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A study of twelve cases of pre-school children referred for unmanageable behavior to the James J. Jackson Putnam Children's Center

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF TWELVE CASES OF PRE-SCHOOL CHILDREN
REFERRED FOR UNMANAGEABLE BEHAVIOR TO THE
JAMES J. JACKSON PUTNAM CHILDREN'S CENTER

A Thesis

Submitted by

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(B.A., Swarthmore College, 1940)

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

1952

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CHAPTER I

DEFINITION OF THE PROBLEM

Purpose and Scope of Study

This is a study of twelve cases of pre-school children who were referred to the James J. Jackson Putnam Children's Center for help with unmanageable behavior. By unmanageable behavior is meant actively or passively non-conformist behavior such that the mother feels unable to control her child.¹ The purpose of the study is to indicate the general nature of the problems which these children presented, and of the settings in which the problems arose. To this end, the study seeks to answer the following questions: In what ways were these children unmanageable? What other problem behavior, if any, did they exhibit? Why did the behavior so concern their mothers as to bring them to a child guidance clinic? On the basis of follow-up interviews, what is the present status of the unmanageable behavior?

As a basis for classification of the cases, this study will explore the children's behavior with reference to the extent of the problems they present. Certain environmental factors will be examined for their bearing on the problem. These factors will include parental practices in feeding and weaning, and in toilet training, as well as the children's ordinal positions in their families. Maternal attitudes as verbally expressed to the social worker will be examined for relevant cultural and emotional factors. On the basis of the follow-up interviews, the later development of these children will be examined, and comparison will be made between

¹ The definition is necessarily relative to the mother's feelings, as not all mothers would be similarly concerned by the same behavior, and maternal concern is an essential element in the problem.

the later development of treated and untreated cases, as seen by the parents.

Sources of Data, Limitations of Study

The twelve cases studied were selected by the chief of social service of the James J. Jackson Putnam Children's Center from the file of closed cases. The earliest of the twelve cases was closed in 1945, while the latest was closed in 1951. The data were derived from the records, with emphasis on the social service records, and from follow-up contacts with the families, and were entered on a schedule (see Appendix). Not all aspects of the data were utilized in this study, which selected only a few unfavorable environmental factors for examination. Certain maternal attitudes were prominent among these factors, but attitudes of other family members were largely unavailable and were not studied systematically.

The extent and kind of data available in these cases depended to some extent upon the length of contact in each case. Thus, although many of the main facets of the problem might become apparent during the period of initial evaluation, the maternal attitudes underlying these facets might not be expressed in words until the mother was well along in treatment. Cases in which the contact was brief might therefore have correspondingly limited material.

An outstanding limitation is the absence of data which can demonstrate the subtle (and largely unconscious) interrelationships within the families which produced these children. This study cannot show in any definitive way how these problems arose; as indicated on page 1 above, it can only show the general nature of the problems and of the settings

in which they did arise, with some indication of the extent and seriousness of the problems.

Definition of Treatment

For the purposes of this study, treatment is defined as periodic interviews over a period of at least three months. Of the twelve cases studied, both mother and child were concurrently treated in seven. In one case, only the child was treated, as the mother was unable to come to clinic during most of the contact. In four cases, the contact was too brief to be defined as treatment.

Agency Setting

The James J. Jackson Putnam Children's Center, to which these twelve children were brought for help, is a child guidance clinic for infants and pre-school children, located in Boston, Massachusetts. It was established in 1943 as an independent agency under the auspices of the Judge Baker Guidance Center. By the time the earliest of these cases was referred, the Children's Center had evolved a procedural form which was essentially the same as its present form.

When a child is referred to the Children's Center, the usual procedure is to make a brief initial study of the problem to determine if it is one in which the clinic can be of service. If continued treatment is then recommended and accepted, the child may begin individual psychotherapy or may enter a group in the nursery school, or may have both aspects of treatment concurrently, depending on the circumstances of the individual case.

This clinic employs the usual teamwork approach to a problem, in that

a psychotherapist, who is usually a psychiatrist, works individually with the child while a social worker works with the parents (ordinarily with the mother). The contributions of clinical psychologists may also be utilized in the initial evaluation of each child and for later evaluations if these are indicated. The Children's Center has made an unique addition to this teamwork approach in its institution of the nursery school. The child's behavior in the nursery school group to which he is assigned provides valuable supplementary observations. It also gives the child an opportunity to work out his problems in a group setting. His nursery school teacher is part of the team and takes part in the regular team conferences.

CHAPTER II

THEORETICAL CONSIDERATIONS

Introduction

As children grow and develop in a community, their gradual adjustment to community requirements for behavior involves some sacrifice of their own self-centered demands, some frustration of the needs of the developing organism. Children may react to these frustrations in a variety of ways, often in ways which are acutely unacceptable to their parents, while they are learning to manage their own feelings and adapt to community requirements. This study deals with twelve children who reacted to their environments with aggressively non-conformist behavior of various kinds, and with twelve mothers who were sufficiently concerned by this behavior to consult a child guidance clinic. It should be kept in mind that such maternal concern stems both from community requirements as reflected in the parents and from any personal needs of the parents to promote certain kinds of behavior (and prevent other kinds) in their own children. A brief discussion of common stimuli to aggressive behavior in the pre-school child will be useful in evaluating the behavior of the twelve children studied here. It should be noted that this discussion is limited to the negative potentialities in the child's experience, and is in no sense intended as a balanced presentation of the total picture.

Common Stimuli to Aggressive Behavior

During the first year of life, the child is a helpless infant, dependent on his mother's consideration and love for the satisfaction of his needs. No matter how considerately he may have been treated, it can be trying for a child to be asked to give up the breast or the bottle at the

time of weaning. If the mother's treatment of the child is unsympathetic or ungenerous, if she weans him early or abruptly, he may become suspicious and resentful, and less willing than otherwise to give his mother the behavior she asks of him. Frustration of this kind may leave the child feeling always unsatisfied and slighted, always wanting more.¹ A bottle-fed baby may be even less willing than a breast-fed baby to exchange sucking for drinking from a cup.²

Beginning about the time when they learn to walk, and often lasting for at least a year, there is ordinarily a period of considerable non-conformist behavior by children in this culture. This behavior may take the form of negativism, in which a child tests his power to disobey parental requirements. It may take the form of active destructiveness, of hitting parents or fighting with other children. It may involve temper tantrums when too much frustration is imposed. The possible forms of non-conformist behavior are many and varied, but they all express the child's difficulties in learning the essential lesson of this period of growth. This is the period in which children have to admit their own weakness relative to their parents, as contrasted with the fancied omnipotence of infancy. This is the period in which children learn to direct their energies within the patterns of behavior required by their parents, in order to keep the all-important parental love and approval.³ When insufficient love and approval are forthcoming, the lesson is that much harder to learn.

1 O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 26.

2 Benjamin Speck, The Pocket Book of Baby and Child Care, p. 178.

3 David P. Ausubel, "Negativism as a Phase of Ego Development," American Journal of Orthopsychiatry, 20:796, October 1950.

Among the required patterns of behavior during this period, perhaps the most personal requirement put on the child is that of training his bowels and bladder to function at certain times and in certain ways. Parental attitudes toward excretory functions in the child, and the demands these attitudes put on him, play a very important part in all the lessons of social behavior which the child is required to learn between the time he learns to walk and when he goes to school.⁴ The child's response to parental demands in the toilet training period, moreover, tend to be affected by the parental treatment he has received during his first year. If he was treated with love and consideration while he was a helpless infant, he will be much readier to give the parents this gift they now require of him.⁵

The effect of ordinal position in a family is another of the problems which every child must face.⁶ If he is an oldest child, displacement by a younger sibling means that he must constantly work to keep ahead, especially if he is so unsure of his mother's love as to find it very difficult to give up the favored position. A younger child is correspondingly under pressure to keep up with the older one who appears to have more privileges and more abilities, while a middle child must both keep up with the older ones and keep ahead of the younger ones. (A middle child is often less well loved than either the first or the last child). An only child, on the other hand, experiences the pressure of undiluted parental attention, and is the focus of all the hopes and fears which parents with more

4 O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, pp. 44-48.

5 Ibid., p. 47.

6 O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, pp. 43-44.

children would divide among the family as a whole. Thus, a child's ordinal position in his family is one of the important factors in the total setting to which he reacts.

Aggressive behavior in children may be in direct response to such frustrating pressures as have been described above, or they may be subtly stimulated by one or both parents as an expression of feelings which are inhibited in themselves. For example, the special meaning of a particular child to his mother affects the relation between them and correspondingly affects his behavior towards her and others: she may use this child to solve her own conflicts in regard to herself and her relationships with other important adults.⁷ In other words, the very behavior symptoms which bring a mother to clinic may be a result in the child of subtle and unconscious stimulation by the mother.

The child loses his original meaning and is subjected to emotional impulses that were not meant to concern him. As the grandson of a hated grandfather, as the son or daughter of a rejected father, as the memory of an undesired, perhaps "sinful" action, and often as a part of his own mother, who directs toward her child her masochistic fury against herself, he is hated or rejected, neglected or maltreated.⁸

A mother who fears that her child will devour her or will "take over" cannot tolerate normal expressions of aggression by the child; on the other hand, it is this same mother who provokes these aggressions. The child intuitively senses and plays upon his mother's vulnerable aspects. "This leads to those long chains of difficulties between mother and child in which the primary and secondary factors are almost indistinguishable. . ."⁹

7 Judith Silberpfennig, "Mother Types Encountered in Child Guidance Clinics," American Journal of Orthopsychiatry, 11:475, July 1941.

8 Helene Deutsch, The Psychology of Women, vol. II, p. 329.

9 Ibid., p. 330.

Although it is common lore that boys are more active and lively than girls, the normal aggressive activity of boys is apparently no more tolerable by some parents than is such behavior in girls, as we shall see in Chapter III below. Parental tolerance, as indicated above, is as much a matter of the special meanings of the behavior to parents as of cultural inhibitions which are general in the community.

Cultural Factors in Aggressive Behavior

Aggressive behavior should also be considered in terms of cultural values, for every culture uses the drives of the human organism in its own ways. Certain legitimate (approved) channels for hostile aggressiveness are ordinarily present in any culture. Seen from this approach, the problem of every child is to distinguish legitimate from illegitimate aggression, and to channel his drives accordingly.

The small, conjugal family units of Occidental culture accentuate the relationships within the family as compared with the more dilute relationships in more extensive kinship units. Thus the small family unit accentuates the importance of conformity, heightening the insecurity of the child who does not please his mother, who is his chief contact with the outside world. Maternal approval tends to be contingent on the child's good social behavior in this culture, and the child's acute need for this approval makes dangerous any direct expression of hostile aggression.¹⁰

Social limitations on overt aggression are considerably greater in the American middle class than in the American lower class.¹¹ It is a

¹⁰ Talcott Parsons, "Certain Primary Sources and Patterns of Aggression in the Social Structure of the Western World," Psychiatry, 10: 167, May 1947.

¹¹ Allison Davis, "Socialization and Adolescent Personality," in Readings in Social Psychology, pp. 143 ff.

matter of common observation that girls of the middle class have much less freedom in overt aggression than boys. Boys in turn are restricted to expressing their aggression directly in certain limited circumstances. They must learn to fight other boys when attacked, but not to be attackers, never to attack girls or supervisory adults, and always to stand their ground in situations of normal competition. There is much less restriction on both boys and girls of the lower class, who learn that aggression is an "approved and socially rewarded form of behavior in their culture." "In lower-class families in many areas, physical aggression is as much a normal, socially approved and inculcated type of behavior as it is in frontier communities and in war."¹² Because of the greater inhibitions on children in the middle class, they are motivated by a greater degree of anxiety and guilt than are children in the lower class.¹³ This would imply that individuals raised with middle class attitudes toward aggression would be more threatened by aggressive behavior than individuals in whom the behavior evokes less guilt and anxiety.

Membership in the Jewish culture, with its history of persecution and violence, is another possible source of special anxiety about overt aggression. This factor has been discussed by at least one writer,¹⁴ but its validity for the cultural groups has not yet been established. It should be kept in mind, however, as a possible source of special feelings about overt aggression in the Jewish mothers with whom this study deals.

12 Ibid., p. 147.

13 Ibid., p. 148.

14 Erik H. Erikson, Childhood and Society, p. 26.

Types of Aggressive Behavior

Destructive activity in young children is often observed to follow some frustration or deprivation, so that they appear to be venting their resultant anger in attacking some object in the environment. In other words, it appears to serve the ego in its adaptation to the environment. As children grow older and accept the parental restrictions as valid for their own activity (internalization of the super-ego), they are better able to control their own aggressive drive and to channel it in ways which do not injure other persons directly. In this sense, the problem of destructive behavior is a problem of ego-development.¹⁵

A child who has been severely rejected from the earliest stages of his relationship with his mother is apt to express this deprivation in such habit disorders as thumb-sucking and masturbation, in other words, by turning for his satisfactions to his own body. If his difficulties have been less severe, and have centered perhaps in the period of erotization of the anal zone, the child has at his disposal the anal-sadistic mechanisms of hate and of mastery by elimination, which may lead to his use of feces as weapons of injury and destruction against his parents. Such a child exhibits conduct symptoms (temper tantrums, destructiveness) rather than the habit disorders of body play, although traces of the latter may remain in any person who suffered very early deprivation.¹⁶ In other words,

¹⁵ Beata Rank, in an article entitled "Aggression," (The Psychoanalytic Study of the Child, vol. III/IV, pp. 43 ff.) discusses the difference between the diffuse motor discharge observed in many atypical children and the goal-directed aggressive behavior observed after treatment has progressed to the point where ego-functioning and reality recognition permit goal-directed reactions to fear and frustration. She considers ego-structure the determinant of how the child reacts to frustration.

¹⁶ Gordon Hamilton, Psychotherapy in Child Guidance (New York: Columbia University Press, 1947), pp. 26 ff., 46 ff.

children direct their aggression largely outward toward someone or something else, rather than turning their energies primarily in on themselves and withdrawing from contact with the environment. Some children may show both kinds of aggressive behavior, for example, the anxious children who are destructively aggressive to compensate for their own sense of weakness and inferiority.

Outwardly directed aggression may be hostile and non-erotic (pre-oedipal) in character, or it may be chiefly erotic (oedipal), or it may show both stages. "It may be active, as in temper tantrums, rebellion, fighting, or running away, or passive, as in stubbornness, obstinacy, disobedience, unwillingness to change unapproved habits. . ."17

In summary, the primary sources of hostile aggressive behavior in children lie in the relationships between them and their parents, especially their mothers, both in terms of obvious frustrations of the children's needs and in terms of subtle evocations of this behavior in response to the mothers' underlying needs and anxieties.¹⁸

17 Ibid., p. 69.

18 To the extent that the fathers are intimately involved in the early child-rearing process, they may be as important as the mothers. However, this study is limited for all practical purposes to consideration of mother-child relationships.

CHAPTER III
PRESENTATION OF DATA, PART 1

Behavior of the Children: Introduction

This study was primarily concerned with the unmanageable (aggressively non-conformist) behavior of these twelve children. However, the unmanageable behavior could have little meaning without simultaneous consideration of any other problem behavior which the children presented. The whole range of problem behavior which the children exhibited was therefore taken into account and was used as the basis for grouping the cases. This behavior was considered in relation to certain unfavorable environmental factors in each case. Those factors were selected on which the data were available in most of the cases and which seemed to the writer to be especially important in their bearing on the problem. Both the behavior symptoms and the environmental factors will be described more fully below.

Because of the intensive and extensive development of the human organism which takes place between birth and the fifth year of life, the ages of these children at referral had some bearing on the behavior they exhibited. For example, a child of two years would be less likely to show interest in masturbation than a child of three and one-half or four years. Two of these children (Donald and Jack) were referred at about two and one-half years. Fae and Karl were four years or more at referral. The other eight children were between three and four years old. Three of these children were girls, while the other nine were boys.

Description of Chart

In order to identify factors common to some or all of the cases under study, the children's behavior symptoms as reported by the mothers were

plotted on a chart together with certain unfavorable environmental factors. (See chart attached). The behavior symptoms were plotted along the horizontal axis, and the environmental factors along the vertical axis. Each child was listed by his initial in the appropriate intersection of "behavior" (column) and "environmental factor" (row).

For example, Karl's behavior symptoms included feeding problems, speech problems, sleeping problems, fears, jealousy of his sibling, temper tantrums, biting, and hitting children and adults. As to environmental factors, Karl was weaned from the bottle before he was a year old, his toilet training was begun before he was ten months old, he shared his parents' bedroom, he was the oldest child, and his mother expressed certain unfavorable attitudes. In the column corresponding to each of his behavior symptoms, therefore, Karl was listed (by the initial "K") in the square at which this column intersected the row corresponding to each environmental factor.

Behavior Symptoms

The children's behavior symptoms were plotted in terms of general areas such as feeding, speech, toilet training, masturbation, and various kinds of social behavior. Where the information was available, the areas were broken down into such specific symptoms as refusal to eat, slow speech development, nightmares, smearing of stool, fears and phobias, and hitting children. It will be seen from the chart that the number of columns was kept at a minimum. For example, where all the children listed in one area were also entered as having a specific symptom in that area, the inclusive column for the area was omitted. An instance of this occurred in area 4, where all the children having toilet problems were also described as wetting and/or soiling. The column for wetting and soiling thus served the

same purpose as an inclusive column for toilet training problems, and the latter was accordingly omitted.

The reader may have some question about area 5, which covers masturbation, fears and phobias, and one child's practices of making balls of fuzz and sniffing at hair. The last symptom was placed here because it appeared to express the child's genital interests and the mother reacted to it much as she did to his masturbation. Fears and phobias were listed here because, like masturbation, they commonly occur in the phallic period of development.¹

Area 8, labelled "hard to manage" (a term used by the mothers), covered non-conformist behavior which was not reported to involve physical aggression by the child (towards himself or his environment), in the sense of action designed to injure the object. Specific symptoms in this area consisted of behavior designated by the mothers as obstinate, defiant, runaway, or using nasty words.

Area 9, in which every child in this study was somewhere represented, covered two kinds of behavior which tended to overlap. One kind covered all forms of physical aggression (violent action) against human beings, including the child himself (such as headbanging). This kind also included violent action which the child seemed to seek out or to provoke against himself. This kind of behavior was labelled "over-aggressive."² The other kind covered aggressive behavior which did not have people as targets of violent action, such as temper tantrums or general destructiveness (of

¹ O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, pp. 119 ff.

² Thumb sucking, which is listed here, may not appear to be violent action against the self in the same sense as is head banging or nail biting. However, it represents a focussing of the child's aggressive demands upon his own body.

objects). What the mothers called "over-activity" also was listed in the latter group, because the unusually active use of muscles as the child dashes from one focus of attention to another is often associated with temper tantrums or destructive behavior. In this study, no clear line could be drawn between these two kinds of aggressive behavior. All the children except Jack were reported to use physical aggression against people, in some form. Jack's record gave the strong impression that further information would reveal details of such action against himself or others, or perhaps provoked against himself at the hands of others.

All behavior symptoms named by the mothers during the period of initial study were listed for each child. One interpretive symptom, "jealous of other children," was added but only where the mother specifically named it. No symptoms unnamed by the mothers were added even though their presence might well be inferred from the record, so that the picture of each child's problem behavior was given as seen by the mother.

A comparison of this group of symptoms with the over-all range of symptoms reported for clinic clientele in general would emphasize the clustering of symptoms for this group.³ For example, the feeding problems of these children did not include vomiting, the speech problems did not include stuttering, and the toilet training problems did not include retention of stool. In general, these twelve children could be described as actively meeting their environments rather than as withdrawing from the struggle.

³ See Hamilton, *op. cit.*, for descriptions of the various kinds of symptoms manifested by children referred to child guidance clinics for treatment.

Environmental Factors

Against these behavior symptoms, certain unfavorable environmental factors were plotted to give a rough indication of their significance in relation to the behavior symptoms. Only a small number of possible factors was selected for this purpose, as indicated above. They included certain aspects of feeding and of toilet training practices, sharing of the parental bedroom with the child, the child's ordinal position in the family, and a group of maternal attitudes.

In the charting of feeding practices, no entry was made for bottle-feeding as against breast-feeding. This was because bottle-feeding was not only a very common practice in the American culture, but also because it could be handled in such a way that the child would not lose the maternal contact which accompanies breast-feeding. In other words, bottle-feeding is not necessarily an unfavorable environmental factor; nonetheless, it should be kept in mind as a possible source of deprivation for the child. Eleven of the twelve children (all for whom details were available) were reported to be bottle-fed. Of these, Irving had the breast for the first fourteen days, and Fae for two and one-half months. The other nine children were fed by bottle only.

The first row on the chart lists children whose weaning began when they were less than one year old, on the basis that such early weaning often inflicts added deprivation on a bottle-fed child. Three of these five children were weaned much earlier than one year. The second row lists four children whose weaning began when they were one year or older and which involved difficulties. Fae, for example, although she had the breast for the first two and one-half months, was weaned only reluctantly from the bottle at two years of age. Similarly, children whose weaning was

described as abrupt, or who lost their taste for milk, are included in this row when the weaning occurred later than the age of one year. These two rows together include nine of the twelve children. Details of feeding history are not available for the tenth child (Charles). Donald was weaned at one and one-half years, while Barbara gradually weaned herself, both with no reported difficulties.

The third environmental factor charted (Row 3) is toilet training (especially bowel training) which began before the child was ten months old, that is, before he could reasonably be expected to be able to control his sphincters. All of the nine children whose mothers reported this information fell into this row, and the ages at which their training began ranged from three weeks to nine months. Six of the mothers of these nine children verbally expressed their distaste for soiling and wetting. Even without this verbalization, however, the fact of their demanding this much control before the child's nervous system permitted it might imply the existence of this distaste in them, which would accordingly put a strain on the child. This implication is the more likely because six of these nine children were born during a period in which consideration of the child's abilities and preferences was coming very much into fashion.⁴

The fourth factor (Row 4) is the child's sharing of the parental bedroom, something which is often a source of difficulty, especially in the oedipal period. Of the four children listed here, Barbara (aged three and one-half) had slept in the parents' room since birth, Harry (over three and one-half and referred for masturbating) was sleeping with them during the clinic contact, and George (three and one-half) had shared his parents'

⁴ These six (including the three whose mothers did not verbalize their distaste for disorder) were all born in 1946 or later. Benjamin Spock's Pocket Book of Baby and Child Care was published early in 1946, giving impetus to already current concepts of the child's needs.

room till he was three. Karl, the fourth child, slept with his parents until he was two and one-half, but was not referred until he was four.

Rows 5 through 8 indicate the ordinal position of each child, that is, whether he was a youngest child, an oldest child, a middle child or an only child. Each child is listed once in these four rows. Two children (Jack and Larry) were the youngest in their families, while six (Alice, Charles, Fae, George, Harry and Karl) were the oldest. Irving was a middle child, while there were three only children in the group (Barbara, Donald and Edward). As discussed in Chapter II (page 7), certain special pressures on the child may accompany each of these ordinal positions, pressures which play a part in the total picture of the child's situation.

Rows 9 through 21 consist of twelve sets of maternal attitudes, presented in summarized form. These attitudes may be divided into those concerning the child and his behavior, those concerning the child's father, and those concerning important members of the mother's family. This material does not include attitudes which can only be inferred, for example, from a mother's tone of voice or manner of presentation, or from her emotional response in any given situation. It therefore excludes much of the basis for the social worker's impressions of the situation. The charted attitudes are limited to those which the mother expresses in words, and which are therefore conscious attitudes, even though the mother may be unconscious of their implications.

Row 9 lists three children (Donald, Edward and Harry) whose mothers wanted a perfect child (or who looked for problems). Row 10 indicates that the mothers of four children did not want these specific children (or any children). Two mothers preferred working to being at home (Row 11). Seven mothers felt that children of the opposite sex from their problem children would be easier or pleasanter to raise (Row 12). (It is

interesting that six of these children are boys. The seventh is Alice, whose mother had special reasons for preferring Alice's little brother.)

Row 13 lists four children whose mothers were embarrassed by their behavior, or felt that the children knew and exploited their weak points. Six mothers (Row 14) could not stand disorder, or conflict, or being out of control. Two mothers (Row 15) expressed conflicting attitudes toward the aggressive behavior of their children, which implies the possibility that this behavior may have expressed something which the mother had inhibited in herself.

Three mothers (Row 16) felt that their sons took after some other important male figure in the family, such as the child's father or maternal grandfather or maternal uncle. (This attitude suggests that the mothers' reactions to their children may have been colored by their feelings about these male relatives). Five mothers (Row 17) felt that the maternal grandmothers favored either the mother's siblings or her children, as compared with mother herself. Six mothers (Row 18) expressed in various ways that the maternal grandmothers did not love them, for example by saying that maternal grandmother had never let mother do things like other children, or never helped mother. Three mothers stated that they had some conflict with maternal grandfather (Row 19). Five mothers expressed a conflict with the fathers in their personal relationships, for example because of the mothers' fear of pregnancy (Row 20). Four mothers (of whom one had appeared in Row 20) expressed conflict with the fathers over methods of rearing the children.

Analysis of the Chart

Although no significant quantitative inferences can be made from a charting of so few cases, certain qualitative aspects of the results are

of interest. Because nine of the twelve children appear in Row 3, the clustering of symptoms is most obvious in this row. Examination of the chart from this viewpoint, however, should take into account that the other three children (Barbara, Charles and Jack) may appear in the column in question (may show the behavior symptom in question) although they are omitted from Row 3.

The symptoms of over-aggressive behavior show all the various forms discussed in Chapter II (page 11), that is, they include aggressive action against the child himself, against other children and against adults, as well as aggression provoked by the child against himself. Among these children, the most frequently reported symptom is hitting other children, which is listed for nine cases (all but Fae, George and Jack). (Hitting adults runs a poor second, being listed for five children). By examination of the various environmental factors which coincide with this behavior symptom, some indication of their relative significance may be obtained. The largest cluster of children in this column (seven children) occurs at its intersection with Row 3 (toilet training begun under ten months). Another cluster of five children appears at Row 12, which corresponds to a maternal attitude that another child (usually a daughter) is easier or pleasanter to raise. The largest number of children listed for any other row is four, occurring in five rows. Three children are listed for each of eleven other rows. Two children are listed for Row 15, and one each for the three remaining rows. This scatter, which is characteristic throughout the chart, is in accord with clinical experience that similar behavior in a number of individuals may be associated with a variety of environmental factors.

Certain other clusterings on the chart deserve mention. All of the six children who were reported as "hard to manage" were also subjected to toilet training before ten months of age. Five of these same six children

had mothers who verbally expressed (in Row 14) their low tolerance of disorder or conflict or being out of control. A similar pattern is found in the column for wetting and soiling, where six of the seven children who were reported to wet and soil received early toilet training (Row 3), and five of these six were also listed in Row 14. It is interesting that four children appear in both of these columns (Fae, Harry, Irving and Larry). This set of observations is in agreement with the common observation that children in conflict with their mothers tend to exhibit their non-conformist behavior in just the areas in which they have been under undue pressure, which are generally the areas in which misbehavior is best calculated to bother their mothers.

Grouping of the Cases

Study of the chart will reveal that the children vary widely in respect to the number of behavior symptoms they present, as in the number of areas into which these symptoms fall. Some children have behavior symptoms in almost all of the areas listed. Others are represented in very few areas, and still others fall between these extremes. The children are classified into four groups, as described below, on the basis of the number of areas into which their behavior symptoms fall and of the seriousness of these symptoms.⁵ While there is a clear contrast between Group I and Group IV, Groups II and III represent less clear gradations in the scale. Given fuller information, some of the cases might be classified differently.

⁵ Seriousness of the symptom was judged by the writer on the basis of clinical details given in the record, and of the assumption that, other things being equal, the earlier the developmental stage in which the symptom appeared, the more serious was the problem it represented.

Group I is represented by one case, Charles (aged three and one-half years at referral), whose aggressive behavior consisted chiefly in hitting children and adults. No behavior symptoms were reported in other areas.

Group II is composed of two children, Barbara and George, both of whom were around three and one-half years at referral. Barbara's aggressive behavior consisted in taking children's toys away, hitting and kicking children; she was also over-active. Barbara was jealous of other children, nervous and unhappy. Shortly before referral, a problem of regression in toilet training had been resolved. George was over-active and permitted other children to beat him up. He cried and was unhappy, he was also obstinate and defiant and something of a runaway. Neither child was reported to have problems of feeding or speech, sleeping, masturbation, or to have serious toilet problems.

Group III comprises three children, Edward, Fae and Harry. Edward and Harry were around three and one-half years at referral, while Fae was four and one-half. Besides their aggressive activity, all three had toilet problems (soiling and smearing). Edward and Fae were "hard to manage" (obstinate, defiant, runaway, using nasty words), while Edward and Harry were masturbating overtly. Edward was slow in speech development, and Harry was a sleeping problem.

Group IV covers the remaining six children (Alice, Donald, Irving, Jack, Karl and Larry). Donald and Jack were referred at about two and one-half, Karl was referred at four years, and the others between three and four years. Besides their aggressive activity, all these children had problems in feeding. Three were slow in speech development, and four had problems connected with sleeping. All the other areas on the chart were represented also in two or more of these children.

Group I - Description and Case Summary

Group I is represented by one case, Charles, who had no reported problems beside the aggressive activity which concerned his mother. In other words, no indications appeared of any deep-rooted or long-term problems of the sort often encountered in a child guidance clinic.

Case Summary 1: Charles

When Charles was about three and one-half years old, mother telephoned the clinic in a state of great fright because he had seemed especially rough in play with his baby sister. Seen the next day, mother was no longer frightened, but impressed the worker as a feminine, motherly woman who appeared well-adjusted to her married life and the care of her children. Although not upset, mother was concerned over Charles' hitting of children and adults, so that an intake study was undertaken.

Charles was a planned child, the first of two children in a middle-class Jewish family. Pregnancy and delivery were normal, except for false labor pains some weeks early. Developmental history was normal and average. Charles had begun to hit at one year, beginning with maternal grandmother, and continuing with attacks upon any children and adults in the house. These attacks often had no apparent cause, although he would hit mother when she said "No" to him. His baby sister was born when Charles was almost three. He would pinch her and otherwise bother her, but not more than he did to others. Mother described him as really loving his sister, and not a child who would go out of his way to hurt her. Maternal grandmother, however, favored the sister and had always been a little afraid of and aloof from the boy, warning mother to watch lest he hurt his sister. Maternal grandmother had been present when the rough play occurred, and her reaction had been accompanied by mother's panic. Later, mother felt he had been only playing.

Mother had an older sister and two younger brothers, in a closely-knit family whose members, including maternal grandparents, were together every week. Maternal uncles habitually quarrelled and got into fights, of which mother was very frightened as she grew up. She was often unintentionally struck as she tried to separate them. Mother had had many childhood quarrels with her sister, despite being fond of her. To the worker, mother expressed her aversion to hurting others' feelings and to saying things which upset them.

Mother and father, who were in their late twenties when Charles was born, had a good, companionable marriage in which they shared many interests. Father saw relatively little of his own family, which was not so closely knit as mother's. Father had to work long hours building up his business, so that mother was alone with the children most of the time. They were in difficult circumstances financially,

which had mother very much worried, although she did not bring pressure on father because she knew where every penny went. Mother wanted to work in the evenings to ease the financial need, but was afraid of upsetting father by this proposal.

Father's attitude to Charles' hitting was that the parents had done something wrong to produce such behavior. He had tried to spend time with Charles, during which he taught him to fight with gloves, but was hurt when Charles would now hit father without reason. Shortly before referral, Charles had hit father so as to draw blood, which distressed father very much. Mother was extremely ashamed of Charles' behavior, and was sure he copied maternal uncles. She observed that Charles was always worse on days after visiting her family. Mother felt that she could get along much better with her little girl, who was dainty and good.

In the clinic, Charles was not seen to attack anyone but played mostly alone. He was rather passive and fearful in the new surroundings, and impressed the therapist as presenting a rather normal picture for his age. Treatment was not recommended.

This normal youngster was at the age where he was becoming aware of his masculinity and his physical differences from his baby sister, with some natural anxiety expressed in hitting. His hitting was further stimulated by the frequent exposure to his uncles' fights, by his mother's interest in these fights and by her tendency to liken Charles to his uncles. Other sources of anxiety in the home, which would of course be sensed by Charles, included the parental worry over finances and his mother's tendency to reflect maternal grandmother's attitude to male violence.

Group II - Description and Case Summary

Barbara and George, the children in Group II, present a limited range of problems as described on page 23 above. This limited range implies that both children received some fairly good mothering, but within parental limitations which imposed some deprivation on them.

Case Summary 2: Barbara

Barbara, an only child, was referred at about three years of age because she was over-active and over-aggressive, striking other children without provocation. Mother said Barbara always played happily alone

in the house and liked to help mother with domestic occupations, but the trouble began when she had contact with other children. When the neighbors became critical and other children began to pick on Barbara, mother felt something had to be done.

Some time after marriage, when mother was still in her early twenties, she had become pregnant with Barbara specifically to relieve a physical infirmity. She had an excellent pregnancy and an easy delivery. When mother took over full care of the baby, the infirmity returned in full force and was often a real handicap, especially at the menses. Mother was frequently afraid she would drop the baby, and often found it impossible to go to her when she cried at night, so had to wake father who then cared for Barbara or brought her to mother. Barbara was a good baby, undemanding and apparently considerate of mother's handicap. She was not breast-fed, but accepted the bottle with no problems and gradually weaned herself. Her development was average, with toilet training presenting the only real difficulty. Beginning at ten months, Barbara was put on the toidy after meals for bowel training, and from fourteen months was put on the toidy before sleep for bladder training. Barbara was fully trained at eighteen months, but regressed after an illness at two years. At three years, she was still wetting and soiling, despite spankings. Mother's infirmity often prevented her putting Barbara on the toidy, so she had to depend on the child's cooperation. Shortly before referral, Barbara was trained successfully with the help of a reward.

Barbara had begun to play with other children when she was about two and one-half years, and the trouble had begun then. She would always take other children's toys and refuse to share her own, fighting any attempt by other children to regain their toys. She had become gradually more and more aggressive, until by referral she would kick or scratch even a strange child on the street without provocation. Barbara was jealous of other children to whom mother gave attention, waiting till mother had put them down before attacking. Neighbors were making critical comments about Barbara blaming her for any trouble which arose, and children in the neighborhood were persecuting her, both of which facts disturbed mother very much. Barbara also had become very nervous.

Mother's own history involved a number of problems. She was the younger of two daughters, born fairly close together. Maternal grandparents were strict and unsociable, entertained few friends, and objected to their daughters' going out. Maternal aunt had a good time nevertheless, and mother was blamed for everything. Mother felt that maternal grandfather was a wonderful person, but that maternal grandmother favored maternal aunt. Mother could not remember anything good which maternal grandmother had ever done for her. She always felt inferior because she never had any parties, nor could she bring friends home. After mother left school, she worked hard at an office job while maternal aunt had an easier job and a better time. Both sisters married, but maternal aunt had more children and continued to be favored by maternal grandmother, something about which mother felt very strongly. Barbara would attack her cousins when she played with them, and mother said Barbara was being blamed for everything just as mother

had been. Mother never liked to argue with people and always got walked on, particularly by maternal aunt. Mother always felt left out and alone, therefore did not want Barbara to be left out by other children. She did not want Barbara to grow up the way mother did, but wanted her able to stand up for herself, as mother felt that was the only way to get anywhere. However, she did not want Barbara to be so aggressive that she was disliked, and mother would get upset when people criticized Barbara.

Mother had met father at her work, and they married when she was about twenty and he was several years older, despite a difference in their cultural backgrounds. Mother had gone to an all-girl high school, where she had learned nothing of the world. She had felt unable to ask questions of maternal grandmother, so was quite unprepared for marital relations, which had so frightened and shocked her that she felt this was closely connected with her infirmity, which developed soon after marriage. Father was gentle and considerate, but mother continued to feel extremely guilty and nervous, and worried all the time lest she get pregnant again. Barbara always slept in their bedroom, and mother felt she must know a great deal, but there was nowhere else to put her in their small apartment.

Father had come from an unhappy home and had been reared very strictly. Paternal grandfather had died early and father had gone to strict boarding schools. He never got along with his stepfather. Paternal grandmother was independent and bossy and had not approved of the marriage. Father himself was a very kind person whose gallant treatment of women had impressed mother when she first knew him. In the marriage, mother felt that he was wonderful and considerate, without a mean streak in him. His insistence on a quiet and orderly household, however, caused some strain when he was at home. He felt mother was too lenient with Barbara and was quicker to strike her than mother was. Mother felt he demanded too much of the child and got Barbara flustered and nervous, although she adored her father.

In the clinic, where Barbara and her mother were in treatment for over a year, Barbara was very demanding of the nursery school teacher's attention and jealous of the other children. The therapist felt that Barbara's primary problem centered around severe early deprivation at the hands of her ambivalent and handicapped mother, which left Barbara starved for close relationships with children and adults. She was unable to express her aggression directly toward her mother, so deflected it to small children. In the clinic Barbara showed her need to control. The therapist felt also that there was some evidence of her involvement in the oedipal situation, although most of Barbara's difficulties were at the pre-oedipal level.

The aggressive activity of this child would appear to have a number of functions. It was not only reserved for children, who were not such powerful figures as the parents, but it also served as an indirect attack upon mother, who was embarrassed by Barbara's reputation. This mother was also

strongly identified with her child and derived some satisfaction from seeing behavior in Barbara which was inhibited in herself. Barbara's behavior must also have been influenced by the underlying tension between father and mother, both over rearing methods and over their personal relationship, with all the deep-rooted fears it evoked in mother.

Group III - Description and Case Summary

The three children in this group (Edward, Fae and Harry) present more extensive behavior symptoms than those in Group II, but less extensive than those in Group IV. Edward and Harry were the only children among the twelve for whom masturbation was given as a presenting problem about which their mothers were much concerned. (Alice, in Group IV, had been masturbating, but her mother mentioned it chiefly to get permission to ignore the practice). Fae's central problem was her great conflict with her mother, so that her defiance and general non-conformity had her mother in a state of great anxiety. Of the three children, Harry had the more serious involvement with pre-ocedipal problems, in his smearing and strewing his room.

Case Summary 3: Harry

Harry was the elder of two sons in a middle-class Protestant family whose mother referred him at about three and one-half years because he was difficult to manage and would masturbate with slippery fabrics. He also had a history of extensive soiling.

Harry was not a planned child, but was born barely nine months after the marriage, following an easy pregnancy. He was fed by bottle on a demand schedule, and had no reported feeding problems until he was weaned at fourteen months, after which he lost his taste for milk. Motor development was a little slow for this large, heavy child. By contrast, he was toilet trained at the age of five months. He was sometimes constipated, a condition which mother combated with suppositories. Also at five months, Harry developed large, heavy sores on his penis. Before he was two years old, Harry cut his hand severely enough to require orthopedic attention. His brother was born when Harry was about two and one-half years, and when mother came home again, Harry wanted to sit on her lap all day long. Soon thereafter, Harry had his tonsils out.

Harry's parents first noticed his masturbating when he was just over three years old, when he began to seek out soft and slippery fabrics. At the same time, he became increasingly difficult to manage. He was always getting into things, and had been known to strew the contents of a drawer all over the room. At other times he had a bowel movement all over the room. Although Harry liked his brother, he was also jealous of him, expressing this occasionally in aggressive use of urine. He would not mind his parents, daddled over his food, and ran away several times. Harry had fights with the other children in the largely Catholic neighborhood and did not play well with them. He was currently sharing the parental bedroom, because maternal aunt and her new baby were using his room, and mother had trouble getting him to go to sleep.

Harry's parents were both attractive young people who were quite concerned about Harry. They had had much worry over financial difficulties in the early days of their marriage. More recently, since the birth of the second child, father had been troubled by a bad back which immobilized him a good deal. Father was very fond of Harry, taking over with him when he came home at night, but felt that Harry should be able to fend for himself and get along even with the tough youngsters of that neighborhood. The parents had some continuing disagreements over how to handle Harry.

Mother, who was the youngest of three daughters, spoke little of her own background but emphasized that she got along very well with her sisters because of their good home life. (However, she was quite sensitive to paternal grandmother's favoring paternal aunt over father). She described maternal grandfather as a very kind and understanding person, the sort who let the children do as they pleased. On the other hand, maternal grandmother appeared to mother as a very nervous person who was afraid of what would happen if she did punish her children. Mother's difficulties in managing her own child had reached the point where she was afraid to leave him alone anywhere lest he disrupt everything in the room. She could not believe him when he said he was being good, and would have to go and look.

Mother was rather impatient at the time involved in helping Harry to learn to do things around the house, because she could do them herself more quickly and easily. On the other hand, she believed in answering children's questions. Harry was allowed to watch mother as she dressed, and she answered his questions about anatomical details, apparently stimulating his interest in masturbating.

Harry and his mother were in treatment for several months. Although he was not reported to attack adults at home, Harry did hit his therapist and his teacher at the clinic.

Both Harry's masturbation and his unmanageable behavior appear related to the stimulating and frightening situation in which he found himself, sharing the parental bedroom and being allowed great freedom with his mother. His history of physical difficulties and the competition with his brother would

both encourage regression (the smearing episodes) and increase his fear of punishment for the feelings which his parents did not help him to suppress. His behavior also served as retaliation for parental treatment, a need which was expressed directly by hitting adults in the clinic. Personal and financial tensions between his parents also probably entered into the stimulating and frightening situation.

Group IV - Description and Case Summaries

Group IV includes the six remaining children of the study, all of whom had problems in feeding and in other areas, as well as in over-aggressive behavior. This group includes three of the four untreated cases. The spread of symptoms in these children indicates the extent of damage. Two case summaries are given below for this group, those of Donald and of Jack.

Case Summary 4: Donald

Donald, the only child in a middle-class Jewish family, had been taken by his adoptive parents at the age of six weeks. At ten months, the adoptive mother applied at the clinic for psychological tests for Donald, but did not follow through. She brought him again at two and one-half years because of his over-activity. At that time he also did not talk, he wet and soiled continuously, ate excessively, and would not go to sleep unless one parent lay down with him. Mother was especially concerned by his over-activity and his slow speech development. She had been aware before taking Donald that his own mother was intellectually backward.

When Donald was taken by his adoptive parents at six weeks, he was banging his head, but this soon cleared up. He always slept and ate well, and was weaned at one and one-half years from bottle to cup with no difficulty. Motor development (aside from speech) had been normal, but there had been real trouble in toilet training, which was first attempted at eight months. Donald had broken a number of toidies and refused to relieve himself till he was no longer on a toidy. His over-activity had become a problem first at about one and one-half years, when he would stand up in his crib at night and shake the bars so violently that he kept the neighbors awake. He liked to play with other children, but tried to dominate them and often got into fights.

Mother, who was described as very rigid, hostile, and quite frank,

had been the youngest by seven years in a family of three boys and one girl. Maternal grandparents had come over from Eastern Europe. Mother had been especially close to maternal grandmother and was openly bitter against maternal grandfather, whom she described as cruel to her mother, a selfish and mean old man. Mother had escaped the conflict at home by going out a good deal, working and later marrying father. A few years after her marriage, maternal grandmother died, leaving mother with a heavy burden of guilt because she felt she could have saved her mother had she not been preoccupied with her own life. Mother had little to do with her family after maternal grandmother's death, although she evinced some attachment to one brother, who had taken her out and given her some attention in her youth, and whose bicycle she had always liked very much. In contrast to her own family, mother was enthusiastic about father and his family, whom she characterized as good-natured and straightforward. Father's own physical difficulties rarely interfered with his good humor.

Parents had turned to adoption after medical treatments failed to resolve mother's sterility, and had taken Donald after maternal grandmother's death. Mother felt they had always been looking for problems and had been a little scared, trying not to show Donald their emotions. Toilet problems had been particularly difficult for her. Mother described herself as a painfully clean person who just could not stand disorder, nervous and high-strung, and apt to fly off the handle both with Donald and with father.

In the clinic, Donald was very active and quite sociable, rarely playing alone. He was cooperative and friendly, well able to go after whatever he wanted. He was sometimes alert and aware of everything about him, sometimes out of contact. He spoke quite distinctly at first, less distinctly later, and used a large vocabulary with children but not with adults. He hit his male therapist very vigorously. Donald and his mother were in treatment for several months, and returned for further help a few months later, at the time of follow-up.

This meticulous and anxious mother demanded more of her adopted child than he could perform. Her burden of guilt and hostility towards her own parents, together with her concern over disorder, lessened her ability to give warm mothering to this child, who in turn refused to give her the speech she wanted and controlled both his parents by his own activity. Donald's mother knowingly selected a child of doubtful parentage, and her ensuing anxiety about him both implicitly encouraged him to be a problem child, and reflected her feelings about her own imperfections.

Case Summary 5: Jack

Jack was the younger of two children in a close-knit Jewish family,

and was referred by his mother at about two and one-half years for his over-activity. He was also destructive and a sleeping problem. Mother wanted to leave him in the nursery school.

Jack was born several years after his sister. Medical treatment had been necessary before either pregnancy was possible. Mother was ill all during her pregnancy with Jack, staying in bed two months to avoid a miscarriage. He was born several weeks prematurely, after easy labor. Mother did not remember much early history, but did report that Jack was bottle-fed and weaned at eleven months.

Jack's activity had been a problem ever since he was able to walk. He did not play with toys but ran from one thing to another, refusing to sit still long enough to eat. He jumped out of his high chair when he was small and had practically pounded his crib to pieces. Another big problem was his refusal to go to sleep. Jack slept in the parents' room and would awake after two or three hours, then would talk and demand one thing after another, so that mother got about four hours' sleep. Mother enjoyed Jack's brightness and his delightful sense of humor, but was unable to control his activity. Jack never cared if he was punished. The family was living with maternal grandparents, but was under pressure to move because Jack was too much for the grandparents, and also because they were upset over the imminent departure of a maternal uncle to a hazardous job.

Mother contrasted Jack with his sister, who was a brilliant girl and very well behaved as a child. Mother used to enjoy reading to her and having tea parties with her, but Jack would not sit still long enough to be read to. Mother said sister was very attractive, while Jack was homely even as a baby, resembling mother and also looking a little like father.

Mother, who was in her early thirties, had been born in Eastern Europe and came to this country with her family when she was very young. She had two brothers, one away from home and the other about to leave. Mother said that she had been ill ever since Jack was born but not before. She had been under treatment at a hospital, where she was told that Jack was the cause of her illness, although she had not thought of this before. She was troubled with fainting and vomiting, together with many other symptoms, and could not sleep because Jack made so much noise. Mother had been ill some months before referral, had fainted a lot, and therefore had moved to maternal grandparents' home. Her nervousness kept her pretty much at home, and she felt she could not leave her parents' home until she got help with Jack. She proposed simply leaving him at the clinic all day, although she expected him to yell and cry all day long if she did so.

Mother gave little information about father, who was about her age and born in this country. He worked very long hours, so that he could not help mother much. He also considered Jack a problem, for he had been all worn out after spending just one day with him.

Mother brought Jack very irregularly to clinic, where she watched him with "utter despair" on her face, and was barely able to suppress

criticism and nagging. At one point, she seemed more relaxed as she reported that maternal grandfather was fixing up a nearby apartment to which mother could move. At the same time, the therapist found Jack less noisy, smiling often, with no temper tantrums, and enjoying his group in nursery school. Several weeks later, after a prolonged absence, Jack had a severe temper tantrum, tried wildly to destroy all the objects in the room, yelled, and attacked the therapist. Mother sat through this session with a facial expression of "deepest depression and repugnance," brought Jack one more time, then stayed away.

This mother's intense rejection of her active son, in contrast to her pleasure in the older daughter, provided sufficient stimulus for his destructive activity, which mother was unable to limit. What lay behind the rejection and weighted it more heavily than her concurrent enjoyment of her son, was only dimly suggested by the known facts, but presumably centered in the area of her own family relationships and her reaction to being asked by her parents to leave their home.

Parental Motives for Referral

Nine of these mothers brought their children directly to the Children's Center for help. Two mothers went first to other agencies from which they were referred to the Children's Center, but in both cases the mothers apparently initiated the attempt to find help. Irving was referred through a private casework agency, which took responsibility for getting him to clinic while his mother was unable to do this. Even in Irving's case, however, his mother came for the initial interview at the clinic. It would therefore appear that all the mothers were interested in getting help. However, the sources of this interest were probably many and varied. The following discussion is based on the writer's interpretations of the case material, and is in no sense intended as an exhaustive analysis.

While every case is unique, and the material does not allow of any

deep understanding of individual motivations, certain similarities can be seen among various of these twelve mothers. For example, mothers who feel it necessary to "do something" about non-conformist behavior are often the same ones who cannot stand disorder or having things out of control. Six of these twelve mothers verbalized their intolerance of disorder (Row 14), and the tendency to impose early toilet training suggests the presence of the same attitude in still other mothers in this group (see Row 3). However, some of the mothers who had great need to control were also those who did not stay in treatment or who, like Donald's mother, found it very difficult to participate in treatment. This may be because their anxiety over being involved in treatment was greater than that over the children's behavior, or perhaps because they could not endure the examination of this behavior and of their feelings about it which would be entailed in treatment. A good example is the mother of Larry (Group IV), a very meticulous woman who was upset over being in the menopause, and disappointed that all her four children were boys. She seemed equally unable to nurture Larry and to tolerate either his messiness or the aggression he directed against her. However, talking with a social worker or a psychiatrist was even more of a threat to her, so that she found various excuses and quickly withdrew from contact.

Some of these mothers were driven to the clinic by great fear, such as the mother of Fae, who had attempted suicide and who consciously feared that she would kill her daughter, with whom she was in intense conflict. Karl's mother also said she felt like killing him or killing herself when he was younger. Later her fear was expressed in terms of Karl's possibly developing like herself and like maternal grandfather, whom she described as an ugly, bitter, sullen person with moods like her own. Fear of one's own aggression may intensify the necessity to control, and thus the re-

sultant anxiety when control is threatened.

Several of these mothers impressed their workers as immature, and at least two of them (mothers of Alice and of Barbara) were very dependent people reaching out for support. Alice's mother complained specifically of Alice's demands on her and was disturbed by Alice's refusal to fight her own battles. This mother used her interview time to pour out her personal problems with little reference to her child. The extreme dependency of a child, which turns into hostile demands when his needs are not met, becomes too much for a dependent and immature parent to sustain alone. Irving's mother, who was unable to come for treatment but who had a strong relationship with a worker from another agency, apparently used this worker to meet her own dependent needs.

Besides the personal motives indicated above, cultural factors in sensitivity to aggressive behavior may also enter into these parental motivations. One aspect is the American middle-class aversion to personal violence, as contrasted with relatively greater tolerance of it in the lower class.⁶ Eight of these mothers were convincingly middle class in terms of their education, economic status and family occupations, while their system of values bore out this classification. The other four mothers were difficult to classify in these terms, three of them because of insufficient information and the fourth because she was a Negro and thus a member of a special group.

Another possible cultural factor lies in membership in the Jewish minority, as discussed on page 10 above. Five of the clearly middle-class mothers were of Jewish families, as was one of those difficult to classify. Of these six Jewish families, three mothers reported that their

⁶ See page 9 above for discussion on this point.

parents came over from Eastern Europe, while the immediate origins of the others are not known.

This chapter has covered material found in the records of these twelve closed cases. Chapter IV will deal with the follow-up material on these children, procured chiefly by the writer in personal interviews.

CHAPTER IV
PRESENTATION OF DATA, PART 2

Follow-Up Interviews

Information on the later development of these twelve children was sought in follow-up interviews with the parents, conducted by the writer as part of regular clinic procedure on closed cases. These interviews were conducted preferably with the mothers, because the earlier contacts were chiefly with the mothers. However, interviews with the fathers were accepted where this seemed preferred by the mothers. Face-to-face interviews were conducted by the writer with seven mothers and with two fathers. Where only the father was seen, there was also a brief telephone contact with the mother. One mother was interviewed entirely by telephone, as she was unwilling either to come in or to be interviewed at home, but she seemed to talk quite freely and willingly on the telephone. Follow-up information on another case was obtained from the worker who saw mother and child on their spontaneous return for further help. The twelfth mother did not keep her appointment nor respond to the letter in which it was offered, so that the follow-up material on her child (Fae) is lacking. Only two of the follow-up interviews were home visits (Charles and Jack), as the other parents seen were willing to accept clinic appointments.

It was found that these face-to-face interviews were very helpful to the writer in giving life to the recorded case material and in providing the writer with a source, however limited, of independent judgment on the parents' personalities.

Description of Table I

Table I (see page 39 below) presents certain basic facts abstracted from the follow-up interviews. The children are listed in this table according to their grouping in Chapter III, and brief summaries of the follow-up material for each case presented in Chapter III will follow below.

The first two columns in Table I indicate whether the child was treated or not treated, according to the definition given on page 3 above. The next column gives the interval between closing of the case and follow-up. The children's ages ranged from four to ten years at the time of follow-up. The interval for these children varied correspondingly, ranging from four months to seven years. Time is given in terms of years plus months, with dashes dividing the digits.

Material on the children's behavior symptoms is arranged in two triple columns, one for over-aggressive behavior and the other for other behavior symptoms. Each column is divided into three sections, indicating respectively no improvement, some improvement, and good improvement. These columns are checked according to the evaluation given by the parent, so that they express the conscious attitude of the parent toward the child's behavior.

The last column concerns the parent's attitude toward the clinic, in terms of whether clinic contact was felt to have helped or whether further help was desired. Not all parents verbalized this attitude. The only parent who expressed a feeling that the clinic had not helped was one who was asking for further treatment of the problem.

Analysis of Table I

Examination of the table shows that four children were felt to have

TABLE I
 FOLLOW-UP INFORMATION ON TWELVE CHILDREN
 REFERRED FOR UNMANAGEABLE BEHAVIOR

Case	Treated		Inter- val	<u>Over-Aggressive</u> Improvement			<u>Other Problem</u> Improvement			<u>Att. to Clinic</u>	
	Yes	No		None	Some	Good	None	Some	Good	Did help	Wanted help
C		x	1-4			x				x	
B	x		0-8			x		x		x	
G	x		1-2			x		x		x	
E	x		0-4		x			x			x
F	x		5-1	(No follow-up information)							
H	x		0-6			x		x			
A	x		0-9	x				x			x*
D	x		0-5		x			x			x
I	$\frac{1}{2}$		5-9		x			x			x*
J		x	7-		x			x			
K		x	0-6		x			x			x*
L		x	3-4		x			x			x

* These mothers spoke of getting further help but were not sure they wanted it.

shown good improvement in their over-aggressive behavior. These are Charles in Group I, Barbara and George of Group II, and Harry in Group III. Edward of Group III was rated as somewhat improved, while follow-up material was lacking for Fae. None of the children in Group IV was rated as showing good improvement. Five of them were rated as somewhat improved, while Alice's mother felt that there was no improvement.

In the group of other behavior symptoms, no parent cited good improvement for her child. Eight parents indicated some improvement, while two (mothers of Alice and of Karl) felt there was no improvement. Charles had no other behavior symptoms at the time of referral to be rated.

It might be thought that age would help to resolve some of the behavior problems of these children, so that children for whom the follow-up interval was longest might be expected to have done better than those with very short intervals.¹ However, the three children with the longest intervals (Irving, Jack and Larry) were all rated as only somewhat improved in their over-aggressive behavior. Of the six children who were followed up in less than a year, Barbara and Harry were rated as showing good improvement, while Edward, Donald and Karl were rated as somewhat improved. Alice, the sixth child, was rated as not improved. Age would not appear to be an important factor.

Comparison between treated and untreated cases reveals that, of the four untreated cases, three are rated as showing some improvement and one as showing good improvement. The seven treated cases on whom material is

1 The follow-up interval is given in the table in preference to exact age at follow-up, as a precaution to disguise the children's identities. The four longest intervals (including Fae's) correspond in fact to the greatest ages at follow-up, ranging from seven to ten years. The ages of the six children followed up in less than a year range from four to five and one-half years. Ages of the remaining two children fell between five and six and one-half years.

available are grouped into three who show good improvement, one who shows no improvement, and three who show some improvement. Irving, whose mother was not treated, is among the three who show some improvement.

While a scatter in results is to be expected, it is interesting that the six children in Group IV, whose problems appear to be the most far-reaching, are all either only somewhat improved or not improved at all, according to the judgment of their parents. In contrast, the children showing good improvement constitute all of Groups I and II, and include one child in Group III. There appears to be some relationship between extent of the problem and degree of improvement.

Similarly, it is the mothers of the three children in Groups I and II who verbalize a feeling that the clinic contact was of help. The other mothers who spoke of this either wanted further treatment, or, in the case of two untreated children, raised the question of getting treatment at the time of follow-up.

Follow-Up Summaries

Those cases which were summarized in Chapter III for each group are presented here as illustrations of the kinds of follow-up material which the parents brought to the interviews, as well as to round out the picture.

Follow-Up Summary 1: Charles

Charles' mother was interviewed in a home visit after an interval of one and one-quarter years, and described Charles as greatly improved. She had realized that he was very shy with people and had given much attention to helping him with this. Charles gradually became at ease with other children, was sometimes rough but never destructive, and was doing very well in kindergarten. His hitting had eased off gradually. He saw much less of his uncles now because he did not like their fighting.

Mother expressed the feeling that the trouble had been really with the parents and other adults, not with Charles. She was happily working in the evenings at a congenial occupation which helped financially

and which she was handling so as not to hurt father's pride, so that the financial tension had eased also. Mother felt that the clinic contact had helped if only to assure her that Charles was normal.

Follow-Up Summary 2: Barbara

Seen at the clinic less than a year after Barbara had left, her mother was enthusiastic about the changes which had continued in her behavior. Barbara was behaving like a little lady now, and was welcome wherever she went. Her health was improving, she had put on weight despite a recent minor operation. She played well with older children but still resented the younger ones and sometimes really hurt them. In school, Barbara was quick and alert, but was still nervous and tended to roam around rather than stay in her seat. The teacher described her mother as over-anxious to take on responsibility and bossy in the school room. Mother herself was feeling great physical relief from her infirmity following a major operation, from which she was still recovering. Mother felt that the clinic had been just the thing to help, that she herself would not have known what to do.

Follow-Up Summary 3: Harry

Father was seen at clinic only a few months after Harry left, and reported that Harry was behaving better although he was sometimes irritating. He was playing well with children in the neighborhood, fending better for himself, and the earlier friction with the other children was gone. Harry also got along much better with his brother. Harry was not masturbating much, and never wet in the daytimes now, although he still wet sometimes at night. He sometimes persistently did just what he was told not to do at home, although he minded very well in kindergarten and was doing well there in every way.

Father indicated that there was still disagreement between the parents on rearing practices, as he felt mother unnecessarily spanked Harry two or three times a day. Mother, on the telephone, said she now realized that Harry could not possibly be a perfect child, and that they were enjoying him a great deal more than before. Things were easier financially and parents hoped to move soon, expecting that life would be easier in a new place with more room.

Follow-Up Summary 4: Donald

Mother was back at clinic asking for further help just a few months after Donald had left. He had improved and calmed down a great deal, and was talking much more than earlier, but was still very active and did not talk well enough to reassure mother about him. Donald no longer wet or soiled during the day, but wet every night. He loved to play with other children but did not know how, and they would beat him up. Mother's two main concerns were Donald's constant demands for attention, which wore her out, and her anxiety over his possibly being retarded, so that she continued to ask for a definitive answer on this. Donald had been going to a nursery school, where there had been no trouble unless mother came, when he would throw sand.

Follow-Up Summary 5: Jack

Jack's father was seen in a home visit about seven years after Jack left the clinic. Father, who evidently had a warm relationship with his son, reported that Jack was a little gentleman at home now, no longer wild and destructive, but helpful and thoughtful as far as father was concerned. Some difficulties continued in his behavior with mother, and he also was obstreperous in school. Jack was getting good grades in school despite his poor conduct, but had to change schools a number of times because of conduct. Father had seen Jack through a period of fire-setting and playing with matches, but he was over that now. There were no current problems with sleeping or feeding.

Both father and mother mentioned that Jack's older sister was doing extremely well, and mother indicated there was quite a difference between them. Jack took so much attention and was such a live wire that mother was glad she had only two children.

CHAPTER V
SUMMARY AND CONCLUSIONS

Twelve case records of children referred to the James J. Jackson Putnam Children's Center for help with unmanageable behavior were studied to learn what sorts of unmanageable behavior these children exhibited, what other behavior symptoms occurred in the same children, and what sorts of motives impelled their parents to bring them to a clinic. Follow-up interviews were conducted with eleven parents to determine the later status of the behavior symptoms.

The behavior symptoms of each child, as given by the parent, were abstracted from the record and plotted on the horizontal axis of a chart, in terms of general areas and specific symptoms. The vertical axis of the chart was composed of certain unfavorable environmental factors, including specific rearing practices, the ordinal position of each child in his family, and a set of unfavorable maternal attitudes. All of these children displayed over-aggressive behavior of one kind or another, of which the most frequent (occurring in nine children) was that of hitting other children. There was a wide range of concurrent behavior symptoms in other areas, with some children having symptoms in many more areas than others of these children. It was noted that the range of behavior symptoms of these children did not include many symptoms characteristic of the anxious or the withdrawn child, and that these twelve children could be described, in general, as actively meeting their environments rather than as withdrawing from the struggle.

Examination of the environmental factors associated with the behavior symptoms revealed a scatter, characteristic throughout the chart, which was in accord with common experience that similar behavior in a number of indi-

viduals may be associated with a variety of environmental factors. The most frequent environmental factor was early toilet training, listed for all of the nine children whose mothers gave information on toilet training.

The chart also revealed a clustering of cases who were "hard to manage" and were toilet trained early, with a parallel cluster of mothers who expressed their low tolerance of disorder. A similar pattern was shown for children who wet or soiled, that is, most of these children were toilet trained early and many of their mothers could not tolerate disorder. This pattern of clustering bears out the common observation that children in conflict with their mothers tend to misbehave precisely in the areas in which they have been under special pressure, which are generally the areas in which misbehavior is best calculated to bother their mothers.

On the basis of the spread of symptoms for each child, the children were divided into four groups, ranging from Group I for fairly normal behavior, to Group IV, whose six members had problems in all the areas charted and who therefore appeared more damaged than children in the other groups. One case summary was presented for each group with the exception of Group IV, for which two case summaries were presented.

Parental motives for referral were examined in terms of the sources of referral and of the underlying concerns of the parents. The generality of early toilet training in these cases, and the frequent verbalization of the mothers' intolerance of disorder, suggested that many of these mothers came to the clinic in order to "do something" about a situation which they felt it necessary to keep under control. The writer suggested that the need to control underlay the refusal of some of these same mothers to accept treatment, although in the case of other mothers their anxiety over the problem was sufficiently intense to outweigh their anxiety over what might be involved in treatment.

The difficulty experienced by an immature mother in tolerating her child's hostile dependency was mentioned as another factor operative in several of these mothers.

Certain possible cultural factors in parental sensitivity to aggressive behavior were discussed, especially the traditional American middle-class aversion to personal violence. The possibility was mentioned of a special sensitivity to violence in members of the Jewish minority. Eight of these mothers were listed as middle-class in terms of education, economic status and family occupation. Six mothers, five of whom were middle-class, were of Jewish families.

The circumstances of the follow-up interviews were described, and their results tabulated in Table I, in which the children's current status was given as seen by the parent interviewed. Examination of Table I indicated no appreciable significance for the factor of age at the time of follow-up. Comparison of treated and untreated cases revealed that more treated than untreated cases were rated by the parents as showing good improvement in over-aggressive behavior, while all untreated cases were rated as showing at least some improvement. Comparison among the various groups revealed that Good improvement appeared only in Groups I through III, while none of the children in Group IV was rated as better than somewhat improved. There would appear to be some relationship between the extent of the problem and the degree of improvement as seen by the parents. Summaries of the follow-up material were presented for each of the five children whose recorded cases had been summarized earlier.

Approved:



Richard K. Conant

Dean

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APPENDIX

ScheduleGeneral Information

Date of referral
 Referral agent
 Other agency contacts
 Date and disposition of case
 Problem as stated on referral sheet
 Other problems listed
 Number of interviews, name of worker
 child with doctor
 mother with social worker
 psychologist
 other

The Child

Name	Age at referral
Birthdate	Age at termination
Birthplace	Sex
Race	Religion
Description of child	
by psychiatrist	
by psychologist	
by nursery school teacher	
other	
Date when problem first occurred	
Intensity and development of problem	
Aggression to self	
to children	
to parents or other adults	
Pertinent developmental history	
pregnancy	
delivery	
feeding	
motor development	
toilet training	
Siblings	
age, problems	
Ordinal position of child	
Child's relationship with family	
Child's relationship with others	
Child's reaction to separation	
Other	

MotherFather

Age
 Race
 Religion
 Nationality
 Educational experience

CHART I

BEHAVIOR SYMPTOMS AS RELATED TO ENVIRONMENTAL FACTORS
 CASES OF TWELVE CHILDREN REFERRED FOR UNMANAGEABLE

Environmental Factors

Conflict with F-rearing practices. (21)	L	L		EL	H			BE HL	E H	EH		E	L	B	BH	HL	L		H	H	BL		L
Conflict with F-personal (fear of pregnancy). (20)	AF IK	AF I		K	AK	K	A	BF I	F	A	AK		A	B	AB FK	AF I	AF	F	I	I	BF IK	IK	
Conflict with MGF. (19)	DI K	I	D	DK	DK	DK		DI			K				K	I			I	I	DI K	IK	D
MGM never let M do things like other children; won't help M. (18)	AJ L	AL		L	AJ H	J	A	DH L	H	AH	A		AG L	BG	AB H	AG HL	AG L	G	GH	H	BG JL		JL
MGM favors M's siblings (or child). (17)	AF	AF		E	A		A	BE F	EF	AE	A	E	AG	BG	AB F	AF G	AF G	G	G		BF G		
Child takes after: { Father MGF uncles (16)	AK	A		K	AK	K	A			A	AK		A		AK	A	A				K	K	
Feels two ways about child's behavior. (15)								B						B	B						B		
Can't stand disorder (conflict, being out of control). (14)	DF IL	FI L	D	DL	DH	D		DF HI L	F H	H			L	G	FH	FG HI L	FG L	FG	GH I	HI	DE GI L	I	DL
Embarrassed; child knows her weak point. (13)	F	F		E				BE F	EF			E		B	BF	F	F	F				BF	
Daughter (other child) easier or pleasanter to raise. (12)	AI JK L	AI L		KL	AJ K	JK	A	IL		A	AK		AG L	G	AK	AG IL	AG L	G	GI	I	GI JK L	IK	
Prefers working to being at home. (11)	FK	F		K	K	K		F	F		K				FK	F	F	F				FK	K
Did not want this child (did not want children). (10)	AF IK	AF I		K	AK	K	A	FI	F	A	AK		A		AF K	AF I	AF	F	I	I	FI K	IK	
Wanted a perfect child (looked for problems). (9)	D		D	DE	DH	D		DE H	HE	EH		E			H	H			H	H	D		D
Ordinal position: only child. (8)	D		D	DE	D	D		BD E	E H	E		E		B	B							BD	D
Ordinal position: middle child. (7)	I	I						I								I			I	I	I	I	
Ordinal position: oldest child. (6)	AF K	AF		K	AH K	K	A	FH	H	AH	AK		AG	G	AF HK	AF GH	AF G	FG	GH	H	FG K	K	
Ordinal position: youngest child. (5)	JL	L		L	J	J		L					L			L	L					JL	JL
Shared parents' bedroom. (4)	JK			HJ K	JK			BH	H	H	K		G	BG	BH K	GH	G	G	GH	H	BG JK	K	J
Toilet training begun under 10 months. (3)	AD FI KL	AF IL	D	DE L	AD HK	DK	A	DE FH IL	EF H	AE H	AK	E	AG L	G	AF HK	AF GH IL	AF GL	FG	GI	HI	DF GI KL	IK	DL
Weaning begun over one year; involving difficulties. (2)	FI	FI		E	H			EF HI	EF H	EH		E			FH	FH I	F	F	H	HI	FI	I	
Weaning begun under one year. (1)	AJ KL	AL		KL	AJ K	JK	A	L		A	AK		AG L	G	AK	AG L	AG L	G	G		GJ KL	K	JL
Feeding Problems	1																						
Won't eat.																							
Eats too much.																							
Speech: slow in development.																							
Sleeping Problem.																							
Won't go to sleep.																							
Night wares.																							
Toilet: Wets and/or soils.																							
Toilet: Smearing.																							
Masturbation.																							
Fears, phobias.																							
Makes balls of fuzz; sniff hair.																							
Cries.																							
Nervous, unhappy.																							
Jealous of other children.																							
Hard to Manage.																							
Obstinate (won't mind).																							
Defiant (mischievous).																							
Runaway.																							
Uses nasty words.																							
Over-active.																							
Temper Tantrums.																							
Destructive.																							

Behavior Symptoms

RS IN THE
BEHAVIOR.

E	L			L	B	E	H	BE	HL
B	I	A	AF	K	B			AB	K
I	D			K				DI	DK
B	H	A	AG	L	B		H	AB	HL
B	F	A	AF		B	E		AB	
C		A	A	K				AC	CK
C					B			BC	C
F	H	D	GF	L			H	DH	DH
C	F		F		B	E		BC	C
C	I	A	AG	KL				AC	CK
L	K		F	K				IK	L
K								L	
F	K	A	AF	K				K	K
E	D							AI	K
E	D					E	H	DE	DH
D	D				B			H	
D								DE	DH
D								H	
D								BD	D
D								E	
D								I	
D		A	AF	K			H	AC	CH
D			G					HK	K
D				L				L	L
D		G	K	B			H	BH	HK
D								K	
D		A	AF	KL		E	H	ADE	DH
D			G					HIK	KL
D			F					L	
D						E	H	EH	
D								I	
D		A	AG	KL				AK	KL
D								L	
Head-banging									
Thumb sucking nail biting									
Provoking, beating by others.									
Biting.									
Kicking, taking toys away.									
Pulling hair.									
Urinating on sibling.									
Hitting children.									
Hitting adults.									

KEY

- A = Alice
- B = Barbara
- C = Charles
- D = Donald
- E = Edward
- F = Fae
- G = George
- H = Harry
- I = Irving
- J = Jack
- K = Karl
- L = Larry

Schedule, cont.

Income
 Living conditions
 Date of marriage
 Physical factors
 Other

Mother

Description by social worker
 by psychiatrist
 other

Mother's expressed attitudes:

toward coming for treatment
 toward herself
 toward father
 toward her parents
 toward her siblings
 toward her in-laws
 toward her children
 toward this child and these problems

Father's attitude toward this child and these problems, expressed by
 father or by mother

Other relevant expressed attitudes

Maternal Grandparents and Paternal Grandparents

Age
 Race
 Religion
 Birthplace
 Economic level
 Size of family
 Mother's place in family
 Father's place in family
 Living conditions
 Marital relationship
 Other

Follow-Up

Age at follow-up
 Interval

<u>Home</u>	<u>School</u>
Present behavior	
Present problems	
Status of previous problems, if different	
Parents' expressed attitude toward clinic contact	
Other	

Case Summary and Impressions