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A study of the attitudes of mothers who withdrew from treatment in the Providence Child Guidance Clinic between July, 1950 and June, 1951

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Thesis
Williams, M.
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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE ATTITUDES OF MOTHERS WHO WITHDREW FROM TREATMENT IN THE PROVIDENCE CHILD GUIDANCE CLINIC BETWEEN JULY 1950 AND JUNE 1951.

A Thesis

Submitted by

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(A.B., Tufts College, 1944)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1952

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CHAPTER I

INTRODUCTION

Unique in its position as the only privately supported child guidance clinic in the State of Rhode Island, the Providence Child Guidance Clinic is necessarily concerned with its responsibility of serving the community to the optimum. Realistically limited both as to its staff and budget, the clinic is constantly seeking to determine the most effective utilization of its given capacity.

With this in mind, the cases which had been accepted for study by the clinic during the period from July 1950 through June 1951 were examined to determine the outcome of treatment in each instance. From the 188 cases examined, it was found that in thirty-eight or 20.2 per cent, the mothers withdrew from the clinic before treatment was completed. The clinic itself is interested in a study of these cases with a view toward ascertaining more about the attitudes of these mothers who withdrew before clinic treatment had been completed. Prior to this time, such a study has not been made in this clinic.

PURPOSE

The writer will examine ten cases in which the mothers withdrew from treatment. An attempt will be made to study the attitudes of these mothers in an effort to determine what relationship, if any, exists between the mothers'

attitudes as revealed during clinic contact and their subsequent withdrawal from treatment. The following questions will be considered in the process of reaching a more thorough understanding as to the nature of these attitudes:

1) What is the mother's attitude toward the problem as expressed during the initial interview?
2) What is the mother's attitude toward the clinic as recognized during both the initial and subsequent interviews?
3) What is the mother's attitude toward the child as detected during clinic interviews?
4) To what extent do any of the attitudes influence the mother's withdrawal from treatment?

This study is not concerned with an analysis of the casework techniques employed in the treatment of these attitudes but rather with a description of them as revealed by the mother during her contact with the clinic.

METHOD

This is a study of ten cases in which the mothers withdrew from treatment in the Providence Child Guidance Clinic. The study has been restricted to treatment cases, for although the clinic offers both diagnostic and treatment service, the treatment cases average from twelve to fifteen interviews while the diagnostic studies average from two to three interviews. A minimum of three interviews between the

child and therapist was used as a criterion as it was felt that it would be evident at that point whether the case was diagnostic or treatment. Also in examining the records of the cases which withdrew from the clinic, it was found that it was advisable to set a minimum of three interviews in order to have sufficient material for this study. All cases which withdrew before completing three interviews were eliminated from this study.

Of the total number of cases which had withdrawn after three or more interviews, six were eliminated after discussion with the Director of the Clinic who did not consider them actual withdrawals due to unusual circumstances connected with their termination. Two others were eliminated in view of (1) the child's prolonged absence due to illness and (2) inadequate material in the case record.

A specifically designed schedule facilitated the abstraction of material from the individual case records. The selected material was then analyzed and classified in relation to the purpose of this study.

LIMITATIONS

The limitations of this study are essentially in the case records of the Providence Child Guidance Clinic. It is noted that the method of recording differs according to the individual psychiatrist, psychologist and social worker. Some records are more complete than others; in some cases,

processed recording was used; in others, a series of interviews was recorded in summarized form, while in still other cases, individual interviews were summarized and recorded. Consequently, the case records do not provide an equal amount of information or detail which would tend to reveal the fine nuances descriptive of the maternal attitude. In each instance, the thinking of the clinical staff person was accepted as final.

SETTING OF THE STUDY

This study will be based on an analysis of ten cases taken from the files of the Providence Child Guidance Clinic, Providence, Rhode Island. This is a private agency, originally sponsored by the Rhode Island Mental Hygiene Society, and now supported primarily by the Rhode Island Community Chest, Inc.

The clinic offers a team work type of service consisting of psychiatric, psychological and psychiatric social work services or any combination of these three. In the long histories connected with the growth of psychiatry, psychology and social work are many indications of the contribution of each discipline in working toward the common goal[1] of helping the individual to adjust. It was only after the idea of

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1 George S. Stevenson and Geddes Smith, Child Guidance Clinics: A Quarter Century of Development (New York, The Commonwealth Fund, 1934), p. 13.

prevention had been reached that the child guidance clinic was realized. Its inception was directly related "to a conviction that preventive work in all these fields should concentrate on the childhood period"[2] and that emphasis should be placed on the causes and meaning of the behavior rather than on the overt behavior itself. A child guidance clinic functions broadly to serve the "children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior, or inability to cope with the social and scholastic expectations".[3]

As previously mentioned, the services of the clinic are "rendered through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist and psychiatric social workers".[4] The goal of treatment is accomplished through the teamwork of staff members, each dovetailing his special skill into the coordinated treatment of the total situation. For the most part, the psychiatrist works with the children who are accepted for study at the clinic; occasionally, the psychiatric caseworkers may see a mildly disturbed child and conversely, when

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2 Ibid., p. 11.

3 Ibid., p. 1.

4 Ibid., p. 1.

a parent is extremely disturbed, he may be seen by the psychiatrist. The psychologist administers various intelligence and projective tests in an attempt to evaluate both the functional and potential level of the child's intelligence, as well as to evaluate his personality. These psychological evaluations constitute a significant diagnostic tool in both the diagnostic and treatment studies. In this particular setting, the clinical psychologist, with his training in educational psychology, is equipped for therapy in cases of educational disabilities. In cases where reading disability is a factor, the psychologist is especially helpful in the retraining and re-education necessary for the child.

The psychiatric social worker usually works with the parent although, as previously mentioned, she may occasionally work with the child. In the intake interview, the caseworker has the special task of evaluating the situation described by the parent in an effort to determine whether or not it falls within the function of the clinic and if so, if it seems that clinic treatment would be beneficial. The caseworker carries the main responsibility for exploration of the familial and social background necessary in the formulation of the diagnosis and subsequent treatment plan.

The aim of treatment with the parent is to alleviate guilt and anxiety and to help him to see the connection

between his problem and the child's.[5] The caseworker is interested in the parent both as a person and a parent for the emotional environment of the child is to a large degree, evidenced by the feelings and attitudes of the parent on whom he is dependent. During the course of treatment, she attempts to work toward the gradual removal of certain defenses leading to partial insight and at the same time strengthening the more useful defenses of the parent. The relationship established between the worker and the parent is of prime importance in the casework process for it is according to the degree to which this relationship is helpful to the parent that the goal of casework is achieved. In this relationship the worker must offer the parent new form of relationship wherein he will be helped to connect the distortion of his reactions and make the best possible use of the strengths he has.

Implicit in the child guidance focus on parent-child relationships is the assumption that the parent is part of the clinical problem. "Child Guidance is the treatment of sick relationships of total situations.....it is our job.....to understand the total situation and help those who are involved in it to understand it."[6]

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5 Gordon Hamilton, Psychotherapy in Child Guidance, (New York, 1947), p. 282.

6 Temple Burling, M.D., Memorandum written to the staff and directors of the Providence Child Guidance Clinic, date unknown.

The central focus of clinic treatment is the interaction between the parent and child; through her own participation in the interviews, the parent is gradually helped to see her psychological involvement in this interaction. Every attempt is made to help the parent to spontaneously enter into the casework relationship for this is an essential factor in the acceptance and progress of treatment.

Sometimes parents apply to the clinic as a result of their own recognition of a problem; more often, however, they are referred by some other agency, professional person or interested person who pressures the parent to apply to the clinic. Whichever the case may be, the general policy of the clinic is to have the parent contact the clinic directly before the name is placed on the waiting list. There is usually a two to four month period before the parent can be given an intake appointment due to the length of the waiting list. Exceptions to this are made in cases of dire emergency. However, in the belief that all problems brought to the clinic are emergent to some degree, the clinic adheres to the waiting period as strictly as possible.

At the time of the intake interview, the parent presents the problem as she sees it and the caseworker explains the function of the clinic and the services it can offer the parent. If in evaluating the situation, the caseworker feels the case does not come within the function of the clinic,

referral may be made to an appropriate agency. The parent, too, has an opportunity to evaluate the clinic as to what treatment implies and may at that time withdraw or continue as she wishes. Although the clinic is supported largely by funds from the community chest, there is a voluntary fee system in which it is suggested the client pay according to his income. There is a guide indicating a fee of three dollars per visit for an income of $3,000 with fees over ten dollars being arranged. This fee schedule is flexible and may be altered at any time the client desires. However, as the clinic is responsible for raising a given amount through fees each year, the fee is discussed routinely with each client as part of the intake procedure.

Cases are further screened at the weekly intake conference attended by the Medical Director and casework staff. Tentative plans are made and cases are classified as to possible treatment or diagnostic studies at this time.

Specific cases are presented at weekly staff conferences as means of evaluating the effectiveness of the treatment plan as it involves both the child and the parent. It is at this time particularly that the thinking of the three disciplines is pooled and the dynamics of the problem synthesized. Subsequent treatment plans are formulated as a result of the discussion at these staff conferences.

The clinic is a teaching center for students in the field

of mental hygiene and during the course of the year there are usually four students receiving their field work experience in the agency.

It is in such a setting that the clinic team--the psychiatrist, psychologist and psychiatric social worker--strive toward the common goal of preparing "an emotional soil and climate in which the child can achieve the fullest rounded development of his own nature".[7]

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7 Temple Burling, M.D., Ibid.

CHAPTER II

THEORETICAL DISCUSSION: PERSONALITY DEVELOPMENT, RESISTANCE AND THE USE OF THE INITIAL INTERVIEW

Basic in the practice of child guidance is the study, evaluation and treatment of parent-child relationships. Regardless of the nature of his problem, a child rarely, if ever, comes to the clinic alone; in the absence of the own parent, a parent substitute accompanies him. Implicit in this is the assumption that the parent of the child is part of the clinical problem and as such must be included in the treatment plan. The general thesis that parent-child relationships are determined primarily by the attitudes of the parents and that these attitudes spring from the dynamic forces within the parents' personalities is fundamental in this procedure. Although the attitudes of each parent, both toward the child and toward each other, is of great importance in the development of the child's personality, we tend to think more particularly of the mother and her attitude. Both the biological and cultural reasons for this are obvious. Further, it is noted that in general it is the mothers who come to the clinic with their children although there is no specific ruling about this and either or both parents may be seen according to the individual case. However, inasmuch as this is a study of the attitudes of the mothers in each instance, and also for further ease and clarity of discussion, hereinafter reference will be made to the mother alone except

where father is specifically mentioned as such.

The biological relationship of the infant to his mother begins with conception. Old wives' tales and many other superstitions as to how the child is influenced by prenatal impressions have been largely discounted. However, no convincing refutation has yet been offered relative to one important prenatal factor. In her reference to this, Dr. Josselyn has stated that "the emotional experiences of the mother during pregnancy have considerable bearing on the attitude of the mother toward the newborn child, and thus upon the early relationship between the child and the mother".[1] Also, Dr. Deutsch has pointed out that the recognition of the mother's prenatal attitude is important and that this attitude depends largely on social values and varies greatly with the milieu.[2]

Emphasis is placed on the fact that the essence of a mother-child relationship is more in the parent's attitude, in how she feels rather than in what she does. Concisely, maternal feeling is more important than maternal behavior. Implicit in this is the fact that if, basically, the mother loves her child, he can withstand much of what might be

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1 Irene M. Josselyn, M.D., Psychosocial Development of Children, Family Service Association of America, 1948, p. 28.

2 Helene Deutsch, M.D., The Psychology of Women: Motherhood, Vol. II., New York: Greene and Stratton, 1944, p. 15.

considered "mishandling" without its affecting his personality to an unfavorable degree. On the whole, mothers, like everyone else, want to be considered as good parents and as a result, usually make an attempt to display only the feelings which are considered acceptable as those of a good mother. Consequently, the more subtle aspects expressed in the mother's attitude toward the child are of primary concern. The parent is almost certain to betray her true feelings, whether positive or negative, in chance remarks which can be detected by the clinic worker.

The child's deepest need is the consistent, understanding care of his mother.

> The phase of mothering which comes directly after birth reflects inevitably her (mother) own upbringing, to which other emotional relationships have contributed. The woman who is herself emotionally sound and whose deeper needs are satisfied in the marriage relationship gives her child this love without the help of a pediatrician or a psychiatrist, just as naturally as she secretes milk. Unfortunately, however, our highly impersonal civilization has insidiously damaged woman's instinctual nature and has blinded her to one of her most natural rights--that of teaching the small baby to love, by loving it consistently through the period of helpless infancy. It is for this reason that the modern woman may need help and guidance in her relationship with her baby. She needs reassurance that the handling and fondling which she gives are by no means casual expressions of sentiment but are biologically necessary for the healthy mental development of the baby.[3]

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3 Margaret A. Ribble, M.D., The Rights of Infants, (Columbia University Press, New York, 1943), p. 14.

Many factors are related to the development of motherliness and the manner of its expression and application in each relationship between a mother and her child. Recognizing that the children of today are the parents of tomorrow, the relationship between the dynamic development of a child's personality and parental attitudes can more readily be seen. It is concluded that in her position as a mother, as in all other relationships, a woman's attitude toward herself grows out of the attitude her mother has previously shown toward her. In view of this it is felt a general discussion of the basic physical and psychological factors would provide a better understanding of the evaluation of an individual personality.

From the very beginning, there is evidence of both physiological and psychological components in each individual. As the child grows, these develop simultaneously and it is recognized that the factors which enter into the personality development of the child are linked up definitely to the physiological processes. Inherent in the individual at birth is an impulsive, goal-seeking force which demands gratification regardless of the environment. This unorganized source of instinctual impulses, emotions and tensions, is known as the Id. "The Id is the core of the personality dominating all psychological reactions of the infant in full accordance with the Pleasure Principle,

before he is influenced by socializing forces."[4]

The child is not born with an ego but may be considered as an "undifferentiated mass"[5] in so far as his physical and emotional life are concerned. This undifferentiated mass first reacts to the environment in two particular ways--excitation and relaxation. The differentiation between the physical and emotional aspects of the infant occurs very gradually under the influences of the external world. At this point "the functions that later constitute the ego and consciousness are not yet developed: the taking of the external world (perception), the mastery of the motor apparatus (motility), and the ability to bind tension by countercathexis".[6]

It is not possible to relate the differentiation to any single episode. In general, however, the various periods of physical development are considered to be of corresponding importance in the development of personality. The first period is referred to as the oral--a period where the infant is primarily concerned with sucking and biting.

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4 Ives Hendricks, M.D., Facts and Theories of Psychoanalysis, Alfred A. Knopf, Inc., New York, 1950, p. 145.

5 Irene M. Josselyn, M.D., op. cit., p. 33.

6 Otto Fenichel, M.D., The Psychoanalytic Theory of Neurosis, Routledge and Kegan Paul Ltd., 1946, p. 34.

Stimulated by hunger, the infant turns toward the outside world for gratification. Equally as important as satisfying his physical hunger is the relief of his discomfort, or tension, which the infant gradually comes to associate with his mother--the means of his gratification. Thus, it is seen that the emotional and social feelings, as well as the early feeling of self, are connected with oral activity.

The attitude of the mother during this period is of vital importance for it is in this primary relationship that the personality of the child begins to germinate. Dr. Deutsch points out that:

> "All of the mother's interests during the child's first life period are chiefly directed toward the goal of the physical thriving. Her activity is applied to his feeding and bodily care. At this stage the mother's urge to preserve the unity with the child is the strongest and the possibility of gratifying it the greatest; the child's helplessness during the suckling period furthers this unity."[7]

This urge to preserve the unity described by Dr. Deutsch is something which must gradually lessen if the child is to develop his own individual ego. Development of the ego is relative to the child's opportunity to try things out for himself, to explore and gradually learn his own methods of adaptation. The mature parent tries to provide for both the physical and psychological needs of the child, at first

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7 Helene Deutsch, M.D., op. cit., p. 294.

accepting his need for the security of a dependency in which he can absorb maternal love without having reciprocal demands made upon him. Lack of a satisfying dependency relationship during this period of infancy is of real significance on the ultimate pattern of the individual's personality. An individual passes most readily from one emotional level to the next when gratification has been optimal.[8] If the early dependency needs are not sufficiently gratified, the emotional development of the child tends to be arrested at the infantile level. Adequate emotional gratification at the lower level does not imply a cessation of the activities and needs of the oral period for they continue throughout life.

This second phase of the child's development lasts roughly from the end of the first year to the end of the third year and is referred to as the "anal" period.[9] Up until this time, the child has been primarily the receiver--he has been dependent on his environment and has not been responsible for contributing anything to it. Of the many experiences of psychological importance during this period, the child's conformance to bowel and bladder

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8 Irene M. Josselyn, M.D., op. cit., p. 41.

9 O. Spurgeon English, M.D. and Gerald H. J. Pearson, M.D., Emotional Problems of Living, W. W. Norton & Co., Inc., New York, 1945, p. 43.

training is of the greatest significance. Each child has his own particular rhythm in regard to training just as he does in his habits of eating and sleeping. If the mother has been genuinely related to the child and his needs during the oral period, and maintains this interest in the individual child for himself rather than in comparison with another child or in how she is reflected in his accomplishments, the training period would be infinitely more satisfactory for both mother and child. In general, the cooperation of the child is likely to be somewhat in proportion to the gratification he received during the oral period. On the whole, children wish to conform--they want the love and approval of grown-ups. With patience, tolerance, affection and praise, most children will satisfactorily master toilet training. That is, there is a gradual adaptation to the reality principle as opposed to the continued adherence to the pleasure principle.

The mother's attitude during this period of development is of great importance and has a marked influence on the child's subsequent attitudes and character traits. This is a period of confusion and dilemma for the child who, on one hand, wishes to relieve his instinctual tension as he feels the urge which on the other, he senses that such uncontrolled expression may jeopardize the love and acceptance of his mother. With his need to be loved coming into sharp conflict

with his own discomfort, the child resents the parent who is imposing the restrictions. The child experiences ambivalent feelings of affection and hostility toward his parent. Gradually becoming aware of this ambivalence, the child recognizes he can feel hostile toward the person he loves and conversely, that his parents can love him even though they are angry.[10] However, if the mother is harsh and reproachful and fails to treat the child with consideration and understanding, his hostility is built up and may find its way into many diverse channels.

Keeping hostility at a minimum is one of the real problems relative to the inevitable give and take of training during the oral period. Real understanding of the child's ego limitations and the responsibilities being thrust upon him during this period will contribute greatly toward the mother's genuine appreciation for his efforts and accomplishments. Demands which are beyond the child's capacity to handle are carried to adulthood as unresolved conflicts. Hopefully, the child will gradually learn to harmonize his desire to carry out his impulses with his desire to maintain a secure relationship with his parents, evolving from the anal period with a minimum of unresolved conflict.

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10 Irene M. Josselyn, M.D., op. cit., p. 50.

The third phase in his psychosexual development occurs approximately between the ages of three and six; this is sometimes referred to as the genital, oedipal or phallic period. With oral pleasures no longer important and toilet training fairly well mastered, the child has evolved the capacity to give love as well as receive it and his interests are diverted from himself as he becomes more and more concerned with the world about him. Having loved the person who has been his source of pleasure and security, normally during this period the child turns toward the parent of the opposite sex as his primary love object; simultaneously the parent of the same sex becomes a rival, arousing resentment and hostility in the child who consequently becomes quite ambivalent in feelings toward that parent who is standing in his way as it were.

During this oedipal period, the love object of the boy remains the same--his mother. He becomes more possessive and demands her attention to the exclusion of other members of the family. It is not uncommon to hear a little boy verbalize his desire to marry his mother and displace his father in her affection. Finding his father an obstacle to the fulfillment of his desire, the child indulges in a magical sort of thinking, wishing his father were dead in order that he might have mother entirely to himself. His intense resentment for father as his rival at this point

arouses the child's hostility, fear and subsequent guilt. To varying degrees the boy fears his father's anger and the consequent punishment he may receive from him; greatest among these is the fear of castration at the hands of his father. This fear that his masculinity may be destroyed is intensified by the child's discovery that every person does not have a penis; greater anxiety and confusion are created. Efforts to depose his father prove even more futile when the mother fails to accept the boy in his father's place. Thus, faced with the possibility of castration by his father and lack of acceptance as a lover by his mother the boy attempts to repress his own hostile thoughts and desires. Coincidentally, he determines to win his mother by being like his father. He strives to incorporate the father's goals and standards into his own pattern of behavior and denounces his mother as a sexual love object. The mother's positive response to the boy's increasing masculinity coupled with the father's expressed satisfaction in his son's development serve as gratification to the boy who has gained a more limited goal than he originally sought.

Unlike the boy, the girl shifts her feeling from her mother to her father as the primary love object. Implicit in this is the fact that the mother is both the source of dependency and security as well as a rival for father's affection. Further complicating the situation, the little

girl senses her lack of a penis as a loss of power and/or prerogative which her male counterpart seems to possess. This causes considerable anxiety to the child who should have definite reassurance as to her own adequacy and completeness as it were. The little girl struggles between her wish to renounce her dependency security on one hand and her wish to renounce the developmental process in which she finds herself.

If she is to achieve healthy, emotional maturation, the female child must find gratification and security in a feminine role, identifying with her mother but repressing the sexual aspects of her identification. She, like the boy, incorporates the pattern of the rival parent in her behavior. This incorporation of the parent's pattern by the child is to a large degree on an unconscious level as the motivations make it too dangerous for consciousness.[11] In the normal solution of this problem the child's superego--through the incorporation of parental standards--comes into being. Also, with the conflict of this period worked through, the child channels his energies into non-sexual areas and turns toward relationships with others in his environment--such as schoolmates, neighborhood chums, or brothers and sisters if he has any.

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11 Irene M. Josselyn, M.D., Ibid. pp. 64--74.

This is a most important phase of the child's development for the reaction pattern formed in the solution of this difficult problem of relationship serves as a pattern of reaction in subsequent relationships throughout life. The more understanding and accepting the parents are during this period, the easier it is for children to solve the Oedipus confliot without too many difficulties.[12] Being of particular emotional significance, this period of development has a marked affect on subsequent feelings and attitudes of the child. The full significance of the repressed impulses may not be apparent until adult life--particularly at the time an individual takes on the responsibilities of parenthood. A satisfactory resolution of Oedipal strivings frees the parent from complicating emotional factors such as unresolved rivalry and competition or unsatisfied love needs which might later affect the parent's attitude toward his child.

Beginning approximately about the sixth year, the child enters the latency period which lasts for the next five or six years until the onset of puberty. The word latency itself suggests that this period of development is less charged than some of the others. Relatively, it is a rather quiet time, characterized by a repression of instinctual

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12 O. Spurgeon English, M.D. and G. H. J. Pearson, M.D., op. cit., p. 80.

desires and a channeling of these energies toward adjustment to an ever growing environment. With his emotional problems to a large extent temporarily resolved, the child can devote his energy to learning about the world around him, establishing self-control, perfecting his motor and social skills--in general achieving a certain stability within himself and his environment. The following abstract from Dr. Fenichel further clarifies the dynamic manifestations of the latency period.

> The influence of the superego first manifests itself typically after the passing of the Oedipus complex as a cessation or as a decrease of masturbatory activities and of instinctual interests in general. Changes of partial instincts through inhibitions of their aims, sublimations of various kinds, and often reaction formations manifest themselves. The character of the person, that is, his habitual manner of handling external and internal demands, becomes consolidated during this period.[13]

With his relationship to his parents fairly well worked out, the child has reached a point of identifying with his own sex. There is evidence of a strong tendency to form groups or gangs according to sex; this is particularly true among boys. Interest in sexual matters does not disappear, but it is likely to be found in disguised forms. The extent of sexual curiosity varies with different individuals and it is quite unlikely that such curiosity would be revealed to an adult, particularly a parent. Part of the child's defenses

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13 Otto Fenichel, M.D., op. cit., p. 110.

during this period is found in his having secrets from adults, and such things as hideouts, codes or other mysterious ways of communicating with contemporaries.

It is not uncommon for a child to have an insatiable curiosity at this time. This factor contributes to the attitude expressed by many parents who actually say they are glad when their children are off to school. It is recognized that a great deal of the child's training during these years is delegated to the school system, with the individual teachers exerting a profound influence on the child. His reaction to the teacher is directly related to the way in which he has resolved the conflicts in relation to his parents during earlier periods. The child's tendency to imitate and identify becomes even more intensified during this period; he is interested and inspired particularly by older people. Further, he is motivated by the desire for love and acceptance both from his parents and other adults. Consequently, he tends to incorporate characteristics, mannerisms, ambitions and ideals of particular people; he tries to imitate and develop his own ego so as to be like a specific individual--his ego-ideal. As previously indicated, this may be his teacher, or a relative, scout master, movie star or other prominent person, whomever it may be, one of the strongest motivations for incorporating that person as an ego-ideal is the child's desire to maintain the love of that person--in

accomplishing this he makes their ideals his own. During this period the child may have many objects of his hero worship for he himself is constantly changing; with each new experience there is movement and the child's love responds spontaneously, positively or negatively, with each development. As a result, the ego-ideal may be a mixture of contradictory features, with one person satisfying certain ego-ideal requirements but not others. With the shifting ego needs of the child, the loved object too may change. However, each identification contributes to the growth of the child's unfolding personality. Thus, it is evident that although this latency period is often considered as a time when there is not much happening in regard to the dynamic development of the child's personality, the many factors to which a child is exposed during these years contribute significantly in the formation of the ego and has a direct bearing on the coalescence of what has gone before and what is to come.

Generally between ten and twelve years old, the child leaves the relative equilibrium of the latency period during which he has managed to stabilize certain attitudes hostile to his instinctual drives. During this period there has been little actual change in the instinctual demands although there has hopefully been marked development in the ego, with the formation of definite patterns of reaction toward the external and internal forces. It is recognized that the

nature of these reactions will be in relationship to the child's experiences during the previous periods of development. During the transitional period from latency to puberty or adolescence, there is marked physical growth and glandular activity in both sexes. This physical process is accompanied by psychological reverberations in which a not too secure ego is fencing with intensified instinctual drives. The infantile sexual struggle with the basic drives of love and hate is reactivated with frightening intensity during this period and carries on into puberty. The adolescent ego responds in accordance with the strength it has inherited from the earlier infantile experiences.

> The return of the infantile sexual impulses is partly due to the fact that genital primacy has not yet been completely established, and puberty brings with it an increase in total sexuality; in part, however, the return of infantile impulses is caused by the child's fear of the new forms of his drives, which makes him regress to the old and more familiar forms. The asceticism of puberty is a sign of fear of sexuality and is a defense against it. A similar set of contradiction in behavior is characteristic of the psychology of puberty also outside the strictly sexual realm. (...). These contradictions can be traced back by analysis to conflicts between the newly strengthened drives and anxieties or defensive tendencies. The effectiveness of these defensive tendencies is not a sufficient basis for the assumption that the ego is primarily hostile to its instincts or basically afraid of them. It is true that up to a certain point every unexpected emotional experience, especially if it is intense, may have a frightening effect until the ego becomes familiar with the new phenomenon and learns to master it. This

> holds true for the first pollution or the first menstruation, but for the most part the usual fears of new instinctual phenomena are much more intense than the fright over the initial incidents themselves would be. During the period of infantile sexuality and especially at the time of the suppression of the Oedipus complex, the child learned to consider sexual impulses as dangerous. In a society that treated infantile sexuality differently puberty, too, would assume a different course.[14]

It is further pointed out that mental phenomena characteristic of puberty are attempts to re-establish the equilibrium that has been disturbed by the resurgence of the instinctual drives. Adaptation of the personality to the new conditions which have been largely effected by physical development is the primary task during this period. The contradictory behavior, mood swings and unpredictability characteristic of the adolescent is directly related to the struggle of the ego to gain the upper hand over the surging internal forces.

The parent-child triangle of the oedipal period is reawakened with increased intensification and consequently with increased anxieties. The fears and guilt originally related to oedipal fantasies are now found in connection with masturbatory activity. The degree to which this particular problem troubles the adolescent will be directly

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14 Otto Fenichel, M.D., Ibid, p. 111.

related to its earlier resolution. The recrudescent conflict with the parent of the same sex is frequently handled by the adolescent's depreciating this parent, thereby minimizing his sexuality and reactive threat as a rival. He is vigorous in his denial of any attachment to the parent of the opposite sex. This attitude of the adolescent is not always understood by the parents who, more often than not, have difficulty in accepting the full impact of the ambivalent, erotic behavior, directed in disguised ways toward themselves; they are thrown into a panic and their distrust of their own impulses as well as the child's adds new burdens to the struggling youth. Under such circumstances the adolescent feels rebuffed and let down by his parents; as a younger child he would feel he was not loved; as an adolescent he feels he is not understood which in essence amounts to the same thing.

Withdrawal of love and support by the parent of the opposite sex at this time, creates anxiety and insecurity; he needs this love as support in his efforts to bridge this last period of dependency into independency and maturity. Equally important is the understanding and acceptance of the parent of the same sex, subject alternately to overevaluation and depreciation. In working through this relationship the child is forming the basis for subsequent hetrosexual relationships outside the family

constellation--a new love object. The importance of completely resolving this conflict cannot be overemphasized, for failure to completely renounce sexually the parent of the opposite sex may set up a serious barrier to forming future healthy hetrosexual relationships.

In addition to this drive to establish himself sexually, the adolescent is further driven to free himself from parental control--to be recognized as an adult himself. This impulsive desire for emancipation is frightening to the adolescent with his unresolved dependency needs. If the experience is too frightening, he may regress to the security of an earlier age. However, with proper parental support, these needs will be gratified and successive attempts toward independence will be made. If previous periods of development were resolved in an emotionally healthy way then the superego can more satisfactorily withstand the temporary dissolution of part of its structure.

> In so far as the super-ego is at this point still cathected with libido derived from the relation to the parents, it is itself treated as a suspicious incestuous object and falls a victim to the consequences of asceticism. The ego alienates itself from the super-ego, the estrangement from part of its contents, is one of the greatest troubles of adolescence.[15]

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15 Anna Freud, The Ego and Mechanism of Defense, International Universities Press, Inc., New York, 1946, p. 182.

The adolescent attempts to disregard the standards of his parents adopting his own and those of his peers. If this group has a desireable mode of behavior, then this incorporation becomes a valuable part of the adolescent's modified superego and contributes to the individual's maturation and relative emancipation. With increasing confidence in his own ability to handle himself, the adolescent is gradually able to respect the opinion of others and turn to them for help when needed. He can then depersonalize his superego and accept its dictates. Thus modified, the superego now embraces elements from an earlier level, insight gained from actual living experiences and the new qualities incorporated from the contemporary group. Normally new attachments and authorities are integrated with the old, and the parental antagonism and conflicts are modified to greater or lesser degree, relative to the early ego-ideal which they formed. The healthy superego then fuses these elements into the sound, adaptable, unconscious pattern of behavior that is adult.[16]

The depths, severity and final resolution of these conflicts depend on many factors such as the strength and organization of the ego developed in infancy, the adequate development of the sexual drive during the pre-school

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16 Irene M. Josselyn, M.D., op. cit., p. 105--110.

period, and the actual attitudes of the parents in meeting the actual dependency needs of the child throughout the entire process of physical and emotional maturation. Hopefully, the adolescent will have had a broad enough background of parental love, acceptance, support, and understanding so as to enable him to securely take the final step in the maturation process and so become an adult capable of channeling his drives in socially acceptable ways, viz., vocation, marriage and parenthood. In reflection, then, it is apparent that the parental attitude of today is of primary importance as a molding environmental pressure shaping and modifying the attitudes of the child who will be the parent of tomorrow.

> How successfully a given individual will traverse the path from the asocial and amoral state of infancy to an adequately socialized adulthood, how well he will surmount the difficulties inherent in the early family romance of which we have spoken, will depend more on the character and wisdom and attitudes of his parents than on anything else.[17]

Space does not permit an elaboration of the manifold parental attitudes which, singly or in combination, begin to subtly influence the individual from the moment of his birth and still more indirectly from the time of his conception. However, it is pointed out that this is not a

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17 Bernard Glueck, M.D., "The Significance of Parental Attitudes for the Destiny of the Individual", Mental Hygiene, Vol. XII, No. 4, October 1928, pp. 741.

one-sided situation for the infant is not merely a passive entity, permitting itself to be molded and influenced by the environment, his parents; but is also an energizer and conditioner of parental attitudes and not merely an effect of them. Dr. Glueck has stated that man is motivated in his attitudes and behavior by factors of his being of which he is only dimly aware or not at all conscious.[18] Thus it is recognized that the sources of parental attitudes actually lie in the pre-parental stage of an individual's life.

With a better understanding of the significance of early experiences in the formation of the ego, its strengths and weaknesses, the subsequent manifestations in the behavior and attitude of clients can be more clearly discerned. During its development, the ego has employed various mechanisms which react in response to anxiety and frustration. The ego has at its disposal a variety of resistive measures which become active whenever anxiety anticipates danger. According to Wilsnack,[19] learned resistances become marked characteristics which help to define an individual's personality.

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18 Ibid., p. 727.

19 William H. Wilsnack, "Handling of Resistances in Casework", American Journal of Orthopsychiatry, 16: 297, April 1946.

The learned resistances characteristic of one's personality are referred to as the ego-resistances by Anna Freud.[20] These are in contrast to the transference resistances which are differently constituted. With this point, it is evident that it cannot be said that every resistance is the result of a defensive measure of the ego.

In social work, resistance "... covers any and all of the client's defenses against treatment which requires understanding in order that the case will not be lost to treatment".[21]

Resistance in casework is based on the same dynamic psychological concepts as is used in psychoanalysis. This involves the entire concept of the unconscious; the repression by the ego of the painful and disagreeable impulses and their conscious associations into unconsciousness; the resultant neurotic symptom formation as these impulses remain active and express themselves in altered undesirable form; and finally the opposition by the ego through the aforementioned defense mechanisms, to the efforts of the analyst and the individual to make these impulses again conscious. Unlike the psychoanalyst, the social worker

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20 Anna Freud, "The Ego and Mechanisms of Defense", International Universities Press, Inc., New York, 1948, p. 33.

21 William H. Wilsnack, op. cit., p. 297.

makes no attempt to interpret the unconscious motivations of resistance but is more concerned with preventing resistance from interfering with the casework process and inhibiting the treatment goal. The resistive client uses energy which might otherwise be expended more therapeutically. A long-standing resistance pattern gives one the confidence that he has his personal problems in check and consequently is invulnerable. The success of treatment is dependent upon a conscious effort to cooperate and overcome resistances in whatever manner they are expressed.

In work with mothers in a child guidance clinic setting, resistance is shown in a variety of ways. It is necessary to understand the close relationship that exists between mother and child as previously discussed, and the importance of the far-reaching effects of the unconscious attitudes that are the result of the mother's own human relationships during her childhood.

Resistance may be shown in the mother's attempt to control the interview, in an unwillingness to participate in treatment, late or broken appointments, jealousy over the child's relationship with the therapist or in any number of ways varying in degree and intensity during the course of treatment. Resistive mothers have so mobilized their fears and anxiety that they are unable to relax enough to benefit from treatment. Frequently the problem is complicated by

their strong feelings of guilt. Somehow they feel responsible for the difficulty of the child. Sometimes a mother unconsciously feels that the child's disturbance is only a part of the whole disturbed home situation and that any change in the child would have direct affect on her. In that event, she defends her own neurosis along with that of the child and distrusts the person who tends to rid her of the disturbance. Such resistance is rarely open and conscious; usually it is unconscious and well rationalized.[22]

Often times the mother's resistance is related to her own insecurity, a condition in parenthood not uncommon in our culture. It is also related to the immediate circumstances in the family which are threatening the mother. The anxiety of coming to the clinic together with the tense home environment is more than the mother can accept. She takes the most obvious means of escaping part of the frustrating circumstances--that of withdrawal. The underlying fears and conflicts create an anxiety which leads the mother to this decision.

Actually the mother comes to the clinic with some anxiety which has been aroused by a problem which has been

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22 Otto Spranger, "Some Features of the Emotional Resistance Against the Psychoanalytic Approach in Schools", Mental Hygiene, 23. 639--640, October, 1944.

causing her difficulty. She comes to the agency under some internal or external pressure and the intake interviews are times when

> Most workers would agree...(they) notice and accept, rather than explore the client's feelings, initiate a friendly working rather than intensive relationship, clarify the situation only to see if it is appropriate for us, find out what the applicant has done about it and give him some idea of our probable role. Application interviews should create a condition of mutual confidence, allow for tentative diagnosis of the area of difficulty and a preliminary estimate of the client's and the agency's capacity to deal with it.[23]

In general, the mothers who seek the help of a child guidance clinic have feelings of inadequacy and failure. Dr. Leroy Maeder expressed it as follows:

> To be obliged to come to an agency with a difficulty he is unable to handle by himself, does in a measure constitute a danger to a person, a threat to his self-sufficiency and his social relationships. The client, therefore, has occasion for a certain amount of uncertainty, confusion and anxiety.[24]

In her fear of the unknown experience, the mother may anticipate lack of appreciation or rejection. She may feel shameful or humiliated by the fact she is coming to a social agency or may be even further threatened by her own attitude

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23 Gordon Hamilton, Theory and Practice of Social Case Work, Columbia University Press, New York 1940, p. 65.

24 Leroy Maeder, M.D., "Generic Aspects of the Intake Interview", The Family, 23:15, March, 1942.

toward psychiatry. Even today, the prevalent attitude among the general public toward psychiatry is one of suspicion and fear. To most people going to a psychiatrist implies an admission of failure and of something wrong mentally.[25] Thus, the mother may have many of these same feelings when taking her child to a psychiatric clinic. The mother feels she has been a failure and regardless of her attitude toward her child, she generally comes to the clinic as a last resort because "under whatever auspices they are conducted, they connote mental abnormality and failure of that control which is so highly prized".[26] Thus, in addition to the usual anxiety and concern which may be present, there is a threat to the parent of mental abnormality in his child.

The intake interviews are crucial periods when mothers express their resistance in some manner. Dr. Allen emphasized the importance of this interview in the following abstract:

> The application interview provides an important situation to give a parent a full opportunity to express whatever feeling he may have at the moment and a chance to work through some of these and participate in a decision as to what he would like to do. It is important that parents feel the clinic is forcing nothing on them that

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25 Helen Leland Witmer, Psychiatric Clinics for Children, The Commonwealth Fund, New York, 1940, pp. 32--33.

26 Ibid. p. 34.

> they themselves do not want, that they feel their opinions have value and that their relation to the clinic is going to be a participating one and a mutual attempt to work out a clearer understanding of the problem.[27]

Success or failure of treatment many times depends on the first interview. Resistance develops automatically as soon as the transference is established, when the defenses are laid aside and the therapist approaches the center of the emotional conflict.[28]

In studies made by students--of the Smith College School of Social Work,[29] it has been concluded that there appeared to be a relationship between the attitudes of the parent expressed in the first interview and the outcome of treatment. It was found that when the attitude of the parent in the initial interview is one of a real desire for help, an awareness of the problem, an understanding of the clinic function, and a real concern about the child's behavior,

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27 Frederick H. Allen, M.D., "Creation and Handling of Resistance in Clinical Practice", American Journal of Orthopsychiatry, 2: 269, 1932.

28 Gordon Hamilton, Psychotherapy in Child Guidance, p. 135.

29 Harriet Mills, "The Prognostic Value of the First Interview", Smith College Studies in Social Work, 8: 1--33.

Louise Ritterskamf, "The First Interview as a Guide to Treatment", Smith College Studies in Social Work, 8: 34--84.

there was generally a successful outcome to the case. In another study[30] relating to this question, it was concluded that the parental attitudes toward the clinic, the child and the problem were highly significant prognostic clues as to the outcome of treatment.

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30 Electra Peterson, "Prognostic Clues in the First Interview in Child Guidance", Unpublished Thesis (1947) Smith College Studies in Social Work, on file in the Providence Child Guidance Clinic.

CHAPTER III

BACKGROUND OF THE GROUP

The tables presented in this chapter are intended to give the reader a better understanding of the case studies which will be presented in the next chapter.

Table I (below) indicates an outstanding difference in the proportion of males to females; however, this is not of particular significance in view of the small number of cases studied.

TABLE I

AGE AND SEX DISTRIBUTION

Age at Intake	Male	Female	Number of Families
6--9	3	2	5
10--13	1	1	2
14--17	3	—	3
Total	7	3	10

The writer has not attempted to study the relationship between the ordinal position of the child and the maternal attitude; however, it is interesting to note that six out of the ten children are either first born or only children.

TABLE II

POSITION IN FAMILY OF CHILDREN
IN THE TEN CASES STUDIED

Position	Number
First born	5
Second born	2
Third born	
Fourth born	1
Fifth born	
Sixth born	1
Only child	1
Total	10

Table III is compiled from the findings of the formal tests given by the psychologist. As noted in the table, there is a wide variation in the range of intelligence.

TABLE III

INTELLIGENCE RANGE OF CHILDREN
IN THE TEN CASES STUDIED

Classification	Number of Children
Dull Normal	1
Normal	5
Bright Normal	2
Unknown	2
Total	10

TABLE IV

SOURCES OF REFERRAL

Source	Number of Cases Referred
Physician	3
School	4
Social agency	1
Self	2
Total	10

Table IV indicates the sources of referral in each of the cases studied. Included under those referred by "Physician" are two cases which were first seen by the clinical director on a private basis and subsequently referred to the clinic for treatment. Designated under "School" are all cases referred by any member of a school system, including a principal, psychologist, or nurse. Two of the mothers in this group had resisted previous referrals to the clinic. The one case referred by a "Social Agency" was one in which the mother voluntarily sought help from the Juvenile Court and was advised to go to the Child Guidance Clinic. In the two cases noted as "Self" referrals, it is indicated that the mothers requested clinic service on their own initiative. However, it should be mentioned that in both records there is evidence of pressure from the court and maternal relatives respectively.

These sources of referral are significant in relation

to (1) the mother's lack of initiative in coming to the clinic and (2) the effect of community pressure. This is shown by the percentage of cases which were referred to the clinic by a community agent.

TABLE V

DISTRIBUTION OF SYMPTOMS AS REFERRED

Problem	Male	Female	Number
Poor school work	4		4
Stealing	2		2
Lying	1		1
Uncontrollable in school	1		1
Unmanageable	1		1
Difficulty in reading	1		1
Anxiety neurosis (school)		1	1
Fearful (school)		3	3
Hyperactive	1		1
Cries easily (school)	1	1	2
Overeats	1		1
Bunking school	1		1
Irresponsible	1		1
Nervousness		2	2
Total	15	7	22

This table indicates the symptoms shown by the child which resulted in his referral to the clinic and not necessarily accepted by the mother as a problem.

TABLE VI

MARITAL STATUS OF PARENTS IN TEN CASES STUDIED

Marital Status of Parents	Number
Together	6
Divorced and remarried	1
Divorced but father in home	1
Mother and adoptive father	1
Father dead	1
Total	10

The above facts were compiled in relation to the marital status of the parents. Particular reference to marital relationships by the mothers is conspicuously absent in these records as a group. In four of the six cases in which the parents are living together, the mothers briefly referred to their husbands in a critical manner, i.e., not spending enough time with the children, not earning enough and being inconsistent in discipline. One mother referred to her husband only by saying he still exploded frequently around the house; the other mother in this class made no significant reference to her husband.

In the one case where the mother was divorced and remarried, she showed definite hostility toward the father and spoke more positively in her reference to the step-father, her second husband.

In the instance where the parents were divorced but the father continued to be around the home most of the time,

father was an alcoholic and there had been definite incompatability between the parents over a long period of time.

The mother of Bobby always referred to her husband (Bobby's adoptive father) in a very positive way.

One father had died when the child was three years old. In general, the mother tended to idealize her husband, although their relationship might be questioned as she had never "felt like a wife" to him.

TABLE VII

NUMBER OF CLINIC INTERVIEWS

Interviews	Mother	Child
1 - 4	3	2
5 - 8	6	5
9 - 12	1	3
Total	10	10

The average number of interviews with the mothers was 5.1 while the average number of interviews with the child was 6.4. This discrepancy seems due largely to one case in which the child was sent regularly for his interview but the mother tended to break her appointments. As the clinic considers twelve to fifteen interviews the average treatment period, it is obvious that these clients averaged a considerably shorter treatment period than did the cases following through to the end of treatment.

TABLE VIII

MAJOR REASONS OF WITHDRAWAL

Reason Given	Number of Cases
Fearful friends would learn child going to psychiatrist	1
Tutor engaged	1
Discontinue until spring (never returned)	1
Situation worse since coming	2
None expressed	5
Total	10

Table VIII reflects reasons given by mothers for withdrawal. It is noted that in five, or fifty per cent of the cases, the mothers did not express any reason for withdrawing but simply did not keep further appointments.

TABLE IX

STATUS OF CASE AT WITHDRAWAL

Status	Number of Cases
Improved	10
Unimproved	0
Total	10

Table IX reveals that there was some improvement noted in every case. Although the degree of improvement varies in each instance, it seems significant in view of the possible implications for the timing of termination, particularly in relation to the goal of treatment and the possibility of the

mother's goal for improvement being less exacting than that of the therapist.

CHAPTER IV

EVALUATION AND PRESENTATION OF CASES

The purpose of this study has been to examine and classify the attitudes of the mothers as expressed in the records of ten cases in which the mother withdrew from treatment in the Providence Child Guidance Clinic. The following paragraphs define and illustrate the mother's attitude toward the problem.

Mother's Attitude Toward the Problem.

TABLE X

MOTHER'S ATTITUDE TOWARD PROBLEM
AS EXPRESSED DURING INITIAL INTERVIEW

Attitude	Number
Acceptance	4
Partial Acceptance	3
Rejection	3
Total	10

Table X reflects the mother's attitude toward the problem as expressed during the initial interview at the clinic.

In the four cases that are shown as having an attitude of Acceptance, there is a definite acceptance of the existence of a problem with the recognition of the possibility of a relationship between the problem and the child's previous experiences or of the possibility of an "emotional disturbance".

An example of mother's acceptance of the problem.

> Mother initially sought the help of the clinic. The main problem was Paul's bunking school but mother recognized that Paul was "different" at home too. He's dishonest, irresponsible and can't be depended on now. Mother felt the trouble started two years before when the youngest sibling was born. Mother also thought a great deal of the problem might be related to Paul's early childhood; mother blamed herself for bringing him up "according to the book" which she now realizes did not give Paul enough affection. Further, she was sick several months and eight different people took care of him. Father may be partly to blame as he is inconsistent in discipline and away much of the time. Paternal grandfather was also very strict and mother felt all these things might have had some effect on Paul.

In the three cases included under Partial Acceptance, the mothers recognize a difficulty with the child but tend to show some ambivalence about it or otherwise express their concern from the standpoint of annoyance to them rather than from the standpoint of the child.

An example of mother's partial acceptance of the problem.

> Mother was referred to the clinic by the school as Anne was suffering from school anxiety. Mother was concerned over Anne's not going to school. She is a shy, timid child and does not play well with others but is devoted to her sister with whom she has always gone to school until their schools were changed this year. Mother gets nervous just as Anne does. Anne has always done well in school, she is bright and has never troubled anyone. She is not excessively good. Mother talked from time to time as if there were nothing wrong with Anne and at the end of the intake denied this possibility saying perhaps the whole thing would pass over.

Classified under Rejection are those who recognize the problem as being caused only by some factor in the environ-

ment. Each of these three mothers refused to admit to the existence of any problem with the child in the home. In each case the cause of the problem was projected on to the school. All three of these cases came to the clinic under pressure from the school.

An example of the mother's rejection of the problem.

> Mother felt the difficulties started in school a year ago; she felt Bruce would outgrow the difficulty he was having in reading. He is a smart boy but poor in reading. Mother feels this may be due to lack of interest or laziness. She further feels the teacher is not assuming her responsibility in teaching Bruce how to read. She made other minor criticisms of the teacher.
>
> Mother strongly denied that Bruce was a behavior problem or was emotionally upset. He does not have any problems. She described him as nervous and fidgety at home and repeated several times that there was nothing wrong with him except his poor reading.

Mother's Attitude Toward the Clinic.

TABLE XI

MOTHER'S ATTITUDE TOWARD THE CLINIC

Attitude	Number
Accepting	1
Ambivalent	4
Resistant	5
Total	10

An attempt was made to classify the mother's attitude toward the clinic in the following three categories:

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK
LIBRARY

Accepting: is used in reference to those parents who accepted the clinic both intellectually and emotionally and were able to use the clinic in so far as they appeared to establish a positive relationship with the worker.

Ambivalent: refers to those mothers who came to the clinic simply as a means to a desired end such as a particular school placement and those who appeared to accept the clinic intellectually and, in a limited way emotionally. This latter group includes mothers who seemingly made a fairly positive relationship with a female caseworker but were unable to achieve the same sort of working relationship when transferred to a male worker.

Resistant: those included in this group were mothers who were considered as either primarily hostile in their attitude or having such a strong unconscious resistance that they were emotionally unable to use the clinic.

An example of the mother's accepting attitude.

> Mother thought it was a good idea to come to the clinic because she worried so much about Angelo perhaps she could get some help here too. There were so many relatives telling mother what to do she felt the clinic would help her in understanding what was right. Mother had an argument with her sister about Angelo's progress, the sister was critical as Angelo continued to lie after his first visit to the clinic; mother felt you could not expect things to be better right away, one week was too soon to expect change. Mother felt she should tell the clinic everything if they were to help her. During her contact with the clinic, mother was able to express her feelings, gain enough support to deal with

her present situation and became more understanding of her son.

There is only one case in which it was considered that the mother accepted the clinic to a degree which enabled the family to benefit from the clinic contact. In this case, mother was self referred and expressed a desire to come to the clinic from the beginning. This mother came regularly for six appointments, withdrawing after expressing how pleased she was about the way things were going and with the knowledge that contact would be terminated soon. This mother belonged to the group who showed an ambivalent attitude toward their children. It was felt that basically she accepted him but reacted to the pressure from the various members of her family who were rejecting of him.

An example of mother's ambivalent attitude.

> Mother thought perhaps the family doctor was right in saying she expected too much from Bobby. She wondered if perhaps this is something she can work out at the clinic. She wanted to enroll Bobby in Country Day School and had been referred to the Clinic with the understanding that Bobby's admission was dependent on the findings of the clinic. Mother was anxious for an appointment and seemed pleased when the worker explained the clinic would help the whole family with relationships. During clinic contact mother expressed a great deal of fear and anxiety about Bobby's intelligence. She was a very compulsive person and spoke with a great deal of feeling. She projected all the difficulty on the school, inferring it was due to Bobby's being a Negro. Mother discontinued at the time of referral to a private tutor.

This mother was referred to the clinic by a private school where Bobby's admission was largely dependent on the findings

of the clinic. Mother was rejecting in her attitude toward Bobby and was willing to come to the clinic if it would further her plan of placing him outside the home. When the psychiatrist advised mother to engage a tutor and postpone the school placement for several months, mother withdrew from the clinic saying she did not want to continue unless the doctor insisted.

Another case in this group was of similar nature where mother withdrew after arrangements had been made for a home teacher to work with a girl suffering from psychoneurosis-anxiety state. Two other cases included mothers who did not have an adequate enough emotional acceptance of the clinic to work through a transfer to a male worker following a positive relationship with a female worker. Of these latter three, each mother revealed a different attitude toward her child, viz., acceptance, ambivalence and rejection.

An example of a mother's resistant attitude.

> Mother put off coming to the clinic for two and a half years after it was recommended by the pediatrician, finally coming under pressure from the school. Mother was concerned as to what she would tell Sandra about coming to clinic and decided to tell her they were going to visit. Mother refused the interpretation of the worker saying she would handle it in her own way. Mother referred to a friend who had withdrawn from clinic because the children seen were mentally defective or retarded and also because of the fee. Before coming to clinic mother and father decided they could pay a two dollar fee; after ascertaining whether or not service was related to the fee paid, mother decided to pay only one dollar.

> Mother denied the existence of any sibling rivalry suggested by the doctor. She was very hostile to the psychiatrist and didn't like coming to the clinic, feeling there was no reason for this other than that the school demanded it. Mother finally withdrew saying Sandra had become much more tense since coming to the clinic.

This case is typical of the five in this group. The mother showed resistance to coming to the clinic, acting finally under pressure from the school; she could not accept the clinic nor its function and concluded her child was more tense although the school principal substantiated the psychiatrist's feeling that Sandra's behavior had improved conspicuously.

In this group of five mothers who were resistant to clinic treatment, two were considered ambivalent in their attitude toward their children, two rejecting and one accepting. The latter's resistance to clinic treatment was directly related to her inability to accept psychiatric treatment which carried a definite stigma for this mother.

Mother's Attitude Toward the Child.

The writer found that the attitudes revealed by the mothers toward their children fell into three broad categories as indicated in the following Table XII.

TABLE XII

MOTHER'S ATTITUDE TOWARD THE CHILD

Attitude	Number
Accepting	2
Ambivalent	4
Rejecting	4
Total	10

No sharp line of demarcation can be in this classification, and there may be some indication of overlapping in cases which fit into more than one category. It is noted that often the difference in the mother's attitude was one of degree rather than kind. In view of the difficulties which would be involved no attempt has been made to cross reference material.

Presentation of cases in which mothers showed an accepting attitude toward the child.

Case #1

Bruce was referred to the clinic by the school as he was having a great deal of difficulty in his reading. He had been tested by the school psychologist and was found to have an I.Q. of 108. The teacher could not understand what was wrong and suggested Mrs. D. come to Child Guidance Clinic.

Bruce was seen by the psychiatrist nine times and mother was seen by the worker seven. The reason for these broken appointments is not clear from the record; however, it is noted that mother was prompt for her appointments, being one-half hour early for her intake interview. She was seen consistently by the same worker.

There was considerable discussion around the fee. It was difficult for mother to understand parents usually pay weekly, finally she agreed to paying two dollars; this is one dollar less than is indicated for her income group.

During the intake interview, mother revealed that the difficulties in school seemed to have started a year ago. At that time Bruce was tested; mother felt from the questions he was asked that he must have been seen by a psychiatrist and was not satisfied with the explanation that it was probably the school psychologist and not the clinic psychiatrist. This woman found Bruce to be very smart but unable to read. The teacher had suggested Mrs. D. go to clinic at the time, but Bruce passed his grade so she stopped worrying and thought it was something he would outgrow.

This year the teacher told mother Bruce had a "mental block"; this bothered mother so much she could not remember coming home and she was very upset as to what it might mean for her child.

Mother was concerned as to what she should tell Bruce about the clinic; he would not come if he knew he were coming to a psychiatrist. "So many people think that coming to a psychiatrist means they are crazy. She of course knew that was not so". Mother was upset that the teacher had "taken it upon herself" to tell Bruce a psychiatrist would be calling him to let him know when he could come to talk about his reading. Mother told Bruce he is going to see a special teacher who will be able to help him read better.

Eight year old Bruce was an only child who lived together with his parents and paternal grandmother. Mother had two miscarriages following Bruce's birth. His delivery had been difficult. Mother was not sure the worker would understand as she was a single woman.

In talking about Bruce, mother "was a little confused as to where to start". He is a smart boy but poor in reading. He is inconsistent. Mother feels his poor reading is due to lazi-

ness or lack of interest. The teacher is not assuming her responsibility in teaching Bruce how to read. When mother was a girl she was kept after school when she did not have her lessons; Bruce is never kept.

Mother denied that Bruce was a behavior problem. "He is not emotionally upset". He is the only child but not spoiled as they have been quite "strict" with him. She has never had to spank him but occasionally will send him to his room. Of course when Bruce was younger she had to slap him sometimes. Bruce is a very polite, well-behaved boy.

Mother expressed resentment at the teacher's asking how things went at home. There is nothing wrong with their family life, and if she and her husband do have a disagreement Bruce does not hear this. About two years ago the family situation was quite upset. A grandfather, to whom Bruce had been very attached, died. A present the paternal grandmother is in the home. "She fits in very well and things are going along just as they were before she came".

The maternal grandmother is in a nursing home. She had previously lived with the D's for about eight years. Her presence in the home was not a pleasant experience for the D's.

Mother did not know just where to begin in discussing the developmental history. However, she responded briefly and concluded that Bruce had always been a very healthy child and she could not think of anything that had been wrong with him. At another point mother referred to Bruce as a nervous child, who is fidgety and cannot sit still at home. She feels he worries about a lot of things that are beyond his age. In response to the psychiatrist's suggestion that Bruce be allowed to grow up and do more things on his own, mother vowed she had tried to do this but finds it hard to give him so many privileges. Mother definitely would not approve of Bruce's talking back to her. Mother does not believe there is anything wrong with Bruce. The teacher has told her he is doing a little better in school; mother thinks he has improved.

Each week when Bruce went to clinic, he told his friends he was going to the dentist. This situation came to a climax when they asked to see the work that had been done and there was none to show. Toward the end of the contact mother expressed her resentment at having to come to the Warwick clinic. She knew many people in that area and did not want them to know Bruce was going to a psychiatrist. Mother said she would like to discontinue unless she could go to the Providence clinic. The impossibility of this was explained and mother withdrew. (Source of funds restricted cases treated in respective clinics).

The psychiatrist found Bruce to be a well developed, unusually clean and neat looking boy, who looked older than his age. He had a most intelligent way of expressing himself. Bruce seemed to enjoy his time in the clinic and used it constructively. The psychiatrist felt the family was closely knit and that too much pressure was put on Bruce to be good and to behave. No great dependency or indecision were noted and it was felt Bruce showed improvement in his reading and certainly could not be called a reading disability.

DISCUSSION

This mother indicated her resistance to the clinic even a year before she actually came. Throughout the intake interview she remained very tense and raised questions concerning face sheet information such as "why did you want to know Bruce's religion?" explaining she knew there was so much prejudice these days.

Mrs. D.'s anxiety about Bruce is expressed in many ways, particularly in her overprotection of him and her fear as to what "a mental block" might mean for her child. This fear is intensified by the stigma she attaches to psychiatry and its

association with "crazy people". She denied her own feelings about this but in the end was unable to accept treatment.

This mother also reveals ambivalence in her discussion of Bruce and the general situation was as inconsistent as her actual handling of the child. She denied the existence of any problem outside the school area and showed strong resentment at the teacher's suggesting such a possibility. In her need to defend herself, mother projects the blame for the school problem first on Bruce himself who is lazy and uninterested, then on the teacher who does not fulfill her responsibility in teaching him how to read. How much real basis mother has for her hostile criticism of the teacher is questionable.

In response to this ambivalence of his mother's, Bruce becomes a serious, conforming youngster. In her anxiety over him as the first and perhaps the only child (in view of the subsequent miscarriages) mother has become overprotecting of Bruce and finds it difficult to let him grow up. Unable to find acceptance in any direct expression of his feelings, Bruce finds expression in failing to progress in school.

From the outset, this mother was unable to accept the clinic or its psychiatrist. She preferred to tell Bruce he was going to a "special teacher" who would "help him with his reading in order that he might have better grades". There may have been some confusion in this mother's mind about the

clinic being part of the school system to which she was hostile. This has occurred at times in view of the clinic's physical location in a school building. However, the more significant feeling, her anxiety about people seeing her come to the clinic where only "crazy" people would be going, made it impossible for her to work through her resistance to the clinic. It was felt that this mother was resistant throughout her clinic contact to such an extent that "a relationship was never established" and the mother finally withdrew, unable to accept the idea of psychiatric treatment in the Warwick clinic.

Case #2

> Thirteen year old Anne B., was referred to the clinic on an emergency basis by the school nurse. Although Anne has always done good school work, the teachers have often noticed that she goes to pieces when called on to recite. At the time of referral Anne was revealing an acute school anxiety, becoming hysterical at the sight of the school. In view of the seriousness of the situation, mother was offered an immediate appointment in the Providence Clinic in order to provide the earliest possible time for Anne to be seen by the psychiatrist. However, mother did not feel she could come to Providence and preferred to wait ten days for an appointment in the Warwick clinic. Anne was seen by the psychiatrist five times and mother was seen by the worker five times.
>
> Anne was in the seventh grade, which meant this was her first year in junior high. Her younger sister, Nancy, age eleven, was completing grammar school. Up until this year the two girls had always gone to school together.
>
> Anne was the second youngest of seven siblings, two of whom were married and out of the home. The

other four, together with Anne's three year old niece lived with her parents in one of the suburban areas.

Mother herself appeared to be a disturbed person who had difficulty in making relationships because of her own timidity and shyness. She did show some concern about Anne's refusal to attend school but on the whole was quite defensive of her behavior. Mother identified with Anne, saying that she herself, gets "nervous" about going out, she feels as if everyone is looking at her, "just as Anne feels". When mother was an adolescent all she wanted was to play baseball with the boys as Anne does.

Mother expressed strong feelings about sex and a need to have all her children perfect. She kept Anne out of school for a week at the beginning of menstruation because of her own anxieties about the situation. It was most gratifying to mother that Anne did not get into trouble with boys and she definitely preferred this school anxiety to that sort of behavior.

From time to time, mother spoke as if she felt there was nothing wrong with Anne; she said there had been no sickness in the family--"we are all normal". It was felt that her resistance was in her great fear that perhaps there was something seriously wrong with Anne.

Mother avoided any mention of her own background and referred only briefly to father. She described him as a loud, rough person who is always working outdoors. He used to be a carpenter but hadn't been working very regularly. Mother felt he completely spoiled the two younger children, making it necessary for mother to do all the disciplining. In general the home relationships seemed to be rather poor. There is no indication of father's feelings about Anne's difficulty.

The worker noted that mother had so much anxiety that it was difficult to help her with her feelings. However, in the fifth interview mother spoke of how much easier she found it to talk with the worker now she was beginning to know him. Mother felt the worker, the doctor and the

school people were very kind to her. She felt this was good as she has always tried to be such a good person. Following this interview, mother broke an appointment sending Anne in with an older brother who reported his mother was ill. Nothing further was heard from the family following this last contact with Anne. During the last two weeks arrangements had been made for a home teacher and it was felt that now Anne was receiving school help the family felt the immediate situation relieved. The family were of such limited intelligence that they would not realize Anne was still a disturbed girl.

The psychologist found Anne to be a girl of "probably bright normal intelligence who is functioning at only an average level on formal tests". There was definite evidence of anxiety interference with maximum functioning. It was felt her problems centered around an unresolved Oedipal conflict and confused feelings for her father, ambivalence toward her mother and difficulty in accepting the feminine role.

The psychiatrist described Anne as a "pale, thin adolescent girl who is very shy". She recommended Anne be excused from attending school because of "psychoneurosis, anxiety state" and arrangements were made for a home teacher during the rest of the school year. It was felt Anne was definitely in need of continued treatment although the family withdrew. The psychiatrist felt that although this whole family was probably very shy and seclusive, that, nevertheless, Anne's conflicts were so acute that the prognosis was not good.

DISCUSSION

Mother was a very anxious person who had great difficulty in allowing herself to form relationships. She was very defensive and was unable to reveal her true feelings. Her verbalization of her own identification with Anne's behavior, focus on the possibility that this mother has transferred her own fears of not being "normal" to Anne and her resistance

was due to her fear that not only Anne but also she herself was a maladjusted person and had problems which should be treated.

During clinic contact mother was considered to be a very disturbed person. She was quite threatened by the treatment situation and withdrew as soon as the immediate situation was alleviated. In view of this mother's limited intelligence it is questioned whether or not she could have used the clinic constructively. However, a maximum effort was made to allow this mother to permit Anne to continue in treatment, but she was unable to allow even this.

Presentation of cases in which mothers showed an ambivalent attitude toward the child.

Case #3

> Paul was referred by the clinic director who had seen him privately and felt it advisable to transfer this case to the clinic where sixteen year old Paul could be seen by a male therapist. This arrangement also provided an opportunity for work with the mother which was not feasible privately.
>
> Initially, mother had telephoned the clinic at the suggestion of a friend. However, as an immediate appointment was not available in view of the clinic's waiting list, and mother did not wish to go to the State Mental Health Clinic, she made arrangements for Paul to be seen privately; a month later transfer to the clinic was effected. At that time, Paul was transferred from a female to a male therapist and mother was seen by a female worker. In view of the previous contact with the clinic director, the regular intake interview with the parent alone was omitted and both Paul and his mother came to-

gether for the first appointment in the clinic. Paul was seen twelve times, having broken four appointments because of illness and a leg injury. Mother cancelled her second appointment because of bad weather and nothing further was heard from her although both the director and therapist wrote requesting mother to get in touch with the clinic. Mother decided on a three dollar fee which was in proportion to their income; however, the fee was paid only on the first visit; all subsequent bills were ignored.

Paul had four younger siblings including William, age eleven, Esther, age seven, Karl, age unknown, and Charles, age two. Living with this family group was an eighty-one year old maternal great Aunt Sue. Father was a fireman and away from home most of the time. Mother, a graduate nurse, worked regularly on night duty.

Mother seemed to be rather nervous and hesitated waiting for the worker to begin the interview. After discussing clinic procedure mother hesitated trying to decide when she would come.

Mother felt the main problem was Paul's bunking school; he started this when Charles was born two years ago. He doesn't seem interested in school; it would be different if he could not do the work but she is sure he is intelligent enough. Two years ago when Paul was attending St. P. School the whole family had the mumps and Paul told the Sister he had to stay home and help his mother who was ill. He repeated the ninth grade at the Academy, then went to Saint John's. This year he wanted to go to Central where he is still in grade nine. Now he does not like it and is bunking again. Mother wanted Paul to have at least a high school education and wanted to send him to college. She would like to send him to a boarding school and inquired about this.

Mother is also concerned about Paul's behavior at home now. He is irresponsible and dishonest. He goes out without telling them where he is going and on two occasions was afraid to come home so stayed in an empty house all night. He has become very indifferent to

the family and frequently fights with his eleven year old brother William. Mother understands it is natural for children to fight with one another but she was an only child and didn't experience this. She was in boarding school from the time she was eleven to seventeen so didn't notice that her cousins fought among themselves. Paul had wanted to be an engineer but mother discouraged him as she thought he should be better in math. She feels this was a mistake and now is looking for something to interest him. Mother was also upset about Paul's not going to Mass and seemed to understand this was another way of his defying authority.

Being the first child, Paul had been brought up "according to the book". He was kept on a definite schedule and seldom picked up. As a result Paul is not affectionate and mother has not done the same with the other children. She blames herself for Paul's being this way but thought she was doing the right thing. Mother contrasted Paul with Charles who is a happy affectionate child, receiving "love and attention whenever they felt like it".

Paul was breast fed one month than mother had a gall bladder attack and had to put him on the bottle. When he was a year old mother had rheumatic fever and was ill for several months. During this time, eight different persons took care of him. Mother thought all these things had some affect on Paul. She definitely feels a baby needs affection.

Mother thought a great deal of the problem might be because father is away so much. He is inconsistent in his discipline. This has caused some difficulty between mother and father. The paternal grandfather was very strict. "You know old German, believed children should be seen and not heard." (direct quote by mother)

Aunt Sue favors Paul and makes it difficult for mother to do anything. Aunt Sue thinks Paul is just going through a stage and "taking him to a psychiatrist is foolishness". She did not do well with her own son who is very dependent on her and "escapes by having asthma attacks" which mother

referred to as psychological and emotional.

> The psychologist found Paul to be of bright normal intelligence. The record suggested a constricted, well defended individual, with a very immature fantasy life and rigid suppression of affect. There was some evidence which was not inconsistent with that shown by an adolescent psychopath.
>
> During therapy Paul related well; most of his complaints sounded like minor irritations present in any family between adolescent boys and younger siblings. He came to the conclusion he had been bunking school "as a method of punishing his mother. He believes that he has changed and he now sees that he wants to do well in school for his own good".
>
> This mother consistently broke appointments and did not respond to letters from both the therapist and clinic director. "In view of the lack of cooperation on the part of the mother this case is considered closed with both Paul and his mother, although it may be reopened if the mother expresses her desire".

DISCUSSION

Many of the things this mother complained about seem quite typical of an adolescent boy. Although she was able to verbalize an understanding of Paul's rebellion she was unable to accept it emotionally. Her anxiety and guilt were so great that she was unable to express any of her feelings of rejection toward Paul. Mother rationalized her handling of Paul as having been "according to the book" and further dictated by circumstances of her illnesses. Although she did blame herself for Paul's not being an affectionate child, mother exonerated herself as "she thought she was doing the right thing". She further directed the focus from herself

by blaming both father and Aunt Sue. She was critical of father and further showed her hostility to him by complaining about the small salary he makes. Mother expressed her hostility toward Aunt Sue in pointing out how unsuccessful she had been in rearing her own son whom mother referred to as a very inadequate person. Mother's pattern toward Paul seemed to be essentially ambivalent. In blaming herself and others, mother attempted to relieve her guilt to some extent. She is unable to accept her feelings of rejection toward him. Her desire to place Paul in a boarding school seems indicative of the pattern she was subjected to during her adolescence.

Although Paul was able to enter into a treatment relationship, mother expressed resistance from the beginning, trying to decide when she should come and explaining Paul's behavior in terms of the obvious, thus protecting her own feelings. This mother was unable to return to the clinic although she apparently wanted help for Paul and permitted him to continue. It is felt that she was too threatened to participate in clinic treatment. To avoid revealing her inadequacies as well as her real feelings toward Paul, this mother withdrew from treatment. As it was felt very little could be accomplished until the mother could be interested in the treatment plan, work with Paul was discontinued until such time as the mother decided to cooperate.

Case #4

Angelo was brought to the clinic by his mother who was "worried" about knowing "what is right" in regard to her handling of Angelo. Father died when Angelo was two years old. Mother and the boy, now eleven, live under rather crowded conditions with the maternal grandmother, age seventy-eight, a single maternal aunt, and another maternal aunt, her husband and four children. There is a great deal of friction in the home with everyone telling mother what to do and how to bring up Angelo.

Mother was a little surprised that she was expected to come to clinic too but readily accepted the explanation of clinic procedure saying it would be a good idea because she worried so much about Angelo perhaps she could get some help here too. Mother is coming to clinic so the doctor will tell Angelo what to do and the worker will tell her what to do and in this way she will know what is right and will not have to do as her family tells her.

Angelo's father died nine years ago and after that her family told her she was "picking on" Angelo. Some people do feel "cheated" losing their husband and take it out on their son; mother doesn't feel this way; it was "God's will", not Angelo's fault. This is the reason she tries to do so many things for him and give him as much as she can.

Mother feels she and Angelo became too close after father's death and she is trying to change this. They used to have separate bedrooms but now they sleep together. She does not think this is good and has put a pillow between them. Some of the fellows have kidded Angelo about having sexual relations with his cousins who live in the same house; Angelo has discussed this with mother. She has "told him everything because the stuff he learns from the other kids is not always true". Angelo "is a very ashamed boy". He won't undress in front of anyone except mother as she has told him she is the only one who could see his body.

Mother feels Angelo is too young to have the privileges her sister thinks should be allowed to grown-ups. "I want to keep him a child"--

she wanted to keep him close to her and illustrated her feeling by cradling her arms as if to hold a baby. Mother chased him all over the house with the strap because he wanted to wash himself. Finally after getting him washed, she slapped his face.

Angelo plays fairly well with the youngsters but is a poor loser and sometimes comes home crying. Mother constantly worries about something happening to him. She will not give him a bicycle as she doesn't want to come home and find him "stretched on the couch". Later someone gave Angelo a bicycle and mother had many sessions with on bringing it in at a certain time and keeping off the street. She doesn't allow him to go around with gangs in the neighborhood as they meet in basements and engage in sex activities. Further she will not let him associate with children at the Boy's Club as she has heard they are not good boys. In his interviews with the psychiatrist, Angelo resented the fact that his mother wanted him to play exclusively with his female cousins.

Mother is glad she kept Angelo in the parochial school although her family had advised her to take him out. Mother felt father would have kept him there so she did. He is doing better this year. Mother wants him to get good grades; to make something of himself and not be like her. She does not help him with his lessons as her sisters helped her and she never really knew the material when a test was given. Furthermore, she does not know Angelo's school-work and does not want him to say "Mother, you're dumb". She hopes he will become a priest.

Mother spoke a great deal about the conflicting authorities in the home. She lived with her mother ever since marriage and at times felt her husband would have preferred a place of their own. However, he said he did not think it right for mother to leave as her mother was so old. Because she was living at home, mother had never "felt like a wife" and advises anyone getting married to live alone, even if only in a room. Mother has thought of moving now. This gets her angry when the family tell her this is so she can "keep men". If she moves she would take her

mother. Her mother would be unhappy and not allow the conflict which exists in the home if she knew of it but she does not speak English and asks why the family does not speak her language. Mother feels she has to divide her attention between her single sister who is tempermental and moody, due to the menopause and Angelo. Mother was unable to work out any move from the living conditions but accepted the psychiatrist's telling her that Angelo was the one who really needed her attention and should get it.

Mother knew if father were living Angelo would be "all right today". Also he would give Angelo the many things she tries to give. Father was a great "kidder" and she thinks Angelo takes after him although her family insists Angelo is lying. He is too young to know the difference between the truth and a lie.

Mother's brother-in-law is a "terror"--he bosses her sister and demands to know where the children are. Mother avoids him as much as possible.

In the last interview before mother withdrew, she talked at length about Angelo's recent confirmation. Angelo had already had two Sacraments. At the time the Sacrament is administered, the child's life changes. With baptism a crying baby should stop; if it does not, it is indicative of his future life. At confirmation the child again changes--he becomes an adult. Angelo was confirmed yesterday and has already shown signs of becoming a man. Last night he did not want to do his studies and told mother he would get up early and do them; she did not believe this because of his previous record. However, he did get up early and completed his lessons. She gave another instance of his becoming a man and assuming responsibility. Mother was obviously pleased with the way things were going and arrangements were made for her to come in a few more times. However, she failed to keep the next two appointments and did not notify the clinic. The case was closed: "Client Withdrew".

The psychologist found Angelo to be a boy of average intelligence with very rigid defenses covering much insecurity, anxiety and general

feelings of inadequacy. Conflicts in relationships with his mother and in accepting the masculine role were suggested. His ego strength was good and there were no indications of abnormal thinking.

The psychiatrist considered Angelo to be a fairly well developed youngster who was friendly and spontaneous. He talked freely of his home situation expressing resentment for the pressures put on him and it was felt he was suffering under the environmental situation. However, during the treatment it was felt that mother was able to show "more warmth toward her child and things are therefore somewhat better".

DISCUSSION

From the reason mother gives for coming to the clinic--to be told what is right to do so she will not have to do as her family tells her,--it is evident that she is a very dependent, immature person who, harassed by the home situation, is turning to the clinic as another authority. She is able to express her resentment toward her sisters for interfering but is unable to handle this directly with them. She finds herself in continual conflict between them and Angelo and finds some consolation by justifying her handling of Angelo as being what she feels her dead husband would have done. Mother is unable to verbalize any hostile feeling toward her husband, whom she has obviously idolized in death and feels that if he were alive things would not be as they are. She did have anxiety about Angelo's inheriting from his paternal uncle who was in jail but was easily reassured on this.

It appears that this mother has no outside interests and

derives all her satisfaction from Angelo. This certainly intensifies his problem of growing up which she clearly did not want. Having such anxiety about this child anyway, this mother was extremely threatened by the thought of his maturation. There is a reality situation of overcrowded living conditions which certainly aggravate the mother's unconscious seduction of this boy. Her own immaturity and unresolved Oedipus situation make this situation even more threatening to her.

With all her own unresolved difficulties in her familial relationships, it is extremely difficult for this mother to give Angelo a wholesome maternal love which is so very necessary to this child already deserted by his father. This mother certainly is striving through Angelo for masculine attainment which she was unable to reach either through her own achievements or through her husband. She expresses her desire for Angelo to become a priest--to become part of that great authority which eventually relieves her of full responsibility for Angelo's maturation. This seems evident in her meaningful discussion of the Sacraments and her unsophisticated faith in the power or authority therein represented. This dependent mother who wanted to keep her son from growing up, gained enough support in the casework relationship to help her work through her ambivalent feelings and deal with the present situation. With Angelo's con-

firmation and mother's belief he was an adult and taking responsibility for himself, she did not have such great anxiety and consequently, withdrew from the clinic where she had felt the "relief" she knew would make things "all right".

Case #5

Sandra S. was referred to the clinic on this occasion by the school principal. Referral had been made two years previous by the pediatrician who suggested mother bring Sandra to the clinic because of her masturbation. Mother did not follow through on the referral at that time. At present the school is concerned about Sandra's frequent crying spells and her "fear complex"; she is particularly fearful of any new work.

Sandra is six and a half years old and in grade one. She is the second oldest of four siblings. Mary, age nine and a half, is an adopted sister; Nancy, age five and Robert, age thirteen months are own siblings. Sandra lives with her mother, father and siblings in one section of a two family house with the paternal grandparents occupying the other part.

Mother had a great deal of question about telling Sandra about the clinic. Disregarding explanations of the worker, mother wanted to handle this in her own way, telling Sandra she was going to visit, not telling her about the clinic until she arrived. The fee was discussed at length in spite of mother's declaring she and father had previously decided they could pay two dollars. Mother was interested in knowing whether or not there was any relationship between the amount of the fee and the treatment given. She was also concerned about the intellectual capacity of children seen in the clinic. Were they all mentally defective or retarded as her friend had said? Mother did not want us to think Sandra was a retarded child.

Mother described Sandra's crying as being a problem in school, denying the existence of any problem in the home. Mother explained this saying that Sandra had been crying for so long now that she is used to

it and if she does cry, mother tells her to stop right away. Mother feels the teacher is afraid of Sandra's cry--it is different--she "cries with her whole body", her face changes color and gets blotchy. Mother talked a great deal about Sandra's nervousness. She thought it probably started when Sandra was eighteen months old, at the time she had pneumonia. It was just at this time that mother went to the hospital for delivery of Joan. Mother thought it was very bad that she had had to leave at the time Sandra was "dying" and felt that following that separation Sandra had never wanted to be away from her mother again. When she was about three, Sandra was hospitalized for about ten days with cystitis. Mother identified with this as she had had cystitis during her pregnancy with Joan. Following hospitalization, Sandra took "nerve medicine" for about one year. At that time she was masturbating a great deal and mother felt this was "a result of the work they had done on the lower part of her body and that it had stimulated her sexually". Mother did not consider masturbation a problem when she came to the clinic.

In giving the developmental history, mother described Sandra as being black and blue from the instruments used in delivery. She said that Sandra was a very much wanted baby; they had had to adopt the oldest girl and mother had had an operation in order to have Sandra.

Mother volunteered that the adopted sibling had been very resentful of Sandra. Mother was angry at the psychiatrist's suggestion that Sandra had a good deal of rivalry toward Joan, denying that Sandra "hates" Joan. Mother blamed the paternal grandparents for not "accepting" Sandra--they did not like her as they had wanted a boy. Mother maintained that she treated all the children alike in fact "if any was favored it was Sandra".

Mother referred to her own childhood very briefly. She had been brought up strictly in a family of seven children. She was taught to "respect elders" and has always held everything in. She is anxious for all her children to speak up. Friends say mother takes too many orders from her husband; she prefers to live with her family or her in-laws as she likes being told what to do.

Father was not seen at the clinic and mother referred to him as working twelve hours a day, seeing the children only on the weekend. Father will spank Sandra if she cries when he is around.

The psychiatrist described Sandra as a spontaneous, outgoing, intelligent youngster without evidence of embarrassment, fear or shyness. The feeling that Sandra improved during the clinic contact was substantiated by the school principal who felt Sandra was less tense and less of a "crybaby".

After four interviews, "mother was very definite in her wish to close as she felt the child had become much more tense since coming to the clinic". The psychiatrist noted that the case was being closed at "the request of the mother who seems quite hostile and not at all cooperative"; consequently, the case was terminated as "Mother Withdrew".

DISCUSSION

Mother is a rigid, inhibited person who had been brought up to repress her feelings rather than to "speak up" which she verbalized as what she wanted her children to do. She seems to project many of her own feelings onto others; particularly the paternal grandparents and the teacher. In doing this, mother was projecting the problem away from herself and Sandra. Basically, her reaction toward the child seemed to be ambivalent with evidence of anxiety and overprotection.

Mother came to the clinic only under pressure from the school and denied the fact that Sandra's behavior caused any problem in the home. Further resistance to coming to the clinic was evidenced in the intake interview where mother tended to control the situation with a compulsive push of

talk about Sandra's problem. Mother's resistant attitude was also indicated in her discussion of the fee as well as the type of children seen in the clinic.

In view of this, mother's strong resistance to the treatment situation, the true source of her conflict, was never reached. She became extremely hostile to the psychiatrist when it was suggested that Sandra had a great deal of rivalry toward her younger sister. After four interviews, mother withdrew from treatment declaring that Sandra had become much more tense since coming to the clinic.

Case #6

Dickie was referred to the clinic by his pediatrician who could find no physical cause for his "nervousness" and thought the Child Guidance Clinic might be able to help. The physical examination had been at the suggestion of Dickie's teacher because of the "nervousness" shown in school. Mother felt Dickie did not "learn too well". Dickie's school history has been a poor one; he spent two years in kindergarten, principally because of a new law effective at that time. He was promoted to grade two on trial although he cannot write his name or read. He did so well in an I.Q. test given at the end of grade one, it was felt he should be promoted on trial.

Seven year old Dickie is the second oldest of four siblings. There is an older brother Ralph, age eleven, and two sisters, Elaine, age four and a half and Norma who is four months old.

Before he was seen by the psychiatrist, Dickie was given full psychological testing during which he showed no obvious tension and was cooperative to all procedures. There were some discrepancies which indicated possible auditory or visual impairment. During the course of clinic contact, mother was most cooperative in carrying out clinic

referrals to local specialists.

After three interviews with the psychiatrist, Dickie was transferred to the psychologist for continued therapy. Mother was seen at intake by a female caseworker to whom she related well. During the interview it was felt that she "responded in a friendly way, impressing the worker as being very relaxed and poised". Throughout the hour mother conversed easily and it was noted that "All of this was told calmly but with real concern".

In successive interviews, mother was seen by a male caseworker. It was felt she "made a positive relationship to a male worker". However, she seemed "pretty nervous" throughout the interview, talking in "a halting fashion and went from subject to subject quickly", speaking in a "superficial way .... and was unable to bring out any depth of feeling although she brought forth a large amount of material".

During intake, mother gave the following developmental history. Dickie was a full term baby, weighing seven and a half pounds. He was one of the few babies who escaped an epidemic of diarrhea and had to be kept in the hospital nursery four weeks after birth. Because of the epidemic, he was not breast fed. He always ate well and was weaned from the bottle at fourteen months. During early childhood he had whooping cough, chicken pox, measles and German measles, each accompanied by a very high fever. When Dickie was about six, he had mumps and was very ill for about six weeks, again running a high fever. For two weeks he was unable to eat anything because of vomiting. For that period mother gave fluids by rectum to prevent dehydration. Mother thinks Dickie enjoys the special attention he gets when he is ill. He cut his teeth at four months, sat at seven months, talked before he walked and walked at sixteen months. His toilet training was accomplished without any difficulty by two years. Mother thinks Dickie is slower than the other children but feels that is because he is such a big boy. When mother was asked about her concern over Dickie's slowness, she volunteered she was not afraid of that as much as she is afraid Dickie is crazy.

Mother identified Dickie with her thirty-seven year old brother who has had two nervous breakdowns. Dickie looks like him and behaves like him; she can't help but think Dickie may also break. Her brother is shy, quiet and unassuming, yet he is very irritable underneath. Dickie never gets mad at anyone and his uncle is about the same way. Grandmother, a "domineering, aggressive person who tells the whole family what to do," compares Dickie with this uncle too.

Mother contrasted Dickie to his older brother Ralph whom she described as a "devil", continually in mischief, easy to get along with, out playing with the gang all the time. He sleeps well, causes no trouble at home and everything seems to go well with him.

Father works long hours so really sees "too little of Dickie to know what he is really like". He is not worried about Dickie and says mother worries too much. Mother talked of father's loving Dickie best but became confused as she spoke saying how well father and Ralph get along. They go to the movies and frequently box together. Father treats Dickie like a much younger child; he doesn't expect Dickie to box. Dickie is his pet because he is good-looking and has a physique which father thinks perfect. The only time father spends with the children, he devotes to Dickie. Dickie loves all this attention; he loves it from any adult he knows. Both he and Ralph have been spoiled by doting uncles and aunts. So much has been done for Dickie he has been slow in learning to do things for himself although he can when mother refuses to do it for him.

Mother thinks Dickie is too obedient. His grandmother and aunts think he is wonderful because he is never disobedient. Mother declared she would put Dickie in his place if he ever expressed any negative feelings toward her and definitely expressed her displeasure at Dickie's hitting his sister. When she talks of the relatives thinking he is a perfect boy, mother showed some irritation and declared she wanted him to be a real boy; however, in expressing her own feelings mother too, seemed to want a perfect boy. Mother talked of Dickie's being a "sissy". He is very sensitive and cries if anyone speaks harshly. She has two girls

but underneath mother thinks she prefers boys. She likes "tomboys".

Dickie cannot stand to have his four months old sister cry or be disciplined; he trembles all over and cannot go back to sleep if awakened by her crying. Mother feels this is Dickie's concern for the baby's comfort and is not indicative of his jealousy. During the clinic contact Dickie had both ear and eye examinations by local specialists. He achieved a good score on his audiometer readings and it was suggested to mother that situations like Dickie's were due to "the youngster's jealousy of a younger sibling". Mother considered this but concluded Dickie's difficulties related to school as he hated to go so much she had a terrific job getting him off each morning. From the beginning mother maintained Dickie did not like school although he was fond of his teacher whom mother felt had been unusually patient and understanding. Mother had not prepared Dickie for Norma's coming as she knew he would miss her. As an example of how "close" Dickie was to her, mother cited the instance of Dickie's ringing in a fire alarm while she was hospitalized two years ago. Whenever she goes away, he always does something. In an effort to scare him as to the consequences for ringing alarms, mother had Dickie visit the Juvenile Court and the Poor House.

Mother complained about the unusual amount of food Dickie consumed, estimating he ate more than the combined family. The pediatrician had found no physical cause and had told mother this was sometimes due to an emotional disturbance.

In describing his sleep habits, mother said Dickie was always "dead tired". He only averaged three or four hours sleep at night--usually getting up about four-thirty.

During the seventh and eighth interviews, mother talked about Dickie's outgoing ways which were new to her. He wanted to bring his favorite gun to clinic but mother was shocked at this.

During the seventh interview with a good deal of warmth and feeling, mother asked about the female worker she had seen at intake. When it was explained the worker had left the agency, mother

said she did not mind and did not feel she would find it any easier talking to a woman. At that point she identified the male worker with her younger brother. Mother said she finds it hard to sit and talk with anyone. The two following interviews mother was quite late in contrast to her promptness on other occasions. She broke the tenth interview explaining the carpenters were coming to fix windows. There was no explanation for her breaking the following week and nothing further was heard from this family.

The psychiatrist found Dickie to be a fairly well developed boy, clumsy, poorly concentrated and with a short attention span. He put all the blame for his poor school performance on the other children saying they were "disturbing him". She felt quite strongly that there was a possible post-encephalitis following the sequela of measles during early childhood.

The psychologist found Dickie to be "a boy with superior endowment who functions at an average level on formal tests and at a defective level in school. These discrepancies appear to be the result of both emotional and physical factors". It was felt there was good prognosis for therapy as his defenses were not too high and he had good intelligence and a capacity to form relationships. During his course of treatment, Dickie "exhibited a great deal of aggression" and seemed "to enjoy thoroughly the interview session, although he continued to avoid both reading and personal matters".

Mother did not give any specific reason for withdrawing but simply did not get in touch with the clinic following several broken appointments. The worker felt mother withdrew after Dickie's behavior changed overtly from a quiet, meek, withdrawing sort to a rough, outgoing youngster.

DISCUSSION

From the very beginning this mother exhibited a great deal of anxiety about Dickie and her fear that "he is crazy". She has definitely identified this child with her younger brother who had had two nervous breakdowns with "another break ex-

pected at any time". She shows ambivalence toward him, particularly in her inconsistent treatment of him; he is too obedient but if he were to give overt expression to any negative feeling, she would "put him in his place". She complains of his being a "sissy" but is horrified at any evidence of aggressive behavior. Mother's own confusion over sex seems evident in her preference for boys which she quickly explained with "she likes tomboys". From the brief mention made of the maternal grandmother as "a very domineering, aggressive person who tells the whole family what to do", speculation seems justified as to mother's being a "tomboy" who had to compete in a masculine way in order to gain recognition herself. This seems further substantiated by the description of the maternal uncle "a shy, quiet, unassuming person who is very irritable underneath". This mother certainly was "irritable underneath" and throughout her clinic contact was unable to express any of her real hostile feelings.

Her rejection of Dickie was indicative of her unconscious hostility to him. Dickie responded to this rejection with equally great anxiety about his own counter-hostility. Being unable to cope with these feelings, he became the "too obedient" conforming child who was unable to tolerate any rebuff, from someone speaking "harshly" to the more drastic form of complete rejection felt in his mother's leaving to go to the hospital.

In counter-action of the basic rejection, there is evidence of this mother's overprotection of Dickie, particularly during periods of illness which she feels he "enjoys". She projected this feeling on to the many relatives who were credited with having "spoiled" Dickie which mother verbalized as a reason for his slowness in taking responsibility for himself. Dickie's anti-social attitude in regard to other children would tend to substantiate the fact that he had spent much time with adults.

Mother's continual attempt to repress her feelings was evident primarily in the great anxiety expressed regarding Dickie. Although she was never able to express her real feelings concerning him, it is felt that her anxiety was reduced considerably during the clinic contact. Her cooperation in carrying out all referrals also contributed in this area of allaying her anxiety.

From the beginning, her resistance to becoming directly involved in the causative factors was evident. This is illustrated in numerous ways, for example, in her forestalling any suggestion regarding rivalry between Dickie and the baby by denying the possibility of any existing "jealousy" being sure Dickie was interested only in the baby's comfort; in her projection on the relatives for "spoiling" and finally her rationalization that Dickie's difficulties all related to school. In view of the apparent difference in mother's

ability to relate to the different workers, it is felt that the transfer of workers increased her resistance to treatment although here again she was unable to verbalize her feelings directly. It is felt that mother's reference to the first worker is indicative of her more positive feelings in these relationships.

Mother further resisted the change in Dickie's behavior and it is felt she was too threatened by this to allow him to act out the feelings he had formerly internalized; consequently, evidences of her resistance increased following her reference to the first worker; during the last two interviews mother arrived quite late, then telephoned to break a third appointment, after which she withdrew without further word.

Presentation of cases in which mother showed a rejecting attitude toward the child.

Case #7

> Mark P. was fourteen years old and in the eighth grade at junior high school. He was the youngest of four siblings. His older brother, Matthew, age twenty-one, was away attending a university under the ROTC program. Margaret and Louise, ages seventeen and fifteen respectively, were living in the home with Mark and his mother. Although the parents had been divorced seven years, father was in the home a large part of the time.
>
> When mother telephoned for an appointment and learned of the waiting list, she requested she be called as soon as possible but in the meantime intended to try other resources. During the intervening month before mother was seen at intake, Mark had been seen three times by Dr. J., a neurologist mother knew through her work as a

nurse. Mother decided she preferred to come to the clinic and discontinued treatment with the neurologist.

On the day of the intake interview, father telephoned asking if he should come in. As he did not wish to come with his wife and there was no other time available, it was left that father would contact the clinic for an appointment at a later date. However, nothing further was heard from father although it was explained to mother that he could see another worker since he felt there would be no use in his coming after mother had "vilified" him here.

Mother was seen six times; the first and last interviews being with the same male worker while the four intervening ones were with a female worker. These changes were necessitated by worker mother had seen at intake going on vacation and the second worker's leaving the agency. Both changes were discussed with mother who accepted the first transfer and developed an excellent relationship with the second worker. This increased the difficulty in having to transfer back to the first worker. It is felt to be a contributing factor in mother's subsequent withdrawal. Mark was seen four times by the psychiatrist and full testing was done. Mother wanted to pay one dollar and fifty cents fee saying Dr. J. had not charged her as she is a nurse and she thinks that is why he did no more for them than he did although she realizes he is a neurologist and not a psychiatrist and might have been unable to do more.

During intake, mother referred to the problem saying Mark has always been in trouble; he is not going to be promoted although the school principal says he is a half year ahead "in intelligence". Mother feels a good deal of the problem may be environmental. Mark and his father do not get along. If something is not done about it, "the state will have to step in and take the child away". Mother feels a good male psychiatrist is the cure for Mark.

Mark has been in trouble since infancy; he was always "busy" in his crib and has never changed. He was irritable and hyperactive, always creating a stir when everyone else was quiet. Mother knows he was calling attention to himself--but with her

it didn't work; she was onto him, ignored him and still does. He would do better if she nagged but he's got to learn he's responsible for himself; "if he wants to be a dope, that's his problem".

Someday Mark will be sorry he didn't take school more seriously. Mother feels it is important to put the proper value on school work. It is funny that girls are studious and never fuss about school work, but boys do although they must grow up and be the head of the family and "provider". "But this is a man's world and it will be for a long time--someday women will assume their proper place." Boys like crime and detective stories so they can identify with the "big shots". When Mark asked mother whom the star of a detective movie reminded her of she said "Mark". Matthew is the only one who can manage Mark; he has no respect for anyone or anything. He does nothing in school; he likes shop and brought home a table which mother felt unfit for the house and relegated it to the kindling pile.

Mark is attending summer school at his own expense; mother felt it would be a waste of money to send him. She does not see how he can pass as he oversleeps and misses so many classes. Mother will not waken him as she feels this is his responsibility.

Mark thinks he can fix anything but mother won't let him try as she is sure he will wreck it. She is greatly concerned because he never reads. He bought "Seven Footprints to Satan" which he has been reading and telling mother about; mother hates those kind of stories. Mother is so exasperated with Mark at times "I could choke him".

Mother understands Mark has reason to be upset because of all that has happened at home--an alcoholic father, quarreling, divorce, mother's working and Matthew really being the only male figure in the home. Mother has been upset and she knows Mark has suffered the impact of all these things. She knows it affected the girls because they have told her how they felt; Mark never has talked about his feelings. Mother often feels very sorry for Mark because all this has happened to him but he makes her very angry going to that "stinking gas station" hanging around where he can be "boss" instead of with the "intellectual boys".

When Matthew was growing up, he was just like Mark; refused to study and was satisfied to take things as they came. He had friends who went to Classical High; fortunately, Matthew went too and learned before it was too late. Mother spoke with animation about Matthew's many accomplishments--his college, travel and photography. She was proud he was homesick and hitch-hiked to see her. Although father disapproved, she always gave him his fare back.

Mother contrasted Margaret's sense of responsibility with Mark's irresponsibility. She was the affectionate one of the family; she worked hard taking care of children, took piano and voice lessons in addition to making all "A's" in school. Mother is "perfectly satisfied" with Margaret "as she is".

Louise is not always as good in her school work, but almost. She used to take temper tantrums and mother almost brought her to clinic. Louise wants to be a fashion illustrator; mother would not allow her girls to become nurses.

Friends say mother is lucky having three grown children help her with the work, "little they know", this year she'll have no help. "It's a swell world we live in!"

Mother had divorced father seven years ago as he was an alcoholic and she couldn't stand living with him any longer. He is still "allowed" to come to the house when sober and seemed to be there much of the time. He cooks and relieves mother of a great deal. Father is a more avid reader than mother but then "he has more time than I do".

Mother herself was the oldest of six girls, one of whom died; an older brother also had died at an early age. Her mother was dead and her father was quite old and had asked one of mother's sisters to return to Nova Scotia with her family including five boys who he thought would help him on the farm and at the lumber mill.

Mother expressed much of her understanding of Mark's problem in her last interview with the female caseworker. She had been accepting of

worker's interpretations and had said she hated to see worker leave as she would miss her. Mother arrived for her next scheduled appointment "brimming over with hostility", declaring things had never been worse with Mark. Things could not go on this way; no one really understands the problem. The doctor tells Mark there is nothing wrong with him and he is in the wrong place and that is not true. "They both should have their heads examined". Mark needs a tough, authoritative person to put him in his place. The probation counselor will be tough with him and will not tell him that nothing is wrong with him. Mark might as well go to the boy's training school and have it beaten out of him as to try to work things out the way they are going now. Mother refused to allow Mark to return to the clinic.

The psychologist found Mark to be a boy of probably superior intelligence who is functioning below capacity due to emotional interference. His problems were seen to be in the area of his relationship with his mother, his difficulty in handling hostility, masculine sexuality and masturbation. He was considered to have good ego strength and good defenses with rather rigid control.

The doctor found Mark to be a tall, gangling adolescent who willingly entered the interview situation and expressed jealousy and resentment toward his sisters whose behavior he contrasted with his own. The doctor did not consider Mark a disturbed boy and was impressed by his wholesome interest in many things. Mark's behavior in the interview situation could not be reconciled with the complaints his mother had about him.

DISCUSSION

It is clear from this case that mother reveals an ambivalent attitude toward Mark vacillating from feeling he never had a chance to times when "I could choke him". The more positive expressions were more than balanced by mother's rejection which she was able to verbalize in so many ways and it

is felt that this mother was basically very rejecting in her attitude toward Mark.

It is interesting to note that this mother mentioned Mark's stealing and probation only in the intake and last interviews at the clinic, and in no way referred to it during her contact with the second worker. Her primary concern was Mark's poor school work.

As early as the intake interview this mother declared that if something were not done right away the state would have to step in and take Mark away. With the support of the female caseworker, mother was able to verbalize some understanding of the problem in relationship to the total family picture. Throughout her clinic contact it was noted that she was a suspicious, hostile person who was bitter about many things particularly her profession, men and the "man's world" in which she found herself. This feeling intensified her hostility to a male caseworker and being already threatened by Mark's good relationship with the doctor, mother could no longer tolerate the situation and withdrew letting it be known in no uncertain terms that she felt "the situation worse by our efforts".

It is clear that mother had never accepted her own feminity and further had apparently not fulfilled her own ambitions which she projected onto her children, with Mark bearing the brunt of this as he was giving mother the least

satisfaction in this area.

The marital relationship was obviously a poor one which mother herself recognized as a contributing factor in the total situation. With a submissive, alcoholic father, Mark's striving for masculinity was more difficult and his conflict intensified. His rebellion to mother's constant pressure for academic achievement is clear.

Case #8

> Six year old Carol had been referred by the clinic psychiatrist who had previously seen her twice on a private basis. In view of Carol's school anxiety and her strong attachment to her mother it was felt that this case would benefit from clinic treatment.
>
> Carol is the older of two siblings and in the first grade at school. She lives with her parents and four year old sister, Sue.
>
> As both Carol and the mother had talked with the psychiatrist privately, the regular intake interview was omitted and both parents and child came to the clinic together for the first visit. Mother had not told Carol that the psychiatrist is a doctor but has simply explained she was mother's friend. However, mother has told Sue about this and Sue is keeping it a secret. During the period of clinic contact it was felt mother overcompensated her hostile feelings toward the therapist by frequently remarking what a wonderful person she was and was it fine she had such a knack with children.
>
> Mother verbalized easily and talked at length about how Carol would not leave her. When first seen by the doctor Carol would not even go to school. Mother seemed quite discouraged by Carol's behavior and expressed resentment at not being able to leave her even to do the shopping.
>
> Mother openly expressed her preference for the younger sibling whom she described as a generous, sweet natured youngster who eats well and has

lots of friends. Mother denied the existence of rivalry between these sisters. She feeds Carol as it is easier than waiting around for her to get through. She frequently punished the child by spanking or depriving her.

Mother feels Carol is a spoiled child and stressed the fact that she (mother) had been with her too much. Carol has had asthmatic attacks since babyhood and has always been underweight.

Mother did not mention her own background except to say that her family had been strict. However, the psychiatrist knew that this mother had been in a concentration camp and finally escaped with father to Spain and later America. Mother did not elaborate more than to say she was having her children taught to believe in the common man and brotherhood--one could never get into trouble believing in things like that.

Mother is a tense, irritable, impatient person with many somatic complaints, particularly acute stomach pains which occurred during periods of stress. Her only mention of father was that he still explodes around the house. However, it is felt that he has become well established and provides the family with a comfortable living.

Mother had broken three appointments during the early part of the clinic contact; finally she broke several successive weeks always because of sickness--either herself or the children. Finally when the worker wondered if mother could see a way of adjusting this situation, she (mother) suggested withdrawing until spring--in the meantime "seeing how Carol gets along". However, nothing further was ever heard from this mother.

The psychiatrist found Carol to be a well-developed, intelligent looking girl who related very easily. She was able to express her hositlity toward Sue and also some feeling about the unhappy relationship between her parents. She showed some anxiety always demanding that the office doors be left open in order that she could see her mother. It was planned that a psychological evaluation would be made as soon as Carol was more sure of herself in the clinic;

however, mother withdrew before this time.

DISCUSSION

This problem was clearly one of parent-child relationships. The mother openly rejected Carol, expressing her preference for the younger sibling whom she always referred to in a much warmer, more accepting manner. Mother expressed her concern over the problem in terms of the annoyance to her rather than in any real interest of Carol. Carol's history of asthma seems further indicative of the existence of a poor mother-child relationship since her infancy.

Mother's only reference to her own background as "strict" seems significant in view of her obvious inability to express her feelings directly. This is evident not only in her attitude toward Carol but also in her feelings toward Dr. Muller. It is felt that this mother was so fearful of her own hostility and so threatened by Carol's relationship with Dr. Muller that she was unable to continue in the treatment situation and finally withdrew after breaking several appointments.

Case #9

Mother was concerned about Tom's lying and stealing as well as his poor school work. She had voluntarily sought help from the Juvenile Court as she had known of several boys the Judge had "straightened out". The court worker referred mother to the clinic.

There was some confusion about the initial appointment which the clinic had scheduled for July eighteenth; this was not kept and mother appeared without an appointment on August eighteenth as that was her under-

standing. Mother was seen on the latter date and during the course of the interview wished she had been seen on July eighteenth as "Tom might have been straightened out in time to pass his summer courses". Both parents were working, however, mother was willing to take time off and come to clinic. She accepted an explanation of clinic procedure in a rather detached way and after some discussion decided to pay a three dollar fee making it clear that she would probably be working only a short time and would want to adjust the fee then.

During the period of contact with the clinic, mother saw two different workers. Her first two interviews were with one person who explained the transfer in view of the worker's leaving the clinic. Mother seemed to accept this change.

Fourteen year old Tom was eight years older than his sister Claire. Mother stated that these children were both of her first marriage, however, she indicated that she was divorced when Tom was three; the details around this were never clarified. At the time of referral, Tom was living with his mother, adoptive father and six year old sister, Claire. Mother expressed a great deal of concern about Tom's refusing to study and his lack of interest in school work. He also steals and lies and she is bothered because he does not seem to have any guilt about this. Mother hoped the Child Guidance Clinic could help her in knowing what is the trouble with Tom.

Later on during the period of treatment mother wondered how the psychiatrist felt about Tom. Mother "realizes change can't come overnight but wondered how long she would have to come here".

Mother has always done whatever she has been advised to do but nothing has helped. She has been told about schools for problem children but she thinks that they help with some problems and not others. It would "tear her heart out" to have Tom go to a special school. Life is empty and she is unable to do anything whenever Tom is in the hospital.

On the day of her second appointment, mother and Tom were parked outside the clinic and called to worker as she passed saying a parking ticket would be the "last straw". Although mother was outside at least fifteen minutes early, she and Tom were late for their appointment. Later mother requested the hour be changed but was not satisfied when this was done; she became quite hostile when Tom's time could not be changed, although she came two more times before she actually did not keep her appointment nor contact the clinic thereafter.

In enumerating the things which she felt might have disturbed Tom, mother referred to "lots of trouble in the home" before he was three but she felt Tom was too young to remember it. For example, when Tom was one and a half years old, his father became very angry and beat him for throwing a plate on the floor. Mother frequently had to interfere to keep father from injuring the child. Father fought for Tom's custody but mother felt he was only trying to get back at her and did not really want the child.

In several instances mother questioned whether it was possible the "child's background" might have something to do with his stealing. He was born with a hare-lip and cleft palate which have necessitated seven operations so far with another to be done on his teeth. Tom has a speech defect which makes it difficult to understand him. Mother does not think this bothers him and cannot see that it has any "connection with the problem". She has talked it over frankly with Tom telling him it was nothing anyone could help and points out he is more fortunate than other children who are crippled or blind. She has told Tom he is handicapped and will always have to work for a living so should take advantage of his opportunities.

Tom has always played with the same neighborhood children and she feels they can understand him and accept him. Although the dentist advised mother to wait until Tom was eighteen before having his teeth fixed she intends to have them done right away as "it is too difficult for him to go through high school this way". The operation is expensive but mother feels it is worth it if it

would "help solve some of the difficulties" with Tom.

When Tom was small and mother was working, she knows he was not abused and nothing was ever said in regard to his lip as she always left him with her family. He was a very good boy when he was small; mother wishes he had done all of these bad things and gotten them out of his system then.

Mother contrasted Tom with Claire whom she referred to as "a little devil"--of course she doesn't do anything "bad". Claire always reports to mother on Tom as he is such a "liar", mother can't believe him and has to "check up". He always denies things mother asks him about. For example, she has asked him repeatedly about a robbery in a local church; he denies any part of it but "deep down inside mother knows he was in on the robbery". She visualizes with horror having to appear in court. He has never taken money from anyone but mother is sure he will.

If he would only be good mother would let him do "nothing but play". He enjoys all sports but these are denied in punishment and mother insists on his doing housework. She is puzzled as he does this willingly. Mother is extremely critical of Tom's companions but feels he would be with the same boys even if she were home (not working) as she never can find him anyway. Mother can see no reason for Tom's stealing or lying. He has always had everything he wanted--clothes, food, toys, television, trips and spending money.

She has deprived him of many things because he will not do his school work. Mother knows he can and does when she stands over him. She has told him again and again he must study; he can have all the education he wants if he will only study. She doesn't see why he doesn't profit from his adoptive father's experiences. He realized he needed an education and worked for it.

The adoptive father was seen only briefly; he was pleasant and seemed to be a more passive person than mother. Mother referred to him as being very good to the children and seemed more positive in

her feeling toward him than her former husband whom she referred to briefly in a hostile manner.

Although mother was pleased Tom was no longer taking money from her and was told by the teacher that he did not need any extra help with his school work, mother seemed quite pessimistic and felt that she had to watch him closely and keep a constant "check" on him. Mother broke the following appointment and nothing further was heard from her.

The psychologist found Tom to be a boy of probably average endowment who was functioning at a dull normal level. His relationship with his mother seemed to be a source of great anxiety which he was afraid to face; his first impulse being to escape rather than to face up to his problems.

The psychiatrist found Tom to be a small sized, thin, tense youngster with very indistinct speech. He minimized his difficulties, relating in a superficial way, he remained cautious and reserved although he always seemed willing to return.

DISCUSSION

This mother had such anxiety about Tom's problems that she voluntarily went to the Juvenile Court for help with them. In doing this, she may have obtained some relief from the great guilt that was driving her in this situation. Her own ambivalent attitude in handling this child is clearly a guilt reaction to her unconscious hostility toward Tom. The basic reasons for her hostility are not clear but it certainly seems safe to speculate from the stress she put on his need to be self-supporting that she had some feeling of this child's being an economic burden. Realistically, he has already had many operations which have cost mother an unknown amount and

although she volunteers "it's worth it if it will help solve Tom's difficulties", it has not solved his difficulties and obviously Tom has not come up to mother's expectations which would also tend to increase her feelings of rejection for him. How much mother is displacing her feelings toward her first husband on this child is not known although it is recognized that her only references to him were hostile and Tom may serve as a constant reminder of him.

In an effort to compensate, this mother attempts to gratify every wish of Tom's--giving him clothes, food, toys, etc. She is concerned about the company he keeps, the places he goes, his school work and tries to atone for her guilt by being a "good" mother. However, she is unable to give him love. In his rebellion, Tom does not meet his mother's demands in school progress and further compensates for her lack of love in his habitual stealing from her.

Mother showed her resistance to the clinic quite consistently during her contact, indicated from the beginning when she arrived a month late for her appointment, was known to be early for her appointment but actually came in to the office late, her continual fussing over appointment time, asking how long did they have to come here?; the worker's observation that "mother is still not relaxed and I have yet to see her smile" followed in the next interview with the notation that mother was hostile and "resistant about clinic

treatment", are all given indications of her extreme resistance.

It is felt that this mother was so overwhelmed by her own hostile feelings she was unable to overcome her resistance to treatment and withdrew without offerring any explanation.

Case #10

Six year old Bobby was referred to the clinic by the Country Day School. He had been expelled from public school and before the private school would accept him they requested a study be made at the Child Guidance Clinic.

Bobby lived with his mother, adoptive father and half-sister, Mary Lou, age one year. The family is Negro.

Bobby was seen five times by the psychiatrist and was tested by the psychologist. Mother had five interviews with a male caseworker. Mother was a little late on three occasions and three-fourths of an hour late precluding the possibility of the second scheduled interview. Mother broke her last two appointments and following this, arrived at the clinic without an appointment. Mother was "relieved" about the fee and decided to pay four dollars per week. As her husband's pay was reportedly ninety-five dollars per week, this was a proportionately low figure. The fee was paid for intake and one treatment visit although several bills were sent to this family.

During the intake interview, mother expressed her concern over Bobby's uncontrollable behavior in school. He is always in trouble in school; he stands on his head, never stays in his seat, refuses to concentrate and is always fighting with other children.

Mother insisted he was no trouble at home; he has never "sassed" mother. He never picks up his clothes or does anything around the house. He refuses to help mother; he plays with older

boys and has run away from home twice and been picked up by the police. The family are trying to make him "respectable". Mother is afraid if this behavior continues he will end up in Sock-anosset. (The training school for boys.)

The family doctor has told mother she is too strict and expects too much from Bobby. Mother says perhaps this is true; she wonders if it is something she can work out in the clinic. Mother showed some anxiety about the possibility of Bobby's being slow. She seemed "pleased" at hearing the clinic would "help the whole family with relationships".

During subsequent interviews, mother talked primarily about Bobby's behavior. She feels he should do the things she tells him to. He is no longer a baby and should become mature. She wants him to go to boarding school but denied she would like to have him go to stay with his grandmother for the summer.

Nobody can get along with Bobby as he is too slow, contrasted with mother who is "fast and quick". Bobby set fire to his bedroom; mother brought out her concern as to how this might cause a fire in Mary Lou's room which was next door. Mother burned Bobby's fingers with a match and spanked him but it doesn't do any good. Mother expressed a great deal of anxiety about Bobby's leaving the yard. She does not permit this nor is he allowed to have any playmates.

Mother has noticed how other mothers "hug and kiss" their children. She couldn't do it with a boy anyway--"they don't need that sort of stuff" and "it is easier to be more affectionate with a girl".

Mother described Mary Lou as being cute, "so active and so much like a tomboy". Mother "loves it because her own family were so strict with her when she was growing up". She referred to her mother as "a nervous woman" who was easier than her father; he made you "toe the line". Mother mentioned her younger brother briefly saying he was always in trouble.

Mother feels Bobby and her husband get along well; he is "no worse than the average father". He gave Bobby a good licking for wandering off.

During her contact with the clinic, mother brought out a good deal of resentment about the intolerance toward Negroes, expressing her anger toward the schools and finally saying she felt the whole school situation revolved around a young white teacher's feelings toward Bobby. She said he was stupid.

At no time did mother mention Bobby's illegitimacy nor his early development. However, this information was known to the clinic through clearance with the Social Service Index. During mother's fifth visit to the clinic, the psychiatrist entered the interview and told mother of our knowing this background material. At the end of that period, mother became very hostile and wondered why the psychiatrist referred to Bobby as a very sick youngster. There was no reason for him to be nervous inasmuch as he had plenty of toys, new clothes and attention either from herself, her husband or the maid.

Mother broke the next two appointments then appeared without one, explaining she was working full time, Bobby was going to a tutor twice a week (as had been recommended by the psychiatrist) and mother did not feel she would continue unless the doctor insisted. The decision was left with mother and she decided not to return. Later mother telephoned the psychiatrist and said "she did not feel free to tell the social worker everything in the story". Nothing further was heard from this family directly although the tutor telephoned several weeks later reporting that Bobby had come willingly at first but later just roamed through the streets instead of going for his appointment.

The psychiatrist found Bobby to be a pleasant, talkative youngster who played like a boy of his age and had a fair attention span. During clinic contact, he became more demanding, restless and difficult to manage. "This child is, from the beginning, completely rejected by the mother and step-father and has reacted to the situation with his great behavior difficulties."

The psychologist found Bobby to be of average intelligence "who apparently feels severely rejected by both parents and is reacting....with hostility

and strong aggression". His aggressive impulses were considered to be so strong and upsetting in the group situation that he "might be unable to demonstrate his capacity in an actual learning situation".

DISCUSSION

Mother's rejection of Bobby was revealed in her expressed attitudes toward him. She came to the clinic only under pressure from the Country Day School. Her rejection was manifested in her desire to place Bobby in a boarding school. If this did not work out, mother concluded he would have to go to Sockanosset. Although mother originally maintained the problem was limited to Bobby's school behavior, she focused most of her interviews on the difficulty in managing Bobby in the home. She was unable to see any reason for his behavior and her rejection was so strong that at no point could she reveal any warmth or affection toward him. Mother openly verbalized her preference for Mary Lou whom she referred to as a "tomboy".

This mother's confused identifications, going back to her own unresolved Oedipus, intensified her feelings of rejection toward her son. She refers to her own brother as always being in trouble but denies identifying Bobby with him.

Her illegitimate pregnancy further signifies her unresolved conflicts which are accompanied by extreme feelings of inadequacy and inferiority.

During her contact with the clinic, mother further revealed her feelings of inferiority regarding her race. She

projected Bobby's difficulty on the school and the white teacher who she felt was prejudiced against him because he was Negro.

This mother showed her anxiety and hostility toward Bobby in her need to restrict his play as well as in her inability to tolerate his wandering away from home.

It is felt that her great anxiety about his possible retardation is directly related to the guilt caused by her feelings of rejection toward him. Further, Bobby is a constant reminder and perpetuation of mother's earlier relationship with the alleged father and as such becomes the object of her hostility toward him.

This mother was considered by the worker to be a "very disturbed, affective woman. She talked in a very compulsive way....." This mother seemed to pour out material in a compulsive way in an effort to keep away from material in any way relevant to her illegitimate pregnancy with Bobby. This material was too painful for mother to tolerate and when she was made aware of the clinic's knowledge of this, mother became extremely hostile to the psychiatrist and withdrew from the treatment situation.

This mother's hostility toward Bobby was so pronounced that when she was unable to place him in boarding school, she went to work (there was no reality basis for this) leaving the child in the care of the maid and the tutor whom he was scheduled to see twice a week.

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this investigation has been to study the attitudes of the mothers in ten cases which withdrew from treatment in the Providence Child Guidance Clinic. In this study an effort has been made to determine what relationship, if any, exists between the mothers' attitudes as revealed during clinic contact and their subsequent withdrawal from treatment. In so far as possible, comparable material from each record has been abstracted through the use of a schedule specifically designed for this purpose. The group has been analyzed individually and as a whole. The specific attitudes expressed by the mothers toward (1) the problem (2) the clinic and (3) the child were each analyzed and classified into three groups. These groupings were not indicative of motivations or other causative factors but rather reflected the common attitudes encountered during clinic contact with these mothers. Because of the variability in these attitudes, the writer illustrated the respective groups, presenting individual case summaries to provide a clearer understanding of the conclusions which may be drawn from this study. It is felt that the following factual and theoretical findings may be drawn from this analysis.

It was found that both the age distribution and intelligence range of these ten children varied considerably

and consequently do not seem to have any significance in this study. Further, it was revealed that seven out of ten of these youngsters are males; also, sixty per cent of this group are either first born or only children.

The sources of referral indicate that pressure was put on the mother to bring the child to the clinic for treatment, particularly by the schools. Included in the symptomatic behavior described in every case at the time of referral, was a problem in the area of school adjustment. These symptoms, as referred, ranged from "poor school work" to an "acute school anxiety". It was evident from material found in all of these cases that the reported behavior had existed for some time before the clinic contact. Twenty per cent of the mothers indicated their resistance to previous suggestions relative to their seeking treatment at the clinic.

The mothers' attitudes toward the problem as expressed during the initial interview fell into three classifications. That is, four mothers accepted the fact that a problem existed; in three cases the mother showed ambivalence and only partially accepted the existence of a problem; in three other cases, the mothers did not recognize that the child's behavior constituted a problem. Therefore, in these ten cases the attitudes of the mothers toward the problem were seen to vary considerably, being proportionately distributed in all three classifications--accepting, ambivalent and

rejecting. The writer feels that this is significant as it is illustrative of the fact that there does not seem to be any significant relationship between the mother's attitude toward the problem as shown during the initial interview and her subsequent withdrawal from treatment.

Evaluation of the mothers' attitudes toward the clinic revealed that in only one case was the mother accepting of the clinic and able to benefit from her contact there. This mother withdrew from treatment only after she had satisfactorily fulfilled her own needs and recognized that things were going better as far as the child was concerned. Just prior to this mother's withdrawal, the progress of this case had been recognized by the clinic and plans had been made for closing it.

In four cases in which the mothers were ambivalent in their attitudes toward the clinic, it was found that although these mothers appeared to want help for their children, they were unable to work through their own resistance to treatment and subsequently withdrew.

The five remaining cases, or fifty per cent of the total studied, were found to be resistant to clinic treatment. The one factor common to each case in this group was the hostile attitude revealed by the mother. In these last two groups, ambivalent and resistant, representing ninety per cent of the total cases studied, it was found that resistance to the clinic was the most conclusive factor in the attitudes

expressed by these mothers.

In analyzing the mothers' attitudes toward the child, it was found that two mothers were accepting, four were ambivalent and four were rejecting in the attitudes expressed. In a previous study[1] on the outcome of treatment of rejected children, it was found that the successful treatment of the child was largely dependent upon the modification of the mother's rejecting attitude. Three of the four rejecting mothers were resistant to the clinic and not interested in cooperating in a treatment plan. However, it is felt that the combination of attitudes expressed by the mothers toward the problem, the clinic, and the child varies so widely that no significant conclusions can be made in this area. On the basis of the evaluation of this material, it is not felt that there is any conclusive relationship between the mother's attitude toward the child and withdrawal from the clinic.

The fact that the sample studied was small and the number of uncontrolled variables large, makes the findings of this study tentative.

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1 Helen Witmer and others, "The Outcome of Treatment of Children Rejected by Their Mothers", Smith College Studies in Social Work, 8: 187--234, March, 1938.

The findings of this study suggest that the resistance expressed in the mother's attitude toward the clinic is the most significant causative factor bearing on her subsequent withdrawal from treatment. Implicit in this is the possibility of future study of techniques of casework in an effort to develop greater efficacy in the handling of resistances.

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APPENDIX

Schedule

Case Number
Assigned Number
Name
Age
Sex
Siblings
Ordinal place in sibling group
I.Q.
Referral
Problem as referred

Parents	Father	Mother
Marital Status		
Age		
Nationality		
Occupation		
Religion		

Experience at Intake	Father	Mother
Who came?		
How did parent happen to come at this time?		
Parent's attitude toward problem.		
Parent's attitude toward clinic.		
Parent's attitude toward fee.		
Was fee actually paid?		
weekly		
monthly bill		
other		

Was there any discussion regarding possibility of change of workers between Intake and first treatment interview?

Time between intake and second visit with child
Clinic personnel involved

Doctor	Male	Female
Worker	Male	Female
Same at intake and treatment		
Other change		
Psychologist		
testing		
therapy		

Mother's attitude toward clinic

Appointments	Mother		Child		
	Worker	Doctor	Doctor	Psychologist	Worker

- Number of appointments
- Regularity
  - No broken appointments
  - Reason given by parent for breaking
  - Promptness
  - In office without appointment

Attitude Toward Clinic
- Worker
- Doctor
- Other clinic personnel

Mother's Attitude Toward the Child
Mother's Attitude Toward her Husband
Mother's Attitude Toward Persons in the Environment

- The teacher
- In-laws
- Parents
- Others

Child's Attitude Toward the Clinic
Status of Case at time of Closing

- Reason given by parent for closing
- Doctor and/or psychologist
- Social Worker

Evidence of any agency follow-up or contact known to Child Guidance Clinic subsequent to closing of case in clinic