1963

The motivation of mothers on the aid to dependent children program to benefit from treatment at a child guidance clinic

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE MOTIVATION OF MOTHERS ON THE AID TO DEPENDENT CHILDREN PROGRAM TO BENEFIT FROM TREATMENT AT A CHILD GUIDANCE CLINIC

A thesis

Submitted by

Eleanor Klau

(B.A., Russell Sage College, 1961)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1963

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES (Cont'd)

CHAPTER I

INTRODUCTION

This is an exploratory descriptive study of ten mothers, at a child guidance clinic who are receiving public welfare under the Aid to Dependent Children Program to examine their motivation for treatment.

In 1960, there were 806,000 families with a total number of 2,320,000 children receiving public welfare under the Aid to Dependent Children Program.[1] The families requiring help from the Public Welfare Department are, in a very real sense, multi-program families, ninety-five out of every hundred of them having a combination of serious problems to which the community gives official recognition.[2] Despite the fact that there are so many of these families having a combination of serious problems which might have an adverse effect on the growth and development of the children, they comprise only a very small proportion of the child guidance clinic population. An exploration of the motivation to benefit from treatment of these ten mothers will reflect on the total Aid to Dependent Children population and will, perhaps, offer an explanation as to why so few come to a child guidance clinic.

---

1 U.S. Bureau of the Census, Statistical Abstract of the United States: 1961 (Washington, D. C., 1961), p. 265.

2 Public Welfare Commission, City and County of San Francisco, Rehabilitation For Independence (San Francisco, 1962), p. 7.

Because of the mother's close involvement with the child, treatment is generally necessary for the mother as well as the child. The mother's motivation to benefit from treatment is an important determinant of the success of treatment and, therefore, must be understood and considered before a case is initially accepted and before the most appropriate means of helping her can be decided upon.

In order to determine whether the findings of this study can be considered unique to the mothers on the Aid to Dependent Children Program, a comparison group was established in which the cases are those of clinic mothers who are not on the program. The matching of the two groups was done on the basis of the children's presenting symptom, age, and sex.

In this study, motivation to benefit from treatment will be defined in terms of the following: the mother's concern about the child's problem; her attitude toward the child; her attitude toward the clinic; and her attitude, as well as the father's toward involvement in the helping process.

These areas will be examined by applying a schedule to the application and diagnostic interviews recorded in the case records. Rating scales will be used to classify the data. The process by which the mothers came to the clinic will also be explored since the mothers

on the Aid to Dependent Children Program do not usually come to a clinic.

The setting for this study is the Douglas A. Thom Clinic for Children situated in Metropolitan Boston. The clinic provides diagnostic, treatment, and consultation services related to the emotional problems of children.

CHAPTER II

THEORETICAL CONSIDERATIONS

This was an explanatory study of mothers, at a child guidance clinic, who are on the Aid to Dependent Children Program with respect to their motivation for treatment.

The Aid to Dependent Children Program, established under the Social Security Act in 1935, is a financial assistance program which provides money to maintain a minimum standard for food, clothing, shelter, and other essentials for children whose fathers are absent from the home or incapacitated, but whose mothers are deemed capable of providing them with suitable homes given family guidance and service. Lack of sufficient money to maintain this standard is the basic criterion for eligibility for this program.

The attitude toward the "needy" and the responsibility of the community to take care of them has changed through the years as a result of historical, economic, political, and philosophical forces. Individuals incapable of self maintenance were, during the eighteenth and nineteenth centuries, relegated to the status of inferior persons who were inherently bad: they were believed to be poor because they wanted to be poor. Gradually over the years and finalized in law by the passage of the Social Security Act in 1935, there has been the acceptance of the federal

government's responsibility for providing maintenance to meet basic human needs which is a recognition that in our industrial economy certain citizens are denied this right through no fault of their own or because of physical or mental incapacities.

Despite the fact that the government assumes this responsibility and believes it is the right of every person to receive financial assistance under the ADC program if they meet the eligibility requirements, many people still carry the 18th and 19th century attitudes toward the "needy" over to the present day. They attach the stigma of inferiority and inherent badness to ADC recipients even though many of the recipients have problems which are not very different from those of the lower-lower class.

Some of these views are held by people in the social welfare field, but certainly not by all. However, it is often said of casework with ADC clients that it must have limited goals and modest expectations over long periods of time. It is often assumed that casework cannot substantially help the less intellectual, less well-educated, or less verbal client and it is generally believed that these are the usual characteristics of the ADC clients.[1]

---

1 Margaret A. Dennis and Charles C. Goodrich, "Co-ordinated Medical Care for Public Welfare Clients: Implications for Medical Social Work Practices," Social Casework XLIV (January, 1963), p. 14.

All of the families on ADC had to lack sufficient income to maintain their basic human needs in order to be eligible for the program. It is generally accepted that a low income group is particularly susceptible to the tides of economic prosperity and depression, to the traumas of death, desertion and incapacitating illness. We can expect that any group at the bottom of the economic heap would suffer more keenly these conditions which lead to dependence on public support of all kinds and on ADC in particular.[2]

What is this group like and what are the conditions which faced them? In 1960, the average income per family was $2,500 a year.[3] Depending on the particular locality, the proportion of Negroes on the ADC program varied from fifty to ninety-two per cent.[4] The average age of the mothers is thirty-three years and the average family includes three children.[5] In sixty-six per cent of the families, the fathers were absent from the home because of divorce or legal separation (13.5%), separation without court decree (8.0%), desertion (18.0%), imprisonment (4.6%),

2 Greenleigh Associates, Inc., Agenda to Facts, Fallacies and Future: A Study of the Aid to Dependent Children Program of Cook County, Illinois (New York, 1960), p. 86.

3 U.S. Bureau of the Census, Statistical Abstract of the United States: 1961 (Washington, 1961), p. 265.

4 Greenleigh Associates, Inc., Op. Cit., p. 105.

5 City and County of San Francisco, Public Welfare Department, Rehabilitation For Independence (San Francisco, 1962), p. 2.

out of wedlock status (20.3%), and other absences (1.1%). The remaining thirty-four per cent of the fathers were either dead or incapacitated.[6]

Nearly all of the families on ADC present to the community and to themselves the problem of financial dependency. But they also present many other social problems many of which are related to the disruption caused in the family by the absence of the father.

In San Francisco, where an intensive study of the characteristics of ADC families was conducted by Community Research Associates, it was found that nearly all of the families were dependent for food, clothing, and shelter or having medical problems for which they required help at public expense. Marital problems were present in 90.4 per cent of these families and child rearing problems, which would include neglect, foster home care, and adoption were found in 17.4 per cent of the families. In 6.7 per cent of the families, child development problems such as delinquency, truancy, school drop out, and mental institutionalization were present. There were problems of adult adjustment in 11.1 per cent of the families.[7]

In the study done by Community Research Associates, it was discovered that one-half of all of the ADC families required help from social welfare specialists. More than one-tenth needed psychiatric services

6 Alfred J. Kahn, "Child Welfare: Trends and Directions," Child Welfare Journal XLI (December, 1962), p. 462.

7 City and County of San Francisco, Public Welfare Department, Op., Cit, p. 14.

and two in five required medical services.[8] Despite the fact that so many required help, they all did not receive it. For instance, less than one per cent of the children were receiving help from child adjustment centers.

In view of the fact that many people attach the stigma of being inferior and bad to ADC recipients, and because many persons in the welfare field feel that casework cannot substantially help ADC clients, the writer felt that it was important to examine the motivation of these mothers to benefit from treatment compared to other mothers at a child guidance clinic. Their motivation to benefit from treatment is one indication of their desire to improve their situation and it is also an important factor in the success of their treatment. A study of their motivation might also explain why so few come to child guidance clinics.

At a child guidance clinic, treatment of the mother is usually a necessary component of treatment with the child because of the interrelatedness of the child's problems to those of his mother. Whether or not the help of the staff is successful will depend on many factors. One of the most important relates to the readiness and capacity of the parent and child who are needing help to make effective use of these skills to

---

8 Ibid., p. 5.

bring about changes in themselves and to give meaning to these changes in their day to day functioning.[9]

No one can effect change in another person without the participation of the person in whom the change is desired. The readiness and capacity of the mother to make effective use of the clinic services to bring about change will be taken together and referred to as her motivation to benefit from treatment.

Dr. Van Amerongen found in a review of forty unsuccessfully treated cases that the conscious wish for treatment expressed by the mother and the theoretical treatability of the child had been an insufficient basis upon which to make the decision for clinic treatment.[10] Some parents may be able to take the initiative in seeking help, but this move does not of necessity mean that either child or parent will utilize the help that is available.

If it is not possible to assess motivation solely on the basis of the conscious wish for treatment expressed by the mother or the fact that parents have taken the initiative in seeking help, how can it be assessed?

Assessment of the mother's motivation must be meaningfully related to her current problem situation, as casework service has as it

9 Frederick H. Allen, M.D., Psychotherapy With Children (New York, 1942), p. 243.

10 Suzanne T. Van Amerongen, "Initial Psychiatric Family Studies," American Journal of Orthopsychiatry XXIV (January, 1954), p. 81.

function helping people who are experiencing difficulty in some aspect of their social adjustment.[11] Studies have been conducted which define this further and which ascertain the patterns of motivation which are associated with the success or failure to use clinic help. The discussion which follows will explore more fully these patterns of motivation.

How a person perceives and feels his problem will greatly determine what he will want and be able to do about it. A person must feel more uncomfortable than comfortable with a problem in order to want to do something about it. The discomfort will push him to gain greater comfort and motivate him toward the goal of solving the problem. It will also sustain the willingness to work at the problem solving.[12] The mother's concern about the child's problem is, therefore, one factor contributing to her motivation to benefit from treatment.

A study by Lake and Levinger found that motivation to benefit from treatment is related to the degree to which the parent sees the problem himself rather than with its having been brought to his attention by the community. Those parents whose concern is activated by forces outside the community are less likely to have serious and stable concerns

11 Lillian Ripple, "Motivation, Capacity, and Opportunity as Related to the Use of Casework Service: Plan of Study," Social Service Review XXIX (June, 1955), p. 38.

12 Helen Harris Perlman, Social Casework, A Problem-Solving Process (Chicago, 1957), p. 186.

about the child's problems.[13]

The duration of the problem and the efforts made to cope with it such as what the mother thought or actually tried to do, herself or with the help of others, is also related to her degree of concern about the problem. If the problem has been present for quite awhile and she has not made many attempts to cope with the solving of it, we can assume her degree of concern might be low.

The role played by the father in the mother's current problem solving effort and the role played by other "significant" persons who have an influence on the upbringing of the child are factors influencing the mother's motivation to benefit from treatment.

In a study of forty children who applied for treatment at the Douglas A. Thom Clinic for Children over a period of a year, and who were unsuccessful treatment cases, it was found that one factor in the lack of success was that the father's attitudes were not taken into consideration.[14]

It is important to have an understanding of the structure of the family and the role played by the father or other "significant" persons in the problem solving effort because it furnishes a key for the

---

13 Martha Lake and George Levinger, "Continuance Beyond Application Interviews at a Child Guidance Clinic," Social Casework XLI (June, 1960), p. 305.

14 Van Amerongen, p. 73.

prediction as to what action or decision will be taken when there is a disagreement within the family group.[15]

Parents, and mother substitutes, such as grandmothers or aunts, interact not only with the child but also with representatives of the clinic with whom they come in contact. If there is a negative interaction between these persons and the agency, the patient's chances of getting therapeutic help or of retaining therapeutic gains may be seriously impaired. The father's or "significant" other person's antagonism toward the clinic might weaken the mother's motivation to benefit from treatment.[16]

Carl Rogers has said that:

> "If we were to gamble on the outcome of treatment in the case of a problem or delinquent child and had to base our gamble on one item alone, we would do best to disregard the child entirely and investigate simply the way in which the parents behave toward the youngster and the attitudes which they hold toward him."[17]

Despite intensive effort by skilled workers, the destructive attitudes and ways of behaving on the part of parents toward their children show a stubborn resistance to change.[18] In a study conducted by Helen

15 Otto Pollack, Social Service and Psychotherapy for Children (New York, 1952), p. 41.

16 Ibid., p. 73.

17 Carl R. Rogers, The Clinical Treatment of the Problem Child (Boston, 1939), p. 182.

18 Ibid., p. 184.

Witmer, it was found that among clinic cases where there was extreme rejection of the child on the part of the parents, there was no improvement in sixty-four per cent of the cases. At the other extreme, when a normal affectional relationship existed between the child and his parents, and where the faults were those of inadequate handling of the child, only three per cent of the cases were unimproved. Between these two extremes were varying parental attitudes with treatment results also showing a variation. Aside from extreme rejection, the most unsatisfactory situation seemed to be present when the mother was highly protective of the child, finding in him an outlet for her emotion.[19]

The mother's involvement in the helping process is another indication of her motivation to benefit from treatment. Motivation consists of more than just the mother's wanting treatment. "It also consists of seeing one's self as a potential force in shaping one's ends; of charging one's self with taking an active part in making whatever changes must come about; and of mobilizing one's self to act."[20]

In a study by Lake and Levinger, the hypothesis was confirmed that continuance in treatment is positively associated with the mother's desire to see change in herself as well as in her child or spouse.[21] The

19 Ibid., p. 183.

20 Perlman, p. 186.

21 Lake and Levinger, p. 305.

assumption was that if parents desired to see change in their own behavior as a means of dealing with the child's problems, they would have a better understanding of the true problem since parents usually play a part in the problems of their children. In their ability to assume some responsibility for the problem, they would be more likely to tolerate its treatment than those who are unwilling to assume the responsibility.[22]

In the same study, it was also found that the more willing the client is to participate in the initial interviews, the more likely he is to remain in a future relationship.[23]

The most telling revelation of the client's motivation to benefit from treatment is his responsive behavior to firsthand knowledge of the agency and to his experience with its caseworker. The client may have mobilized himself to come, but his motivation may be dissipated when he finds that the solutions he seeks are not readily available or that the kind of help that is offered involves demands as well as rewards.[24]

Pronounced ambivalence and anxiety about psychiatric help expressed openly or indirectly is usually one factor in unsuccessful treatment cases.

In this theoretical discussion, reasons why the motivation of ADC mothers to benefit from treatment was selected for study were

---

22 Ibid.

23 Ibid., p. 306.

24 Perlman, p. 186.

presented. The characteristics of the general ADC population were examined as well as the areas which define motivation such as concern about the problem, the role played by the father and "significant" other persons in the mother's current problem solving effort, the mother's attitude toward her child, her involvement in the helping process, and her attitude toward the clinic.

CHAPTER III

METHODOLOGY

PURPOSE OF STUDY

The purpose of this study is to determine if the mothers, at a child guidance clinic, who are on the Aid to Dependent Children Program are unique in respect to their motivation to benefit from treatment compared to other mothers at the clinic. It is believed that a fuller understanding of the elements which combine to make up the motivation of these mothers will lead to more effective diagnostic and treatment services for them. It will also offer, perhaps, a partial explanation of why so few of the mothers on this program come to a child guidance clinic.

THE SETTING

The Douglas A. Thom Clinic for Children, a pioneering agency in the child guidance field founded in 1921, provides consultation, diagnostic study and treatment services for families and children with emotional problems.

The clinic considers for treatment services, children between the pre-school and adolescent years, although the majority of children referred to the Thom Clinic are between the ages of five and twelve. Families who have sufficient financial resources are encouraged to seek private treatment as the fee at the clinic is based on gross income and the number of children in the family.

An attempt is made to select only those families who can benefit from and utilize the services available.

> "Of the children referred to us, we treat all whom we believe we can treat from the standpoint of our estimate of their pathology, and of willingness and ability of their parents to permit change in their child and from that of the capacity of our clinic facilities."[1]

Due to the limitation of staff time and the increased demand for services, the clinic has had to adopt a more selective policy in which only those cases are accepted for whom outpatient therapy once a week is an indicated and reasonable approach. The decision to adopt this policy was the result of some years of struggling to treat effectively a large majority of children who suffered from very serious character disturbances or pre-psychotic and psychotic states and who came from families with long standing social or emotional problems. The clinic realized that for many of these children the traditional scheme of

1 Annual Report for the Year 1957, The Douglas A. Thom Clinic for Children, Inc. (Boston, 1957), p. 11.

psychotherapy once a week with the child and casework with the mother were often not sufficient to bring about the desired changes in the child's condition.[2]

The seriously disturbed children who come from families with long standing social or emotional problems and who are not able to benefit from therapy once a week may be referred elsewhere, for instance, to a residential treatment center or a psychiatrically-oriented day school.

The selective and diagnostic process begins at the point of the telephone referral and continues through the application and diagnostic interviews. Both parents, or just the mother if there is no father in the home, are seen in an application interview. The mother and child are then seen separately, three times, in diagnostic interviews. The father is usually seen once. These interviews offer the staff an opportunity to assess the family member's strengths and weaknesses, family relationships, and the motivation and ability to involve themselves in the helping process. At any point in these contacts the family may be referred elsewhere if it is felt that they cannot benefit and utilize the services offered by the clinic.

A treatment plan is made based on the diagnostic impressions.

2 Annual Report for the Year 1960, The Douglas A. Thom Clinic for Children, Inc. (Boston, 1960), p. 12.

One or both parents is always included in treatment because the child's difficulties are related to the problems of the parents and their relationship to the child. However, the treatment plan may differ for different parents and families. A team approach is frequently employed with the parents being seen by a social worker, and the child by a psychiatrist or psychologist. This is not a rigid procedure, though, because assignments are made in accordance with the client's needs and the workers' ability so that each of the disciplines sees parents and children. Some parents may be seen in a consultation-guidance type of interview, or in an attempt to stabilize the multi-problem family there may be weekly contact for six months to a year followed by regular consultation to keep track of the family.

While treatment for the child and mother continues to be a major part of the clinic's program, the clinic has extended its function by providing consultation services to other agencies in the community such as a nursery day care center. Research is also an integral part of the clinic program providing a greater understanding of particular types of difficult families and the investigation of newer treatment techniques. Thom Clinic also serves the function of being a training clinic for the three disciplines of psychiatry, psychology, and social work.

SAMPLE SELECTION

There is no organized classification system available at the

clinic to determine who are the mothers on the Aid to Dependent Children Program. It was possible to select the cases by examining the address on the duplicate copy of bills sent out by the clinic because the fees for this group are paid by the Department of Public Welfare.

There were two requirements in the selection of these cases. They were that the mother had not previously been to the clinic and that she had been seen, at least, through the diagnostic interview series. No attempt was made to follow these cases into treatment or final disposition. A total of ten cases was found. All of these mothers at some time in their contact with the clinic had been on the Aid to Dependent Children Program. Information as to the length of time they had been on the program was not available.

It was necessary to determine if the mothers receiving public welfare under the ADC Program had a combination of factors influencing their motivation to benefit from treatment which were unique to them. A comparison group was, therefore, selected against whom these factors could be contrasted.

The comparison group was matched to the mothers on the ADC Program on the basis of the children's symptomotology, sex, and age. They were first matched on symptomotology to minimize the differential effects of a particular problem on their motivation to benefit from treatment. Children of the same sex and age generally present common

developmental problems to the mother. To minimize the differential effect of the developmental problems with which the mothers are faced, matching was also done on the basis of sex and age.

The mothers on the ADC Program brought their children to the clinic with a variety of problems. The problem about which the mother was most concerned and for which she sought help was the one used in the matching of the two groups.

Four of the mothers on the ADC Program were concerned about their children's aggressive behavior. In all of these cases, the mother mentioned that the child was having difficulty both at home and at school. Two mothers came for help because their children were exhibiting anti-social behavior. Their main concerns were fire setting and destructive behavior to property. One mother sought help because the mannerisms and habits of her child disturbed her. Another complained of her child's soiling. The child's fear of going to school was the presenting problem of one mother. Another was quite upset over the fact that her daughter wanted to dress as a boy and act like a boy.

It was possible to select and match a comparison group on the basis of the problems which have just been enumerated. Although there is a similarity between the two groups in regard to the sex and age of the child, it was not possible to match these characteristics exactly.

Eight children, whose mothers are on the ADC Program, are

boys and two are girls. In the comparison group, nine are boys and only one is a girl. A case was not available in the comparison group of a girl who wanted to dress as a boy. As a consequence, a case was selected of a boy who wished to dress as a girl.

The children range in age from five to ten years. One-half of them in each group are eight years or older. The age appearing most frequently in the group of mothers on the ADC Program is eight, and in the comparison group, it is ten. Most of the children in both groups are the eldest of their sibline with the position of second child occurring most frequently after this.

Following the selection of cases, a schedule was applied to the face sheet information, referral data, and diagnostic study (see Appendix). Data were obtained regarding the mother's concern about the problem, her attitude toward the child and the clinic, her attitude, as well as the father's toward involvement in treatment and the process by which she came to the clinic. Rating scales were developed to classify these data.

CHAPTER IV

DATA PRESENTATION

This is a study of mothers receiving public welfare under the Aid to Dependent Children Program who come to a child guidance clinic. Because mothers on this Program do not usually come to a child guidance clinic, attention will be focused on their motivation to benefit from treatment. The general areas that will be covered in this chapter are: personal characteristics of the mother, the process by which the mother sought help, her concern about the child's problem, the role of the father and other persons in her problem-solving effort, her attitude toward the child, her willingness to involve herself in treatment, and her attitude toward the clinic.

In order to determine if the findings can be considered unique to the mothers on the ADC Program, another group of mothers was selected from the general clinic population against whom the findings could be contrasted. In this chapter, the letters ADC will refer to the group of mothers who are on the Aid to Dependent Children Program. The term COMPARISON will refer to the group of mothers who are not on this Program.

BACKGROUND CHARACTERISTICS

Since the two groups were matched only on the basis of the children's symptoms, sex, and age, the background characteristics of the mothers could be considerably different so that it is important to compare them. The background data was obtained from information presented by the mother at the time of the referral call and application interview when she initially discussed the family situation. The description of background characteristics will include the mother's age, race, religion, marital status, socio-economic level and the number of people in the home.

Age

The average age of the mothers in each group is thirty-four. There is a slight difference, however, in the age range. The ages in the ADC group are from twenty-four to forty-six years while in the COMPARISON group they are from twenty-seven to forty-six years. Despite the variation in age range, the distribution in both groups is identical. Half of the mothers are thirty-five years or older. Both the ADC group and the COMPARISON group are therefore similar in regard to the age of the mother.

The age of mothers in this sample is comparable with the

general clinic population in which the majority of mothers are found to be in their mid-thirties.[1]

Race

Three out of ten in the ADC group are Negro and the remainder are white. All of the mothers in the COMPARISON group are white. This is a significant difference between the groups.

Religion

The religious affiliation of the two groups is similar. The majority of mothers are either Catholic or Protestant. In both groups, the proportion of mothers of the Jewish faith is smaller than any other religion. This is interesting in view of the fact that a study made of the total clinic population in 1953, showed the majority of mothers to be Jewish.[2] The following table shows the ages and religious affiliations of the two groups.

TABLE 1

AGE AND RELIGION OF MOTHERS

ADC				COMPARISON			
Age	Catholic	Protestant	Jewish	Age	Catholic	Protestant	Jewish
20-24	-	1	-	20-24	-	-	-
25-29	1	-	-	25-29	1	1	1
30-34	1	2	-	30-34	-	1	1
35-39	1	2	1	35-39	2	1	-
40 +	1	-	-	40 +	2	-	-

1 Annual Report for the Year 1953, The Douglas A. Thom Clinic for Children, Inc. (Boston, 1953), p. 7.

2 Ibid.

Marital Status

No mother in the ADC group was currently living with her husband. All of the mothers in the COMPARISON group were currently living with their husbands. The requirements of the ADC program state that in order to be eligible for financial aid, the father must be incapacitated or out of the home. Six of the ADC mothers at the clinic gave divorce as the reason for the absence of the father with three of them stating separation was the reason. Separation is defined as the mutual consent of both partners to leave each other. Out of wedlock births or desertion were not mentioned. The majority of the ADC fathers have been out of the home five years or more with the average length of time being six years.

Socio-economic level

The socio-economic level of the two groups is significantly different. The ADC group has less formal education, is engaged in occupations with less status associated with them, and has smaller incomes. These measures of socio-economic level are interrelated and in some respects interdependent. For instance, the occupations are usually dependent on level of educational attainment and in turn the income is usually dependent upon occupation. It is not surprising, therefore, that the ADC group is lower in all of these things.

The majority of ADC mothers have not completed high school while the majority of COMPARISON mothers have graduated from or received a partial college education. No mother in the first group has attended college but one mother has attended a business school and another a school for design and pattern making. The fathers in the ADC group have had less education than the COMPARISON. The majority of ADC fathers have not completed high school. One father is a graduate of high school and another went to a technical school. In the COMPARISON group, half have graduated from high school and a third have had graduate and professional education.

There is a similarity in the level of educational attainment between mothers and fathers in the ADC group. In the COMPARISON group three more mothers than fathers have had partial or complete college education. But, those fathers who have had advanced education have reached a higher level of attainment than the mothers.

TABLE 2

OCCUPATION OF FATHER

Group	Unknown	Unemployed	Unskilled Semi-Skilled	Skilled	White Collar	Administrative personnel	Professional
ADC	2	2	4	2	-	-	-
COMPARISON	-	-	4	1	1	2	2

There is a similarity between the two groups as four fathers in each group are unskilled or semi-skilled workers. The difference is

apparent though, as we see that six of the COMPARISON have occupations which, in our culture, we consider of higher status than unskilled or semi-skilled while only two fathers in the ADC group do. In these two cases, the fathers are both skilled workers. One is a carpenter, the other a plumber.

The average income for those in the ADC group is $2,600 a year. Six out of ten receive $2,200. One mother receives $6,200. The income is based on a predetermined standard of basic needs and adjusted to the number of children in the family. The mother who has an income of $6,200 has five children and when computed as income per child, she receives the same amount per child as do the others in the group.

The average income of the COMPARISON group is $5,400. The distribution is not as skewed as in the other. Two families have income between $3,100-$4,000. One, income between $4,100-5,000, and four between $5,100-6,000. There are three families whose income is between $7,100-8,000.

Although the income in the ADC group is considerably lower, none of the mothers was employed outside of the home. In the COMPARISON group, two were employed full time and one part-time. The reason, in two cases, for working outside the home, was to supplement the family income. The third mother said that it gave her an opportunity to get away from the children. Generally, it is difficult for ADC mothers

to supplement their income by working outside of the home. There would not be additional income because their earnings are deducted from their welfare allowance.

Composition of the Home

ADC mothers tend to have smaller families. About half of the mothers in each group have two children, but nine of the ADC have three children or less and only six of the COMPARISON have three children or less. The average ADC family includes 2.7 children while in the COMPARISON family it is 3.2 children.

In only two instances were there others than the family of procreation living in the household. This occurred two times in the COMPARISON group. In one home a niece on the maternal side was present and in the other a maternal grandmother.

PROCESS OF SEEKING HELP

The ADC mothers who come to a child guidance clinic differ from most of the ADC population in the sense that this particular group is not usually treated at this type of clinic. It is therefore important to know why these mothers sought the help of the clinic and the process by which they came.

Six mothers in each group mentioned presenting problems which in some way would bring the children to the attention of the community. All of these children came to the attention of the community through the

schools. They either disrupted the classroom or were so frightened of the teacher that she became concerned. In one case where the boy set fires in the school, his behavior was eventually brought to the attention of the courts.

The remaining four mothers in each group mentioned presenting problems which were of concern only to them and have not brought the children to the attention of the community. It should be pointed out here that the writer is only referring to the presenting problem. Other problems may be present about which the parent is not as concerned or has little awareness.

The following table shows who referred the mothers to the clinic. A favorable attitude toward the referral source is helpful in establishing a more positive relationship to the referred agency.

TABLE 3
REFERRAL SOURCE

Referral Source	ADC	COMPARISON
Psychiatric Agency	5	5
Social Agency	3	1
School	2	4
Self referral	-	-

In both groups, one-half of the mothers were referred by psychiatric clinics for children. This is true of the total clinic population where many of the children referred for treatment come from other psychiatric clinics. Of those referred from the school, three were referred by

a school social worker or guidance counselor and one by a teacher. No ADC mother was referred directly by the Public Welfare Department, but in one case the public welfare worker made a recommendation to a family service agency where the mother was a client that she seek help for the child. It appears from the data regardless of the presenting problems, as they were similar in both groups, that the ADC mothers tended to be referred more from established mental health agencies in the community while the COMPARISON group were referred more from places where they have day to day contact such as the school.

One-half of the ADC group had been referred elsewhere first, while in the COMPARISON group almost three-fourths had been referred elsewhere first. This is, at least, one indication that this ADC group has not been discriminated against more in terms of receiving service than the COMPARISON group. In both groups, where the mother had been referred elsewhere, most of the mothers did not receive help because the referral source did not feel their services were appropriate or the waiting list was too long. One ADC mother did not follow through on a referral because she felt that City Hospital was recommended only because she was receiving public welfare. A COMPARISON father had a professional association with one of the clinics and therefore was referred elsewhere and the psychiatrist of an ADC mother left and she was also referred elsewhere.

CONCERN ABOUT THE PROBLEM

This study is focused on the ADC mother's motivation to benefit from treatment at a child guidance clinic. One important consideration in the use of service is the mother's concern about the child's problem. The determinants used in assessing the mother's concern will be her stated degree of concern, willingness to come to the clinic, the duration of the problem, the amount of activity used in handling the problem, and prior attempts to solve it.

Stated Degree of Concern

TABLE 4
STATED DEGREE OF CONCERN

Group	High	Moderate	Low
ADC	4	5	1
COMPARISON	6	-	4

The mothers with a high degree of concern expressed a great deal of discomfort and anxiety about the situation. For example, one mother said "I'm at the point where I'm ready to jump out of a window" or another would lie awake nights thinking about her child's behavior. A moderate degree of concern is illustrated by the mother who said, "I'm concerned and anxious to get help." But, she occasionally tolerated her son's delinquent acts. The mothers with a low degree of concern tended to understate and deny their discomfort. One mother said of her son's problems, "I didn't think too much of his firesetting as his brother has done it for awhile." She was quite cheerful discussing many of the

problems. It is quite evident that fewer ADC mothers than mothers in the COMPARISON group have a low degree of concern.

The mother's statement of and concern about the problems of her other children will now be examined in order to compare it with the degree of discomfort she manifests over the specific child who was brought to the clinic.

TABLE 5

CONCERN ABOUT PROBLEMS OF
OTHER CHILDREN IN FAMILY

Problems	ADC	COMPARISON
No Problems	4	6
Problems - Concerned	2	1
Problems - No Concern	4	3

A mother who would come under the heading of "no problems" is one who either did not mention her other children, stated that they had no problems, or spoke of her children as having attributes which were good. Under the heading of "problems, but concerned" would be, for instance, the mother who said "My oldest daughter always gives me a hard time. She is demanding and nervous." An example of "problems, but not concerned" is the mother who said that her youngest boy wets the bed, is nervous and cries easily, but "he is a good boy and doesn't give me trouble."

More mothers in the ADC group spoke of problems with their other children than did the COMPARISON group. There does not seem

to be a significant difference between the two groups in regard to their concern or lack of concern about their other children's problems. However, of those who were not concerned, two expressed a low degree of discomfort about the presenting problem while none of the mothers who were concerned about the other children's problems expressed a low degree of discomfort about the presenting problem.

Mother's Willingness to Come to Clinic

TABLE 6
CONDITIONS UNDER WHICH MOTHER CAME TO CLINIC

Group	External Pressure	Suggestion
ADC	4	6
COMPARISON	3	7

The condition under which the mother came to the clinic is not necessarily the same as the referral source. The former refers to the way in which psychiatric care for the child was presented while the latter refers to how the mothers got to the particular clinic.

The majority of mothers in both groups, although slightly less in the ADC group, decided to seek psychiatric help for their children on the suggestion of another person. In many cases, the mother was concerned about the child's behavior and asked the advice of another person who suggested she seek help. A particular clinic was not necessarily mentioned. In some cases, the person volunteered the advice without the mother asking, but it was done in a helpful manner leaving the

decision to the mother. In the ADC group, three mothers sought help on the advice of the school, two on the suggestion of physicians in the outpatient department of a hospital, and one on the advice of her psychiatrist. A pediatrician suggested seeking psychiatric help for the child in five of the COMPARISON families. The school and the church were the source of suggestion for two mothers in this group.

External pressure was considered to be present when an individual or institution strongly recommended psychiatric help for the child or made it conditional or obligatory. In both groups, the school most frequently exerted external pressure. The teachers, rather than suggesting it, made psychiatric evaluation or treatment mandatory if the child was to remain in school. One mother came under pressure exerted by the Public Welfare worker and in the COMPARISON, a mother came under the pressure of the court.

Of all the mothers who came to the clinic under pressure, about three-fourths came with a presenting problem which was, in some way, brought to the attention of the community. There was no significant difference between the two groups in this respect. This explains why the source of external pressure was so frequently the school. That two mothers came under pressure with a presenting problem which did not come to the attention of the community is interesting. There may have been secondary problems which brought the child to the attention of the

community but about which the mother was not as concerned or she may have had a greater need to deny these problems.

One factor in successful treatment is a desire on the part of the client to want to do something about her problem. If an external source has to apply pressure in order for the mother to seek help, it is possible to infer that the desire is not very great.

Let us now examine the relationship between the conditions under which the mother came to the clinic and the degree of her concern. Logically, those mothers who came under pressure, who did not have a great desire to do something about the problem, will have low concern. Conversely, those who desire to do something about the problem will have a higher degree of concern.

TABLE 7

RELATION OF STATED DEGREE OF CONCERN AND CONDITIONS OF MOTHERS COMING TO CLINIC

	Degree of Concern					
	High		Moderate		Low	
	ADC	COMP.	ADC	COMP.	ADC	COMP.
Pressure	2	1	1	-	1	2
Suggestion	2	5	4	-	-	2

Although the sample is small, the trend of the data supports this assumption. Two mothers in COMPARISON group who voluntarily desired to do something about the problem had a low degree of concern. Perlman's explanation is that desire without discomfort, without any

inner sense of wanting to strive, "is the mark of the immature, wishful person, he who depends on others or on circumstances to work for his interests."[3] Another exception, more meaningful for this study, is that three ADC mothers came under pressure and have a high or moderate degree of concern. They did not desire to do anything about the problem; yet, they manifest discomfort. It is possible to say that this degree of concern and discomfort is not related solely to presenting problem but to other factors.

Duration of Problem

Table eight shows the number of years the mother waited after recognizing the problem, to bring the child to the clinic.

TABLE 8

DURATION OF PROBLEM

Number of years	ADC	COMPARISON
1 year or less	5	2
2-3	2	4
4-5	3	4

More mothers in the ADC group bring their children to the clinic sooner after the problem is recognized than in the COMPARISON group. One might speculate that part of the reason the ADC mothers tend to come sooner is related to the specific incident of their husbands leaving the home. Faced with an acute situation, the equilibrium of these mothers may have been disturbed, and they were less able to cope with their

3 Helen Harris Perlman, Social Case Work (Chicago, 1957), p. 187.

child's problems and their own. This speculation was not proved true by the findings in this study. There is no relationship between the specific time the mother decided to come to the clinic and the specific incident of her husband leaving the home. In one-half of the families, it was four years after the father had left the home that the mother recognized the child's problem. Two mothers recognized the child's problem two years after the father had left. Three mothers recognized it, one, three, and six years, respectively, after the father had left the home.

TABLE 9

RELATION OF DURATION OF PROBLEM AND DEGREE OF CONCERN

	Concern					
	ADC			COMPARISON		
Duration	High	Moderate	Low	High	Moderate	Low
1 year or less	2	2	1	1	-	1
2-3 years	1	1	-	3	-	1
4-5 years	1	2	-	2	-	2

The mother's handling of the problem in the past and her prior attempts to solve are two other indices to her concern about the problem. These two areas will now be examined.

Amount of Activity in Handling Problem

TABLE 10

HOW MOTHER HANDLED PROBLEM IN PAST
(Amount of Activity)

Group	Maximum	Moderate	Minimal
ADC	1	6	3
COMPARISON	5	4	1

A maximum amount of activity is illustrated by one mother who first tried to reason with the child, then spanked and yelled at him, and then deprived him of things he enjoyed. As a last resort she sent him to his room. Moderate activity is exhibited by the mothers who made some efforts to handle the problem. An example is the mother who spanks and yells at her son, and yet she frequently finishes the tasks which he was supposed to do. The mother who ignores the problem, or handles it by constantly giving in to the child would be employing a minimal amount of activity.

Considerably fewer mothers in the ADC group handled the problem with a maximum degree of activity. Rather, they handled it with more of moderate or minimal amount of activity than the COMPARISON group.

Prior Attempts to Solve Problem

Almost all of the mothers in each group had discussed the problem with other persons or agencies before deciding on psychiatric help for their child. Some had discussed it with several people. Many had gone to these sources of their own volition but a few went under pressure. There is not enough information available as to what the recommendations had been to determine how the mothers utilized this help.

TABLE 11

PRIOR ATTEMPTS TO SOLVE PROBLEM

Source	ADC	COMPARISON
None	2	2
Public Welfare	-	-
Social Agency	2	1
Psychiatrist	1	-
School	1	3
Physician	2	4
Friend or relative	4	-
Church	-	1

Two mothers in each group did not mention discussing the problem with another person outside of their immediate family. The ADC mothers who consulted with a social service agency or with a psychiatrist did not go to these sources for the express purpose of discussing the child's problem; they were already receiving treatment for themselves. The mother in the COMPARISON group had gone to a family service agency expressly for her child's problem. The school as a source for consultation refers to school social workers or guidance counselors.

Although the mothers spoke with a variety of people about the child's problem, the ADC group tended to consult more with friends and relatives while the COMPARISON group consulted more with their physicians. The Public Welfare worker was not consulted by any ADC mother. The Public Welfare worker is a social welfare resource that every ADC mother has access to and with whom she has contact at least every six months. For some reason, these mothers either did not want

to avail themselves of the opportunity or the worker, more interested in the financial aspect of his job, didn't provide a climate where the mother felt comfortable enough to speak of her concerns.

It is not unusual for ADC mothers to have contact with various agencies in the community. This writer felt it was important to investigate resources in the community that these mothers had used for problems other than that presented by the current situation. These findings are quite significant.

Nine mothers in the ADC group had utilized the services of either a social agency, a psychiatrist, or a medical facility, and some had gone to more than one. Only one mother in the COMPARISON group has sought help for other problems and she utilized the services of a medical facility. She took one of her children to an eye clinic for exercises.

Let us examine the reasons for the ADC mothers utilizing these services. Six were clients at social service agencies. Of these six, three mothers went for help because of marital difficulties, two went because they placed a child for adoption or placed a child in foster home care, and one mother sought the help of Traveler's Aid because of difficulty in moving from one city to another. Two mothers received psychiatric help. And two had made use of medical facilities in the community. Of the latter, one mother was afflicted with polio while in her

early thirties and required intensive physio-therapy in the home, the other contracted tuberculosis and remained in a sanatorium for six months.

Every mother in the ADC group sought the help of the Public Welfare Department. However, only six mothers commented about their contacts with the Public Welfare Department. Some of their comments were: "receiving aid makes me feel inferior, I'm not happy", " "Sometimes it's difficult, they don't give you enough money," or one mother commented on her fear that her check would be cut off if her worker found out that she had a steady boyfriend. All of the mothers in this group presented to the Public Welfare Department the problem of dependency--financial dependency. But as we have seen they also presented many other social problems for which specialized services were required.

ROLE PLAYED BY FATHER IN PROBLEM SOLVING EFFORT

A common characteristic which differentiates the ADC mothers from most of the other mothers at the clinic is the absence of the father from the home. Therefore, it is important to consider the effect this might have on their motivation to benefit from treatment.

Despite the fact that in the COMPARISON group the marriages are intact, the majority of families do not have a satisfactory marital adjustment.

In six out of ten of the COMPARISON families, the degree of marital harmony is low. This is indicative of predominately negative feelings on the part of both partners toward each other. In one family there were frequent separations with the mother returning to her parent's home for several months at a time or in another, there were severe arguments over the father's lack of participation in the family, and a lack of respect for the other partner's feelings. In two families there was a moderate degree of marital harmony. For example, in one family there were periodic arguments where both partners would yell at each other over trivial things. These arguments would go in cycles with things leveling off for awhile and then beginning again. Only one family had a positive degree of marital harmony. It was also the only family where the mother had previously been married. The parents showed a great deal of consideration and respect for each other. They spoke of working together on problems and trying to reach solutions which would be satisfactory to both of them. In one family there was insufficient evidence to make a judgment.

These findings are not unusual in a child guidance clinic where the classical setting for the behavior problem and anxiety-ridden child is the precariously balanced, rejecting or neurotically tied family.[4]

4 Gordon Hamilton, Psychotherapy in Child Guidance (New York, 1947), p. 276.

TABLE 12
ROLE PLAYED BY FATHER IN
PROBLEM SOLVING EFFORT

Group	Supportive	Impeding	No contact	Insufficient Evidence
ADC	3	1	4	2
COMPARISON	3	2	-	5

Although there is insufficient evidence in seven cases, the trend of the data shows a similarity between the two groups even though the ADC fathers are absent from the home. In both groups, the fathers are more supportive than impeding. The fathers who are supportive display behavior or attitudes conducive to the mother's problem solving efforts. One father in the COMPARISON group, for instance, was anxious to come to the clinic because he wanted to follow through on the school's recommendations. Of the three fathers in the ADC group who were supportive, two were willing to come to the clinic to discuss the problems and one, whose wife is a cripple, went so far as to say that he would bring her to the clinic once a week if it was necessary.

Two COMPARISON fathers and an ADC father played an impeding role. The latter would encourage the child's problem behavior against the mother's wishes. The other two fathers said that they were definitely against the clinic because it was for crazy people or it was felt that the mother was making problems where none existed. There were four ADC fathers who did not have contact with their families.

Role Played By "Significant Others" in Problem Solving Effort

Because in the ADC group the fathers are not living in the home, there is the possibility that these mothers might turn more to others for help with their children's problems. The role of these other people might have an influence, therefore, on the mother's motivation to benefit from treatment.

It was not possible to obtain this information in all cases, but from the evidence that is available, it appears that there is a similarity between the two groups.

Four mothers in the ADC and six in the COMPARISON group didn't mention the attitude of other "significant" persons. A "significant" person is one who has some influence on the upbringing of the children. Two ADC mothers mentioned, respectively, a grown son and a maternal grandmother who were supportive. One COMPARISON mother mentioned a teacher who was supportive and "wonderful for her son." Four mothers in the ADC group and three in the COMPARISON spoke of "significant" persons impeding their problem solving efforts. In all but one case, the maternal grandmother hampered the mother's efforts. The exception, a boy friend of one of the ADC mothers, was afraid the mother would talk about him at the clinic which might upset the balance in their relationship.

In both groups, the maternal grandmother was the most

frequently mentioned (7 cases) "significant" person, and when mentioned, she almost always played an impeding role. In the families where the maternal grandmother was impeding, the mother seemed to have a dependent-hostile relationship with her. She valued maternal grandmother's opinion and approval, but the maternal grandmother would always criticize her handling of the child which evoked a great deal of anger on the part of the mother.

More mothers may have mentioned persons who were impeding rather than supportive because the persons who impeded her efforts presented more of a problem and were, therefore, of more concern to her.

Table 13 shows the relation of role played by father and "significant others" in problem solving effort.

TABLE 13

RELATION OF ROLE PLAYED BY FATHER AND "SIGNIFICANT OTHERS" IN PROBLEM SOLVING EFFORT

	Father					
	Supportive Father		Impeding		Insufficient Evidence	
Other	ADC	Comp.	ADC	Comp.	ADC	Comp.
supportive	1	-	1	1	1	-
impeding	1	2	-	-	3	1
insuf. evid.	2	1	-	1	1	4

Two of the ADC and three of the COMPARISON mothers are in a conflict. For instance, one mother in each group would be impeded in her problem solving efforts by the child's father and encouraged by the maternal grandmother. The relative influence of the father or the "significant other" would depend on the family relationships, etc. How

this would affect the mother's motivation to benefit from treatment is difficult to say, but it should be taken into consideration.

ATTITUDE TOWARD CHILD

The attitude of the mother toward her child is an important determinant in assessing her motivation to benefit from treatment. The question confronting the therapist is to what extent treatment can affect parental attitudes toward the child and so improve the social functioning of the family. The question confronting the mother is to what extent does she want to change her attitudes toward the child.

TABLE 14

MOTHER'S ATTITUDE TOWARD CHILD

	Attitude			
Group	Accepting	Overprotecting	Ambivalent	Rejecting
ADC	2	1	3	4
COMPARISON	2	3	2	3

Accepting is a positive recognition and permission for the needs of others. For example, one mother said her child "was a lovable cuddly baby and he is a delight to her now."

Overprotecting indicates a need to shelter the child unrealistically from environmental influences. One mother does not let her son play by himself because she is afraid he might get hurt. Another mother is very indulging of her son and keeps him close to her, yet there are elements of rejection in her overprotectiveness because she has always had a disdain for baby boys.

Ambivalent is when both positive and negative feelings are indicated but neither predominates. For example, the comment "He is an active, restless child who irritates me sometimes, yet I want to be a good mother to him."

Rejecting indicates the withdrawal of libidinal investment in the needs of another. One mother said of her son, "I seriously considered foster home placement. In many ways, I hate him."

Generally, the attitudes of the mothers toward their children are similar in both groups except that the ADC mothers are less overprotective of their children.

Sometimes, one child in a family seems to suffer so much more than the others. One can only assume that this child touches off the same problem that the parent herself has. The child may remind the mother of someone or may be an extension of her hidden impulses. "The problem may be transmitted from mother to child through the stream of unconscious motivation."[5]

Because of the nature of the separation from their husbands, the ADC mothers may have more negative feelings toward them which are displaced to their children. In the following table, the mothers' attitudes toward the child's father are examined.

---

5 Ibid., p. 289.

TABLE 15
ATTITUDE TOWARD FATHER

Group	Positive	Ambivalent	Negative
ADC	-	4	6
COMPARISON	2	7	1

There is a significant difference between the two groups. The ADC mothers are more negative in their attitudes toward the child's father than the COMPARISON group. Some negative comments were, "I never should have married him, he drank, didn't work, and did not support the family." Or, "I had a miserable life with him and got 'rid' of him before the child was born."

It is interesting that four of the ADC group were ambivalent in their attitudes. One of these mothers described the childs father as unstable with a vicious temper and said "I can't understand why I put up with him, but I loved him." Two mothers, both in the COMPARISON group, had positive attitudes. One said, "we see eye to eye on a lot of things and he is good to me."

TABLE 16
THE RELATION OF ATTITUDE TOWARD FATHER AND CHILD

Child	Attitude toward Father: Positive		Ambivalent		Negative	
	ADC	COMP.	ADC	COMP.	ADC	COMP.
Accepting	-	-	-	2	1	1
Over Prot.	-	1	-	2	1	-
Ambivalent	-	-	1	2	2	-
Rejecting	-	1	2	1	1	1

When the attitude toward the father is compared to the attitude toward the child, it is difficult to see a trend in the total sample or between the two groups. It is not possible to say from the comparison of the total sample that the mothers who have a negative attitude toward the father tend to have more of a rejecting or ambivalent attitude toward the child. The ADC group who have ambivalent attitudes toward the father tend to have more of a rejecting and ambivalent attitude toward the child than do those in the COMPARISON group.

Let us look at whether the destructiveness toward the husband is actually displaced to the child. The following table examines who the mother feels the child is similar to.

TABLE 17

TO WHOM CHILD IS SIMILAR

Group	Mother	Father	Maternal Grandfather	Insufficient Evidence
ADC	3	5	-	2
COMPARISON	4	2	1	3

The number of mothers who felt that the child was similar to them was not very different between the two groups. One child reminded the mother of herself because they were both domineering. Another mother said that she had gone through the same phase as her daughter is now going through, but it was not as bad.

The trend of the data indicates that more of the ADC mothers feel that their child is similar to the father than do the COMPARISON

group. Comments such as "he is lazy, just like his father" or "he looks and talks just like his father" are examples of this.

There is more evidence of destructiveness being displaced when the attitude toward the father and child is compared in the group of mothers who felt the child was similar to the father. In no case where the child was similar to the father was their an accepting attitude toward the child. Two mothers in the ADC group and two in the COMPARISON who were ambivalent toward the father were respectively rejecting and overprotective of the child. No mother in the COMPARISON group who identified the child with the father had a negative attitude toward the father, but three of the ADC group did. Of these, two were ambivalent and one overprotective toward the child.

MOTHER'S INVOLVEMENT IN TREATMENT

At a child guidance clinic the mother and child are both usually seen in treatment. One might say that the minimum conditions for therapy would be readiness to let the child take help. In still more favorable situations, parents should have a readiness to take and use help for themselves, and for a therapeutic result, they should become able to see the interconnection between the child's problem and their own behavior and needs.[6]

6 Martha Lake and George Levinger "Continuance Beyond Application Interviews at a Child Guidance Clinic," Social Casework, XLI, (June, 1960), p. 305.

Because ADC mothers do not usually come to a child guidance clinic, it is important to consider whether they are as motivated to involve themselves in the treatment process. Such factors as the goal in coming to the clinic, the assumption of responsibility for the problem, and who will do the work at the clinic will now be examined.

Goal in Coming to Clinic

TABLE 18

MOTHER'S GOAL IN COMING TO CLINIC

Group	Change Desired: Child Only	Self and Child	Self	No Change
ADC	3	6	-	1
COMPARISON	3	5	1	1

The two groups are similar in respect to their goals in coming to the clinic. Most of the mothers in both groups desired to see a modification of their own behavior and attitudes as well as the child's. There was some ambivalence in regard to modification of their own behavior, but the ambivalence was weighted more toward change. For example, at first, one mother was a little hesitant about being seen as she felt it was the child who needed help. However, after she had talked about herself for a little while, she said that she realized that she needed help in her relationship to her child.

Three mothers in each group only wanted to see a modification in the behavior and attitudes of the child. These mothers usually concentrated on the child's problem and were reluctant to talk about themselves.

One mother said that she would like something done so her son will behave better in school, denying that she would have to change in order to accomplish this.

A mother in the COMPARISON group wanted help mainly for herself. Her desire in obtaining treatment was to "be happier and better able to enjoy her family."

One mother, in each group, did not want to see any change in herself or the child. In the ADC group, the mother verbally expressed her desire for help yet she did not want to see change in behavior. She wanted her child placed or for someone to take the responsibility for him. The other mother was quite threatened by the discussion of the child's needs and the fact that he was quite inhibited, depressed and withdrawn. She was not able to recognize that change was necessary.

Responsibility for Existence of Problem

The ability of the mother to see the interconnection between the child's problems and her own behavior and needs is an important factor in her treatability and willingness to involve herself in treatment. One way of determining this, or at least part of it, is to look at whether the mother assumes the responsibility for the existence of the problem. The following table shows to whom the mother mainly attributes the problem.

TABLE 19

RESPONSIBILITY FOR EXISTENCE OF PROBLEM

Source	ADC	COMPARISON
No one	1	-
Self	4	6
Father	2	1
Maternal grandmother	1	1
Teacher	-	2
Adverse social and Economic Condition	1	-
Other	1	-

The mothers in the ADC group assume less responsibility for the existence of the child's problems than the mothers in the COMPARISON group. When the existence of the problem was attributed to the father, the mothers felt, for example, that the child had problems because he had never seen his father or that the problem was a result of the father being punitive and resentful of the child. The maternal grandmothers, who have close contact with the families, were blamed because they indulged the children too much. Teachers were accused of causing the problem because of their attitude toward the child in school. "Other" refers to the mother whose son had a high fever and became delirious. She thought this was the cause of his problems.

It is interesting that only one ADC mother attributed the problem to adverse social and economic conditions. Since their income and level of education are so low, one might expect that they would be confronted with these conditions frequently. The mother who did attribute the problem to adverse social and economic conditions felt that her son had

problems because they had to live in a project where he had contact with a lot of problem children who were a bad influence.

The mother's goal in coming to the clinic and who she attributes the problem to will now be compared.

TABLE 20

RELATION OF RESPONSIBILITY OF PROBLEM AND DESIRE TO SEE CHANGE

Respon. for Problem	Child		Child-Self		Self		No Change	
	change							
	ADC	Comp.	ADC	Comp.	ADC	Comp.	ADC	Comp.
Self	-	-	4	4	-	1	-	1
Others	2	3	2	1	-	-	1	-

Most of the mothers in each group who assumed the responsibility for the problem desired to see a change in their behavior and attitudes as well as in their children. With the exception of three mothers, those who project the problem on to others tend to want to see change only in the child. These three mothers projected the problem on to the fathers and were willing to see change in their behavior as well as in the child.

The following table shows mother's attitude toward who will do the work at the clinic. The more willing the mother's participation in the initial interviews, the more likely she is to remain in a future relationship.

TABLE 21

MOTHER'S ATTITUDE TOWARD WHO WILL DO WORK

Group	Clinic	Clinic-Self	Self
ADC	4	4	2
COMPARISON	6	2	2

Fewer mothers in the ADC than in the COMPARISON group expect the clinic to do all of the work and more of them are willing to share the work with the clinic. The mothers who want the clinic to do the work feel as if by some magic of the clinic, problems will be worked out. "I want to be told what to do" is their attitude. Those who want to share the work are willing to examine their involvement with the child, but would like suggestions and direction. The mothers who see themselves as doing the work are also willing to examine their involvement with the child. But, they are able to make constructive comments using the worker as a sounding board.

ATTITUDE TOWARD CLINIC

In essence, it is the clinic who offers treatment to the mother so that her attitude toward the clinic would be one factor which would influence her motivation to benefit from treatment.

A positive attitude toward the clinic is exemplified by the mother who said that she found it helpful to talk things over and she was not as scared as she had been before. An ambivalent attitude is shown by the mother who was very anxious to come to the clinic for help yet cancelled two appointments before she was ready to come in. The negative attitudes are easier to classify. For instance, one mother complained to the worker that the clinic was not helping her. She wanted help in changing housing projects, not in the mother-child relationship. Others

have said that they do not like to talk with social workers because they "pry" too much or that psychiatry is only for people who are really disturbed.

TABLE 22

ATTITUDE TOWARD CLINIC

Group	Positive	Ambivalent	Negative
ADC	3	1	6
COMPARISON	3	4	3

There is a significant difference between the two groups. The ADC mothers are more negative and less ambivalent in their attitude toward the clinic than the COMPARISON mothers.

CHAPTER V

SUMMARY AND CONCLUSIONS

This has been an exploratory, descriptive study of ten mothers at a child guidance clinic who are receiving public welfare under the Aid to Dependent Children Program with reference to their motivation to benefit from treatment.

ADC mothers are not usually in treatment at a child guidance clinic. It was believed that a study of their motivation for treatment would reflect on the total ADC population and, perhaps, offer some explanation as to why so few are involved in treatment at a child guidance clinic.

In order to see how specific the findings in this study were to the mothers on the ADC Program, a comparison group was selected from self-supporting families. In selecting the comparison group, the children were matched on the basis of presenting symptom, age, and sex. A schedule was then applied to the application and diagnostic interviews recorded in the case records, and rating scales were used to classify the data obtained.

The setting for this study was the Douglas A. Thom Clinic for Children situated in Metropolitan Boston. The clinic provides diagnostic, treatment, and consultation services related to the emotional

problems of children.

The mothers in the two groups differed significantly in regard to many of their background characteristics.

These differences may obscure the meaning of the findings. The only similarities between the two groups of mothers were their age and religion.

No marriage in the ADC group was intact while all of the marriages in the COMPARISON group were intact. This difference is due to the eligibility requirements of the ADC Program. To be eligible for financial aid, the father must be absent from the home or incapacitated. There are a few self-supporting mothers at the clinic whose marriages are not intact, but they did not meet the requirements for the selection of the comparison cases and, therefore, were not included in this study.

The socio-economic level of the ADC group is lower than the COMPARISON group. Financial need is one of the criterion for eligibility on the ADC program. In cases where the income of families is not sufficient to meet a minimum standard of living, the wage earners are usually discriminated against economically or are lacking education or occupational skills with which to further their earning capacity. It is not surprising, then, that the ADC group has had less formal education and is engaged in occupations that have less status associated with them. The income they receive is also lower than the COMPARISON group

because the ADC Program only provides financial assistance to meet the minimum basic human needs.

With respect to the race of the two groups, a significant difference was found. Three of the ADC mothers are Negro while none of the mothers in the COMPARISON group are Negro. Although this percentage of Negro clients at the clinic is high, Negroes comprise a large proportion of the total ADC population.

An analogy is sometimes made between ADC mothers and "the woman who lived in a shoe and had so many children she didn't know what to do." The inappropriateness of this analogy is evident in this study. The ADC mothers at the clinic tend to have smaller families than the mothers in the COMPARISON group. Most of the mothers in the former group have two children, while in the latter group most of the mothers have three or more children.

The process by which the mothers came to the clinic was explored. It was found that more ADC mothers were referred from established mental health agencies in the community than COMPARISON mothers. One possible explanation for this finding is that many mothers on the ADC Program are known to several different mental health agencies because of their contacts with these agencies. Fewer mothers in the ADC group had been referred elsewhere before coming to the clinic. This is, at least, one indication that the ADC mothers had not

been discriminated against more than other mothers at the clinic in terms of service.

In this study, five broad areas defined motivation for treatment. The areas were: the mother's concern about her child's problem; the role played by the father and other "significant" persons in the mother's current problem solving effort; the mother's attitude toward her child; the mother's involvement in the helping process; and the mother's attitude toward the clinic. Items on the schedule delineated these areas further.

It was found that the ADC mothers were not as concerned about their children's problems despite the fact that they had more overt concern than the COMPARISON mothers. Their overt concern tended to be superficial, while the concern of the COMPARISON mothers was more fundamental to a desire to benefit from treatment.

The ADC mothers spoke of more concern about their children's problems, however, some of the mothers in this group who stated a high degree of concern also came to the clinic under pressure. These mothers did not desire to do anything about the problem, yet, they manifested discomfort. It is possible to say that their discomfort and concern were not related solely to their children's problems but to other factors.

The ADC group also came to the clinic sooner after the problem

was recognized than the COMPARISON group. The indication that this group came to the clinic sooner is due to other factors beside the specific crises of the father, leaving the home the conditions under which the mothers came to the clinic, or the stated degree of concern. It may be that this group did not recognize the behavior of their children as a problem until it reached the more acute stages. The ADC mothers as a group may also come to the clinic sooner because they are more willing and ready to depend on others for the solution of their problems.

In an attempt to handle their children's problems by themselves, the ADC group did not employ as much activity as the COMPARISON group. The amount of activity employed by the mother in coping with the problem is an indication of her real concern about the problem. If the amount of activity is minimal, one may assume that the mother is not very concerned about the problem.

It appears that there is a similarity between the ADC group and the COMPARISON group in respect to the role played by the father and other "significant" persons in the mother's current problem solving efforts. In both groups, more fathers played a supporting role than an impeding role. In several of the COMPARISON families, the fathers gave no indication as to the role they played. Because it is highly unlikely that these fathers played no role, one can assume that they either passively supported or impeded the mothers problem solving efforts.

Because the marriages in the ADC group were not intact while those in the COMPARISON group were intact, one might be led to believe that there would be a wide variation in respect to the roles played by the fathers in the mothers' problem solving efforts. Although the COMPARISON families had marriages which were intact, the majority of these families evidenced a low degree of marital harmony. It is not unusual to find this in a child guidance clinic where the classical setting for the behavior problem and neurotic child is the precariously balanced, rejecting, or neurotically organized family.

In this study, it was not possible to assess the structure of the family to determine the extent to which the role played by the father would influence the mother's motivation to benefit from treatment. However, it can be assumed that a supporting role would contribute to her motivation while an impeding role might tend to weaken it.

In regard to the role played by other "significant" persons in the mother's current problem solving effort, the two groups are similar. A "significant" person is one who has had some influence on the upbringing of the child. The maternal grandmother was most frequently mentioned as the "significant" person in both groups, and she generally played an impeding role in the mother's current problem solving effort.

It was found that the mothers in the ADC group evidenced a little more willingness and ability to change their attitudes toward their

children to benefit from treatment than the mothers in the COMPARISON group since they are slightly less overprotective of their children. It was pointed out earlier, that, aside from extreme rejection, the more resistance to changes in attitude and behavior toward the child seemed to be present when the mother was highly protective of the child.

The ADC group is less willing to involve itself in the treatment process than the COMPARISON group. One important consideration in the assessment of the mothers' involvement in the treatment process is the degree to which they assume responsibility for the existence of their children's problems. If the mothers are able to assume responsibility for the problem, they will be more likely to tolerate its treatment than those who are unwilling to assume responsibility. It was found that the mothers in the ADC group assumed less responsibility for the existence of the problem than the COMPARISON group.

The mothers in the ADC group show more overt signs of willingness to involve themselves in the treatment process than the COMPARISON group despite the fact that they have less of the covert, and more fundamental, signs which are the true determinants of their willingness to involve themselves in treatment.

It was found that the ADC group expected the clinic to do less of the work and was more willing to share the work with the clinic than the COMPARISON group. This overt manifestation of their involvement could

be misleading if it was not considered in relation to the aforementioned factor.

The finding that the ADC group was more willing than the COMPARISON group to share the work with the clinic might be explained, in part, by the fact that significantly more mothers in the ADC group had utilized the services of social agencies or psychiatrists in the past. Their past contacts with these agencies and personnel may have made them more aware of what the clinic expected from them and what role they were supposed to play.

A significant difference was found between the two groups in respect to their attitudes toward the clinic. The mothers in the ADC group were more negative and less ambivalent in their attitudes toward the clinic than the mothers in the COMPARISON group. There are many factors that could account for this difference. A few of them will now be enumerated.

The ADC group has a lower socio-economic level. A higher socio-economic level may bring with it more sophistication toward psychiatry and child guidance clinics in general. The ADC mothers were not as concerned about their children's problems and, therefore, they might not have been as anxious to make use of the services at the clinic. It has also been pointed out that the ADC group had utilized more agencies in the community for other problems so they may have come

preconceived attitudes toward the clinic which were negative. Fewer mothers in the ADC group assumed responsibility for the existence of the problem and they, therefore, might not have been as willing to be a part of the treatment process. Since one of the services offered by the clinic is casework with the mother, the ADC mothers may have been more reluctant to accept what was offered by the clinic.

CONCLUSIONS

In this study, it has been found that mothers at a child guidance clinic who are receiving public welfare on the ADC Program are unique in respect to their motivation to benefit from treatment compared to other mothers at the clinic.

The ADC mothers displayed more overt manifestations of a high degree of motivation than other mothers at the clinic but less of the covert, and more fundamental, attitudes and ways of responding which are the real determinants of motivation to benefit from treatment.

The mothers in the ADC group spoke of being more concerned about their children's problems than the other mothers, but did not show by their actions that they wanted to do as much about correcting the problem. In the diagnostic study, the ADC mothers implied, by what they said, that they were more willing to involve themselves in the treatment process, but did not assume as much responsibility for the existence of their children's problems as did the other mothers. This

is one indication that they are not as motivated to involve themselves in the treatment process in order to benefit from treatment. The ADC mothers had more negative attitudes toward the clinic which would certainly influence their motivation to benefit from treatment as it is the clinic that offers treatment services.

It appears from the findings in this study that, as a group, ADC mothers at a child guidance clinic are not highly motivated to benefit from treatment. It can be assumed that the ADC mothers who did not come to the clinic are even less motivated. This may be a partial explanation of why so few mothers on the ADC Program are in treatment at child guidance clinics.

Because the ADC mothers are not as highly motivated as other mothers at the clinic, it seems that the clinic will make exceptions for this group and accommodate them. This has several implications. In the future, close attention should be paid to the covert, but more fundamental, indices of the motivation of ADC mothers as compared to their overt manifestations of motivation to better assess their readiness and ability to change in order to benefit from treatment. Further studies should be undertaken with a larger sample of ADC mothers to determine the amount of accommodation a clinic can make to this group before a point is reached where the services of a child guidance clinic are no longer beneficial or appropriate.

accepted May 1963
Marvin J. Schlaffer

APPENDIX

APPENDIX

SCHEDULE

I. BACKGROUND CHARACTERISTICS

1. Age
2. Race
3. Religion
4. Marital Status
   a. Intact
   b. Not intact
5. Number of present marriages or if separated, number of previous marriages.
6. If separated, separation was due to:
   a. Death of husband
   b. Confinement of husband to a hospital or institution
   c. Divorce
   d. Separation with or without legal decree
   e. Desertion
   f. Never married to father of child
7. If separated, length of time father has been absent from home.
8. Socio-economic level
   a. Income
   b. Educational background of parents
      (1) Has not completed high school
      (2) High school graduate
      (3) Partial college completed or technical school
      (4) College graduate
      (5) Graduate or professional school
   c. Occupation of father
      (1) Unknown
      (2) Unemployed
      (3) Unskilled or semi-skilled worker
      (4) Skilled worker
      (5) White collar worker
      (6) Administrative personnel
      (7) Professional

d. Employment of mother

(1) Not employed outside of the home
(2) Employed full time
(3) Employed part time

9. Composition of home

a. Number of children in family
b. Other members related
c. Other members unrelated

II PROCESS OF SEEKING HELP

1. Referral Source

a. Self referral
b. School (teacher, school guidance counselor, school social worker)
c. Social service agency
d. Psychiatric agency
e. Public Welfare worker

2. Is this first Place referred at present time?

3. If referred elsewhere, why did they not receive help?

a. Agency did not feel their services appropriate
b. Mother did not feel agency was appropriate
c. Other

III MOTHER'S CONCERN ABOUT PROBLEM

1. Who recognized problem?

a. Mother
b. Brought to her attention by the community

2. Conditions under which mother came to clinic

a. External pressure - another person or institution recommended strongly or made it conditional or obligatory that she seek help for child

b. Suggestion - mother was concerned about the problem and asked the advice of another person who suggested she seek help for the child

3. Stated degree of concern

a. High
b. Moderate
c. Low

4. Duration of problem

5. Way by which mother handled problem (amount of activity)

   a. Maximum
   b. Moderate
   c. Minimal

6. Prior attempts to solve problem

   a. No attempt made
   b. Public Welfare worker
   c. Social agency
   d. Psychiatrist
   e. School
   f. Physician
   g. Other

7. Mother's stated concern about problems of her other children

   a. No problems mentioned
   b. Problems but concerned
   c. Problems but not concerned

8. Mother's concern about problems in the past

   a. Marital difficulty
   b. Placement of children for adoption or in foster homes
   c. Psychiatric help for self
   d. Major medical problems
   e. Other

IV ROLE PLAYED BY FATHER IN MOTHER'S CURRENT PROBLEM SOLVING EFFORT

1. If marriage intact, degree of marital harmony?

   a. High
   b. Moderate
   c. Low
   d. Insufficient evidence

2. Role played by father

   a. Supportive
   b. Impeding
   c. Insufficient evidence
   d. Father does not have contact with family

V ROLE PLAYED BY "SIGNIFICANT OTHERS" IN PROBLEM SOLVING EFFORT

1. Relationship of "significant others" to mother?

a. Maternal grandmother
b. Male companions
c. Son
d. Teacher

2. Role played by "significant others"?
   a. Supportive
   b. Impeding
   c. Insufficient evidence

VI ATTITUDE OF MOTHER TOWARD CHILD

1. Mother's attitude toward child?
   a. Accepting
   b. Overprotective
   c. Ambivalent
   d. Rejecting
2. Who is child similar to?
   a. Mother
   b. Father
   c. Mother's side of family
   d. Father's side of family
   e. Insufficient evidence
3. Mother's attitude toward the child's father
   a. Positive
   b. Ambivalent
   c. Negative

VII MOTHER'S INVOLVEMENT IN THE HELPING PROCESS

1. Goal in coming to clinic
   a. Seeking change in child only
   b. Seeking change mainly in self
   c. Seeking change in child and self
   d. Seeking no change
2. To Whom does mother attribute existence of problem?
   a. Her own behavior or attitudes
   b. Behavior or attitudes of child's father
   c. Behavior or attitudes of members of family or close relatives
   d. Behavior or attitudes of persons outside of above but with whom mother or child has direct contact
   e. Adverse social or economic conditions
   f. Other

3. Who will do work?
    a. Clinic
    b. Clinic-self
    c. Self

VIII MOTHER'S ATTITUDE TOWARD CLINIC

1. Positive
2. Ambivalent
3. Negative

BIBLIOGRAPHY

BIBLIOGRAPHY

BOOKS

Allen, Frederick H. Psychotherapy with Children. New York: W. W. Norton & Co., 1942.

Hamilton, Gordon. Psychotherapy in Child Guidance. New York: Columbia University Press, 1947.

Perlman, Helen Harris. Social Casework: A Problem-Solving Process. Chicago: University of Chicago Press, 1957.

Pollak, Otto. Social Science and Psychotherapy for Children. New York: Russell Sage Foundation, 1952.

Rogers, Carl R. The Clinical Treatment of the Problem Child. Boston: Houghton Mifflin Co., 1939.

U.S. Bureau of the Census. Statistical Abstract of the United States: 1961. Washington, D. C., 1961.

ARTICLES

Dennis, Margaret A., and Goodrich, Charles C. "Co-ordinated Medical Care for Public Welfare Clients: Implications for Medical Social Work Practice," Social Casework, XLIV, No. 1 (January, 1963).

Kahn, Alfred J. "Child Welfare: Trends and Directions," Child Welfare Journal, XLI, No. 10 (December, 1962).

Lake, Martha, and Levinger, George. "Continuance Beyond Application Interviews at a Child Guidance Clinic," Social Casework, XLI, No. 6 (June, 1960).

Ripple, Lillian and Alexander, Ernestina. "Motivation, Capacity, and Opportunity as Related to the Use of Casework Service: Nature of the Client's Problems," Social Service Review, XXX, 1956.

Van Amerongen, Suzanne T. "Initial Psychiatric Family Studies," American Journal of Orthopsychiatry, XXIV, No. 1 (January, 1954).

REPORTS

Addenda to Facts, Fallacies and Future: A Study of the Aid to Dependent Children Program of Cook County, Illinois. New York: Greenleigh Associates, 1960.

The Douglas A. Thom Clinic for Children, Inc., Annual Report, 1953. Boston, 1953.

_____ Annual Report, 1957. Boston, 1957.

_____ Annual Report, 1960. Boston, 1960.

Rehabilitation For Independence: A Report of the Family Rehabilitation Program. San Francisco: Public Welfare Department, City and County of San Francisco, 1962.