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Maternal attitudes in school failure

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Boston University
MATERNAL ATTITUDES IN SCHOOL FAILURE

A thesis

Submitted by
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(A.B., Marymount College, 1947)

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Chapter I

INTRODUCTION

Every child, if physically and intellectually able, attends school in the United States. The child enters this new experience between the ages of five and six. To one it may be a pleasant and satisfying experience; to another it may be filled with fear and trauma.

The child brought up with love and security finds the beginning of school an easy adjustment. For the insecure child this can be a most difficult time. The teacher, failing to see that the child's behavior is a result of confusing attitudes toward adults, may further intensify his feelings. School is then difficult for the child from the start.

Children present problems in school for different reasons. The chief cause of these difficulties, however, is usually found in the parent-child relationship, particularly in the relationship with the mother with whom the child has spent most of the time in his formative years. "It is generally accepted that the most potent of all influences on social behavior is derived from the primary school experience with the mother."¹

However the father cannot be excluded from the process of development if the child is to be secure and well adjusted. As the first six or seven years of the child's life are the formative ones where the child has several stages of development to master, it is necessary for the child to have successfully passed through these to live adequately a happy and useful

¹ David M. Levy, Maternal Overprotection, p. 3.
life. The role of the father cannot be overlooked in this development, particularly at the time of the oedipal conflict where the child must work through his role in the family and his identification. From this time on the child begins to grow away from the family. He moves to school and the group situation.

This study is thus focused on the problems in the mother-child relationship as they are seen in the child who is failing in school; the mother's attitudes towards the child and his failure; the role of the father in relation to the child; and the role of the Providence Child Guidance Clinic in effecting a change in this relationship.

Assuming that the school failure is only a symptom of the underlying difficulty in the parent-child relationship, the questions to be answered are as follows:

1. What are the maternal attitudes shown towards the child?
2. What are the maternal attitudes towards this school failure?
3. What is the relationship between father and child?
4. Was the clinic able to effect a change in the parent-child relationship?

**METHOD AND SCOPE**

Material, obtained by the case study method, was used. The record containing the child's history, parent's history, and the psychological testing and evaluation was read. If the worker was still at the agency, she was interviewed.

Where treatment was completed, the intake book was used. Here cases accepted by the clinic were entered, and at the time of entry the child's
name, age, sex, reason for referral and plan of action were listed. Cases were taken for diagnosis only as well as for diagnosis and treatment but only the records of children accepted for diagnosis and treatment were used. The present book was started in 1952, so that the review of the cases began in that year and continued through 1954.

Slightly over fifty cases were studied. The majority were eliminated for the following reasons: IQ too low; (this group constituted the majority) mother withdrew; outstanding marital difficulty; father out of the home; an organic factor in the child; mother never seen in treatment; lack of dictation in the record; and referral to an institution or other agency.

All the cases were closed as of the end of 1954, although one was reopened in January 1955 for one visit to the clinic by mother and son.

Case material was compiled by the use of a schedule (Copy in Appendix.)

Case material was further summarized as to the maternal attitudes found toward the child; attitudes toward the school failure or toward the school; and the role of the father.

In making a diagnosis of the maternal attitude, it was possible in five cases to substantiate the conclusion of the writer by discussing it with the worker who carried the case. In the remaining cases it was necessary for the writer to use her own judgment in making the diagnosis, which was based on the material found in the record.

LIMITATIONS

Two limitations on the selection of cases were placed before they were reviewed. They were the sex and age of the child. First boys were chosen
because they represented about two-thirds of the children treated at the clinic as well as being the more prevalent sex in the area of school failure. The second limitation was age. Boys from five to ten were studied, as it was felt after the age of ten the difficulties might be due in part to the onset of puberty and adolescence at which time added problems are apt to arise.

The study was further limited to cases where mother and child were seen in treatment at least five times, as it was felt there could be little movement in the treatment in less time than that.

As the material in the study came primarily from what the mother related to the worker, there is an element of subjectivity in it. In three cases the father was seen, although not on a continuing basis so that in those cases there is a clearer indication of his role, his feelings and attitudes.

The case material as recorded varied according to the worker and therapist, and therefore, some records were more complete than others. In all instances their findings were used and accepted. This was true also in the use of the test findings, as in every case the child was tested in the clinic by the psychologist.

**SETTING OF THE STUDY**

The Providence Child Guidance Clinic was started in 1925, but did not assume its present name until 1928 when it merged with the Juvenile Court Clinic. From that year until 1933 the clinic was run by the Mental Hygiene Society and supported by private philanthropy and client fees. In 1933
the clinic was taken over by the Providence Community Chest Organization. Support was not only maintained by this organization, but also by a fee plan based on the amount a client can pay.

The services of the clinic are given to selected cases chosen as those which can best be served by the team of psychiatrists, psychologist and social workers. In treatment the child is seen by the psychiatrist and the parent or parents by the social worker. In a few exceptional cases the child may be seen by the psychologist or social worker and the parent by the psychiatrist. The psychologist administers the intelligence and projective tests in an attempt to evaluate the child's intelligence and personality.

The staff of the Providence Child Guidance Clinic consists of the medical director, trained as a child psychiatrist and who works on a part-time basis. Two other part-time psychiatrists and a part-time pediatrician with specialized training in psychiatry assist. Two psychiatric social workers, a full-time psychologist, two student social workers and an executive secretary, part-time basis, together with an office manager and two stenographers, complete the staff.

Two conferences are held each week. The first is a staff conference at which a case is presented by the team and a determination is made of the present status of the parent-child relationship, and consideration given to future treatment plans. The opinion of each staff member is valued and sought, and a better understanding of the total situation gained.

The intake conference, with the entire staff, is held to determine
which child can be accepted by the clinic and benefit from its services. Some children are accepted for just a diagnostic study, others for both diagnosis and treatment.

Cases are referred by the client, by other agencies, doctors, schools, former clients and friends. If the referral is from an agency, doctor or school, the clinic keeps in touch with them as treatment progresses. The intake worker talks with each applicant on the telephone and may be able to determine at that time whether the agency can be of service. The agency has a waiting list and the applicant is advised that his name can be placed on this waiting list if he so wishes. This list is reviewed frequently. If one case is felt to need immediate help it may be scheduled earlier, but as a rule cases are chosen in the order of application. The applicant is then given an appointment for an intake interview. After this interview a decision is made at the intake conference as to whether the clinic can be of help. If so, the client is notified. Throughout treatment the psychiatrist, psychologist and social worker frequently confer regarding treatment goals.
Chapter II

THEORETICAL BACKGROUND

The personality of a child is formed to a greater degree by the environment in which he is raised, than by the constitutional factors with which he was born. The child from the day of birth begins to grow and develop, both physically and emotionally and this growth occurs through the experiences of every day care. At first, the nursing process is his only source of satisfaction. Here his dependency first finds a source of fulfillment. When these needs are not met by a loving and giving mother then the child is not able to grow emotionally beyond this level and may spend the rest of his life seeking some satisfaction. If this early period has been one of acceptance and love, not of anxiety and hostility, the child has developed a sense of trust and is able to continue his emotional development. He can enter the period of training without a great deal of anxiety. This period of the child’s life is one where his horizon is expanding. Demands are made on him to which he must conform. The toilet training which takes place during this period is the experience which puts the most demands on him in our culture and thus, if handled in a hostile way, can lead to anxiety and frustration in the child.

In the matter of toilet training and, incidentally, in all other little things that the child has to begin to learn in this period, his cooperation is likely to be good somewhat in proportion to the way he was treated during the oral period.\(^1\)

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The ego of the child begins to form at this time. It is important not only in toilet training but in all the areas of control of his actions. Through imitation of parents and accepting their ideals the child incorporates these as part of his own personality. The child develops feelings of ambivalence towards his parents in accepting these controls and, the degree of hostility will depend upon the way his parents treated him in the past and the way they are presently handling their demands upon him.2

Along with the toilet training of this period is bladder training. This is usually accomplished by the time the child has reached age three or three and one-half. If it persists after that time it is considered a sign that something is wrong. It may have many causes, and is often associated with other emotional disturbances. Enuresis may be associated with the child's disturbed perception of himself in relation to the parent of the opposite sex. It has been found in boys with a dominant, harsh mother whom the child is afraid to love as a boy, but feels it would be safer to castrate himself and love her as a girl.3 Enuresis may be a reaction to the birth of a sibling, fear of masturbation, poor or no training, or other causes stemming from the parent-child relationship.

As the child is in the so-called phallic period, he is completing bladder training and meeting with new situations. The greatest of these is the resolving of the oedipal situation, where the child works through

2. Irene M. Josselyn, Psychosocial Development of Children, p. 57.

his relationships with father and mother. For the boy it means taking on a masculine identification, and incorporating the father's example into his own personality. By the solution of this problem his super-ego has come into being.

Orgel speaks of the ego and super-ego as being products of identification. He speaks of identification as, "A mechanism by which the growing child finds a solution of tensions, the commonest of which are ambivalent drives of love and hate."5

The solution of the oedipal situation for some does not take place by the time the child has entered school. In others it is never fully resolved. The parents play an important part in this process and must be willing to give and accept a great deal. This is often difficult for them. The boy of six is keenly aware of his parents' moods, emotions and feelings even though the parents feel they are hidden.6 As his personality is becoming more complex, the child in turn will react to these attitudes.

By the time the child enters the first grade he is entering the period of latency. For the child who has loving parents and a life with little frustration and anxiety this will be a relatively calm period in the child's emotional growth.

If the child has not had adequate emotional security during the previous stages of development, or if his relationship with his parents has been such as to necessitate a distortion


5. Ibid, p. 121.

of the healthy emotional growth process, the effect may be evident in the poor adjustment the child makes in latency.\(^7\)

The period of latency is the one in which the child grows away from the close family ties to become part of the school and the group. The boy plays with those of his own sex. With these boys he learns about life; he can discuss his curiosity and wonderment with his friends. Much false information regarding physiology comes out, particularly concerning sex.\(^8\)

If the adults do not give the explanations that the child needs for these phenomena the child will find out for himself. Alpert\(^9\) feels that this expression of curiosity has a strong emotional drive.

The school plays an important part in the life of any child. The school is personified by the teacher and he or she, next to the parent, plays the biggest role in his life. As the child begins his school experience he also begins to learn to work and play with other children and to learn to share. He must share the teacher's time and affection as he did not have to do extensively with his mother. The teacher by sharing her time equally helps the child to work and play with others. Adjustment to school can be very hard for some children. It can be made more so by the teacher with whom the child comes in contact.

Difficulties of adjustment are exacerbated if the teacher has a cheerless, disciplinary personality, if the methods of instruction are over rigid with excess stress on academic proficiency,

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School Failure

In latency one of the frequent school problems found is in the area of learning based on emotional blocking.

All learning is conditioned sociologically by the society in which the individual functions. It is deeply affected by the family organization with all of its ramifications.

A child may fail in one particular subject or in all areas of classroom learning. Some instances of failure in the average or bright child may be due to the method of teaching. This can be corrected before the child becomes so anxious he gives up. In many more instances the failure is based on an emotional problem.

"The whole school and learning experience itself means something different to each child, depending upon the pattern of his identification with the achievement values and successes of parents; and with the emotional connections which are made between the school situation as a whole - teachers, children, materials and tasks - and the pattern of values and resistances or anxieties which the child brings to school."12

If a child has not had his questions regarding sex answered satisfactorily by his parents, or having felt this interest was wrong, the child will deny his interest in this area. Josselyn13 speaks of this

curiosity as related to other aspects of life and grows into an interest to learn other things. If the curiosity about sex is repressed before this new interest occurs the wish to learn is repressed as it is a forbidden pleasure too.

Liss\textsuperscript{14} feels that learning is a sensuous and erotic experience. He clarifies this further by saying:

Where the acceptance of one's biological destiny is within the norm, and the learning process has been eroticized as a practice pertinent to that sex, the learning process functions with a minimum of conflict.\textsuperscript{15}

If a boy has been continually repressed for his aggressive activities in early years, he may carry this repression of his aggression over into learning. He may outwardly appear as passive as he has repressed his aggressive strivings. Thus aggression and learning may be associated. Learning may have a competitive aspect. As competition implies aggression, guilt feelings may arise around this aggression and be projected into all learning. Guilt feelings about competitive aggression are apt to arise at the time of the oedipal situation and in sibling rivalry. Those whom the aggression is directed towards, are those who should be loved, not disliked, and thus, there is conflict.

Thus it seems that intellectual endeavors may become associated with, and work in the service of various impulses. The fate of intellectuality will then depend upon the fate of these impulses. If the intellect functions "in the service" of aggression, and if the individual feels guilty about aggression and tends to

\textsuperscript{14} Edward Liss, "Learning Difficulties", \textit{American Journal of Orthopsychiatry}, 11:520, July, 1941.

\textsuperscript{15} Ibid., p. 520.
repress it, the servant intellect may share the fate of his master - and intellectual blocking may result.16

This is corroborated by Liss who says: "Early parental and sibling relationships particularly affect the inherent implications of the purposes behind intellectual practices."17

Many children who feel rejected by their parents retaliate by poor school work or failure. As the child is still dependent upon the parent this retaliation against them is undertaken in an indirect way, and is usually unconscious. This is particularly true of boys in whom resistance to adults is more pronounced. The parent's reaction to this failure further plays into the child's hostility towards the parent. Levy and Munroe18 feel that children get their motive powers of concentration from their feelings not their intelligence. Thus, if the child is reacting to the attitudes the parents have toward him, he is not going to be able to progress in school. This, in the majority of cases, further intensifies the feelings the parents have, and, not realizing the basis for this failure they attempt to help the child with school work so that he will be promoted. As illustrated in chapter four in the case of Charles Wade. In this case the mother helped her son at home with his work. She also used various methods of punishment in an attempt to get Charles to do better in


school. The mother resisted giving up these methods, and thus, no improvement was seen in Charles' school work.

Attempts to apply pressure of a disciplinary or tutorial nature is likely to result in an intensification of feelings of frustration or defeat. These emotional difficulties are usually, at school age, due to parental attitudes.19

In other children poor school work may be a resistance to growing up, for as the child grows he gives up his infantile pleasures. Thus, intellectual growth means giving up many dependency needs. By failing in school the child does not give up this dependency.

The child who has had difficulties in the oral and anal period of development may carry the attitudes he acquired at this time through his life. These attitudes towards matters of orality and anality may be displaced onto other fields in which there is a similarity. Weisskopf says:

Attitudes towards orality and anality are most likely displaced upon activities which possess certain similarities with drinking and eating and defecating. Intellectual activities show such similarities. Learning is similar to drinking and eating inasmuch as it is an intake and assimilation process.20

Thus we see, from the works of authorities in the field, that in a great many instances failure to learn for the child with adequate intelligence has an emotional basis. This basis comes from the emotional relationship of the child with his parents. This relationship of child and parent has been, to the greater degree, with the mother, as she is the one with whom the child has spent most of his time in his formative years. To understand why a particular child reacts as he does we must know the

19. Ibid., p. 259.
attitude the mother has toward him.

Healthy personality development in children does depend in large measure on the character of the parents' attitudes and the nature of the parent-child relationship.21

Maternal Attitudes

Silberpfennig in speaking of the child says, "Their behavior since early infancy is a reaction to the mother's unconscious and conscious wishes in relation to the child."22

The maternal attitudes found in this study were: rejection, rejection by overprotection, overprotection then rejection and ambivalence. In categorizing attitudes there is always over-lapping, so that those presented were the dominant attitudes found in this study. It is not always possible to say how these attitudes came about. Allport is quoted as saying in speaking of the genesis of attitudes:

One of the chief ways in which attitudes are built up is through the 'accretion of experience' that is to say, through the interaction of numerous specific responses of a similar type.23

Rejection

In the ten cases used in this study, elements of love and hate were found in each one. In those cases where the maternal attitude was found

to be one of rejection, very little love for the child was found. Symonds speaks of the rejecting parent as neglecting her child physically, by denial of him, by punishment and maltreatment, humiliation and in her general attitudes and feelings towards the child.

The surest way for the outside observer to discover most quickly the attitude of a parent towards a child is to note in what terms he refers to his child. If a parent mentions his child in a spirit of criticism and dissatisfaction and emphasizes the child's shortcomings and limitations then one may suspect that justly or unjustly the parent holds feelings of hate toward the child.

There are many reasons for a mother's rejecting attitude toward her child. Deutsch speaks of women who have not received maternal love in their childhood as having less than others, and how the rejection of their own mother interferes with their feelings of motherliness. Another mother, so deprived, may react by an excess of love.

Rejection by the mother may stem from her hostility towards one of her siblings projected onto her child, or her hostility towards the child's father projected onto the child. Speaking of this projection of attitudes, Symonds says:

"The projected attitudes are frequently due to the fact that the parent is unable to accept his or her own sex role and projects the lack of acceptance onto the child."

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25. Ibid., p. 22.
27. Symonds, op. cit., p. 47.
Overprotection

Levy\textsuperscript{28} speaks of excessive contact and inseparability of mother and child as the greatest evidence of overprotection. However, no case was found to be of a purely overprotective nature. Those found were either early overprotection followed by rejection, or rejection by overprotection. The former is what Levy\textsuperscript{29} refers to as a mixed form of maternal overprotection. The mother who is rejecting by overprotection is the one who is spoken of in Silberpfennig's\textsuperscript{30} article as a mother who over-compensates her aggression towards the child by being overly anxious about him. Levy says, "The overprotection is considered compensatory, derived from a feeling of guilt because of unconscious, hostile attitudes toward the offspring."\textsuperscript{31}

Ambivalent

The ambivalent person is spoken of by Sayles as the one, ...

...whose emotional life has failed to achieve full maturity, antipathy and sympathy, liking and disliking, love and hate, alternately assumed control of the forces that find expression in daily acts and words - an oscillating emotional state.\textsuperscript{32}

With the ambivalent mother there is no one definite reaction toward the child. She may overprotect some and reject some, but it appears to

\textsuperscript{28} David Levy, Maternal Overprotection, p. 40.
\textsuperscript{29} Ibid., p. 26.
\textsuperscript{30} Silberpfennig, op. cit., p. 477.
\textsuperscript{31} Levy, op. cit., p. 18.
\textsuperscript{32} Mary B. Sayles, The Problem Child at Home, p. 81.
have no deeply rooted pattern. This ambivalence however, will produce emotional insecurity, anxiety and inferiority in the child, as he is confused by the oscillation in his mother's attitude towards him.
Chapter III

THE GROUP AS A WHOLE

In studying the maternal attitudes of boys referred to the Clinic for school failure, it is helpful to present the findings of the cases as a whole. In this study the maternal attitudes were found to fall into four categories, shown as follows:

Table I
ATITUDES OF THE MOTHERS TOWARDS THEIR SONS

<table>
<thead>
<tr>
<th>Mother's Attitudes</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejection</td>
<td>2</td>
</tr>
<tr>
<td>Rejection by overprotection</td>
<td>3</td>
</tr>
<tr>
<td>Overprotection then Rejection</td>
<td>2</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

These four categories were defined on the basis of the reading done by the writer, and from which the definitions of each type of maternal attitude, found in Chapter II, were formulated.

These ten cases can further be divided into those who withdrew from treatment and those whose treatment the Clinic terminated. Three mothers withdrew from clinic treatment, and seven cases were terminated by the Clinic. In one of these seven treatment was terminated because of the boy's long illness.

Improvement was noted in the mother's attitude towards the child, and in the child's attitude and behavior and school work in all cases where
the Clinic terminated treatment. In two of the three cases where the mother withdrew no improvement was noted in either mother or child. In the remaining case there was improvement noted in both, but further treatment was indicated.

In the cases where the three mothers withdrew the attitudes found were: one rejecting, one overprotecting then rejecting. These are the two cases where no improvement was noted. In the third case where mother withdrew, but where improvement was found, her attitude was found to be that of rejection by overprotection.

Table II

<table>
<thead>
<tr>
<th>ATTITUDES</th>
<th>TERMINATED</th>
<th>WITHDRAWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejecting</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rejecting by Overprotection</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Overprotection then Rejection</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

In all ten cases the mother was seen by a social worker. In five cases the child was seen by the psychiatrist, two were seen by the pediatrician and three by the psychologist.

In eight of the ten cases mother blamed the school for the child's failure, and in seven of the ten cases she helped him at home with his school work. In four cases where the mother was giving help the child's behavior in school was overactive. In two cases where she helped the child
behavior was no problem. In the cases where no help was given four were no problem and two were overactive. This, therefore, does not indicate that helping the child at home leads to any definite behavior reaction in the classroom.

Table III indicates that the largest number of children in the study referred for school failure during the latency period were age seven. As to grades four were in Grade One, four in Grade Two, one in Grade Three and one in Grade Four. Four were repeating or had repeated the First Grade, two had repeated Grade Two and another while in treatment, began repeating the Second Grade. The one boy in Grade Three had repeated Grade Two and on a return visit to the Clinic in 1955 was found to be repeating Grade Three. He was the son of the rejecting mother who withdrew from treatment.

The range of IQs was from 94 to 133 with only two boys having IQs under 100. The psychologist found that five were superior in intelligence, one very superior, three average, and one with an IQ of 111 showed a potential for a higher IQ.

The Rorschach revealed that only two of the boys were achieving or accepting a masculine identification. This was the six year old boy and one of the seven year old boys. Thus the problems of the other eight boys studied appeared to be pre-oedipal in origin. In six cases the school problem has been in existence since school began. The difficulties of the other four boys were not noticed until they entered their present grade.

The parents of these boys ranged in age from thirty to forty-three for the mother and from thirty-one to fifty for the father—with the average age being thirty-five for the mother and thirty-nine for the father.
Table III
CATEGORIES AS RELATED TO AGE, GRADE, SOURCE OF REFERRAL, ORDINAL POSITION AND MATERNAL ATTITUDES

<table>
<thead>
<tr>
<th>CASE</th>
<th>AGE</th>
<th>GRADE</th>
<th>SOURCE OF REFERRAL</th>
<th>ORDINAL POSITION</th>
<th>MATERNAL ATTITUDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Souza</td>
<td>6</td>
<td>2</td>
<td>Friend</td>
<td>Middle of three</td>
<td>Rejecting</td>
</tr>
<tr>
<td>Charles Wade</td>
<td>9</td>
<td>3</td>
<td>School</td>
<td>Third of four</td>
<td>Rejecting</td>
</tr>
<tr>
<td>Thomas West</td>
<td>7</td>
<td>1</td>
<td>Physician</td>
<td>Youngest of two</td>
<td>Rejection by over-protection</td>
</tr>
<tr>
<td>George Phillips</td>
<td>7</td>
<td>2</td>
<td>Self</td>
<td>Youngest of two</td>
<td>Rejection by over-protection</td>
</tr>
<tr>
<td>John Moore</td>
<td>9</td>
<td>2</td>
<td>School</td>
<td>Youngest of three</td>
<td>Rejection by over-protection</td>
</tr>
<tr>
<td>Randy Harris</td>
<td>7</td>
<td>2</td>
<td>Physician</td>
<td>Oldest of two</td>
<td>Overprotection then rejection</td>
</tr>
<tr>
<td>Oran Levitt</td>
<td>7</td>
<td>1</td>
<td>Friend</td>
<td>Oldest of two</td>
<td>Overprotection then rejection</td>
</tr>
<tr>
<td>Henry Gould</td>
<td>10</td>
<td>4</td>
<td>School</td>
<td>Oldest of four</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>Robert Imbeau</td>
<td>7</td>
<td>1</td>
<td>School</td>
<td>Middle of three</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>Edward Post</td>
<td>7</td>
<td>2</td>
<td>Physician</td>
<td>Middle of three</td>
<td>Ambivalent</td>
</tr>
</tbody>
</table>
All the families appeared to be in the middle income group with two being in the lower bracket of this group. This is based on their ability to pay a fee for the Clinic service. Three families paid five dollars for each visit, one paid four dollars, four paid three dollars and two paid one dollar.

Two other factors were noted in this study:

1. In eight cases there was some amount, in varying degrees, of sibling rivalry between client and one or more of his siblings. In only one case was this emphasized greatly by the parent. In the other nine cases it did not assume great importance. It is felt to be something common to the average family with more than one child. In the one case where mother seemed to emphasize this there appeared to be a basis for it. This is one of the cases where mother was overprotecting and then rejecting and the boy was displaced by his brother.

2. Another emotional problem presented in six of the ten cases: Three boys stuttered. One, along with his stuttering, stole and lied. Of the other two boys who stuttered, one had a possible organic cause for it. Two boys age seven were enuretic as was the sixth boy who was nine years old. In the case of the three boys who stuttered improvement was noted in the speech of all - one very markedly by the end of treatment. The boy who lied and stole had reformed by the end of treatment according to his mother. The mothers of two of the boys with enuresis withdrew from treatment so that it is not known whether this ceased or not. In the third boy enuresis was eliminated by the end of treatment.

The appearance of other emotional problems is not unusual in a child referred to a Child Guidance Clinic.
Chapter IV

CASE PRESENTATION

Chapter IV contains illustrations of the four types of maternal attitude found, separated, as they fall into each of the four groups.

Rejection

The following two cases illustrate mothers who were rejecting their sons. In the first case, the mother was able to accept the school failure as emotional and therefore was able to involve herself in treatment. The second mother could not, and therefore withdrew from treatment. No improvement was noted in either mother or son.

Paul Souza

Paul, age six, was referred because of school failure. He was the middle child in the family, having an older sister and younger brother. He had done well in the first grade, but since entering the second was failing in most subjects.

Mother, in her first contact with the clinic, spoke of Paul as lacking something, and being different from other children. His behavior in school was good.

Mother, from the beginning, found it hard to get into treatment, and continually broke down and cried. She found it necessary to start each time at the beginning, but could involve herself when she worked through this.

Mother and father were of a different religion and cultural background. Father was Roman Catholic of Portuguese parentage, mother was English and Protestant. Mother's family was prejudiced against Catholics, and mother herself showed antagonism about this. She resented Paul's attending a private Catholic school. She felt her family had prestige and position in the community, where as, father's family did not.

Mother was one of triplets, born rather late in her parents'
marriage. The other two children were boys. One was preferred by his father, the other by his mother, so that mother was left out. She was required to do a great many chores as a child, and apparently was rejected by both her parents. When mother was young, maternal grandfather committed suicide.

Mother stated that, in contrast to her brothers, she had difficulty with school work, but did go so far as to complete nursing school.

Mother found it very difficult to show her feelings, but with acceptance was able to express her feelings about Paul. She had not wanted a second child so soon, but when she did accept her pregnancy, wished for a girl. When Paul was born, mother thought he was homely. Mother was very strict with Paul and did not permit him to be out of line in any way. She expressed her favoritism for his younger brother, and allowed this boy to do anything he wanted. She also spoke lovingly of her daughter.

Very little was known about father. He appeared to be a more mature person than mother. Father was home very little, and seldom spent any time with his children.

Paul was tested by the Psychologist and received an I.Q. of 115. The Rorschach revealed oedipal tensions and conflicts in the area of relationships with mother. Paul was achieving a masculine identification. His greatest problem seemed to be in the area of expressing hostility.

Paul was seen four times by a woman therapist and was then transferred to a man who was experienced in the problems of school failure. He saw Paul for a period of thirteen months. During therapy, Paul made real progress in school and at home, became happier and more relaxed, felt less rejected by mother, and was able to express his hostility more directly, although in this area he still maintained many defenses.

DISCUSSION

Mrs. Souza verbalized her rejection of her son from the very first, and admitted she had never been able to accept him. She was concerned over his poor school work, and somehow related this to her own inability in school. However, the reality of this was questionable because of her achievements. Mrs. Souza felt rejected by her own family, and her social worker felt she had many unmet dependency needs. She married a man whom
she felt superior to, but had somehow made a satisfactory adjustment in marriage. Mrs. Souza's brother married while she was in treatment and this marriage was apparently a great threat to her, but she was unable to talk about it, and the social worker felt that her relationship with her brother and with Paul was somewhat confused.

I feel that Paul's failure in school, and at the same time his good behavior, was a method of getting back at mother in a passive way. As he was not allowed to step out of line in any way, this was the only safe way to retaliate.

Both Paul and his mother came a long way in therapy. Mrs. Souza was able to relax and allow Paul to express himself, even to being able to accept his telling her that he hated her. As Paul's school work began to improve, Mrs. Souza was greatly relieved, and she began to show a positive attitude towards her son.

Charles Wade

Charles, age nine, the third of four boys, was referred to the clinic by his school. He had repeated the second grade, was now in the third and doing failing work.

At intake, mother emphasized Charles' school problems, and then discussed at great length that he was a "pest", who didn't get along well with his three brothers. She further emphasized many little things he did at home that annoyed her. Immediately after school every day, mother helped Charles with his school work. At that time, mother was running a convalescent home, and felt this was the only time she had for him. Mother appeared to plan her entire life. She spaced each child four years apart; bought a house at a definite time, and so on. Mother stated at intake that she felt the third child was the difficult one. Charles' birth had been the only hard one, and she felt he must have been injured at that time. She had planned on a girl and was disappointed at having another boy.

Charles was pictured as a boy with no masculine interests. He
had a heart murmur which he used as an excuse for not participating in sports. He played with dolls and designed clothes for them. Mother stated that she was not upset over this, and the fact that he was called a sissy, as she felt he was exceptionally gifted and sensitive. He did many of the household chores for her.

Mother was the only girl in a family of three boys. Her younger brother she compared Charles to, and called her brother a "stinker." Maternal grandmother was dead, and maternal grandfather, who lived with mother, was old and senile. Mother was a graduate nurse, who, like father, regretted her lack of a college education. She did well in school and found it easy. She felt that she was a perfectionist, and therefore this boy was a disappointment to her.

Mother used every method of punishment on Charles that she knew, to get him to do better in school, but felt it did no good. She used pressure on all her children to make school progress, and each of the boys had had his own difficulty in school.

Father was unemployed during most of the time Charles was in treatment, and on several occasions came to the clinic in place of mother. He was able to relate to the worker and revealed several psychosomatic complaints, which the many doctors he had been to had not helped. At one time, he was very active in the community, but when he began to worry about his children he dropped many of these activities to spend more time with his children. However, he gave little evidence of any real relationship with Charles.

Charles' testing revealed an I.Q. of 95 on the Children's Wechsler. The Rorschach pointed to a higher level of intellectual endowment. It also revealed excessive fantasy, and internalization far in excess of the normal. He was afraid of acting out. He appeared to fear father, and was adopting a feminine orientation. Also hostile feelings towards mother were repressed.

Charles was seen by a woman psychiatrist for a period of six months at the end of which, treatment was terminated because of mother's withdrawal. The therapist did not feel she was able to accomplish much with Charles. Towards the end of this time he could talk of the many fears he had.

Charles was seen once in January 1955. The same therapist felt that he was in a situation where the clinic could be of little help to him because of his mother.

Mother at this time, related she had had a "nervous breakdown" in the fall. She gave the appearance of still being very nervous. At this visit she stated that she did not know whether she could accept Charles as he was. Although the clinic had planned to continue treatment, mother and Charles again withdrew.
DISCUSSION

Mrs. Wade was overly concerned about Charles' failure in school, as shown by her intensive tutoring of him. At the same time, she blamed the school for his failure. Both Mrs. Wade and her husband put emphasis on the value of a college education and pushed their children with this in mind.

Mother disliked the femininity she saw in Charles, at the same time she played into it by encouraging him in any activities in this direction. Mrs. Wade felt Charles was over-affectionate with her, and frequently wanted to go to bed with her. She did not like this and it was one of the few areas which Mrs. Wade could admit she did not know how to handle.

Mrs. Wade rarely mentioned anything she liked or admired in her son, and continually belittled him. No improvement was seen in either Mrs. Wade or Charles, and neither seemed accepting of treatment. Both were felt to be very much in need of help. Mother particularly resisted the clinic, and any recommendations made were ignored. Father went along with mother's thinking in every area.

It was felt by the clinic that poor school work was a result of the personality pattern Charles had adapted as a shield against his domineering, castrating and rejecting mother.

Rejection by Overprotection

The next three cases presented are those where the mothers' attitudes were those of rejection by overprotection. In all three cases a change was noted in the mother's attitude. All three boys showed improvement
in their school work and behavior as well as in other problems that were upsetting.

**John Moore**

Mother was referred to the clinic by the school, as John, age nine, was failing. He had repeated the first grade, and a repetition of the second grade was being indicated. The school had felt that the greatest difficulty was in reading, but mother did not accept this. At intake she expressed her anxiety over this failure and her feeling that John must at least finish grammar school. Although father and children were not aware of it, mother, because of illness, had only completed the sixth grade. Mother’s poor health has continued throughout her marriage.

John, the youngest of three children, lived at home with his parents, and thirteen year old sister. His nineteen year old brother is in the army overseas.

Mother was unable to accept John’s problem as emotional, and projected onto the school the blame for his failure, stating that the school discriminated against him. John was frequently enuretic but mother showed little or no concern regarding this. Mother was unable to remember John’s developmental history, but remembered getting toilet training over with as soon as possible.

John liked to play outdoors, was very active, both at school and at play, and made friends easily. Mother did not permit him to play with everyone. She always knew where he was. John was not considered “fresh” by mother, as his sister was. He was helpful and considerate of mother when she was not feeling well.

Mother had a fear of the water and did not let John go in swimming without his father being present. She was afraid to let him go to camp. Maternal grandparents had been living in the home for some time and maternal grandmother was very strict, mother felt she herself, was not, and thus a problem of discipline was present.

John had many ways of getting around mother to get his own way. He watched TV until fairly late at night, and stayed out to play after dark, both of which mother disapproved. Mother had finally caught onto his complaining of feeling ill to avoid attending school. Mother continued to tuck John in bed every night, having done so with her older boy until he was sixteen. She liked to cradle John in her arms and rock him.

Throughout most of the time mother was in treatment at the clinic, she continued to contact the school regarding John’s work. When
it was suggested that the worker would be willing to do this
mother readily agreed, but continued to do so herself until im-
provement was noted in John's work.

Mother was able to talk only slightly about herself and her back-
ground. Her childhood was lonely, and because of poor health
she left school. She had hoped to attend a conservatory but
because of family finances went to work in a laundry where her
hand was caught in a mangle.

Father was seen as giving little time to John, due, to a great
extent, to his long working hours as a truck driver. He occasion-
ally took John to an athletic club where they both played ball.

John was tested by the psychologist and was also seen by him in
treatment seven times. Psychological testing showed John to have
a full scale I.Q. of 100. The Rorschach showed an extremely well
defended boy who completely suppressed all affect, and whose energy
was spent in maintaining his high defenses. He was unable to re-
veal his hostility overtly. The record was indicative of anxiety,
insecurity, inadequacy and fearfulness. There were conflicts and
anxieties concerning his feelings for a mother figure. He had not
yet accepted a masculine identification nor had he rejected it.
His poor school progress could thus be a method of expressing
hostility to his parents in an indirect fashion.

The therapist felt that John's reading background was adequate
and felt his need to punish his mother was the cause of his poor
school work. He showed hostility towards his maternal grandmother
living in the home. He verbalized his resentment of his mother's
overprotection, particularly in the area of restricted activities.

DISCUSSION

Mrs. Moore's chief concern was over John's failure at school and what
it would mean to John to be with younger children if he again failed. She
showed much hostility toward the school and her neighbors, feeling that
they discriminated against John. She continually helped him at home with
his school work, but by the end of treatment was able to give this up.

John's school failure appeared to be a need to punish his mother for
her rejecting-overprotecting attitude. He verbalized his resentment of
her forcing him to study, and when mother was able to let up on this, John
began to improve in his school work. John, by failing in school, found a way to get back at mother, for school achievement was the thing she valued and emphasized.

Mrs. Moore found it hard to verbalize her feelings of hostility, showing it chiefly in her restricting attitude in allowing John to participate in few activities. Again John retaliated by using the school. He could fool and act out, for here mother had no control.

John formed a quiet, but rather close, relationship with his male therapist and began to show improvement in his school work.

Mother was able to form only a superficial relationship with the social worker, cancelling many appointments, and finally terminating contact at the point where John was anxious to come and where he was showing improvement. However, further treatment for both was indicated.

The two following cases are those in which the clinic terminated the treatment.

**Thomas West**

Thomas, age seven, the youngest of two children, was referred by his family physician for poor school work and stuttering. He was in the first grade and was repeating part of it. His behavior in school was annoying, and this increased after treatment started.

At intake mother appeared to be a tense, anxious person, who blamed the school for failure to do a good job with Thomas. She was not able to accept, that emotionally, it was possible for children to be younger than their chronological age. She felt her child was "perfectly normal." She felt that her son's being held back would be traumatic for him. She felt the teachers were not equipped to teach him.

As Thomas' speech difficulty also had a physical basis, he had a speech therapist, but mother also gave him help in this area, as she did with his school work.

Mother found it difficult to relate to her worker and showed much
resistance to the clinic. After the eighth visit, both parents came to talk with Thomas' therapist at which time they were told that his difficulty in school was purely emotional. This was difficult for them to accept, but it was felt to be necessary to help them involve themselves further in the treatment process. It was after this visit that mother was able to express that Thomas was not the completely adequate boy she had pictured him to be. At this time, with difficulty, she was able to relax her standards somewhat.

After many months of treatment, Thomas was returned to the first grade from the second where mother had insisted he be placed. Thomas appeared much happier in this placement and his school work showed marked improvement. Mother could not understand how it was possible for him to be happier in the first grade.

Mother appeared to have a very close attachment to her own parents, particularly her father. She frequently went to New York to visit them. Mother disliked her mother-in-law with whom she lived when first married, but while in treatment expressed a desire to be more patient with her as she was now old and sick.

Thomas wanted to be, and was, the center of attention in his home, and any acting out here was always minimized by mother. He would go to any length to get his parent's approval. Mother admitted to very strict standards in the home and stated that she used discipline on Thomas. Mother felt she was over-indulgent with the children.

Father was seen at clinic twice. These visits were at his convenience because of his work. Father had a responsible and well paid position, yet, he refused to pay a clinic fee commensurate with it. Mother felt father was a mature person, but one who was easily upset. The clinic staff felt this was true. Father was home very little, and used his weekends to rest, so that he had little time to spend with Thomas. Father was not in favor of clinic treatment, and could never really accept Thomas' trouble as being emotional. His attitude appeared to be one of annoyance at what was going on.

Thomas was tested early in treatment, and received an I.Q. of 124. His Rorschach indicated that he was at a pre-oedipal level of development, and there was little discrimination between parents. People in the environment were threatening, and there were indications of a desire to escape from a dominant mother. Indications were that this dominance had a seductive element, which was causing his disorganization and regression.

Thomas was seen by the pediatrician for eleven months, and contact was terminated because of the boy's reluctance to continue, and the
fact that improvement was seen in all areas. Thomas was very active in therapy, at first very childishly. As therapy progressed, his behavior became more adult and he was able to talk of his wish to act sometimes like a small boy, and sometimes like a big one. Thomas also discussed his mother's concern over his school work, and felt she worried too much about him.

**DISCUSSION**

Mrs. West was greatly concerned over Thomas' inability to work at school. Although anxious for help, she took some time to see an emotional basis for his difficulties and to form some sort of relationship with her worker. She continually contacted the school and attempted to win the teacher's favor to keep Thomas in the second grade, by bringing her presents.

Mrs. West's overprotective attitudes were evident in her shielding of Thomas from any hurt, particularly with regard to school. She worried about his outside activities, and feared something would happen to him. She gave into his many wishes, and would also cajole him to do things for her.

Mrs. West showed evidences of rejection in her desire for more outside activities, feeling confined to the home, and in her wish to go to work. She was planning to send Thomas to camp for the summer. She was encouraged not to do this in view of the fact that Thomas did not want to go. Mother indicated some preference for her daughter whom she spoke of as being bright and popular.

Mother's social worker felt that, to mother, Thomas was a substitute, in some respects, for father. There appeared to be no close bond between the parents. Father's chief interest appeared to be his work. Mrs. West was felt to be a very lonesome woman. Her relationship with Thomas
appeared to be a somewhat seductive one in that she sometimes allowed him
to sleep with her. She related that this was annoying to father.

As mother was able to involve herself in treatment she relaxed her
standards and her pressure on Thomas, and he began to show improvement in
all areas. However this was very difficult for mother, and as Thomas im-
proved a painful arthritic condition was reactivated.

The third case in this category was a seven year old boy, George
Phillips, who had always had difficulty adjusting in school, was now a
behavior problem and was failing in all subjects. He had an I.Q. of 94,
and had tentatively accepted a masculine identification.

Little was known about mother's background. Father was a nervous,
tense person who spent little time with his son.

Mother was placing a great deal of pressure on her son in the area
of school work, and when this was relieved, improvement was noted. Mother,
however, never saw any connection between her attitude and George's emo-
tional problems.

Overprotection then Rejection

The two following cases are those where the mothers' attitudes were
those of overprotection, followed, as the child grew older, by rejection.
In the first case the clinic terminated treatment and improvement was
noted in both mother and son. In the second case, mother withdrew from
treatment and no improvement was seen.

Oran Levitt

Oran, age seven, was referred to the clinic by a friend. He was
the oldest of two children, having a sister, age five. Other
complaints besides failing in school were, lying and stealing. Oran's attention at school was poor, and he was very active in the classroom. He was repeating first grade and mother blamed the school for his failure.

One of the first things emphasized by mother at intake was that Oran had been planned for. She felt that his problem was insecurity, and she could not understand this, as they had always tried to make him feel secure. Mother gave a complete developmental history. Mother emphasized the importance of Oran's going to college. Both parents were college graduates.

During this interview, mother spoke of Oran's stealing, and felt he did this because he felt insecure. He was destructive of his, and others', possessions. At this time mother spoke of his thumb sucking, and of some jealousy of his sister, but showed little concern about either.

Mother had an unhappy childhood, due to the early death of her mother by suicide. She lived first with relatives, then with a housekeeper, and then when her father remarried she went away to high school. Mother felt her life was lonely, she had few friends, particularly girls, and had never had money. She felt she got along better with men.

Mother identified herself with Oran in many areas where she found fault with him. However, as her relationship with the worker deepened, she became less critical of him. During the course of treatment, mother reported that Oran had given up lying. This was soon followed by his giving up stealing. With the relationship mother was able to form she worked through many of her conflicts around Oran. Prior to that, she was never able to speak of her son in a loving and motherly way.

Mother spoke of father as being a smart and clever man who had always had a good position. His disposition was good, but she felt he had a peculiar sense of humor. Father never considered others when he made plans, and apparently the family did what he wished. Mother emphasized his preference for his daughter, and the little time he devoted to Oran.

In testing Oran received an I.Q. of 127. His Rorschach indicated poor ego strengths. Little conscious anxiety was shown, although there were indications of strong feeling of rejection. Hostility towards both parents was evident, particularly in fantasy.

Oran was seen by a female therapist over a period of seven months. He formed a good relationship with her, and improvement was noted in his speech soon after treatment began. He expressed hostility against his father and sister, but did not verbalize any against
his mother. By termination his therapist felt that he had improved in all areas, and had reached a stable emotional level.

**DISCUSSION**

Mrs. Levitt was able to immediately involve herself in treatment, although at first this was not easy. She came with the idea that perhaps she and father were responsible for his problems, and thus, it was easier for her to look at Oran's problems realistically. Mother's own childhood was unhappy. The values set for her at that time were not easy for her to accept. Although she put emphasis on social prestige, her inclinations did not appear to be in that direction.

Mrs. Levitt found it hard to verbalize her rejection of Oran. It was felt that this was associated with the negative feelings about herself that she projected onto him and found hard to tolerate. Mrs. Levitt spoke of her daughter as being cuter and easier to handle. She complained about such things as Oran's inability to care for his things; his wanting everything he saw; his uneven disposition; lack of friends and inability to adjust to new people. She herself felt that the ideal thing was to combine a career and a home.

Treatment was interrupted for part of the summer, and mother made plans to send Oran to day camp. When he refused to go after the first day, she was able to accept this and allow him to stay home.

I feel that one element that played into Oran's feeling rejected, was his having been sent to nursery school at the time of his sister's birth. Previous to this birth he had been the center of attention. With the birth of a second child both parents seemed to lose interest in Oran, and to give their love and affection to his sister. His failure in school was
therefore a method of trying to gain back the attention and love he had once had.

Oran began to improve in school when his mother became less anxious about him, and began to devote more time to him. Through case work help mother became more accepting of Oran, and he in turn was able to give up the symptoms he felt he needed to get back at his parents.

**Randy Harris**

Randy, who is seven, and the oldest of two boys, was referred to the clinic by a physician, with many complaints, chief of which was school failure. Others were: enuresis, jealousy of his brother, crying, bossy, and poor behavior in school.

During the first month of contact, mother always gave the appearance of being high strung and nervous. She seemed to gain more control as she continued to come. She gave a history of some bizarre behavior on her own part, and was at one point convinced that she was about to die or enter a mental hospital. She resisted clinic treatment from the start, and was never able to look at the relationship between herself and Randy.

Randy, who was in the second grade, was failing in all subjects. He was over-active and destructive in school. Mother blamed the school for these difficulties. Randy's enuresis was a source of annoyance to mother, particularly in so far as it created work for her. Therefore, to punish Randy, she would not change the bed during the night. Mother discontinued using the medicine prescribed for this enuresis.

Mother was not able to accept the fact that there was no immediate improvement in Randy. Father too, had reservations about the clinic, and resisted paying the fee of five dollars. This had been set by the parents as a fee within their means.

Although mother knew Randy enjoyed his clinic visits, she decided to terminate.

Little is known about father. Mother spoke of him as being very smart and capable. At thirty-one, he was the youngest executive in the bank where he was employed. He spent little or no time with his son, and from what mother said, appeared to have little interest in either child.
Randy received a full scale I.Q. of 133 on his testing. His Rorschach showed conflict both with the father figure, and at a deeper level with a mother figure. There were oedipal tensions. Hostility towards his brother was apparent together with guilt feelings about this.

Randy was seen ten times by a female therapist. At the end of this time, mother withdrew. No improvement was noted, and this was felt to be due to mother's unchanging attitude.

**DISCUSSION**

Mrs. Harris was able to verbalize her feelings about Randy, and to say that she gave everything to him his first four years. She thought he was the nicest boy she knew. Mrs. Harris said that she was no longer interested in Randy after his brother was born.

Mrs. Harris showed her present rejection in many ways. She punished him more than was indicated. She screamed and yelled at him. At times, mother made him wash his bed clothes when he wet at night. She deprived him of doing things he might enjoy. Mother spoke of Randy as disrespectful and fresh, and complained about everything he did. Mrs. Harris resented, and became upset when Randy fought with his brother, and yet was unable to do anything about it.

It was felt by the clinic that in many ways Mrs. Harris was upset herself, and if she had been able to, could have benefited from treatment.

Randy's school failure, as well as his enuresis and other problems, appeared to be a way of getting back at mother for her rejection of him. I feel too, that the strong sibling rivalry, with the brother who replaced him in mother's affection, is evidence of his feeling rejected.
Ambivalent

The three following cases presented are those in which the maternal attitude was that of ambivalence. The ambivalent attitudes found in these three mothers, although containing elements of love and hate, were not found to the degree of intensity as were the feelings found in the cases where there was rejection and overprotection. Termination was brought about by the clinic, and improvement was noted in all three cases.

Henry Gould

Henry, who was ten at the time of his referral by the school, was the oldest of four children. A fifth child was born while Henry was in treatment. Henry seemed accepting of his failure and exhibited no feeling about it. This problem had not been noticed until this year.

Henry was born while his father was in service during World War II. Some months after Henry's birth, his mother went to work, leaving him in the care of a neighbor. When father returned home, mother began to have more children. She had had a child every year for three years, and Henry had had to assume some responsibility for them. Along with this, he had many chores to do on the small farm on which the family lived.

Mother was eight months pregnant when she came for intake. She was able to give a good background history of Henry. His early development appeared to be normal. There was some sibling rivalry, but this was not emphasized. Mother had answered all Henry's questions about sex, so the birth of siblings was not felt to have been upsetting to him.

Mother was one of sixteen children, thirteen of whom had lived. She expressed a great deal of resentment against her mother who gave her little love or affection as a small child. The resentment she had for her mother she later transferred to a woman with whom she had lived during high school, and who was now living with her. This woman was old and bed-ridden and it was necessary for mother to care for her.

Mother formed a fairly good relationship with her worker, and missed only two appointments during the course of therapy. These absences occurred while mother was in the hospital for the birth of her child. Father came in with Henry at that time. Mother was
able to express her feelings freely. She felt that the poor relationship Henry had with his father as being partly responsible for his difficulties. Mother expressed some hostility against her husband, and indicated that in her dreams her mother was a symbol for her husband.

The worker felt mother indicated a certain amount of conflict about her role of mother and wife, and that this had a definite influence on her relationship with her son.

Father suffered from migraine headaches, and in the year prior to treatment at the clinic, had been quite ill. He used this as an excuse for not going places and doing things with Henry. Father was seen as a passive, mild man who was dominated first by his mother, and now to some extent by his wife. He told of having always turned his pay over to his mother, and of the fact that she always made decisions for him. He told of the two big decisions he had made since his marriage. Mother spoke of father as not having the same feeling for Henry that he did for the other children. Father was strict with Henry, yelled at him, and if he cried, father spanked him until he stopped. Mother spoke of father's headaches as being caused by emotions, and of how they became worse whenever she was pregnant.

Henry's testing revealed that he had an I.Q. of 106. The Rorschach revealed an emotionally disturbed boy with a personality structure of inhibition and repression, with poor control indicated when under stress. Apathy appeared to be a defense against strong hostility. Strong oral aggressive strivings were suggested, and the problems appeared to be pre-oedipal in origin.

Henry was seen by a male therapist over a period of six months. The main emphasis was to help him to express his feelings. During the third month of therapy another boy, who was active and aggressive, was seen with Henry to see if it would stir up hostility in him. During the second week with this boy, Henry began to act out some. Henry began to show direct hostility and aggression towards his therapist and to carry this, to some extent, home. Treatment was terminated at the beginning of summer, and a camphership was arranged for Henry.

**DISCUSSION**

Mrs. Gould, when she first came to clinic, was at a loss to understand Henry's failure this year, and was anxious that he get help. She was able to look into her own feelings to some extent, and to participate in treatment.
Mrs. Gould was a dominant, aggressive woman, who appeared to have assumed much of the responsibility of the male in the family. She married a weak, sickly man, who transferred his dependency from his mother to his wife.

Mother had many ambivalent feelings about her son. In some ways she overprotected him. This was shown in her concern about the children with whom he played. Her inability to devote her time to him after the birth of her children was, to Henry, a rejection. Mrs. Gould felt guilty about being unable to give Henry more time and attention. However, as she became involved in treatment, she began to give him praise and encouragement for the things he did. Too, she gained more understanding of him.

It was felt by the clinic that Henry's problem was tied up with both father and mother. There was a poor relationship between Henry and his father, and there had been no identification with him. His relationship with mother was a much more positive one.

I feel that Henry's apathy, as indicated by the Rorschach, was a defense against hostility and aggression. He carried this passivity into the learning process, so that the aggression needed to learn was repressed, and thus, failure was the result. In a therapeutic situation Henry was able to lessen the intensity of this defense, and begin to be aggressive.

The two other cases of ambivalent mothers were those of Edward Post and Robert Imbeau.

Edward was referred for school failure and enuresis. His behavior in school was disturbing. The family had always had health and financial
problems and these did have an effect on Edward.

Mother made good use of the case work relationship, and despite difficulty in changing workers, was able to work through many of her feelings. She showed insecurity in her role of wife and mother, and when she was able to clarify this role she was able to support father, who was a weak and passive man, in his role. With the happier home that resulted, Edward began to improve in all areas.

Robert, also age seven, was referred for school failure and stuttering. Mother was able to admit that the stuttering had an emotional basis, but was unable to do so regarding the school failure.

Robert's testing revealed an I.Q. of 121. His Rorschach showed excessive rejection particularly by father.

Mother's attitude toward Robert had many positive aspects, and his problem appeared to be more in the area of relationship with his father, who had never emancipated himself from his own father and mother.

With case work help mother was able to lessen her anxiety about her son. During treatment the relationship between father and son became more positive so that Robert showed improvement in all areas except reading. Because Robert became ill, the clinic terminated the case, and it was never known what motivated the change in father's attitude.
CHAPTER V

SUMMARY AND CONCLUSIONS

Determination of maternal attitudes in the ten cases of boys referred to the Providence Child Guidance Clinic for school failure between 1952 and 1954 constitutes the purpose of this paper. The selection of cases was based on the limitations set beforehand: cases where the client was a boy between the ages of five and ten who was failing in school; and where both mother and child had been in treatment at least five times.

Clinic treatment was oriented towards removing, not only the symptom of school failure, but also the underlying difficulty in the parent-child relationship.

The questions answered are these:
1. What are the maternal attitudes shown toward the child?
2. What are the maternal attitudes toward school failure?
3. What is the relationship between father and child?
4. Is the clinic able to effect a change in the parent-child relationship?

The maternal attitudes found fell into four groups: rejection, rejection by overprotection, overprotection then rejection and ambivalence. Taken as a whole, the attitudes found in these cases appear to have a negative aspect, ranging from severe rejection in the two mothers who rejected their sons, to mild manifestations of rejection in the ambivalent mothers. Of these ten mothers, three withdrew from treatment, indicating their resistance to involve themselves in treatment, and an unwillingness
to change their attitudes. In two cases no improvement is noted in either mother or child. In the third case, despite mother's withdrawal, some improvement is noted in both the mother's attitude and the boy's school progress.

All mothers were concerned to some degree over their child's failure in school because they came to the clinic for help with this problem.

A majority of the mothers, seven, were helping the child at home in an effort to secure improvement in their school marks. At the same time, six of these mothers blamed the failure on the school. The school was blamed by two other mothers who were not helping. We therefore can conclude, as far as this study is concerned, that the mother who gives help to her child appears to intensify the child's insecurity, and in no way helps him to do better work in school, as these children improved when the mother stopped giving this help. This would concur with the findings of Levy and Monroe in Chapter Two when they speak of the feelings of frustration or defeat being intensified when attempts are made to apply pressure.

The ten children varied as to their behavior in the school. In the two cases where the mother's attitude was a purely rejecting one, the boys were quiet and passive in the classroom. Where the mother's attitude was that of rejection by overprotection and overprotection followed by rejection the behavior noted was aggressive. Two of the sons of mothers who were ambivalent were aggressive, the third was passive. No definite conclusions can be drawn from a study of this size as to the way the child is reacting in the school to the way his mother feels towards him. However, it would appear that when there is an element of more than one attitude,
the child acts in an aggressive way in school. The reason for this type of behavior is assumed to be a possible way of getting back at mother in a situation where she has no control, but in a manner which displeases her; or as a means of getting the attention not received at home.

In all ten cases studied, the father was found to have spent little time with his son, and to be lacking in genuine interest in him. In the three cases where mother's attitude was found to be one of ambivalence the emotional problem appeared to be related more to the relationship between father and son than mother and son. Because only three such cases were in this study, this can be stated as a conclusion only in so far as this study is concerned.

The age of both parents had a wide range. Because of this, no definite conclusion as to how their age might affect the children can be drawn.

It was further found that only two boys had achieved any form of masculine identification. Therefore the remaining eight boys were, according to the Rorschach test, in a pre-oedipal stage of their psychosexual development. Thus, their inability to learn may be due to a fixation at an earlier stage in development. This aspect was not the main focus of my study, but it does point to an area for further research, and does add validity to Weisskopf's premise presented in Chapter Two.

We can conclude that it is not lack of intelligence that was causing this school failure, as every boy had at least average intelligence, and six had superior intelligence. Failure, therefore, can be attributed to an emotional cause in all ten cases.

All of these boys were in the latency period, with the majority being age seven. As we have concluded that the school failure was based on an
emotional difficulty, we can further conclude that the statement by Josselyn on p. 9 is correct. This is the age when the results of the child's earlier emotional deprivations will begin to appear.

Since only one case was self-referred, we can conclude from the source of referral in the remaining cases that the mother was not alone able to recognize the need for psychiatric help for her son.

These ten children referred for help were divided as to their ordinal position in the family. Three were the youngest, three the oldest, three the middle and one was the third of four. Therefore, this would tend to show that the attitude the mother has toward her child presumably is not determined by his ordinal position in the family.

As to the factor of repeating a grade in school, eight boys were repeating, or had repeated, a grade. As the boys were still failing at the time of referral, we can conclude that the problem had been in existence for some time, and that merely repeating the school grade would not eliminate the failure.

In eight of the cases studied, the clinic was able to effect a change in the parent-child relationship. The clinic noticed no change in the two remaining cases where the mother withdrew.

This change is noticeable in the fact that the mother, with case work help, was able to effect, to some degree, a more positive attitude toward her son. With this change on the mother's part, and with a lessening of pressure, the child, through psychotherapy, was able to work through his feelings toward mother. He was therefore, free to learn in school.

As this study shows, the mother is the one who must be willing to
accept treatment and to change the environment in which the child lives if
his treatment in a Child Guidance Clinic is to be of any value.

Approved:

David Landy
Research Instructor
## APPENDIX

### Schedule

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<tbody>
<tr>
<td>Age</td>
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<td>Referred By</td>
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<td>Date Opened</td>
<td>Closed</td>
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<td>Grade in School</td>
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<td>Grade Repeated</td>
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<tr>
<td>Duration of School Problem</td>
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<td>Additional Problems Presented</td>
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<td>Mother - age</td>
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<td>Father - age</td>
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<td>Siblings - ages</td>
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<td>Economic Status</td>
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BIBLIOGRAPHY

Books


Periodicals


