as to what should be done after the consultation is more to the point and gives better results than the practice, unfortunately not so uncommon as it should be, of berating the parents, even if they seem to deserve it, for mistakes made previously due to lack of knowledge, or for the sake of convenience, or in order to keep peace with a dictatorial mother-in-law.5

There is danger, at times, that the psychiatrist will take advantage of his position as the one in authority. By a critical, unsympathetic attitude he will humiliate parents with all the obvious mistakes which they have made. He will send them away from the clinic more discouraged and less able to cope with their problem than when they came. It is a very delicate piece of work to deal with a mother who has been a failure with her child, for this is often the problem, especially if one has to point out the seriousness of the difficulty as well as the difficulty itself. It is in this respect that the Habit Clinic differs from most agencies.

4 Allen, op. cit., p. 261.

5 Kanner, op. cit., p. 24.
Hospitals, schools, and many other organizations have the law behind them, or, if not the law, the fear of death or destitution, or an actual and conscious want, and they afford concrete and tangible assistance. The habit clinic has no definite authority, but has to depend for its cooperation upon the parental instinct and a friendly contact, and its assistance is at times very subtle and intangible.\(^6\)

**Social Worker**

Seven mothers, 23 per cent of the group studied, made recommendations relative to the social worker. All of these suggestions referred to the initial history-taking interview.

Mothers recommended that less material be gathered by the social worker in the initial interview. They suggested that detailed questions be eliminated, as "It's too much to tell a person before you know her," or "It breaks off a good feeling, for in social life you just cannot probe so and yet be liked." These mothers all felt that the function of the social worker in the first contact was actually to begin treatment and to help mothers, and not simply to know how to get facts and "to record answers like a secretary." A few mothers thought that the social worker should be able to see most of the factors in the situation as readily as the psychiatrist, "For after all she's a trained person, not a dumb-bell." Then, to make the initial contact most profitable, the social worker is expected to make suggestions for managing and relieving the situation. However, to see the total picture and to be able to make worthwhile suggestions, more than the initial interview is required. It is necessary to know the causal elements that produced the end-result of a referral problem. "To offer advice, too

\(^6\) Thom, *op. cit.*, p. 6.
frequently is merely equivalent to short-circuiting cause and result. 7 Also, it robs the receiver of it of self-determination.

The alleged value in accumulating complete histories seems to be in the belief that, if enough facts can be learned about situations and attitudes, change will take care of itself; or in the belief that a person can be changed by the complete understanding a worker has in knowing all the facts.

To understand the present, even though its content may be largely in past terms, is the major therapeutic responsibility, and from that understanding can emerge, actually, a better evaluation of the past. 8

It seems more important that, in this first interview, mothers find a person concerned with them and their feelings, someone who recognizes their fear and shame and hesitancy, someone who can give some explanations as to what may occur should they decide to bring the child and his problems to the Clinic, and to begin to see their part in the process of change. This first contact is important, for the first person mothers see is invested with significance for them, in terms of all responses called forth by having taken this vital step of seeking outside help.

There are real differences of opinion as to the value of exhaustive case histories, when the essential fact that needs to be established at the outset is the nature of the difficulty, as parents and the Clinic conceives of it, the willingness of the Clinic to proceed, and the capacity of the parents and child to use treatment.

A few mothers suggested that the social worker contribute more to the preparation of the child for his first contact with the Clinic, that she

7 Fink, op. cit., p. 153.
8 Allen, op. cit., p. 56.
spend a few minutes in the first interview discussing factors in "making children like the Clinic from the start and helping them to understand why they are going there." These mothers saw the relationship between the child's first contact and the progress of treatment. The preparation is definitely a part of the treatment, not simply preliminary to it. No human being, whether child or adult, wants to be made over by forces outside his own control. To win him by a good preparation may help him to accept more readily an attempt to make him over.

Yes, the first interview is important. Extreme tact and diplomacy are needed in order not to offend parents, and in order to impress them with the importance of the mental side of the child's life.

They invariably feel that they have used all the patience and good judgment that might be expected of anyone handling the problem with which they are confronted. Thus, it is necessary to generalize and speak in a more abstract way on the first visit than is necessary after working relations have been established and the parents have developed confidence in the clinic.9

The mothers who made recommendations relative to the first history-taking interview wanted less interview and more explanations; they wanted a slower start, less emphasis on what the Clinic wants from the interview and more emphasis on them and their problems and how the Clinic can help in the solution of them.

**Psychologist**

Six of the thirty mothers made recommendations in relation to the psychologist's giving of the psychometric tests.

A few mothers suggested that tests be given in the home where the child

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9 Thom, op. cit., p. 21.
is more relaxed. As might be expected, these mothers either rated their children as considerably brighter than the psychometric tests revealed or were mothers of children found to be uncooperative about taking the tests.

All six of the mothers suggested that the psychological tests not be given on the child's first visit to the Clinic, that he be given the opportunity to get acquainted with, or at least to see, the psychologist before the testing is done. A few mothers even suggested that mental tests not be done for a considerable period of time, "because it is impossible to get the best results if a child is seriously upset." However, in direct antithesis to these comments are Kanner's views.

It was found best to begin with the intelligence rating. The child who, in expectance of a discussion of his behavior difficulties, may have been tense or reluctant or even hostile, relaxes soon, and becomes more comfortable if confronted with questions which to him seem irrelevant and more in the nature of an interesting game.10

Physician

One mother suggested that there be a physician or pediatrician, a medical doctor, at the Clinic, so that physical examinations could be done along with the social, psychological, and psychiatric examinations. The basis for this one mother's recommendation was that, as the Clinic is now organized, it omits a most important phase of the child's development. Yet, only one mother made this suggestion. Since the Clinic's beginning in 1921 the emphasis has been on help other than medical care that children need for full development. To make the distinction between mental and physical assistance places the problem in its true area, and is the first step in mothers' and children's accepting the problem in that area.

10 Kanner, op. cit., p. 21.
Father

Eight mothers made recommendations relative to the desirability of having fathers participate in Clinic contacts. They agreed that the Clinic should require fathers to take a more active part in the treatment and in Clinic visits. Five of these eight mothers were included in the nine who blamed fathers for their insistence that the children be withdrawn from Clinic treatment. These mothers felt that these fathers did not understand the Clinic, and that "what one does not understand one runs away from." They agreed that fathers should be made to come to the Clinic "to find out what's what, for things cannot progress if one parent is unwilling to let things progress." Since both parents are responsible for the development of the child, "both should be educated together." Ideally, both should be educated together; the whole family, including the father, should be the focus of treatment, even though the name, Habit Clinic for Child Guidance, emphasizes treatment of the child.

While the mother, no doubt, bears the brunt of the responsibility for the physical and mental training of children, her efforts will rarely result in the best possible success if she lacks the understanding cooperation of the father.11

Mildred Burgum has clearly discussed some of the factors involved in fathers' negative feelings towards the child's treatment.12 The loss of his status is important in his disturbance. Often the treatment of the child, together with the greater security of the child in relation to his mother, or Clinic psychiatrist or social worker, stimulates the child's dissatisfaction with his father and his inadequate supervision and training, leaving

11 Bassett, op. cit., p. 169.
the father deprived of his role of a good parent and so leaving him deprived of ego gratifications. Too, the improved relationship of mother and child is threatening to him and activates his own latent aggression against his child, the same aggression that had previously found vicarious expression through the child's mother. Often this stimulates the father's feelings of sibling rivalry with the child through father's being displaced by his child as a favored sibling of the mother. And many a father himself desires to obtain dependent gratifications from the Clinic in competition with his wife and child.

Yet, desirable as it is to see the father to enlarge the picture of the child's background and to make the father feel a part of the effort to help his child, it is usually the mother who is most involved in the responsibility for the child, most apt to be troubled by the child's behavior through long periods of contact, and most accessible insofar as time and Clinic hours.

**Interpretation**

Eight of the thirty mothers interviewed suggested that more time be spent in explaining the Clinic, its scope of work, its source of funds, its aims, and that more information be given to publicity sources. These mothers stated that they had never had the opportunity to ask these questions and never felt free enough to do so. They did not remember having been so entangled in their own problems that they were not concerned with general policies and principles.

Six of these mothers recommended that a course for mothers and friends be given several times a year, giving details on the Clinic, so that satisfied mothers would have a firmer basis on which to make referral and on
which to explain the agency. One mother said, "After all, the Community Fund can sure use a person who can act as real spokesman for a place." Two mothers emphasized their complete surprise in learning that this was a "charity organization" after treatment had been terminated. They suggested that this be explained to mothers at the first contact, "because some people definitely would not like to tie up with that kind of organization."

Through a broader interpretation program, Dr. Thom's early ideal of extending the benefits of the Clinic beyond the immediate child to an ever-growing circle outside is possible. His concept of Habit Clinics is as follows:

not merely to initiate routines for establishing eating, sleeping and toilet-habits, .... it would also help give all who were associated with its work a better understanding of human behavior, greater tolerance for human failing, and increased strength for helping themselves and others make a happy adjustment to life. 13

Fee

Six of the thirty mothers suggested improvements concerning fees, that a charge be made for Clinic service. This was based in all instances on a desire not to take "distasteful charity". One mother was so disturbed about taking charity that she had to send the Clinic a check in payment. It was the feeling of these mothers that to have a fee basis placed the contact on a firmer professional basis.

In July, 1942, after the beginning of all the cases studied, and after the termination of many of these cases, the Board of Directors decided upon a plan for the payment of Clinic fees. This policy follows.

13 Mona Volkert, Habit Clinic History, p. 13.
(1) The fee of five dollars will be charged for the ordinary routine Clinic service, exceptions to be made at the discretion of the Director.

(2) Charge for service made in cases that are re-opened will be made according to the ability to pay at that time.

(3) In dealing with the low-income group, an effort will be made to obtain a fee, however, small.

(4) Clients who promise to pay will have a definite understanding that they will pay at an early Clinic visit, or be sent a bill early in treatment. 14

Since July, 1942, the scaled fee system has been in operation with the result, according to the Executive Secretary, Mrs. Ada Reeve Joyce, that approximately one-fourth of the new cases paid fees, one-fourth promised to do so but did not continue payments, and with one-half the subject was not discussed because of low economic level.

Though not a significant source of income, fees can be a most important part of the treatment process. They give mothers another share in the treatment process; they put the relationship of mother and Clinic on a more professional, less charity basis.

Appointments

Seven of the thirty mothers made recommendations relative to Clinic appointments. All these mothers made suggestions about the regularity and frequency of appointments. It was suggested that no more cases be accepted than could be given as regular appointments as desired by the Clinic personnel. Mothers thought it unfair to begin treatment of a child and then to be unable to have him seen for three or four week intervals because of a too

crowded schedule. This indicates the need for more regular and intensive treatment, and a greater number of contacts. To accomplish this, it is necessary to either increase the staff or to reduce intake. It is impossible for a Clinic to accept all cases referred to it from the community and still to maintain high standards of work. The Clinic may block its own usefulness by trying to do more than it can do well; it must not squander its resources. If financial reasons hinder the acquiring of an increased staff, it need be noted that, as a Community Fund agency, the income given it indicates the estimated validity of its contribution to the general welfare.

A few mothers suggested that longer appointment periods with the psychiatrist be allowed for, an hour interview for each visit similar to the hour appointment of the first interview. It was thought that in this way longer periods would be available for discussion and direct treatment, and so less frequent appointments would be more acceptable.

Six of these same seven mothers made suggestions about the degree of pressure exerted on mothers to keep appointments. Four of them thought it desirable that "someone at the Clinic" make mothers keep coming by home interviews and by repeated letters giving appointments. These mothers thought that this would be a drive to "push in people who know they should continue contacts but just do not."

In direct antithesis to these views, two mothers suggested that mothers be left entirely free not to return to the Clinic if they so desire. They resented the dropping in of social workers, and disliked the same appointment letters that the others wanted in greater quantity. One mother said, "You can't expect every case to be a long time thing; you shouldn't expect mothers to return if they already have the help and assurance they sought." The
second mother stated, "Don't always expect a mother to return. Most mothers know if they have to go back. There's no need to pull them in."

The clinic, as a community agency, is willing to have its services used by the parent and child, but it leaves the responsibility for coming to the clinic entirely to them, and also the decision as to whether this is the kind of help they need and want.¹³

**Location**

Four of the mothers made recommendations for improvement relating to the location of the Clinic. All four mothers suggested decentralized branches or Clinic days in different parts of the community served, in the various areas of density of population and need, to make the Clinic service more easily available and more convenient for mothers who could and would want to profit by the contact. With the difficulty of transportation since the war restrictions on the use of private cars and public vehicles, the period of time necessary to reach the Clinic has become a real handicap to continued contact. With mothers' growing pre-occupation with problems relating to the war in the home and in the community, decentralized, mobile units may be necessary if the maximum needs of the community are to be served. Services need be made available to those who need and want them.

**Clinic Name**

One mother made a suggestion in regard to a change in the Clinic name. She suggested that the name be changed to "Consultation Center" or "Guidance Center," thus giving the Clinic a more understandable and acceptable name. She objected to the words, "Habit Clinic," in the name, Habit Clinic for

¹³ Fink, op. cit., p. 149.
Child Guidance, objected to "Habit" on the basis that it limits the function to the lay public to problems of bed-wetting and thumb-sucking; objected to "Clinic" in that it connotes an impression of long waits on hard benches, as well as an emphasis on the financially dependent group. And to her these impressions did not give a real picture of the Habit Clinic.
PART III

SUMMARY AND CONCLUSIONS

CHAPTER XII

SUMMARY AND CONCLUSIONS

This study has attempted to present a cross section of the cases studied at the Habit Clinic for Child Guidance, in Boston, Massachusetts, with some of the children's mothers' attitudes and feelings toward the Clinic, and their understanding of it, together with their suggestions as to how it could be improved. This information was obtained by personal interviews with the mothers of a group of children who had already terminated treatment at the Clinic. A total of thirty-two cases were considered, including a total of thirty mothers, as there were two sets of siblings in the group.

Valuable as worker's evaluations of treatment are, the real efficiency of clinic treatment is determined by its value for the client. The vast majority of the mothers studied were satisfied that at least some improvement was made in them or their child or both. Only three mothers stated that no adjustment had been accomplished. In 44 per cent of the cases there was perfect agreement between the social workers' and mothers' evaluations; the total correlation between the two judgments was .31. Eight of the nine cases that were evaluated by the social workers as having had no adjustment, and the three cases that were evaluated so by mothers were under treatment.
for less than eight months.

Another indication of satisfaction with the Clinic was seen in the number and kind of suggestions recalled by mothers, that were earlier made by the Clinic staff members, and the "carry over" value of these suggestions as noted by mothers. Almost all concrete suggestions were recalled, while the more abstract and indefinite suggestions, apparently less understandable at the time they were given, were less readily recalled and verbalized. Only three mothers could recall no suggestions given them in the course of the Clinic contact. The mothers of eighteen of the children stated that they were still following some of the suggestions and theories given them. Many spoke of their long-continuing changed attitude and approach to their child. Three mothers reported that they had only recently begun to appreciate and to follow the suggestions. So, twenty-one of the mothers were able to see a continuing benefit from the Clinic suggestions, beyond the time of the actual Clinic attendance.

Mothers' reasons for the discontinuance of treatment further indicated some of their feelings about the Clinic. Of the thirty-two cases considered, twenty-five children were withdrawn before the Clinic discharge. However, this does not imply that all were withdrawn because of a dissatisfaction with the Clinic, for a mother's feelings that her child is cured or that she has already gained sufficient assurance to carry on alone may indicate very positive feelings. Negative feelings were evident in reasons stating dissatisfaction with the Clinic personnel and with the treatment and with the Clinic's inconvenient location. The reason most often given as contributing to withdrawal was the mother's dissatisfaction with the Clinic personnel, in most instances with the psychiatrist, either because of his impersonality and
coldness or, if a woman, because of the likelihood of her lowering standards. However, in only one instance was this the only cause for the discontinuance of treatment. Mothers' dissatisfaction with the treatment related to its being too lengthy or that no miraculous changes occurred or that no drastic cures were even attempted.

Still, the total feeling toward the Clinic was positive, and the vast majority of the mothers were sufficiently satisfied with the Clinic to either have already made referrals of new cases to it, or to state that they readily would do so in the future.

The mothers' reasons for improvement is one indication of their understanding of the Clinic. It is significant that sixteen, or 56 per cent, of the twenty-nine mothers who stated that their child had improved stated as a contributing factor that the child grew older. This negates the influence of the Clinic treatment that was undertaken. It contradicts a mental hygiene principle that with time one more firmly grows into a pattern of behavior rather than growing out of it. The second largest category of reasons for improvement, related to the mothers' own changed attitude to the child. Yet, unlike the growing older reason which was listed in only one case as the only reason, the mother's changed attitude was listed by itself in eight cases. This was the reason most often recorded by the social worker as accounting for the change.

It is valuable to determine mothers' feelings about coming to the Clinic for her initial contact, not only because her attitude and behavior to it is often influenced by her attitude and behavior to her problem child, but also to get a glimpse of mothers' understanding of habit clinic work at that time. In 33 per cent of the cases, the mother's predominating feeling toward
contacting the Clinic was one of shame, shame that she had to resort to outside assistance of a psychiatric, a mental, sort. The second largest category of feelings was a readiness for help, usually accounted for by an acceptance of the kind of treatment ahead, achieved by an adequate preparation by the referring source. However, though there was an acceptance of psychiatric help as being no different from medical help, there is a fundamental difference between the two. Only psychiatric treatment always necessitates the parent's active participation in the treatment process.

That in the case of 33 per cent of the mothers the main desire, on first coming to the Clinic, was for a quick cure correlates with the large group in which the mothers had feelings of shame. Because it was a shameful and painful step to take, they desired that an impossible, miraculous cure be obtained. This emphasis is in contradiction to the main reason assigned for improvement, that a child outgrew his difficulties, for the latter statement indicates a growing realization that time is required for change to occur.

The mothers' understanding of the work of the Clinic at the time of the personal interview after the termination of treatment indicated interesting differences from the expectations at the time of the initial contact. At the time of the follow-up the emphasis was less on treating the child, for 37 per cent of the mothers stressed that the main work must be in dealing with parents. Still, the majority of the references were to the child, as the Clinic's name suggests. A smaller number of mothers related the Clinic's work to its part in the larger community. If it is agreed that mothers' attitude towards and understanding of the Clinic is an important force in work with the community, mothers need be educated about the agency. Satisfied and informed mothers are excellent community interpreters of the agency.
Treatment work must involve not only work with children and their families, but also work with the community. Always it needs be the case and the community that are the foci of child guidance service.

Although mothers' comments and recommendations were not always based on a sound habit clinic basis, not always accurate statements of fact, not always practical, they none the less have indicated those areas in which confusion and conflict lie, those areas in which parents need further education. And interestingly, a number of mothers requested an educational program for them.

Parental education may be said to be the backbone of habit clinic procedures, supplemented by a direct psychiatric approach to the mental health of the child in an attempt to understand his particular difficulties in making the necessary adjustment to life.1

It should be stressed that mental hygiene is for normal people and not for the mentally deficient or neurotic or insane. Parental education is important because of the role placed by parental ignorance and attitudes in the contributory factors to the problems of childhood, and because of their part in the promotion of mental hygiene through their part in the general public education. E. Stanley Abbot lists parents as first on the list of persons by and to whom mental hygiene needs be applied.2 Through his discussion he includes the child, the teacher, the employer and employee, the physician, the clergyman, the judge, until finally the entire general public is reached. It is the general public that uses and supports measures for the promotion of mental health; it has a right to understand what it is using and supporting. It must see that good psychiatric service is the most expensive of all

1 Thom, op. cit., p. 15.

the medical specialties and it must not be annoyed by the relatively high costs. Gradually there needs develop a new orientation, a change from the static practice of mere mending, to a vision and practice of attention to the health, happiness, and efficiency of the rank and file of people, of the general public. Prevention of mental problems of children lies in large measure in the creating among adults of a general understanding of the needs of the child for healthiest mental development.

Perhaps the most striking conclusion of this study relates to the mothers' placing the social workers in a role that is very subordinate to the psychiatrist. In not one of the fourteen cases in which there was a change in social worker was there any negative feeling expressed. In not one of these fourteen cases was there a sufficiently strong relationship established with the mother to make a transfer meaningful to her. The three transfers of psychiatrist brought the expected response. He was the most important person at the Clinic and to lose him was a real loss. Also, that 67 per cent of the mothers made recommendations concerning the psychiatrist, as against 25 per cent concerning the social worker, does not necessarily imply that the psychiatrist's work was nearly three times as bad as the social worker's, but rather it more likely indicates the mothers' emphasis on him, with a less important role given to the social worker. With a reduced case load and less acceptance by the social worker of her subordinate role, she could some into her own, into a role of greater usefulness, to contribute her full one-third to the three-sided Clinic team.

APPROVED:

[Signature]
Dean
BIBLIOGRAPHY


APPENDIX
SCHEDULE A (from record)

Appointment:  
Name:  
Address:  
  Directions:  
Referred By:  
Why Referred:  
Date Referred:  
Religion:  
Age Referral:  
Index:  

Length of Treatment:  Psychiatric Interviews:  S.S. Interviews:  
No. Social Workers:  No. Psychiatrists:  
Child's Problems:  Social Problems:  

Mother's Feelings During Treatment:  
Clinic Recommendations:  
Reasons for Closing:  
Record Evaluation:  

Month closed:  
Sex:  
Case No.:  
Tel. No.:  
I.Q.:  
Age Closing:  

SCHEDULE B (from interview)

Date:  Time:  Case No.:
Where:

(General conditions during interview)

1. How is child getting along, as compared with the time of referral? New problems?

2. Has child improved since the start of clinic contact? Why?

3. What clinic suggestions do you recall?

4. How long did you carry out suggestions? What are you still carrying out?

5. How did you feel about coming to the clinic at first? How did child feel about coming to the clinic at first?

6. What did you expect and want from the clinic when you first came?

7. Why did you discontinue clinic contact?

8. What do you think is the main work of the clinic? Have you referred anyone? If not, why not? If not, would you?

9. How did you feel about changes in social workers? How did you feel about changes in psychiatrists?

10. What recommendations would you make for the improvement of the clinic?

How was the interviewer received? Mother's general feeling to clinic?
LETTER TO MOTHERS WITHOUT TELEPHONES

March 20, 1943

Mrs. John Doe
0 Brown Street
Boston, Massachusetts

My dear Mrs. Doe:

We are conducting a study at the Clinic in which we would like your help in improving some of our methods. You are one of the mothers who has been selected to help us.

Could I see you at home on Tuesday, March 23, at 2 o'clock?

If this time is not convenient for you, do feel free to contact me with the enclosed postal card, indicating other times that I might see you.

Unless I hear otherwise, I will be looking forward to meeting you at the indicated time.

Sincerely yours,
OUTLINE FOR HISTORY-TAKING INTERVIEW

Environment

Home conditions
Neighborhood
Previous residences
Economic situation
Religion
Language
Surrounding personalities
   The Household
   Relatives

The Child

Prenatal
Birth
Development
Health
Habits
   Sleeping
   Eating
   Elimination
   Minor neurotic traits
Sex development
Intellectual development
School life
Play life
Personality
Discipline

Social Summary
OUTLINE FOR CLOSING NOTES

1. Record age and sex of patient, source of referral, statement of problem or problems for which referred, and list of other problems found.

2. Outline family situation, important factors in social history.

3. State results of psychological examination with recommendations.

4. State recommendations of psychiatrist and outline treatment carried out.

5. Evaluate results
   (a) in problem or problems for which referral was made,
   (b) in other problems which became apparent as case progressed,
   by classifying (a) and (b) as "adjustment satisfactory," "some improvement," or "no adjustment,"
   and indicating factors in success or failure.


7. Clinic active _____ months (month of referral and month of closing inclusive).
   No. of clinic visits ______.
   No. of social service visits ______.
   No. of office interviews ______.