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A study of maintenance of treatment contact in mothers of runaways

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BOSTON UNIVERSITY
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A STUDY OF MAINTENANCE OF TREATMENT CONTACT
IN MOTHERS OF RUNAWAYS

A thesis

Submitted by

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CHAPTER I
INTRODUCTION

Delinquency is a problem which has become a great concern to every community, and one specific aspect of this problem, running away, has become more important because of the delinquent acts accompanying it and the increase in its occurrence. This is a study of factors related to the maintenance of treatment contact in mothers of twenty-six runaway children seen at the Youth Guidance Center in Worcester, Massachusetts. Due to the great number of cases where treatment was broken it seemed important to return to the initial contacts between the client and the agency to look for factors which might help in assessing situations to determine their treatability. By taking two groups of mothers, one where mothers stayed and one where mothers withdrew from treatment, and examining and comparing them (on an exploratory level) an attempt was made to determine factors in each group which might relate to their remaining or breaking treatment. A schedule of questions was posed to each case. These questions concerned the family unit, the referral, the period of the first interviews, the mothers, the children and the mother-child relationships.

The problem of running away in children concerned the staff of the Worcester Youth Guidance Center, a clinic offer-

ing to children and their parents in the Worcester community¹ diagnosis and treatment of emotional problems. They found in a review of the literature that the material tended to be descriptive rather than dynamic, and there was a divergence of opinion as to the significance, seriousness and meaning of running away.² Because of the active interest on the part of the staff in detecting and investigating early and prodromal symptoms of mental disorders and delinquency, a Runaway Project was set up in April 1955 with the intent of conducting an exploratory investigation of the runaway child with the following specific aims:

"(1) To determine the adjustment and psychiatric status of runaway children: -is running away the act of a normal child or a symptom of emotional disturbance: if it is pathognomic, how extensive and severe is the disturbance, are there prodromal signs, associated symptoms, and what is the prognosis? What is the adjustment of other members of the family?

(2) To determine the personality structure of runaways: do they have consistent personality traits and defenses? Is running away itself a defense? What is the organization and effectiveness of major defenses?

(3) To determine the psychodynamic meaning of the runaway act: what are the primary needs and conflicts involved?

(4) To determine the relationship between running away and other delinquencies: does running away frequently

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1. "Youth Guidance Center" a pamphlet published by the Worcester Youth Guidance Center. p. 1.
 2. Theodore Leventhal, Robert M. Counts, and Eleanore M. Gridley, "Preliminary Report on the Research Project on Runaway Children by the Worcester Youth Guidance Center." An unpublished paper presented at the Massachusetts Society for Research in Psychiatry. Boston, Massachusetts, October 8, 1957, p.1.

precede delinquent acts of a more serious nature? Are there other types of behavior that are frequently prodromal to delinquency?

(5) To evaluate and determine effective therapeutic methods for handling runaways in a child guidance clinic. This would include what useful techniques are for "reaching" and working with families, how extra-clinic resources such as the police and courts can be utilized."³

In this study an attempt will be made to explore the research data to formulate possible factors related to families maintaining or breaking treatment.

3. Ibid, p. 1, 3-4.

CHAPTER II

METHOD

1. The Sample

The families referred to the Research Project came mostly from other agencies. The community was aware of the Center's interest in runaways and referred many cases, other cases were referred by parents either as a presenting problem or as an accompanying symptom.

From the total population of forty-five runaway children referred, twenty-six cases were selected for study. Of these twenty-six, twelve cases stayed in treatment and fourteen withdrew. Ten cases were boys and two were girls of the twelve cases that stayed, in the group that withdrew seven were boys and seven were girls. Cases were selected where there was adequate material recorded and where it was clear that a client stayed or withdrew. If the client stayed or acted on the advise of the Center (for example, referral to another agency) after being seen it was considered "staying" in treatment, and if the client discontinued on his own it was considered "withdrawing." In a few instances there was no space available to continue seeing the clients so that it was not possible to determine if the client would have stayed or withdrawn.

This study was concerned with the initial interviews

between the client and the agency, the intake or diagnostic (consultation) period. The parent(s) was seen by the social worker for one or more interviews to examine with the parent the area of difficulty and their feelings about it, to get a picture of the parent himself, and to begin to form a working relationship. After a period of time the parent was prepared for the child's being seen in a psychiatric interview and for psychological testing. Finally, a conference was held for each case and possible plans discussed. The worker and client then planned between them whether treatment should follow or some other plan should be tried.

A preliminary examination of the two groups showed a great dissimilarity between the boys and girls of the sample; therefore, no attempt was made to compare the boys and girls. Comparison was between the two groups of each sex.

2. The Schedule

A great many of the cases in the Runaway Project did not stay in treatment, and this study attempted to find what factors seemed to be related to maintenance of treatment contact. A review of the literature on runaways and maintenance of treatment helped in suggesting areas of study.

Running away refers to a child's absenting himself from home without his parent's knowledge and/or consent. The duration of the episode varies with each individual, and can range from ten to twenty-four hours to a number of days. The im-

portance of these episodes as well as its meaning to the child varies considerably with different writers. Thom, in talking about "normal youth", feels running away is almost a positive thing, an enjoying of new experience.⁴ Kanner felt running away was not an ordinary form of behavior and in fact was "atypical" behavior; however, he admits that these episodes are often harmless and seen later as amusing.⁵ Reimer feels that running away constitutes a very negativistic and narcissistic disorder.⁶

The meaning this had for the child related to the degree of importance felt by these authors. Thom feels running away is "pushed by a spirit of wanderlust," and exemplifies this in the experiences of Columbus and Byrd.⁷ Kanner speaks of running away as the result of an unpleasant home situation, a response to situations evoking fear, anger or spite.⁸ Reimer feels these episodes represent a denial of the helplessness and insecurity the child feels, a way to satisfy their need for love, hostile aggression and self-esteem.⁹

4. Douglas A. Thom, "Normal Youth and Its Everyday Problems" (New York and London: D. Appleton and Company, 1932) p. 239-46.

5. Leo Kanner, "Child Psychiatry" Second Edition, Second Printing (Springfield, Illinois: Charles C. Thomas, 1950) p. 80.

6. Morris D. Reimer, "Runaway Children", American Journal of Orthopsychiatry, July, 1940, Vol. 10, No. 3, P. 522-26.

7. Thom, op. cit., p. 245.

8. Kanner, op. cit., p. 80.

9. Reimer, op. cit., p. 522-26.

The preliminary findings by Leventhal, Counts and Gridley showed that: (1) the group was homogeneous in the severity of the disturbance, (2) the children studied were seriously disturbed, and their parents were also disturbed, (3) the children had poor control over their sexual and aggressive impulses and are fearful they are going to lose control, (4) the parents are inadequate, find it difficult to control their own impulses, role and identity are confused (the child often taking parental roles), and there is a lot of blatant oedipal material (in the boys' eroticized relationships with their mother were evident), (5) these are difficult treatment cases, often treatment is terminated by the parents. ¹⁰ This study was primarily based on the findings of Leventhal, Counts and Gridley. These findings along with results of other studies formed the basis for the questions on the schedule.

Leventhal, Counts and Gridley found that these were extremely disturbed families. ¹¹ In comparing the two groups it seemed important to look for indices of difficulty in the families and in the individual members. First it seemed to be important to get a glimpse of the family as a unit to see if there was a difference in the two groups. Redlich, Hollingshead and Bellis found some differences in "class III" and "class V" people in their attitudes toward psychiatry.

10. Leventhal, Counts and Gridley, op. cit., p. 7-14.

11. Ibid, p. 11.

The "class III" families were composed of small business proprietors, white-collar workers, and skilled manual workers who had predominantly high school education and who lived in flats and single family dwellings in widely scattered areas. The "class V" families were composed of unskilled and semi-skilled workers who have an elementary education or less and who live in crowded city areas. They found that the lower class people knew less about psychiatry although both classes had attitudes against it; the lower class patients were less likely to change and had a harder time communicating with the therapist; moreover, the therapists tended to disapprove of the things the lower class patients did.¹² This was related to the findings of Burgum which emphasized the values of patient and therapist; that they could be a detriment or an asset to treatment.¹³ This pointed to a possibility that a class difference might effect the use of the clinic services, and questions were set up in the schedule pertaining to the family makeup and socio-economic level, for example, looking at incomes and occupations. Overton found in multi-

12. J. D. Redlich, A. B. Hollingshead, and Elizabeth Bellis, "Social Class Differences in Attitudes Toward Psychiatry." American Journal Of Orthopsychiatry, January, 1955, Vol. 25, No. 1, p. 60-69.

13. Mildred Burgum, "Values and Some Technical Problems Psychotherapy," American Journal of Orthopsychiatry, April, 1957, Vol. 28, No. 2, p. 338-348.

problem families that outside help represented authority which they resented.¹⁴ This posed two possible means of comparison, the first, whether these were families with many problems, was approached in terms of contacts with other social agencies and whether there were problems within the marital relationship. This second means was determined by asking a question about the marital relationship, was this a happy marriage or one with serious marital discord. Burgum's emphasis on values caused the writer to think in terms of a possible religious difference in the two groups. The Gluecks found that children in the families of delinquents were more deprived of maternal supervision through the mother's working than non-¹⁵delinquents. A question was asked concerning the mothers' working, whether this was related to the maintenance of treatment. The Gluecks also found that non-delinquent families had, on the average, fewer contacts with social agencies than the delinquent group,¹⁶ and this suggested the possibility that there might be a difference in the group that stayed and withdrew in the number of previous contacts with social agencies.

Lau found that one reason for discontinuance of treat-

14. Alice Overton, "Serving Families Who 'Don't Want Help'" Social Casework, July, 1953, Vol. 34, No. 7, p. 304-309.

15. Sheldon and Eleanor Glueck, "Unraveling Juvenile Delinquency", (New York: Commonwealth Fund, Hildreth Press, 1950) p. 112.

16. Ibid, p103.

ment in a child guidance setting was that the mothers were not adequately prepared for the contact,¹⁷ and this suggested that a look at the referral and attitudes around it might show a relationship to maintenance of the contact, and their being prepared to receive help. Overton suggested that outside help represented authority to multiproblem families. An attempt was made to determine the source of referral, agencies suggesting they come, and the motive for seeking help. The possibility of determining if there was a difference in motivation in the two groups was further illustrated by Bruch who found that there were parents who felt there was no problem, who were under a pressure to come in but who did not believe in treatment, and the parents who "dropped" their children at the clinic for experts to "cure" as some of the types of parents with whom treatment was difficult.¹⁸ Lau further pointed that waiting for an interview tended to make the mothers feel rejected,¹⁹ so the time between the initial contact and the first appointment was studied; moreover, the importance of looking at transfer of workers was shown by Coughlin who found that one reason for broken treatment was the client's

17. LaVay Lau, "An Investigation of Some of the Factors Involved in the Discontinuance of Child Guidance Treatment", Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1956. p. 62.

18. Hilde Bruch, "The Role of the Parent in Psychotherapy with Children," Psychiatry, May, 1948, Vol 11, No. 2. p. 169-175.

19. Lau, op. cit., p. 62.

being seen by too many workers.

Lau also found that factors in the intake interviews were important in the clients' leaving,²¹ so the diagnostic period was studied to see what differences there were in the two groups. Clues were sought to determine what factors in this diagnostic period could have been a sign that things in the contact were not going well, and promptness, attendance and the mother's ability to share information were studied as possible signs. Leventhal, Counts and Gridley found these mothers to be quite disturbed.²² Whether a mother was able to discuss her own problems might indicate her readiness for help. Coughlin found that many clients were not able to face their problems or did not feel the need to have treatment.²³ The question arose what the mothers felt about being seen, they came to the clinic because of their child's runaway episode and the children were not seen until later. Leventhal, Counts and Gridley found that both parents and children found it difficult to control themselves, and that in some instances (especially in boys) there was blatant oedipal material with a seductive quality to their relation-

20. Joseph B. Coughlin Jr. "An Investigation of the Reasons for Broken Treatment at the Briggs Clinic for Emotional Problems in Adults from Feb. 15, 1950 to Dec. 1, 1950." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1951. p. 71.

21. Lau, op. cit., p. 62.

22. Leventhal, Counts and Gridley, op. cit., p. 13.

23. Coughlin, op. cit., p. 72.

24
ships. These were mothers who had many problems. The number and type of the symptoms were explored to see how much they were able to talk about their problems and also to get an idea of what kind of problems they had. Leventhal, Counts and Gridley discovered that the children often became a part of these problems,²⁵ so the question arose what these mothers could see in terms of their part in the child's problem and how much they had to control the children to help with their own troubles. In talking about the mothers who are controlling in their handling of the child, Hirsohn felt that resistance in these women was particularly strong and was manifested in a variety of ways.²⁶ All this alluded to the fact that it would be hard for these mothers to look at their problem; this was studied to see if there was a difference in the groups as to their ability to discuss their problems with the worker. These mothers might find it difficult to have the child seen, Spranger found that some parents see the psychoanalytic approach as an immediate danger; it meant insanity. They had fantasies about the child's mind being pulled apart and they needed to defend the child's neurosis as well as their

24. Leventhal, Counts and Gridley, op. cit., p. 13.

25. Ibid, p. 11.

26. Sid Hirsohn, "Casework with the Compulsive Mother," Social Casework, June, 1951, Volume 32, Number 6, p. 255.

own, especially where they are bound up with the child.²⁷ This was the basis for studying the mothers' feeling about the child's being seen and their expression of the cause of the difficulty.

The children were studied to see if there were differences in the groups that remained in treatment and those that did not. The children's ages were studied. Hirsohn found that the mothers who were controlling discovered it increasingly difficult to maintain their own defenses as the children grew older and more independent;²⁸ age differences could effect maintaining the contact. The number of children in the family and their position seemed another possible area of study, the Gluecks stated that only children, first children and the youngest children are thought to be especially vulnerable to the development of behavior difficulties because they receive preferential treatment, although in their own study they found that the middle children had more problems.²⁹ Blom states that the first sibling in the family is subject to the full impact of the family neurosis.³⁰ The

27. Otto Spranger, "Some Features of the Emotional Resistance Against the Psychoanalytic Approach in Schools" Mental Hygiene, October, 1944, Vol 28, No. 4, 639-51.

28. Hirsohn, op. cit., p. 255.

29. Sheldon and Eleanor Glueck, op. cit., p. 120

30. Gaston E. Blom, "Ambivalence and Resistance to Treatment in an Adolescent", Case Studies in Childhood Disabilities Volume I, George E. Gardner, editor (New York: American Orthopsychiatric Association, 1953) p. 183.

children's symptoms were studied to see if there were any symptoms that seemed to relate to the parents accepting help more readily and what the relationship was between the child's and mother's symptoms. The children's spare time activities and peer relationships were studied and related to the maintenance of treatment contact; moreover, the mothers' knowledge of and control of these areas were studied to see if there was any variance in this between mothers who stayed and mothers who withdrew. The length of time the child had the problem seemed to be another indication of how difficult it was for the mother to face the problem.

Despite the fact that the fathers were not all seen at the agency, his participation and interest might influence maintenance of the treatment contact. Coughlin found in some of the clients he studied that their wives interfered with treatment.³¹ Josselyn speaks of the family as a psychological unit with each individual contributing to it. Changing culture has modified the family roles and fathers are often thought of as "forgotten men" and seem to have been allocated the role of less importance in handling children.³² When these mothers came to the clinic the father had something at stake because the psychological unity was threatened, and

31. Coughlin, op. cit., p. 72.

32. Irene M. Josselyn, "The Family as a Psychological Unit" Social Casework, October, 1953, Vol. XXXIV, No. 8, p. 341.

his part in dealing with the children is denied him. The father's role in the treatment contact and his interest in the contact were examined. Finally the prognosis of the cases were tabulated to see if this had any relation to whether cases that seemed hopeful worked out and ones that were not hopeful failed or withdrew, or whether this made no difference.

3. Justification and Limitations of the Study

The reason for studying factors related to maintenance of treatment in mothers with runaway children was the concern over the large incidence of discontinued treatment. It has been pointed out that the phenomenon of running away is increasing in frequency, so that in studying this phenomenon it would seem to be important to get some beginning ideas on what factors in mothers coming to the social agency with this problem could effect their treatability. It is uncertain whether these factors will differ in mothers of runaways and mothers of children with other problems; however, there seems to be a particular quality to these relationships causing the child to run away that do not appear in other problems effecting children. These families appear to have special problems which might effect treatment.

This study will not attempt to give definite answers. The level of this study is exploratory and therefore will attempt to look at areas which seem to be important and to point up areas of further study. Any generalizations made

will be limited to this study because of the sampling problems inherent in the study. This study has brought up some questions in relation to the maintenance of treatment contact; there are many more which should be asked but which were not a part of this study. For example, the whole area of the worker-client relationship and the handling of the case is important, but was not taken up here. The method of data collection used (case material) had many pitfalls, and this was a limitation. Material was taken from cases almost exclusively, and these had varying degrees of completeness which left a wide margin of error.

CHAPTER III

RESULTS

The purpose of this study was to delineate factors which may have a bearing on the maintenance of treatment contact in families with a child who has run away, using as its basis the preliminary findings of Leventhal, Counts and Gridley.³³ The factors studied were the family, the referral, the diagnostic (intake) period, the mother, the child and the fathers' participation. The intense relationship between the mother and child was studied to determine if it appeared in a case and if it seemed to have a relationship to the maintenance of treatment.

1. The Family

The size of the families of the runaways did not seem

TABLE I
NUMBER OF FAMILY MEMBERS

Number in the family	Boys		Girls	
	Stay	With	Stay	With
10	0	1	0	0
9	1	0	0	1
8	0	0	0	1
7	3	1	0	0
6	2	0	0	2
5	1	1	2	1
4	1	4	0	0
3	2	0	0	0
2	0	0	0	1
TOTALS	10	7	2	7

33. See page 7.

to be related to the maintenance of contact in the boys. The families of the runaways were large; there were only three with but one child. The boys who stayed had an average of 5.70 members which was slightly higher than those who withdrew. The same was true in the girls' cases; the average for the girls was the same in both groups. In the boys' cases broken homes seemed to be related to maintenance of contact, two boys stayed and one withdrew who had experienced parental loss. In girls this seemed a contraindication for a continuance of treatment; two of three girls who experienced parental loss withdrew.

To get a clearer idea of the home situation and supervision of the children the mothers' employment was studied. The occupation of the boys' mothers was not related to maintenance of treatment contact; all but one mother was a housewife. In the girls' cases the mothers' occupation seemed to

TABLE II
MOTHERS' EMPLOYMENT

Occupation	Boys		Girls	
	Stay	With	Stay	With
Housewife	9	7	1	2
Waitress	0	0	0	2
Stitcher	0	0	0	1
Diet Aide	0	0	0	1
Secretary	0	0	0	1
Factory Work	0	0	1	0
Clerk	1	0	0	0
TOTALS	10	7	2	7

be related to withdrawal, only two mothers who withdrew were housewives. The fathers' occupations were varied, covering a range of incomes. There was a doctor, painter, draftsman,

builder, laborer and two factory workers to mention a few.

With an idea of the family composition it seemed important to look at their religion to see if their spiritual values were related to maintenance of the treatment contact. The religion of the mothers was related to the maintenance of contact, in the boys' mothers seven out of ten were Catholic who stayed and six of the seven who withdrew were Protestant. Further evidence for this was found in the girls' groups where both mothers that stayed were Catholic and three of the five

TABLE III
RELIGION OF THE FAMILIES

Religion	Boys		Girls	
	Stay	With	Stay	With
Roman Catholic	7	1	2	2
Protestant	1	6	0	3
Jewish	1	0	0	0
Greek Orthodox	1	0	0	0
Unknown	0	0	0	2
TOTALS	10	7	2	7

known cases that withdrew were Protestant. In most of the cases there was no indication of church attendance, however, in the cases where it was mentioned church attendance was irregular.

Having a glimpse at the family size and religion it seemed important to know about their problems and previous experience with social agencies. Most of these families had previous contacts with social agencies.³⁴ In the boys' groups the number and type of agency contact did not seem to be related to remaining in treatment except the contact with sectarian and

34. See Appendix II

public agencies. Where there was contact with a sectarian agency the case remained in treatment, if there was a contact with a public agency the cases tended to withdraw. Contact

TABLE IV
CONTACT WITH OTHER AGENCIES

Agency	Boys		Girls	
	Stay	With	Stay	With
Youth Guidance Center	2	3	1	2
Juvenile Division	5	5	1	6
Sectarian Agency	3	0	1	0
Private (non-sect) agencies	2	3	1	1
Public Agencies	4	6	0	2
TOTALS	17	17	4	11

with the police in the girls' cases was related to their leaving treatment. There was also a relationship between girls withdrawing and contact with public agencies.

A look at the marital relationship was indicated to determine if this was a problem, and what sort of situation the children lived in. The status of the marital adjustment had little relationship to maintaining the contact, as most

TABLE V
MARITAL STATUS

Status	Boys		Girls	
	Stay	With	Stay	With
Serious Marital Discord	4	4	2	2
Happy or Mildly Happy	3	2	0	2
Separated	1	1	0	1
Divorced	1	0	0	1
Mother Divorced and Remarried	1	0	0	1
TOTALS	10	7	2	7

of the cases showed an unhappy situation. It is important to remember that in this study case records were used, and the evaluation was made by a combination of the parent's statements, and subjective evaluation by the worker and the writer,

however, examples will be given to help clarify the categories. Both boys' groups had a prevalence of marital discord and about the same number of happy or mildly happy marriages, but the boys that stayed had experiences more serious: parental separation. The parents of girls that stayed both had serious discord, and the girls that withdrew had an equal number of parents with serious discord and happy relationships, but they experienced separation more. Mr. and Mrs. E. had serious marital discord. They argued continually over every aspect of their home. They disagreed on the care of the children, finances, and every other aspect of their married life. Mrs. K. felt she no longer loved her husband and was going with another man; in another

TABLE VI
MARITAL STATUS AND RELIGION

Status	Stay Boys With				Stay Girls With			
	Cath	Prot	Cath	Prot	Cath	Prot	Cath	Prot
Serious Marital Discord	3	0	0	4	2	0	1	1
Happy or Mildly Happy	2	0	1	1	0	0	1	0
Separated	1	0	0	1	0	0	1	0
Divorced	1	0	0	0	0	0	0	1
Mother Divorced and Remarried	1	0	0	0	0	0	0	0
TOTALS	8	0	1	6	2	0	3	2

case, Mrs. M. was in poor health and she did not feel her husband sympathized with her, nor would he care for her when she was ill. Separation implies discord, however in the former both husband and wife were still in the home. The happy or mildly happy parents got along acceptably well in many of the aspects of their marriage. Mr. and Mrs. P. felt they were

very close, they could talk and share things together. Mr. and Mrs. N. had some points of difference, however, they were together on the treatment plan and both participated. Spiritual values may be related to the management of marital problems, and this can be related to their feeling about help and what they can do about their situations. The Catholic mothers of boys with marital troubles tended to stay in treatment, Protestant mothers of boys who had marital difficulty tended to withdraw, so religion, marital status and maintenance of contact seem to have some relationship. In the group that stayed three of the boys' parents that had serious marital discord were Catholic, in the group that withdrew four were Protestant.

2. The Referral

Preconceived ideas of the agency or attitudes toward the people who referred could effect the client's maintaining contact with the Center. Almost all these cases were refer-

TABLE VII
SOURCE OF REFERRAL

Source	Boys		Girls	
	Stay	With	Stay	With
Juvenile Division	5	4	1	6
Psychiatrist	1	1	0	0
Youth Service Board	0	1	0	0
Parents	3	0	0	1
School	0	1	0	0
Friend	1	0	0	0
Hospital	0	0	1	0
TOTALS	10	7	2	7

red by the Juvenile Division of the Police (sixteen out of

twenty-four). There was a relationship to maintenance of treatment in boys' mothers who stayed when the parents referred their child. In the girls' cases referrals by the police eventually withdrew. Generally, with the boys the referring source did not seem to be related to remaining or leaving treatment except when parents referred.

Referral applies to the source calling the Center to refer a case. Many times other people influenced a parent to come in to the agency, for example a friend or a relative may suggest it. Table VIII outlines those agencies or individuals

TABLE VIII
AGENCIES SUGGESTING CONTACT WITH CENTER AS STATED BY THE MOTHER

Agency	Boys		Girls	
	Stay	With	Stay	With
Juvenile Division	5	4	1	5
Psychiatrist	1	1	0	0
Youth Service Board	0	1	0	0
School	2	1	0	0
Relative	1	0	0	0
Neighbor	1	0	0	1
Hospital	0	0	1	0
Telephone Book	0	0	0	1
TOTALS	10	7	2	7

communicating to the parent about the services of the Center, or suggesting they follow up on the referral. The relationship of suggesting agencies to maintenance of the contact was similar to the distribution in the referring agencies. In the boys' cases there was little relationship to treatment contact, except where friends suggested it, in these cases they stayed. In the girls that withdrew the police suggested six times, so the police influence in these cases seems to

be related to the girls' mother withdrawing.

Whether the agency or the parent made the first contact (usually a phone call) was related to the maintenance of treatment contact. Sometimes the agency would call or write to the parents after the referral, other times the Center would receive the referral but the parents would make the first move towards coming in. The group that stayed almost all initiated

TABLE IX
FIRST CONTACT WITH THE CENTER

Initiator	Boys		Girls	
	Stay	With	Stay	With
Parents Initiated	9	3	1	2
Agency Initiated	<u>1</u>	<u>4</u>	<u>1</u>	<u>5</u>
TOTALS	10	7	2	7

the first contact, while those who withdrew had fewer parents initiate the first contact. In the boys' group that stayed ninety per cent initiated the contact, forty-three per cent in those that withdrew, fifty per cent in the girls that stayed and twenty-eight per cent in the girls that withdrew.

Along with outside motivations mothers had their own ideas of what they came for; an examination of these ideas attempted to find if they had general concerns about the child or if the concern was the runaway episode only. The mothers' seeing difficulties other than the runaway episode was related to maintenance of treatment contact. Five of the mothers of boys who stayed saw problems other than the runaway (school difficulty, stubbornness, and mother-child problems); and boys that withdrew had only two mothers who saw other problems

(unacceptable peer relationships and mother-child difficulties).

Some mothers felt they wanted help in the mother-child relationship, for example, Mrs. K. had a history of running away herself and she felt that the big problem was that she thought the child was too close to her and will run away as she did if they do not have help with it. Mrs. C. was concerned because she felt disturbed because she did not love her son as she should: "I don't love him or kiss him like I do with other kids." One girl who stayed was referred mainly because of an attempted assault; she threw a chair at her sister and tried to stab her. One boy who stayed was said to be stubborn, the mother could not reach him and she wanted help with this: "He

TABLE X
MOTIVE FOR SEEKING HELP AS STATED BY THE MOTHER

Motive	Boys		Girls	
	Stay	With	Stay	With
Runaway Episode	5	5	0	6
School Difficulty	3	0	0	1
Unacceptable Peer Relationships	0	1	0	0
Stubbornness	1	0	0	0
Mother-Child Difficulties	1	1	1	0
Attempted Assault	0	0	1	0
TOTALS	10	7	2	7

just will not do anything I ask him to do." One mother who withdrew felt that the problem was that her son was friendly with an unacceptable group of boys. Examples of the school difficulty were: Mrs. C. who said that the problem that concerned her the most was that her son was not interested in school, he never finished what he started. Mrs. D. felt the problem was that her son did not get along with the children

in school and was very poor in reading, if these things were cleared up then things would be better in all areas.

The factors studied above combine to form an attitude toward the whole referral, and the data was examined to see if a particular attitude came out in the initial interview and if it was related to continued treatment. In the boys' groups acceptance or being anxious for help was related to remaining in treatment, eight who stayed fell into these categories; only three of the mothers of boys who withdrew felt

TABLE XI
MOTHERS' ATTITUDE TOWARD REFERRAL

Attitude	Boys		Girls	
	Stay	With	Stay	With
Anxious for Help	3	1	1	2
Accepting	5	2	1	2
Indifferent	0	1	0	1
Cautious	1	2	0	0
Distrustful	1	0	0	2
Unwilling	0	1	0	0
TOTALS	10	7	2	7

positively about help. The same was true in the girls' groups. The girls that stayed had mothers who were anxious or accepting of help; four of the mothers who withdrew were accepting or anxious, but there were two who were distrustful, and one who was indifferent. An example of a mother who was anxious for help was Mrs. K. who felt very upset about the running away and wanted help with it; this would prove to her relatives that she was a "good mother." Mrs. Q. was very upset and wanted help for her daughter who had run away, she wanted to be seen as soon as possible. Mrs. A. accepted the

referral, she had been to the Center previously and she said: "M. (a daughter) was helped here before, and I think you will be interested in R. and help him." These were positive attitudes toward the agency which were expressed verbally, in the feeling tone and expression of the mothers. Indifference in a mother can best be illustrated by Mrs. T. who knew there was a problem. She came in but had difficulty talking and felt the problem was beyond hope. Mrs. R. came in about her daughter although she was not too enthusiastic about help, however, the worker noted that she seemed to have some pride in her daughter's acting out behavior. Mrs. S. was cautious; she balked at the first appointment time, but finally agreed on a time and came in. Mrs. J. said she hesitated to come, she was not sure she wanted this. Mrs. O. did not quite trust the agency, she was especially concerned that no one know she came nor what she said. Mrs. Y. seemed unwilling to go through with the referral. She came in expecting the agency to place her child for her.

3. The Diagnostic Period

The mothers' attitudes toward the referral were discussed, in this section something of what happened to them during the diagnostic (consultation) period will be discussed, how they showed their resistance or acceptance of treatment, and in what ways these feelings were reinforced during the contact. The section will deal with the mechanical aspects of the con-

tact, the handling and content of the interviews was not examined.

The number of days that mothers had to wait for their first appointment varied, although it did not seem to be related to maintenance of treatment contact. The mothers

TABLE XII
TIME BETWEEN INITIAL CONTACT AND FIRST INTERVIEW

Time	Boys		Girls	
	Stay	With	Stay	With
Over Ten Days	1	2	1	2
Nine Days	2	0	0	0
Eight "	1	0	0	0
Seven "	0	0	0	3
Five "	0	1	0	1
Four "	0	2	0	0
Three "	1	1	0	1
Two "	3	0	0	0
One "	1	1	0	0
Same Day	0	0	1	0
Unknown	1	0	0	0
TOTALS	10	7	2	7

of boys who stayed tended to wait either very little time or over a week, and those that withdrew waited from four to seven days. This was the same in the girls' groups where mothers

TABLE XIII
ATTITUDE OF MOTHERS TOWARD REFERRAL WHO WAITED OVER A WEEK

Attitude	Boys		Girls	
	Stay	With	Stay	With
Anxious for Help	2	0	0	1
Accepting	1	0	1	0
Indifferent	0	0	0	1
Cautious	1	1	0	0
Unwilling	0	0	0	1
TOTALS	4	1	1	3

of girls who stayed came in either the same day as the first contact or over a week later, and those who withdrew waited around three to seven days. Waiting over a week did not seem

to be related to a negative feeling about the contact in the groups that stayed, it did in the groups that withdrew, however.

The number of diagnostic interviews was considered as a possible influence on the contact, and also as an indication of how much each group was seen. In the boys' group the number of interviews seemed to be related to remaining in treatment, mothers of boys that stayed had more interviews (three had over ten), however, it did not seem to be

TABLE XIV
NUMBER OF DIAGNOSTIC INTERVIEWS

Number of Interviews	Boys		Girls	
	Stay	With	Stay	With
Over Ten	3	0	0	0
Nine	0	0	0	1
Six	2	4	0	0
Four	0	1	0	1
Three	0	0	2	2
Two	2	1	0	1
One	0	1	0	2
Unknown	3	0	0	0
TOTALS	10	7	2	7

related in the girls' cases, both groups tended to have around three to five interviews.

With the attitudes of the mothers and their experiences

TABLE XV
ATTENDANCE AT INTERVIEWS

Attendance	Boys		Girls	
	Stay	With	Stay	With
Made All Appointments	8	3	1	3
Cancelled Occasionally	0	1	0	0
Cancelled Frequently	1	0	0	1
Missed First Appointment	1	1	1	0
Made Just First Appointment	0	1	0	2
Home Visit	0	1	0	1
TOTALS	10	7	2	7

in early interviews examined, indications were sought to estimate the client's feeling about the contact by comparing their attendance and promptness at interviews. More of the boys' mothers who stayed made their appointments (eight), and only three were regular who withdrew. Girls' mothers who stayed made their appointments or just missed the first one, mothers who withdrew had more cases with repeated cancellations. The category "cancelled frequently" applied to mothers seen more than once who broke appointments often. Home visits were related to withdrawing from treatment; both instances where there were home visits ultimately resulted in withdrawal.

TABLE XVI
MOTHERS' PROMPTNESS FOR APPOINTMENTS

Promptness	Boys		Girls	
	Stay	With	Stay	With
On Time	8	5	1	6
Occasionally Late	1	0	0	0
Frequently Late	0	1	0	0
Always Late	0	0	0	1
Late for First Appointment	0	1	0	0
Early	1	0	1	0
TOTALS	10	7	2	7

Promptness did not seem to be related to the maintenance of treatment contact, most of the clients made their appointments on time; however, being early for appointments was related to staying in treatment, the two mothers who were early stayed in treatment.

Other factors can effect treatment; fees might be important to a client. Transfer to another worker could be a difficult thing for a client, and could effect treatment.

Because this was a research project fees were charged rarely, only in seven cases were they charged, but they were not related to staying or withdrawing from treatment, four clients who stayed and three who withdrew had fees. These fees were all paid regularly. In the group that withdrew there were two mothers who felt they would like to pay for the service or felt they should pay more; in one case a mother feared the fee was too much. In the group that stayed one mother insisted on paying a fee, and another mother felt she could not afford a dollar fee.

There was transfer of workers in only two cases and both subsequently withdrew. Both of the mothers who were transferred verbalized their distress at being transferred, they were attached to the first worker and found this very difficult.

4. The Mothers

Some information on the mothers of the runaways has been presented; mothers' occupation, marital status, and the mothers' participation in the diagnostic period. An attempt was made to look at the mothers themselves, their own problems, their feeling about treatment for themselves and their children, and their relationships with their children, and to try to relate these factors to the maintenance of treatment contact.

The number of symptoms described by the mothers could be

related to their readiness to participate in treatment; moreover, the symptoms themselves were important in understanding the mothers. A number of different symptoms were described by the mothers. The two boys' groups showed little relationship to maintenance of treatment contact in the number of symptoms

TABLE XVII
NUMBER OF SYMPTOMS REPORTED BY MOTHERS

Number of Symptoms	Boys		Girls	
	Stay	With	Stay	With
Four	0	0	0	1
Three	1	0	1	1
Two	3	2	1	0
One	5	5	0	3
None	1	0	0	2
TOTALS	10	7	2	7

reported, the mothers in these groups mentioned one or two symptoms. There seemed to be a relationship in the girls' groups where mothers who stayed talked more about their symptoms, one reported three, the other two; moreover, the mothers who spoke of many (three and four) or few (one or none) tended to withdraw. The mothers of girls who withdrew were at two extremes: one mother mentioned four symptoms, one had three, and two mentioned none at all.

A breakdown of the symptoms of the mothers showed that mothers of boys who stayed reported more symptoms than the other groups. The four groups tended to differ quite markedly on the kinds of symptoms presented. The group that withdrew seemed to have more difficulty controlling themselves and had more physical symptoms; the group that withdrew had fears of loss of control. Mothers of boys that stayed had more

sexual problems, the group that withdrew had more depressed

TABLE XVIII
SYMPTOMS REPORTED BY THE MOTHERS

Symptom	Boys		Girls	
	Stay With	Stay With	Stay With	Stay With
Depression	1	2	2	2
Denial of Part in the Difficulty	0	1	0	0
Fears Loss of Control	1	1	0	2
Tantrums	0	0	0	1
Physical Symptoms	3	3	0	3
Nervousness	1	0	0	1
Present or Past Sexual Problem	4	0	2	1
Fear of Death	1	0	0	0
History of Running Away	2	0	0	0
Fear of Being Attacked	0	1	1	0
TOTALS	13	8	5	10

mothers. Two of the boys' mothers who stayed had histories of running away as a child; both these mothers had sexual problems as well. The mothers of girls who withdrew had many physical ailments. Some examples of depression were homesickness, post-partum depression, and one mother had a depression following a gall bladder operation. One girl's mother who stayed reported that she was not part of the difficulty, it was all her husband's fault. The group that withdrew had three mothers who feared that they would lose control, and one mother who stayed feared this. As one mother stated it: "I'm afraid to lick him, if I started to I'm afraid of what I'd do to him." One mother mentioned that she did lose control with the child, and she feared that she must be the crazy one. Some of the physical complaints could be psychogenic such as stomach trouble, hot flashes and asthma, but ones such as diabetes were purely physical in nature. One

woman had epilepsy which was probably physiological in origin, however, some of her seizures seemed to be precipitated by emotionally charged situations, for example, she had one following her first interview which she linked to feeling "upset" while talking to the worker. Nervousness was described by one mother as a general feeling of being jittery and she went to the hospital because of this. Some of the mothers spoke of sexual difficulties. With some it was a past problem, one mother said that as a girl she had been promiscuous; others described present sexual problems, for example, one mother was afraid of sexuality, another said she disliked it. One mother feared death, she felt that along with her illness (diabetes) the father was going to leave her or attack her which would result in her death. Two mothers (both who stayed) had histories of running away and they described the reason as being lonely and having very deprived homes.

Some mothers were able to talk of their problems, the next question was whether they wanted help for themselves. A mother's asking for help would seem to be a positive prognostic sign in a case. In the mothers of the boys, being anxious or accepting of help for themselves was related to their staying in treatment. Being distrustful was not related to their withdrawing, although mothers of boys who showed unwillingness did tend to drop out. Being cautious, distrust-

ful or unwilling in the girls' group did relate to their with-

TABLE XIX
ATTITUDE OF MOTHERS TOWARDS THEIR BEING SEEN

Attitude	Boys		Girls	
	Stay	With	Stay	With
Anxious for Help	2	3	1	0
Accepting	3	0	0	1
Cautious	0	0	1	3
Distrustful	4	0	0	2
Unwilling	0	4	0	1
No Treatment Offered	1	0	0	0
TOTALS	10	7	2	7

drawing. Initial responses to the necessity (to stay in treatment the mother must agree to continue) of being seen were not always evident at first, however, they usually came out in later material. An instance of being anxious for help was Mrs. T. said that she felt she wanted help for herself, with her problem in the sexual area and in her marital relationship. Another mother wanted help because she felt lonely and insecure. An example of acceptance was Mrs. H. who did not know that she would be seen, but accepted this when she found out what the policy was. Some mothers were cautious, for example, Mrs. I. said she felt wary of the contact, she was not sure she wanted to be seen. The largest group of mothers who were distrustful were in the mothers of boys who stayed. Two mothers of girls who withdrew were distrustful also. Mrs. J. and Mrs O. were both distrustful, they wanted the child seen, could not understand why they should be seen, but they later agreed on this. Four mothers of boys who withdrew were unwilling to be seen themselves, and stated defi-

nitely that they did not want to go into their own problems. Mrs. T. said she did not want to be seen continually, she did not need "psychoanalyzing," another mother did not want to talk about herself, she wanted the child to come in, this was a threat she was using against him. In one case no treatment was offered, as it was felt that the situation had been improved in the diagnostic period, however, these people would have agreed to continue.

Having an idea of the mothers' feeling about being seen, the next question concerned the child's being seen; were the mothers more willing to have the child seen or was this too an area of conflict. When it came to the child's being seen by one of the staff psychiatrists some mothers had great feeling about it. Mothers of boys who stayed tended to be

TABLE XX
ATTITUDE OF MOTHERS TOWARD THE CHILD BEING SEEN

Attitude	Boys		Girls	
	Stay	With	Stay	With
Anxious for Help	5	3	0	2
Accepting	1	3	1	1
Fearful	1	0	1	1
Fears Child's Reaction	3	0	0	3
Unwilling	0	1	0	0
TOTALS	10	7	2	7

more anxious to have their children seen, so there was a relationship between this and remaining in treatment. Five mothers of boys who stayed and three of the mothers of boys who withdrew were anxious to bring their children in. In boys' mothers who stayed there was a relationship between their fearing the child's reaction and the maintenance of treatment.

In the girls' cases being anxious to have their daughters seen did not seem to be related to remaining or leaving the clinic. Three girls' mothers who withdrew were anxious or accepting, only one mother who stayed was anxious or accepting. In the girls' groups fearing the daughter's reaction to being seen was related to leaving treatment. Mrs. C. was anxious for her boy to be seen, she thought he would like this, and it would be good for him to have someone to confide in; Mrs. G. felt that she wanted her child seen to straighten him out, she did not want her other children to become "that way". An example of acceptance was Mrs. I. who felt her child might like to talk to someone, Mrs. H. felt was "all right", she would take the child out of school if necessary. A few mothers were fearful of this. Mrs. S. was afraid of what the psychiatrist would do to her child. This was explained to her by the worker and she saw the playroom. When she met the psychiatrist she said: "He looks like a nice man," however, during her session she heard a child yell and she became frightened, thinking it was her child, but it was not. An example of the fear of the child's reaction was Mrs. X. who felt the child would think going to the clinic would mean she is crazy, and Mrs. L. was afraid her child would not talk to the psychiatrist and he would not find out what a "devil" he really was. She said he was always good with strangers. Only one mother was unwilling

to have the child seen, she asked another son who had been to the Center if he thought this was a good idea and he said it would not help.

The mothers' ability to see the causes of the problem was studied to find if those who had some insight became involved in treatment, and those who blamed external factors were harder to involve. The mothers in the sample gave many reasons for the behavior of their children, and many mothers gave more than one cause. Generally, the causes fell into two categories, those stemming from the home environment

TABLE XXI
AREA OF CAUSATION IN CHILD'S PROBLEM AS STATED BY THE MOTHERS

Area	Boys		Girls	
	Stay	With	Stay	With
Inside the Family	11	6	0	7
Outside the Family	5	3	1	4
TOTALS	16	9	1	11

and those from outside the home. There seemed to be no relationship between the area of causation and the maintenance of treatment, as all the groups had more causes inside the home, the boys that stayed had more causes inside the family but they had more outside causes as well. The two boys' groups were similar in the number of causes that were inside the family out of the total number of causes given. There was a slight difference in the two girls' groups. The girls' mothers that stayed had only one cause given (outside) while the girls who withdrew gave more causes and had more causes inside the family.

A tabulation of the causes of the child's problem as seen by the mother showed that some of the clients' causes were related to maintenance of treatment contact. Mothers of boys who felt that the difficulty was a plot against them withdrew. Putting the blame on the father was related to staying in treatment (five blamed the father); only one mother who withdrew felt it was the boy's father's fault. Another relevant factor in the boys' group was the mothers' ability to see the problem as one between them and the child. Five mother who saw this stayed, three withdrew. The mothers

TABLE XXII
CAUSE OF PROBLEM AS STATED BY THE MOTHER

Cause	Boys		Girls	
	Stay	With	Stay	With
No Idea	3	4	1	2
Plot Against the Mother (int)	0	2	0	0
Peer Relationship (ext)	2	1	1	1
Father's Fault (int)	5	1	0	4
Marital Difficulty (int)	1	0	0	2
Mother-Child Relationship (int)	5	3	0	1
Illness in the Family (ext)	2	1	0	2
Adoption (both)	0	1	0	1
School Difficulty (ext)	1	0	0	0
TOTALS	19	13	2	13

of girls who stayed only mentioned one cause. Seeing the father as a cause in the girls' group was related to withdrawing from treatment. More thought into the causes of the girls' problems was related to withdrawing from treatment. Two mothers of boys who withdrew felt this was some sort of a plot against them, for example, Mrs. M. felt her child did these things deliberately to make her mad, and to get the husband mad at her. Some mothers felt the child's peers

were responsible for the behavior (evenly distributed in the four groups) as Mrs. I. did. She felt the company of "bad girls" was the cause of the difficulty. Some mothers blamed the fathers, for example, Mrs. G. felt the father was too strict, Mrs. A. felt the father spoiled the child, and Mrs. P. felt the father was too lenient with her son. Marital difficulties were mentioned three times. Mrs. O. felt her daughter was upset over their quarrels and subsequent separation. Many mothers of boys felt a difficulty in their relationship cause the problem. Mrs. J. felt she had kept her son too close to her and Mrs. L. felt she had been too lenient with her son. Illness was mentioned as a cause, for example, Mrs. E. felt it was a sister's illness which caused the boy to be ashamed; and Mrs. J. felt that part of the reason for the boy's trouble was his seeing her seizures.

5. The Boys

Having studied the mothers in the four groups, the children were studied next to find out what they were like; if an older child tended to be involved easier, if children with particular symptoms were involved easier and if children who had good peer relationships and healthy spare time activities worked out more satisfactorily. Because of the wide difference in the boys and girls (for example, their ages) separate sections on them seemed appropriate to bring out clearer the differences or similarities between children who stayed and

children who withdrew.

The ages of the boys were related to the maintenance of treatment contact. The average age for the boys was 10.6 years. The boys who stayed in treatment had the majority of ages between eight and thirteen (median, twelve) while

TABLE XXIII
BOYS' AGES

Age	Stayed	Withdrew
Sixteen	2	0
Fifteen	0	1
Fourteen	0	1
Thirteen	2	1
Twelve	2	0
Ten	1	1
Nine	2	1
Eight	1	0
Seven	0	1
Five	0	1
TOTALS	10	7

the boys who withdrew seemed slightly younger (median, ten) and had a more scattered distribution.

The number of siblings seemed to have little relation to staying or withdrawing from treatment. These families were rather large and the number of siblings and the position of each child in relation to them was studied to find if this might be related to their becoming involved in treatment. Most of the boys had one or two siblings, but the boys whose mothers stayed had more instances of having over two siblings, although one boy who withdrew had the most siblings (seven). There was a relationship between position of the boy and running away; also there was a relationship between his position

TABLE XXIV
NUMBER OF SIBLINGS

Number	Stayed	Withdrew
Seven	0	1
Six	1	0
Four	2	1
Three	1	0
Two	3	2
One	2	3
None	1	0
TOTALS	10	7

and their participation in treatment. Almost all the boys who stayed were the first children, two of the boys who withdrew were the firstborn. Of the three boys who stayed who were the second child all were the first male, and two of the boys who withdrew who had an older sibling were the first male children. Although more boys who stayed were firstborn

TABLE XXV
POSITION OF THE BOYS IN RELATION TO SIBLINGS

Number in Family	Stayed	Withdrew
First	7	2
Second	3	3
Third	0	1
Fourth	0	1
TOTALS	10	7

almost all were the first male child.

The boys' symptoms were studied to get a picture of how much their disturbances had generalized to other areas and to see what these areas were. ³⁵ The bases of the material used were comments from the mothers' and therapists' material.

35. See Appendix III for breakdown of the symptoms.

All of the boys had at least one other symptom than the run-

TABLE XXVI
NUMBER OF THE BOYS' SYMPTOMS *

Number	Stayed	Withdrew
Five	1	0
Four	2	1
Three	3	3
Two	3	2
One	1	1
TOTALS	10	7

* Not including running away

ning away. There was a relationship between the number of symptoms reported and staying or withdrawing from treatment. The boys who stayed tended to have more symptoms, but both groups had around two or three other symptoms. In the area of the symptom there was a relationship between antisocial behavior and withdrawing, but boys had a tendency to stay who had trouble with their parents. Both groups had school difficulties as this seemed to be an area where their difficulties came out. Examples of school difficulty were truancy, poor

TABLE XXVII
BOYS' SYMPTOMS

Area of Symptoms	Stayed	Withdrew
School Difficulty	9	6
Sexual Problems	1	1
Antisocial Behavior	4	6
Difficulty with Parents	8	4
Physical Complaints	1	1
Neurotic Difficulties	2	3
TOTALS	25	21

grades and poor relationships with teachers. Both groups had the same number of sexual problems reported (homosexuality), but the group that withdrew had more antisocial behavior

(fire-setting, stealing, and fighting). The boys who stayed had more open conflict with their parents (lying, disobedience, tantrums and defiance), and both groups had a similar number of physical complaints and neurotic difficulties (nervousness, enuresis and fear of loss of control).

There was no relation between the boys' peer relationships and maintenance of treatment. On the whole, the boys seemed to have poor relationships with their peers, they had few friends. The group that stayed had a few more boys with

TABLE XXVIII
BOYS' PEER RELATIONSHIPS

Relationships	Stayed	Withdrew
Large Circle of Friends	2	2
Small Circle of Friends	1	0
One Friend	2	2
No Friends	2	1
Fights with Peers	<u>3</u>	<u>2</u>
TOTALS	10	7

no friends or who fought with their peers than those who withdrew. Both groups had the same number of boys with a large circle of friends and the same number with one friend. The

TABLE XXIX
AREA OF BOYS' RECREATION

Area	Stayed	Withdrew
Inside the Home	5	4
Outside the Home	<u>15</u>	<u>11</u>
TOTALS	20	15

ages of these boys would suggest a great number of spare time activities outside the home, however, the finding on the peer relationships brought up the question of whether these boys

who have rather poor relations with peers spent a great deal of time at home. This was studied and related to the maintenance of contact. There seemed to be little relationship. The boys seemed to have more outside than inside activities despite their generally poor relationships with other children. Of the total number of activities in each group the boys who stayed had proportionately more outside activities

TABLE XXX
BOYS' SPARE TIME ACTIVITIES

Activity	Stayed	Withdrew
Boys Club	4	0
Television	3	3
Sports	4	6
Movies	1	1
Hobbies	1	1
Scouts	2	0
Music	1	0
Church	1	0
YMCA	1	0
Dating	1	0
Working	0	4
Not Mentioned	1	0
TOTALS	20	15

than the boys who withdrew. The boys who stayed had more contact with group work agencies (boys club, YMCA and scouts), the boys who withdrew had no contacts with these agencies but had more boys interested in sports. There were four boys who withdrew who worked, none of the stayed group had jobs. Only one boy dated, and few boys watched television, had hobbies or went to movies.

Having an idea of some of the problems the boys had, the duration of the problems was studied to find out how long

these problems had been evident. There was a relationship between the duration of the problem and whether the family stayed or withdrew from treatment. The mothers mentioned the duration of the problem and this may not be too accurate, but it does signify how long they felt it was a problem;

TABLE XXXI
DURATION OF BOYS' PROBLEMS

Duration	Stayed	Withdrew
Lifetime	0	1
Five Years	1	1
Three to Four Years	2	1
Two to Three Years	0	1
One to Two Years	1	2
Half to One Year	1	1
Three to Six Months	0	0
One to Three Months	1	0
Two Weeks	1	0
One Week	3	0
TOTALS	10	7

moreover, it could indicate this problem was not seen or faced until the runaway episode. There were more problems of shorter duration in the boys who stayed, the shortest duration in the boys who withdrew was half to one year. Three boys who stayed had problems of a week's duration, one boy who did not stay had a problem which his mother described as having existed his whole lifetime.

6. The Mother-Child Relationship In The Boys

Having studied the mothers and the boys, their relationship was examined. Leventhal, Counts and Gridley³⁶ found that

36. See page 7.

these boys had an intense sexualized relationship with their mothers. This study cannot determine the intensity or the sexualized aspect of this relationship; however, the mothers' controlling influence over the children's peer relationships and spare time activities was studied and related to the maintenance of treatment contact. Also, the things the mothers and boys did together were tabulated to indicate the types of mutual activity in which they were involved.

The mothers knowledge of and interference in the child's

TABLE XXXII
MOTHERS' INVOLVEMENT IN BOYS' PEER RELATIONSHIPS

Involvement	Stayed	Withdrew
Knew and Approved	1	0
Knew and Disapproved	3	3
Knew and Interfered	4	2
Did Not Know and Did Not Interfere	2	1
Not Mentioned	0	1
TOTALS	10	7

peer relationships was studied and related to involvement in treatment. Interference refers to a mother keeping a child in the home or in some way trying to get the child involved with other children. The mothers' involvement was related to the maintenance of treatment contact. Few of these mothers knew and approved of their sons' peer relationships, only one did in the group that stayed. An equal number in each group knew and disapproved but did not do anything about it. The relationship to contact came where more of the mothers interfered who stayed. Examples of this were Mrs. T. and Mrs. U. who kept their children in the house so that the children

would not be tormented by their peers. More mothers who stayed did not know of the child's peer relationships.

The mothers' involvement in the child's spare time activities was related to maintenance of the contact also. Most of the mothers who stayed knew and interfered in their sons' activities, more than the mothers who withdrew. Interference in the boys' activities usually took the form of not allowing the boy to do things away from the home. An

TABLE XXIII

Involvement	Stayed	Withdrew
Knew and Approved	2	2
Knew and Disapproved	0	1
Knew and Interfered	7	3
Did Not Know or Interfered	1	1
TOTALS	10	7

equal number of mothers who stayed and withdrew knew and disapproved of their sons' activities, only one mother who withdrew knew, disapproved and did not interfere. One mother from each group did not know of their sons' activities.

The number and kind of activity between mother and child did not relate to the maintenance of treatment contact except with boys who slept with their mothers; these cases stayed in treatment. The kind of activities the mother and boy shared together demonstrated not only what they did but suggested the amount of time they were together by the nature of the activity. Three mothers who stayed slept with their boys, this indicated that a large proportion of the day was

spent together. More mothers who stayed watched television with their sons, in one case the mother said they would watch

TABLE XXXIV
MOTHER AND SONS' ACTIVITIES TOGETHER

Activity	Stayed	Withdrew
Slept Together	3	0
Watch Television Together	2	1
Work Together	1	0
Do Schoolwork Together	1	0
Mother Keeps Child Close to Her	2	3
Fight Together	1	1
Not Seen	2	2
TOTALS	10	7

together evenings and that this was when they felt close. More of the mothers that stayed participated in chores together (housework and schoolwork). Three mothers who withdrew and two who stayed stated that they tried to keep their children close to them all the time. One mother said she was sick a great deal and kept the boy home to attend to her. One mother of each group fought with her son, and two of each group showed no activities in which mother and son participated.

7. Boys' Fathers' Participation

Fathers are often in the background when families come for help but it cannot be assumed that they are unaware of the agency contact. The fathers' participation in treatment was studied in relation to maintenance of treatment. Their interest in the boys' being helped was explored also. The mothers gave most of the information on fathers who were not seen, and the validity of this was questionable, they may be

projecting their own feelings, however, this might be a further indication of difference on this topic, mothers may feel alone in the child's difficulty.

Where fathers participated there was a tendency for the case to stay in treatment, however, when fathers were not seen or when they broke contact there was no relationship to maintenance of treatment contact. More fathers participated

TABLE XXXV
FATHERS' PARTICIPATION IN THE CONTACT

Participation	Stayed	Withdrew
Father Participated	3	1
Father Seen But Broke Contact	2	3
Father Not Seen	3	2
Father Not in the Home	2	1
TOTALS	10	7

in cases that stayed, however, more cases stayed where fathers were not seen at all. Only one more case withdrew where fathers broke contact, and more contacts stayed where there was no father at home. There was a relationship between fathers' encouragement of the contact and maintenance of treatment, however, there was a relationship between negative feelings about the treatment and staying. More fathers encouraged the contact in cases that stayed, more cases that withdrew had fathers accept it. Only one father was not interested, this case stayed; moreover, more that stayed disapproved of the whole plan. Fathers who encouraged the contact generally wanted to participate, and they encouraged the mother and child in their coming. An example of a father who

accepted the idea was a man who came in once and said he felt

TABLE XXXVI
FATHERS' INTEREST IN THE CONTACT

Interest	Stayed	Withdrew
Encouraged the Contact	4	2
Accepted the Contact	0	2
No Interest Shown	1	0
Refused Help for Himself Only	1	1
Spoke Disapprovingly of Plan	2	1
Father Not At Home	2	1
TOTALS	10	7

it was a good idea although he did not openly encourage the mother to come in. A father who disapproved said there was no problem, the child would grow out of it.

There was no relationship between prognosis and the maintenance of treatment contact. Prognoses were made on the

TABLE XXXVII
PROGNOSIS

Prognosis	Stayed	Withdrew
Fair	2	1
Poor	0	1
Bad	8	5
TOTALS	10	7

basis of an evaluation of the family situation, the children and the family's ability to use the help the Center had to offer. Some of the cases in the larger population of runaways had prognoses of "good" but none of these appeared in this particular sample. More of the cases that stayed had a prognosis of "bad", but both groups had about the same proportion. An example of a case that had a bad prognosis was the M. family. Their marital relationship was poor, Mrs. M. was quite depressed, and the child was very disturbed and had been

for a long time. One case that withdrew had a prognosis of "poor," in this situation the child could be helped with limited goals, but the parents were very troubled people. More cases that stayed had a "fair" prognosis. In one of these situations the child was helped, and although the family was disturbed, there was a fairly stable marital relation.

8. The Girls

The same procedure in studying the boys was used with the girls.

The ages of the girls was related to the maintenance of treatment contact. The average age of the girls in the sample was 13.4' years, the youngest girl was ten. The girls who

TABLE XXXVIII
GIRLS' AGES

Age	Stayed	Withdrew
Seventeen	0	1
Sixteen	0	2
Fifteen	0	1
Fourteen	1	2
Twelve	0	1
Ten	1	0
TOTALS	2	7

withdrew were older, one was seventeen, two were sixteen and one was fifteen. The youngest girl stayed, the youngest girl who withdrew was twelve.

The number of siblings and their position (of the girls) in relation to them was tabulated to determine if they seemed to be related to the maintenance of the treatment contact. The number of siblings was found to be related, the girls

who withdrew had more siblings than those who stayed, two had three siblings and two had six. One girl who withdrew was an only child and one had one sibling. The two girls who stayed had two siblings, one who withdrew had two siblings. Being the first child seemed to be related to break-

TABLE XI
POSITION OF THE GIRLS IN RELATION TO SIBLINGS

Position	Stayed	Withdrew
First	0	3
Second	2	2
Third	0	1
Seventh	0	1
TOTALS	2	7

ing treatment, however, in the girls' cases as in the boys' almost all were either the first child or the first child of their sex. Both groups had two girls who were the second child, but all were the first females in the family. One girl who withdrew was the third child and one was the seventh.

The number of symptoms reported was related to a mother's staying in treatment. The number of symptoms of girls

TABLE XLI
NUMBER OF GIRLS' SYMPTOMS

Number	Stayed	Withdrew
Five	1	0
Three	1	2
Two	0	5
TOTALS	2	7

who stayed tended to be more than the group that withdrew, one had five and one had three symptoms. Five girls who withdrew had two symptoms. Concerning the symptoms themselves, there was a relationship between sexual problems and

physical complaints and girls' withdrawing, and girls with antisocial behavior tended to stay. The girls who withdrew had more sexual problems and more problems with their parents, although both girls who stayed had this problem (lying, tantrums, defiance and disobedience). The two girls who with-

TABLE XLII
GIRLS' SYMPTOMS

Symptom	Stayed	Withdrew
School Difficulty	2	5
Sexual Problems	1	3
Antisocial Behavior	2	0
Difficulty with Parents	2	4
Physical Complaints	0	2
TOTALS	7	14

drew who had physical complaints had allergies and one had had rheumatic fever. School difficulty was evident in all the cases except two girls who withdrew. Truancy was the main school difficulty, also there were poor relationships with teachers and poor grades.

Other indications of the girls' adjustment that were studied were the girls' relationships with other children and their spare time activities. There was a relationship

TABLE XLIII
GIRLS' PEER RELATIONSHIPS

Relationships	Stayed	Withdrew
Large Circle of Friends	1	3
Small Circle of Friends	1	0
One Friend Only	0	3
No Friends	0	1
	2	7

between the girls' peer relationships and staying in treatment. The girls who stayed in treatment had friends, and

three of the girls who withdrew had a large circle of friends, but three girls who withdrew had only one friend. Only one girl (who withdrew) had no friends. The area of recreation showed no relation to staying or withdrawing from treatment.

TABLE XLIV
AREA OF GIRLS' RECREATION

Area	Staying	Withdrew
Inside The Home	0	2
Outside the Home	2	11
TOTALS	2	13

Most girls in their teens go outside the home for entertainment in their spare hours with other girls or on dates. Only two girls who withdrew stayed inside for a spare time activity. The girls did not have the variety of activities the boys had. The girls who stayed had only one activity mentioned for each girl; one went to movies and another dated. Five of the girls who withdrew dated and two had jobs. Two girls who withdrew watched television and participated in sports.

The durations of the girls' problems was quite scattered. There was no relationship between the duration of the

TABLE XLV
DURATION OF THE GIRLS' PROBLEMS

Duration	Stayed	Withdrew
Seven Years	0	1
Five Years	1	0
Three to Four Years	0	1
Two to Three Years	0	1
One to Two Years	0	2
Three to Six Months	0	1
Two Weeks	1	0
One Week	0	1
TOTALS	2	7

problems and whether the client stayed or withdrew. In the girls who stayed one girl's problem had a duration of five years, the other was two weeks. The girls that stayed had a distribution similar to those who withdrew, they ranged from one week to seven years in duration.

9. The Mother-Child Relationships In The Girls

The mother-daughter relationship was studied to find if there were close relationships found in the preliminary study of Leventhal, Counts and Gridley.³⁷ Again the peer relationships, spare time activities and mutual activities between mother and daughter were studied and related to the maintenance of treatment.

There was little interference from the mothers in the

TABLE XLVI
MOTHERS' INVOLVEMENT IN GIRLS' PEER RELATIONSHIPS

Involvement	Stayed	Withdrew
Knew and Disapproved	2	6
Knew and Interfered	0	1
TOTALS	2	7

girls' peer relationships, however, there was almost unanimous disapproval of the daughters' friends although they did not try to stop the association with them. All the girls except one who withdrew (mother knew and interfered) had peer relationships of which the mothers disapproved but did not interfere. Most of these girls had many friends. One mother felt her daughter was influenced by some "bad girls"

37. See page 7.

but did not try to stop this. There seemed to be a relationship between the mothers' interference in recreational activities and maintenance of treatment. Mothers seemed to interfere in their daughters' activities more than their peer relationships. Both of the mothers who stayed knew and interfered with their daughters' activities, two mothers

TABLE XLVII
MOTHERS' INVOLVEMENT IN GIRLS' SPARE TIME ACTIVITY

Involvement	Stayed	Withdrew
Knew and Disapproved	0	3
Knew and Interfered	2	2
Did Not Know or Interfere	0	1
Not Mentioned	$\frac{0}{2}$	$\frac{1}{7}$

who withdrew interfered. Mrs. F. sorted out the movies her daughter saw; she did not want her to get "bad ideas." Disapproving of the activities was related to leaving treatment. Three mothers who withdrew knew, disapproved, but did not interfere. One mother felt her daughter was too young to date, but did not prohibit this. Participation with the mother in activities was not related to staying or withdrawing from treatment. In five cases that withdrew and one that stayed there was no evidence of activities between mother and daughter. One girl who stayed confided in her mother on sexual matters and in two cases that withdrew the mothers helped their daughters with their homework.

10. Girls' Fathers' Participation

The fathers of the girls were studied to find if there

was any relation between their participation and interest in the contact and the mothers' involvement in treatment.

There was no relation between staying in treatment and the fathers' participation or interest, except where the father was not seen and when he showed no interest. None

TABLE XLVIII
FATHERS' PARTICIPATION IN THE CONTACT

Participation	Stayed	Withdrew
Father Participated	0	2
Father Discontinued	1	1
Father Not Seen	1	3
Father Not In The Home	0	1
TOTALS	2	7

of the stayed group fathers participated, but two of the group that withdrew participated. Three fathers of the group that (stayed group had one) withdrew were not seen at all. This same distribution was evident in relation to the fathers'

TABLE XLIX
FATHERS' INTEREST IN THE CONTACT

Interest	Stayed	Withdrew
Encouraged the Contact	1	1
Accepted the Contact	0	2
No Interest Shown	1	3
Father Not At Home	0	1
TOTALS	2	7

interest, three of the group that withdrew and one that stayed showed no interest in the contact. Two of the fathers of the group that withdrew accepted the contact, and one in each group encouraged the contact.

As in the boys' group the prognosis was not related to maintaining or breaking treatment. Except for one case with

a "fair" and one with a "poor" prognosis in the group that withdrew, all the girls cases had bad prognoses. The "poor"

TABLE I
PROGNOSIS

Prognosis	Stayed	Withdrew
Fair	0	1
Poor	0	1
Bad	<u>2</u>	<u>5</u>
	2	7

prognosis was a case which could have been helped, the girl was not too disturbed, but she refused help. The "fair" prognosis was a case where the girl worked fairly well in treatment, but the mother was too disturbed to use the help the Center had to offer. The cases with "bad" prognoses were ones with severe disturbance in the child and parents.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The aim of this study was to examine factors which might be related to the maintenance of treatment contact in twenty-six mothers with children who have run away from home. Many cases of runaway children who came to the attention of the Worcester Youth Guidance Center Runaway Project discontinued their contact with the agency. In order to explore the factors which might be related to the mothers' staying or withdrawing from treatment, a schedule was applied to twenty-six cases, twelve that stayed in treatment and fourteen that withdrew. This chapter will discuss and interpret the findings.

An examination of the sample in this study showed that there was a relationship between sex and age and maintenance of treatment contact. The boys were younger and remained in treatment, the girls were older and tended to withdraw from the agency contact. The discussion of maintenance of treatment contact will begin with the boys.

The first section examined factors in the family which were related to the mothers staying or withdrawing. Religion was a factor related to mothers staying or withdrawing from treatment; Catholic mothers stayed while Protestant mothers withdrew. It may be that the Catholic people felt that it

was part of their religious duty to get help for their problems, or they felt guilty about the problem which may have had a religious basis, while the feelings toward the church were less strong in Protestants. Their attitudes toward the referral, acceptance of help for themselves and their children pointed to an active interest in the contact, not just a passive acceptance. The Catholic clients may see in the agency some of the authority they see in their church; they may have more faith and may vest the agency with the power to help.

Contact with sectarian and public agencies was related to the mothers' staying in treatment. More mothers had contact with sectarian agencies who stayed; these were Catholic mothers and would most likely have gone to the facilities set up by their church first. Contact with public agencies was related to mothers withdrawing; this may indicate that these mothers had experiences where they had been forced into an agency contact (Youth Service Board) or had contact with the less flexible social work policy of a public agency (public assistance) and carried the attitude toward these over to the contact with the Center.

Marital adjustment, religion and maintenance of treatment were related; Catholic mothers who had serious marital discord, separation or divorce stayed in treatment, Protestant mothers did not. The Protestants were free to divorce, so

there was not the pressure on them to work out their problems at the Center; however, divorce is prohibited by the Catholic church so there was pressure to work those problems out and mothers who were already divorced or separated may have felt the need for help but may not have felt they could bring these to the priest.

Referral by the parents was related to the mothers staying in treatment, apparently where the parents made the referral there was a greater motivation to seek help and a feeling of being responsible. This was related to the mothers' staying in treatment where individuals close to the family suggested coming to the agency. The suggestions of people close to the family were important, they may have been able to take these easier without feeling compelled or pressured. A factor relevant to maintenance of the contact was the source of the first contact. This seemed to be related to the parents who referred their children, as greater success in keeping mothers involved in the contact was related to the parents making the first call to the agency. In making the first contact, the agency might have aligned themselves too closely to the authoritarian agencies for people who already had problems in relation to authority.

Seeing problems other than the runaway episode was related to staying in treatment. This might have indicated that these mothers had seen other problems which needed help. This could

have been related to the initiation of the contact; parents who were motivated may have seen related difficulties, those who were referred by an agency may have come because they were told to do something about their child's running away. The mothers' attitudes toward the referral was related to maintenance of the treatment contact; acceptance of the referral, related to many of the factors above, was most common in the group that stayed.

The number of diagnostic interviews was related to staying or leaving the contact, however, the group that stayed would have more interviews because those withdrawing would do so by the fifth or sixth interview. Good attendance was related to staying in treatment, those really motivated for help would tend to make each interview. Transfer of workers was related to the mothers withdrawing; the mothers who were transferred might have felt rejected or it might have been an excuse to blame the agency when they withdrew.

Histories of past sexual difficulties and running away in mothers was related to maintenance of the treatment contact. This may have been a mother's ability to share this information with the worker which would enable them to be helped easier, it seemed to be the mothers' increased involvement in the treatment process. Being anxious or accepting of help for themselves was related to staying in treatment; the mothers' ability to be involved in treatment themselves seemed to

be a factor in keeping the case. Distrustful attitudes toward the contact were related to staying; this may have been a raising of defenses (resistance) to the new situation, however, when familiarization with this they were able to become involved in treatment. Unwillingness was related to withdrawing, in these cases the defenses could not be eased to enable the mother to become involved in treatment. Fear about the child's being seen was related to staying in treatment; fear of the contact could have been the mother's own fantasy about a psychiatrist and what he does, and the mother who feared the child's reaction may have projected their own fear onto the child, or it could have been their fear that somehow they would be found to be bad parents through the children's material.

Seeing the mother-son relation as a cause of the problem and blaming the father were related to staying in treatment. This again illustrated the mothers' ability to share information with the worker and to see her own part of the difficulty which would facilitate treatment. Although they could take some of the responsibility they had to share this with the fathers of the runaway children. A mother's seeing the difficulty as a plot against her was related to withdrawing from treatment. This may have been a projection which defended the mother against seeing her part in the difficulty; this mother may have felt some of this in the contact.

The ages of the boys were related to maintaining contact; boys who stayed were older. It may have been that the younger boys were closer to their mothers and there was resistance to breaking this. The position of the boy was related to maintenance of treatment, the first child was more apt to become involved in the parents' neurosis and if the child was the first it may have been the mothers' first experience with the problem and have caused anxiety enough to facilitate treatment. The number of symptoms reported on the boys was related to staying in treatment; this again implied an ability to talk and share information with the worker. Antisocial and difficulty with their parents were related to maintenance of the contact. More boys with antisocial behavior withdrew, this may have meant that the mothers were disturbed only when some open acts against society were committed and public attention was brought to it. Difficulty with parents was related to staying in treatment, this seemed to coincide with the greater number of mothers who stayed who saw the cause of the problem in the mother-son relationship. Difficulty with their sons concerned these mothers so that they were motivated to help this situation.

The duration of the problems was related to maintenance of the contact; the shorter duration was related to staying in treatment, so the initial anxiety from the runaway episode was still there. The mothers who withdrew who had sons with

boys with problems of longer duration may have given up trying for help, or they may not have been able to face these problems having been bound up in these themselves.

The mothers interference in the children's peer relationships and spare time activities was related to their staying in treatment. With these children having poor relationships with peers the mothers tended to keep the children inside, thereby keeping these relationships poor in an attempt to protect the son from unfriendly peers or to keep the child close to them. As poor as the result was, these mothers seemed to have tried with their child, and staying may indicate real concern and desire to help. The same was true of the spare time activities. Almost all activities were outside the home, the mothers tried to interfere with this. The staying in treatment may have been a desire to help the son improve his relationships and to get the child into activities of which the mother approved. The fathers' participation and encouragement of the contact was related to staying in treatment. The fathers' interest and participation would tend to lend support to what the mother was trying to do and to share the responsibility for helping the boy; the mother was not on her own in the difficulty.

The mothers of the girls in the sample had many factors related to the maintenance of treatment contact. The mothers' employment was related to their withdrawing, more mothers in

the group that withdrew worked. These mothers may have found it more difficult to get to the clinic because of their working hours, however, their working may have represented a running away from the problem at home, and the withdrawing may have been another running away from facing these. The mothers' working might be satisfying some unconscious desire which could have been related to the child's problem, however, just what this relationship might have been was not within the scope of the study to determine.

Catholic mothers in the girls' group stayed in treatment, Protestant mothers withdrew. The speculations made in the boys' group might have been related to this group, that the Catholic mothers may have felt it their religious duty to get help. In the girls' families, previous contact with the police, sectarian agencies and public agencies was related to the maintenance of treatment contact. Contact with the police resulted in withdrawing; these families may have had previous unhappy associations around the police, or it may have indicated that these difficulties, severe enough to come to the attention of the authorities, were further along and more deeply embedded into a pattern. These mothers had more contact with public agencies. This may have been related to the severity of the problem or to the contact itself. Contact with a sectarian agency was related to staying in treatment, these mothers were Catholic and would go to a sectarian agency first, some of the feelings of authority invested in

this contact might have been transferred to the contact with the Center. Referring and suggesting agencies were related to maintenance of treatment contact as previous agency contacts were related; where the client had contact with the police mothers withdrew. Another factor related to this was the initiation of the first contact. Where the agency (by telephone or mail) initiated the first contact the mothers withdrew; this may have given these mothers the idea that the agency and police were related, or they may have had fantasies that what they talked about might get to the police which, in turn, might result in more difficulty.

The mothers of these girls had many motives for seeking help and they were related to the maintenance of the contact. Mothers who saw other problems as the main concern stayed in treatment, those who withdrew came because of the runaway. These mothers who withdrew were told to come by the police, they may have not really felt there was any other problem, they were told to come because of the runaway and that was why they came. This may also have indicated the mothers' ability to share information, in order to get help they have to be able to discuss the situation, and part of this would be looking at other areas of difficulty. Mothers who withdrew tended to be more distrustful, those who stayed were anxious or accepting of help. The mothers who were early stayed in treatment; this may have indicated being anxious for

help. The mother who was always late withdrew, this could be related to a greater resistance toward help. In promptness, the relationship to maintenance of treatment occurred only when there were definite patterns established of being late or early.

The number of symptoms reported by a mother was related to staying or withdrawing from treatment. Mothers who stayed mentioned more symptoms, this seemed to be related to their ability to share information about themselves, their involvement in treatment. The mothers who withdrew mentioned fewer symptoms as a group, two did not mention any, they may have felt they were not part of the problem. In this group two mothers did mention a high number of symptoms, so that this group showed either many or few symptoms (mostly fewer). Mothers that mentioned many in this group may have said more than they were really ready to say and have felt anxious and threatened afterward. Presence of sexual difficulties in mothers was related to staying in treatment, fearing loss of control and physical symptoms were related to withdrawing. These mothers may have been more ready for help with sexual problems because of a desire to have a more satisfactory adjustment, however, mothers fearing loss of control may have felt case-work help might threaten the thin control they do have. The illnesses of these women were physiologically based, however, accompanying illness there may have been secondary gain which

was satisfying to an underlying conflict, so that there was not the feeling of wanting or needing help, this may have meant to them giving this up. This is further illustrated in their attitude for help for themselves, they were mostly cautious, distrustful or unwilling, the mother who stayed who was not anxious for self-help was cautious. A mother's being anxious for help for her daughter or her fearing the child's reaction was related to withdrawing. Those who were anxious might have felt the agency would change the child for them, not seeing themselves as part of the plan, and the mothers who feared the child's reaction may have been projecting their own feelings onto their daughters.

The number of causes given were inversely related to stay-in treatment. These mothers may not have thought about why the problem occurred, they may be looking for the cause through treatment. Mothers who withdrew may have had more preconceived notions of the cause and were set to defend themselves. Most of these causes were within the family, however, only one mother saw the problem as between themselves and the daughter, others blamed the father, the marital adjustment or illness in the family.

The daughters of mothers who withdrew were older than those who stayed. These mothers may have felt their daughters were too old to be helped, or this behavior may have been satisfying some unconscious unfulfilled need in the mother. The

daughters who withdrew had more siblings and tended to be the first child more than the girls who stayed. Mothers with more children may have been through this before and may not have felt they had time to concentrate on one child. Although all but two girls in the sample were first female children, both girls who stayed were the second child but the first female. Their being females may have had special meaning to their mothers, however, their older brothers may have been more bound up in the parents' neurosis. Where girls were the first child they withdrew, so they may be involved in the parents' neurosis which mothers may have been resistant to breaking.

The girls' number of symptoms was related to the maintenance of treatment contact; the ability to share information was related to staying in treatment, more symptoms were reported. Sexual problems in daughters was related to withdrawing. These mothers reported fewer sexual difficulties themselves, so their daughters' exploits might be fulfilling some need in themselves which they do not want help with. Like their mothers, these girls had more physical symptoms. Anti-social behavior seemed to be less acceptable in girls, this was related to staying in treatment.

The girls who stayed tended to have more friends, those who withdrew had either many friends or few friends. All the mothers disapproved of their daughters' peer relationships out

did not take measures to stop them. In staying, mothers may have been seeking ways to control them better, mothers who withdrew may not have wanted to stop the behavior unconsciously. Interference in spare time activities tended to be related more in the group that stayed, more mother who withdrew did not know and just disapproved. This may indicate the mothers' attempt at handling the daughters' problems and although more mothers who withdrew interfered with spare time activities than peer relationships, they still may have tended to disapprove consciously but allow the activity to continue unconsciously. From this material there does seem to be evidence that the daughters' activity may be encouraged by the mothers.

Fathers' participation and acceptance of the contact may have been related to the cases withdrawing. Neither father was seen (but one encouraged the contact) in cases that stayed. When fathers were brought into the contact mothers tended to withdraw. These couples may have had marital difficulties such that the fathers' being seen somehow may have represented a rejection by the worker, a fantasized break in confidentiality or some other distortion of this contact. Apathy (fathers not seen nor who showed interest) was realized by the mothers as they tended to withdraw, so it seems that these mothers were confused in the fathers' participation. They tended to withdraw if he was seen and withdraw if he was not seen or

did not show interest, so it may be that these mothers used their husbands participation as a way out of treatment. The fathers background support might be important in staying as long as he did not participate. There may have been a desire on the mothers' part of have the husband seen once or twice so long as he did not participate in the whole plan.

In conclusion, the main factors related to the maintenance of treatment contact were the child's age and sex, the family's religion, contact, referral and suggestion by other agencies, motive for seeking help, ability to share information, position of the child in relation to his siblings, interference by the mothers in the child's spare time activities and the participation and interest of the father in the contact. How these factors were related might be a topic for further investigation; moreover, further study of these factors in a sample with groups more closely equated would be desirable.

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APPENDIX

APPENDIX I

SCHEDULE

I. The Family

1. What is the family makeup, how many people are in the family?
2. What is the mother's occupation? The father's occupation?
3. What is the religion of the families?
4. Has the family had contact with other agencies?
5. What is the marital status of the family; are they happy or is there discord?
6. Does a particular religion and marital status have any relation?

II. The Referral

1. Who referred the family?
2. What did the mother say as to what or who suggested their coming?
3. Who established the first contact?
4. What was the mother's stated motive for seeking help?
5. What was the mother's attitude toward the referral?

III. The Diagnostic Period

1. How much time elapsed between the initial contact and the first interview?
2. Was there transfer of workers in this period and what was the result of this?
3. What was the attitude of mothers toward referrals if they waited over a week?
4. How many interviews were there?
5. Did the mother tend to make the interviews?
6. Were the mothers prompt for appointments?

IV. The Mothers

1. How many symptoms did the mother report?
2. What were the mother's symptoms?
3. What did the mothers feel about being seen?
4. What did the mothers feel about their child being seen?
5. Did the mothers feel the problem was caused by things within the home?
6. What did the mothers see as the cause?

V. The Children

1. What were the children's ages?
2. How many siblings did the child have?
3. What position did the child occupy in relation to their siblings?
4. How many symptoms did the children have?
5. What were the children's symptoms?
6. How did the children get along with their peers?
7. What did these children do in their spare time, was this inside the home or outside?
8. How long has the child had the problem?

VI. The Mother-Child Relationship

1. Did the mother know or interfere in the child's peer relationships?
2. Did the mother know or interfere in the child's spare time activities?
3. Do mother and child do things together?

VII. Father's Participation

1. Did the fathers participate in the contact?
2. Were the fathers interested in the contact?
3. What was the prognosis in the cases?

APPENDIX II

CONTACTS WITH OTHER AGENCIES

Agency	Boys		Girls	
	Stay	With	Stay	With
Youth Guidance Center	2	3	1	2
Juvenile Division (Police)	5	5	1	6
Worcester State Hospital	1	1	0	0
Catholic Charities	1	0	1	0
Memorial Hospital	0	0	1	0
Department of Public Welfare	2	1	0	2
School Department	2	1	0	0
MSPCC	1	0	0	0
House of the Good Sheperd	1	0	0	0
New England Home	1	0	0	0
Catholic Youth Guidance	1	0	0	0
Traveler's Aid	0	1	0	0
Private Psychiatrist	0	2	0	1
Youth Service Board	0	2	0	0
Div. of Child Guardianship	0	1	0	0
TOTALS	17	17	4	11

APPENDIX III

CHILDRENS' SYMPTOMS

Symptom	Boys		Girls	
	Stay	With	Stay	With
Lying	2	1	1	0
Stealing	1	4	0	0
School Difficulty	9	6	2	5
Tantrums	1	1	1	1
Defiant Behavior	3	1	0	2
Sexual Difficulty	1	1	1	3
Disobedience	2	1	0	1
Physical Complaints	1	1	0	2
Fears Loss of Control	0	1	0	0
Nervousness	1	2	0	0
Fights with Peers	2	1	2	0
Eneuresis or Soiling	1	0	0	0
Fire-Setting	1	1	0	0
TOTALS	25	21	7	14