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A study of the relationship between maternal attitudes and treatment results among a group of average children who have received psychiatric treatment for behavior problems in child guidance clinics, 1943 to 1945

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A STUDY OF THE RELATIONSHIP BETWEEN MATERNAL  
ATTITUDES AND TREATMENT RESULTS AMONG A GROUP  
OF AVERAGE CHILDREN WHO HAVE RECEIVED PSYCHIATRIC  
TREATMENT FOR BEHAVIOR PROBLEMS IN CHILD  
GUIDANCE CLINICS

1943 to 1945

A Thesis

Submitted by

Gloria Heitman

(A.B., Brooklyn College, 1944)

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

1946

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1. The first part of the document is a preface, which is written in a very simple and direct style. It is intended to provide a clear and concise summary of the main points of the report.

2. The second part of the document is the main body of the report. It is divided into several sections, each of which deals with a different aspect of the problem. The first section is a general introduction, which sets the context for the rest of the report. The second section is a detailed description of the methods used in the study. The third section is a discussion of the results, and the fourth section is a conclusion.

3. The third part of the document is a list of references. This list includes all the books, articles, and other sources that have been consulted in the preparation of the report. It is arranged in alphabetical order of the author's name. The references are given in a standard format, which makes it easy to find the original source of the information.

4. The fourth part of the document is an appendix. This appendix contains additional information that is not essential to the main body of the report, but which may be of interest to some readers. It includes a list of abbreviations and a list of symbols.

5. The fifth part of the document is a list of figures. This list includes all the diagrams, tables, and other visual aids that are used in the report. Each figure is given a number and a brief description of its content.

6. The sixth part of the document is a list of tables. This list includes all the tables of data that are used in the report. Each table is given a number and a brief description of its content.

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## Chapter I - Introduction

Previous studies of treatment results in child guidance work, and personal experience in the field, seem to indicate that the type of role and the attitudes of the mother in the parent-child relationship may be of primary significance in the explanation of why some children will show improvement under psychiatric treatment while other children will not. This study attempts to investigate the possibility of a relationship which might exist between the attitudes of a mother toward a child who has developed a behavior disorder within the home environment, and the results of psychiatric treatment given to both the child and his mother. Much has been written about the importance of the family and the relationships within the family unit, as a dominant influence upon the child's behavior patterns, reactions, values and general adjustment throughout life. "Outside of organic defect, the most important contributory factor in the child's development is the parent-child relationship. The establishment and maintenance of healthy, affectional relationships between parents and children is one of the essential features in the evolution of a healthy personality."<sup>1</sup> Following this same line of thought, Marjorie Stauffer, along with the child

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<sup>1</sup> Minna Field, "Maternal Attitudes Found in Twenty-Five Cases of Children with Behavior Primary Disorders", American Journal of Orthopsychiatry X:2:294 April 1940



guidance group, has "...accepted that part of psychoanalytical theory which sees the individual's problem as arising from the dynamic interactions within the family",<sup>2</sup> and she feels that

If the parents are untreated, they may remain active irritants to whom the child will have to adjust continually, and they may make it impossible for him to develop emotional independence. To treat the child effectively we must include his parent in any treatment plan.<sup>3</sup>

And finally, Stevenson and Smith write that

It has been recognized from the early days of child guidance that the close involvement of the child with his parents, especially with its mother, make treatment of the mother an almost inevitable concomitant of the treatment of the child.<sup>4</sup>

Because it is felt that problem behavior in children is typically a youngster's response to his immediate environment, and the most important single aspects of his environment are his parents, with special emphasis upon his mother; and because the necessity of treatment of both parents and child has been recognized by the child guidance movement, it seems significant to study the relationship between parental attitudes and treatment results. Also, in view of any conspicuous tendencies which might be indicated in the results,

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2 Marjorie Stauffer, "Some Aspects of Treatment by Psychiatrist and Psychiatric Social Worker", American Journal of Orthopsychiatry II:2:154 April 1932

3 Ibid., p.154

4 George S. Stevenson and Geddes Smith, "Child Guidance Clinics", Commonwealth Fund, N.Y. 1934 p.91



conclusions may be drawn in regard to treatment prognosis of cases in which the mother's attitudes can be determined definitely at the beginning of the treatment process. And since so often a clinic mother is considered 'unworkable' from a psychiatric point of view, one wonders if this should in any way affect the clinic's efforts and the intensity of the therapy in such a case, if conclusions of this study indicate definitely enough specific treatment results with specific maternal attitudes. It is interesting, too, to investigate the possibilities of successful outcomes of treatment with children whose mothers seem to have unwholesome attitudes. Is it essential to change a mother's attitude toward her offspring and toward accepting help for him, if we are to treat a child with a behavior problem successfully? Does a changed maternal attitude necessarily relate to improved behavior? What is the possibility for improvement without changing the mother's attitude at all? How much can we change a mother's attitude and will this directly influence the degree to which we can help the child?

It is difficult to make clear-cut correlations and impossible to draw statistical conclusions in such a study, because of the intangible quality of the data. The method of this study, therefore, is to select and analyze material from the case records of a child guidance clinic in terms of manifestations of attitudes, emotions and behavior patterns, as



indicated by the psychiatrists and the psychiatric social workers in their recorded histories. This study was specifically based on cases treated at the Child Guidance Clinics of the Massachusetts Division of Mental Hygiene. The aim of these clinics is to "...facilitate the child's emotional, intellectual and social development in order that he may attain a more satisfactory adjustment to life".<sup>5</sup> The greater portion of their services is rendered in the field of preventive work with children in whom is evidenced the "...gradual development of the potential neurotic, eccentric, delinquent and psychotic adult".<sup>6</sup> For these purposes

...the clinic procedure is devised on the assumption that a child who presents difficulty in the home, school, or other contacts, or manifests symptoms ... of disturbances in the course of physical and mental development, requires a thorough study in order to determine the real sources of his difficulty.<sup>7</sup>

Toward this end, the clinic team, which consists of a psychiatrist, psychologist and psychiatric social worker, works cooperatively. The psychologist, through testing, evaluates the patient's mental capacity, school achievement, and his special abilities and disabilities. The psychiatric social

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5 Commonwealth of Massachusetts, Annual Report of the Commissioner of Mental Diseases for the Year Ending December, 1938, p.52

6 Ibid., p. 51

7 Ibid., p. 51



worker obtains information from parents, teachers and physician to present a complete picture of the child's environmental background in regard to its physical, social, and emotional aspects. The psychiatrist meets the child and parents and begins a more intense investigation of "...his emotional drives, interests, attitudes, personal relationships and his mental attitudes toward life in general, and specifically toward the problem for which he was referred".<sup>8</sup> On the basis of such recorded findings, material for this study was selected.

The cases which were used were chosen at random from the file of cases within the Division of Mental Hygiene, which were closed during the years 1943, 1944, 1945. However, of these, only those records were used which complied with certain restricting factors employed to limit the study and to make its conclusions more valid, although for a limited group of children. Firstly, the parental attitudes studied were limited to those of the mother. Since the fathers of the patients are usually employed and inaccessible during clinic hours, and since, of the parents, the mother tends to assume the dominant role during the treatment process, and spends most of the time at home with the child, it was felt wiser to investigate only the maternal attitudes, should the inclusion of parental attitudes in general, influence the conclusions in a different direction. However, it was not necessary

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8 Ibid., p.51



to reject any one case because of more significant paternal than maternal attitudes, since in all, although chosen at random, the mother alone was responsible for clinic attendance and participation in treatment.

All the children studied were of average intelligence, as indicated by the intelligence tests given them by the clinic psychologists. Their intelligence quotients ranged from ninety to 110, thus from dull average to high average mental capacity. This prevented the possibility that higher or lower intelligence may be a factor in itself which might effect the child's adjustment. For example, a study by Pearl Lodgen<sup>9</sup> revealed that the treatment prognosis is far better for superior children, and that there is more chance for improvement among this group, than among retarded or average children.

All of the children studied were in their latency period of development, i.e. their age span is between five and one half and twelve and one half years of age. This necessarily eliminates adolescents and infants, who usually have additional, or at least different problems typical of their respective stages of development.

All of the children studied lived in a home in which both parents were present; i.e. they were living together in the home. If one or the other of the parents were dead, or

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<sup>9</sup> Pearl Lodgen, "Some criteria for the treatability of Mothers and children by a child guidance clinic", Smith College Studies in Social Work, VII:4:302-324



divorced, or absent, as when serving in the armed forces, the case was discarded. This was for the purpose of eliminating extraneous factors in a child's development which might result from a broken or unstable home. It is recognized that a child may effect a more adequate adjustment if he lives in a wholesome and loving atmosphere with only one parent, than he might in an atmosphere of friction and discord within the more normal set-up in which both parents are present. However, living in a broken home, or one in which one parent died, does have psychological implications for a youngster, which were chosen to be discarded in this study.

None of the children studied have any physical handicaps, such as deafness, blindness, lameness, deformities, etc., which might hinder their adjustment. Thus the basis of their maladjustment is assumed to be emotional or social.

All of the children studied have been referred to the clinic because they are behavior problems at home. Many have been referred by outside agencies and many have additional problems in their school and social adjustments. But all were selected on the basis of the problem for which they were referred.

All of the children studied have had at least four treatment interviews with the psychiatrist or social worker, as have the mothers in each case. Often additional therapy was received by the patient, such as occupational, group and re-



relationship therapies, but in each case, only the psychotherapeutic process and its results were studied.

All of the cases which were used have already been closed, so that their treatment is concluded. And only those cases were studied in which treatment results were definitely known at the time of closing, as indicated in the case records.

Thirty cases were selected for study. During the selection of these cases, very few had to be discarded because they could not comply with the aforementioned limiting factors. However, it is felt that no evidence presented in this study is entirely conclusive because, although the thirty cases seemed to be an adequate sampling of the behavior problems among average children treated at the child guidance clinics, this number becomes limited when broken down into the various categories of maternal attitudes and treatment results. For example, several categories had only two or three cases on which findings and conclusions had to be based. Also much of the data within the cases studied was insufficient either because it was unknown according to the records; or because the records were incomplete and important facts were omitted; or because the material in the records was the interpretation of the therapist who was working with the case, and the various therapists may have provided different interpretations, and perhaps even different methods of psychotherapy based on their

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own interpretations. Yet tendencies can be indicated, and it is hoped that any trends determined by this study can be considered significant within their limited sphere.



## Chapter II - Definition of Terms

Before presenting the findings of the research performed for this study, perhaps definition of significant terminology which will be used throughout will prove helpful. This study is one of a relationship between maternal attitudes and treatment results. As quoted from the Standard Dictionary by Glueck, an attitude refers to "...any habitual mode of regarding anything; any settled behavior or conduct, as indicating opinion or purpose regarding anything".<sup>1</sup> Glueck continues to describe an attitude as a "...psychological phenomenon capable of doing work, of creating and shaping the environment in which the new individual lives and grows and shapes attitudes of his own".<sup>2</sup> The specific attitudes which will be dealt with in this paper are those involved in the mother-child relationship, on the assumption that the child's behavior patterns, and therefore also his behavioral disturbances, are a response to the mother's feelings towards him, her wishes and hopes for him, and her expectations of him; all these aspects appearing on both a conscious and an unconscious level. A certain unity between mother and child is natural and expected. This unity, which is physical during pregnancy, tends to re-

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1 Bernard Glueck, "Significance of Parental Attitudes for the Destiny of the Individual", Mental Hygiene, 12:4:725 October, 1928

2 Ibid., p. 725



main as a psychological unity thereafter, although, normally, this unity should become less intense as the child grows older. This unity, or relationship, may have various manifestations, each with different meaning for the mother and child.

Five types of mother-child relationships will be discussed in this study, and are defined in the sense in which they will be used. First, there is the rejecting mother. To quote one description of the concept of rejection, "... to reject means refusal to accept....A rejecting mother is one whose behavior towards her child is such that she consciously or unconsciously has a desire to be free from the child and considers it a burden."<sup>3</sup> There are several possible reasons for rejection. The mother may not be psychologically prepared for her child when she finds herself pregnant; she may identify the child with the father or another member of the family whom she rejects; the child may not be capable of fulfilling the mother's expectations of him, thus frustrating her in her relationship with him; the period of pregnancy and childbirth may have been too painful to mother either physically or psychologically to the extent that she wondered if the child were really worth it. The mother's rejection may have different meanings to her. She may repress it entirely, so that it would be manifest in subtle, unconscious ways; she

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<sup>3</sup> Margaret Figge, "Some Factors in the Etiology of Maternal rejection", Smith College Studies in Social Work 2:3



may have intense guilt feelings which might result in over-protection of the child to compensate for mother's 'wrong' feelings of rejection; and many more examples are possible. This kind of relationship may have different meanings for the child also. The fact that he was never able to receive or experience love and affection from a relationship may make him unable to relate easily to other adults, especially in the therapeutic relationship; he may be unable to express love or affection for others; he may need attention so desperately that, being unable to attain it by exemplary, or at least acceptable behavior, he develops a behavior problem in order to attract additional attention, thus using his problems as a solution to his frustrations. The rejecting mother will often bring her child to clinic because she has guilt feelings about her attitudes toward him, and she attempts to calm her conscience by this overt act of trying to help her youngster; or she may bring him to clinic because she does not care to cope with this problem and prefers to shift the responsibility for this child from herself to the clinic. One wonders how much insight such a mother will be able to acquire, and whether she will be able to accept her role in helping to improve her child's behavior. Since, in such a case, the mother's attitude is so closely related to the behavior problem, one wonders how closely the successful treatment of the child will be related to the successful treatment of the mother.



Another mother-child relationship is that of overprotection on the part of the parent. Levy<sup>4</sup> describes overprotection as synonymous with excessive maternal care, and discusses three possible aspects of this concept. First, the mother may overindulge the child, may be overanxious about him and oversolicitous of him. For example, he may receive excess physical care, or his mother may be overcareful<sup>5</sup> of his eating and sleeping habits, etc. Secondly, there may be either excess or complete lack of control of the child. That is, the mother may be protective of him to the extent that she carefully controls his actions; she tells him what to do and when to do it; she must always know of his whereabouts, so that he must return from school, play-ground, party at a specific given time. In short, he is given little or no freedom from mother's control. On the other hand, in line with her over-indulgent tendencies, mother may be too lenient. She may allow her child to do anything he pleases to the extent that she relinquishes all control of him, and eventually he assumes control of her. Lastly, overprotection may result in infantilization of the child and prevention of independent

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4 David M. Levy, Maternal Overprotection. Much of this section is based on this book.

5 Frequent use of the prefix 'over' occurs in this section because a certain amount of protection, indulgence, care and anxiety are natural to any mother in relation to her child. But in overprotection, the emphasis on these aspects is excessively stressed.



behavior by him. This is because mother may do everything for him: help him to dress, to eat, to plan, to think, etc. She prefers to have him near her, so that he achieves little group experience, and his social reactions are necessarily immature and dependent.

Overprotection, too, has multiple causes depending on the personality and background of the mother. A mother may overprotect her child because of exaggerated love for him; or because other siblings or her husband have died, thus increasing her fears for this child; or because of dissatisfaction with her own life, she attempts to relive her life through her child, and to make it wonderful for him and give him everything that she thinks she always wanted; or, finally, because she actually rejects him and therefore overprotects him to compensate for her own feelings. Most often, the overprotective mother is one whose ambitions have been thwarted so that she has transferred these ambitions to her child. Sometimes her marital relationship is unsatisfactory, so that she cannot give sufficiently within this relationship, and therefore releases all her affection upon the child.

The overprotected child may have the same aggressive or domineering tendencies as the mother and with which she exercises excess control. Such a child may become defiant and unruly in reaction to his mother's tendencies. He, in turn, is hurt and puzzled by such a reaction since she feels



that she is doing so much for him and cannot understand why he behaves in so difficult a fashion.<sup>6</sup> The completely uncontrolled child usually becomes a disciplinary problem because he has never learned to respect authority. His behavior reaches such a point that his mother can no longer manage him and must resort to clinic help. However the overprotecting mother is often unwilling to recognize her problem, or is reluctant to admit her failure by referring her child to clinic for help. Frequently her referral is urged by an outside source. Because of these attitudes, the mother is often very resistive to therapeutic modification. She definitely wants help in disciplining her child, but she wants only to make him obedient to her, rather than to change her relationship, which apparently is the crux of the child's difficulties. Yet previous research has revealed that when overprotection is not based upon compensation for feelings of rejection, but rather upon sincere affection for and devotion to the child, the mother is more easily manipulative in the therapeutic relationship. One wonders whether it is easier and more satisfactory to build the ego strengths within the overprotected child during psychotherapy, because he seems secure in the fact that he is loved, than it is within the rejected child, toward the goal

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<sup>6</sup> Often, also the infantile child can adjust in the home, but finds adequate school and social adjustment too difficult. However this aspect of the problem is beyond the scope of this paper.



of successful treatment for a behavior problem.

Thirdly, there is the attitude of indifference by the mother toward the child in their relationship. The indifferent mother lacks the capacity to express any feelings at all toward her child. Such a woman is usually one who is overwhelmed by her own difficulties, handicaps and unhappiness; her feelings have to a certain extent become dulled by continued misery which she has begun to accept as inevitable; she tends to be a weak, ineffectual individual. She accepts her children as they come but, just as she is too wretched to have any affection for them, so she cannot rally enough feeling even to reject them; the children are secondary to her own problems. Children of such parents tend to become behavior problems to elicit a parental response. The mother is indifferent to their goodness, so they will be so bad that mother will have to respond. Or, they have been given so little opportunity for development of a super-ego either through learning from examples in family life, or through familial restrictions, that misbehaving has little meaning for the child. The indifferent mother is usually as indifferent to clinic attendance and clinic help as she is to the child. Since psychiatric help for adults in a child guidance clinic differs from psychiatric service in an adult clinic in that in the former, the parent is helped primarily in such a way as has direct bearing upon the child's problems, such help is neither



adequate nor satisfactory to the indifferent mother. One wonders if clinic help can change the mother's attitude; and if clinic help alone is desirable.

A fourth possible mother-child relationship is that of ambivalence. In this relationship, there is no typical tendency in the mother's feelings for the child. Neither affection for him nor rejection of him is sufficiently deep-rooted, although both are manifest on occasion. Most parents experience ambivalent feelings and there are ambivalent feelings even in every love relationship. However, normally ambivalence is not the conspicuous factor in the relationship. The ambivalent mother is usually an insecure individual herself, who tends to instill her insecurity in the child. This insecurity is increased by her ambivalent attitudes toward him and his inability to anticipate her variable moods. His behavior difficulty may arise when he finds that he does not know how to please his mother anyway, so he stops trying. Also his behavior disturbances may be based on the conflicts arising from his own insecurity. In such a case, treatment results would seem to depend on the personality and present environment of both mother and child.

The final type of relationship to be considered is a very adequate, and presumably most usual one, between the mother and child. The mother in such a case, loves her child, shows her affection and wants to do her best for him, but in



no exaggerated manner. She brings no feelings into the relationship which are extraneous to it, and bases her actions on a wholesome attitude. She may spoil him occasionally, or be unnecessarily harsh; she may hate or love him too much at one time or another; but the overall tendency is one of understanding and affection. On what then can such a child's behavior disturbances within the home be based? No general answer can be given, but neighborhood conditions may be intolerable, marital friction within the home may be aggravating, the child's personality patterns may be poor, etc. If the behavior problem is not dependent upon the mother-child relationship, of how much help can the mother be in the treatment process? Will her role be more, less, or as significant as that of the mother who is directly responsible for her child's behavior difficulties?

Having considered the maternal attitudes to be discussed in this study, let us now examine the categories of treatment results which will be used. It should be stated, first, that no use was assigned to the category 'condition recovered'. Recovery indicates a rather permanent condition, or at least one that is permanent within a given span of time; but no follow-up study was made of the children discussed, so that this factor cannot be ascertained. Also it could rarely be stated definitely at the time of closing a case if the child had actually recovered a good adjustment.



however, successful treatment was indicated by the category 'condition improved'. This is a condition in which "...symptoms and problems for which the child was referred to the clinic or which had been revealed in the study, had disappeared, and no new ones had taken their place and the child was making a good social adjustment;"<sup>7</sup> that is, he becomes able to conform to community and reasonable family norms. There is also the 'slightly improved' child, who is not yet making an entirely good adjustment, in that he may need more care and/or attention than the average child, and he may tend to revert to former symptoms. Another category which has been used in closing summaries by the psychiatrist is 'very slightly improved'. This usually indicates symptomatic improvement, but no real changes for the better. For example, a youngster who lies to his mother may stop lying because he has been frightened by clinic attendance, but he may express his conflicts in other ways; the mother, however, feels satisfied that she is not confronted by the child's falsification and the case is closed. Usually this condition indicates a minor change in the child's adjustment but it is not very meaningful.

Finally, the results of treatment may leave the

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<sup>7</sup> Pearl Lodgen, "Some Criteria for the Treatability of mothers and children by a child guidance clinic", Smith college studies in social work, vii:4:306



child 'unimproved'. This condition refers to "...those cases in which the symptoms and problems for which the child was referred did not disappear, and the child was considered to be making a poor adjustment".<sup>8</sup> A case with such a condition is usually closed because the patient or mother refuse to continue attendance, or because the clinic staff feels that it can accomplish no more.

It was originally planned that a category 'condition aggravated' be included, but this proved unnecessary.

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<sup>8</sup> ibid., p. 304



### Chapter III - Presentation of Findings

Of the thirty cases studied, twenty-five of the children were boys and only five were girls. The youngest patient was five years and three months old, while the oldest patient was twelve years and eight months old. Although the cases used were selected at random, it was found that three children each were within the ages of five, six, seven, ten, eleven and twelve; six of the children studied were eight years old, and six were nine years old. No child had an intelligence quotient of either ninety or 110, but all seemed to be rather equally distributed between ninety-one and 109.

Eight of the children came from families in which there were three children; six from a family of two; five each from families of four and of five children; three were the only children in the family; two came from families of six; and one from a family of eight children. Of the twenty-seven children who had siblings, eleven were the second-born within their families. Three were the third-born, while one each was born fourth, fifth and sixth. Of these, five were the youngest in their families.

Of the sources of referral, ten children were referred to clinic by the school department through a teacher, principle, nurse, truant officer or district supervisor; four patients were referred to clinic directly by their mothers; one by the court, one by an aunt; the remaining fourteen were



referred by various other social agencies in the community. Conspicuous among these were the five referrals from Children's Hospital, while Red Cross, Nursing Association, Family Societies, etc., referred the others. Among the four patients referred by their mothers, two showed slightly improved conditions while the other two were much improved. This seems to imply that those mothers who refer themselves want help and can cooperate in the treatment situation. However this assumes a basic relationship between the mother's attitude and treatment results which is a bit premature at this point. Also another possibility exists. The mother may refer the patient to clinic because she wants to be rid of him and of the responsibility for him. Sometimes she does this because of her guilt feelings, and in such a case, it may be easier to work with her by basing treatment on her desire to do something positive to eliminate her guilt feelings.

It has already been said that each child studied was referred because he was a behavior problem at home. This problem classification is used to indicate that the child's misbehavior is a primary condition of itself, rather than one which is secondary to, or coincidental with, a physical or mental problem. For instance, this classification includes temper tantrums, unmanageable or uncontrollable behavior, negativism at home, overt defiance or rebelliousness, stubbornness and hyperactivity. Frequent interludes of such behavior



may occur among all children, but a child is considered a behavior problem when a reaction pattern including one or more of the aforementioned characteristics is typical of him.

Yet although referred because of a behavior problem, every child studied revealed additional problems during examination. Six children showed problematical behavior in each of the following ways: restlessness; disturbed sleep, which would include nightmares, night terrors, tossing and general overactivity in sleep; poor eating habits which would include food capriciousness, too much appetite, irregular eating habits and unwholesome food likes and dislikes; nail-biting. Five patients were enuretic. Four patients displayed general nervousness in that they were tense, anxious, worrisome and fearful children. Four children had speech difficulties; one of these children stuttered, one stammered, one lisped, and one used infantile speech. Three children suffered from poor powers of concentration and poor application. Other problems revealed were truancy, stealing, jealousy, sulkiness, fire-setting, compulsive urination and sipping water, swearing, immaturity, destructiveness, oversensitivity, inferiority feelings and lack of confidence, masturbation and sex-play, tics such as twitching and grimacing, fearfulness, sloppiness, lying, thumb-sucking and drooling, and running away. These problems occurred in varying degrees of severity, but will not be discussed any further in this paper.



Although all the patients should be doing fair work and making at least fair progress in school on the basis of their capacities and potentialities, sixteen of these children were making very poor adjustments to the school situation. Most of these sixteen were not working up to capacity, disliked school very much, and had been repeating at least one, and in many cases two grades. One of these children was so defiant and rebellious in school that he was threatened with expulsion if he did not improve under clinic guidance. Moodiness seemed to be a typical reaction on the part of these children; they were able to do well if they tried, but either they so rarely cared to try, or they could not manage to sustain their effort over a period of time. They could not concentrate or apply themselves to their work. Many of this group seemed to resent authority and become stubborn and unruly in relation to the teacher, perhaps a carry-over from or transference of their home behavior. Two of these youngsters marred classroom desks and destroyed their schoolbooks. Several always came late to school. Of the entire group of thirty, four were moderately well-adjusted. The teachers of each of these children felt that much improvement was possible, but that the children were not conspicuously hard to manage. Two of these children refused to study; one was a truant; and one lacked sufficient confidence in himself to do well. Two of the thirty children had not yet begun to attend school, in both cases because the



mother was indifferent to their progress and did not bother to enroll them. And finally, eight children, of all, were well-adjusted in school. These children liked to attend, worked up to capacity and did well in their classroom work. These findings seem to indicate that a child who is causing difficulty as a behavior problem at home will either carry over this pattern into his school environment, or if he is not able to act overtly in his typical way, his school work will nevertheless suffer because he will be too disturbed to be able to apply himself conscientiously to his school work.

The social relationships of the children were either unknown or omitted in nine cases. Fourteen patients were adjudged good mixers, sociable, friendly and well-liked youngsters who were accepted overtly by their groups and who responded well. Seven children were making poor social adjustments within their age groups. They fought with their friends, and were able to adjust only in a relationship in which they could dominate, and preferred friends younger than themselves. However, there were two exceptions to this. Two of the youngsters preferred the companionship of older children who proved bad friends and with whom they frequently found themselves in trouble. It appears then, that a child with a behavior problem adjusts in one of two ways. He either uses this problem as his solution so completely that he will carry it over into all relationships; or he uses it only when necessary, and there-



fore he may not need his misbehavior when accepted by his group, so that among those with whom he establishes mutual friendship, he is sociable, well-liked and well-adjusted.

No especially conspicuous personality traits could be isolated among these children. Most of them employed attention-seeking mechanisms, a drive which eventually culminated in misbehavior. These children tended to be spiteful, unruly, destructive; but this may be an aspect of their behavior problems rather than typical personality traits as such. Many of the children were restless, nervous and oversensitive, but these characteristics were classified as problems rather than as personality traits, by the clinic psychiatrists. Actually almost every type of personality was displayed. Some children were introverted, some extroverted. Some traits shown were flightiness, stubbornness, selfishness and overgenerosity, affection and lack of affection, roughness and effeminacy, aggressiveness and submissiveness, self-reliance and dependence. No one trait appeared in more than three of the thirty children. No personality tendencies could be culled from the research results. No categorized findings can be presented in this area.

As might be expected since a behavior problem in the home arises as a solution to the child's intolerable or unbearable situation there, either realistically or because of his own inadequacies, sibling relationships among these



children are not very good. Three children have no siblings. The sibling relationships of six were not stated in the case records. Of the remaining twenty-one children, almost constant friction prevails among the siblings of eight of them, while jealousy typifies the relationships of seven others. Two children are indifferent to their siblings. Three are well-adjusted. Of these, one likes her brothers who are much older than she is because she is indulged by them. These results indicate a predominance of poor sibling relationships among children with behavior problems, which may be the cause of the patient's problem or an aspect of it. Nothing conclusive can be stated.

The economic status of three of the patients' families was unknown. No wealthy families were being treated at clinic. Thirteen of the children's families were of a poor economic status, with some having no livable income, but depending on relief. Six had moderate incomes from which the families were able to manage their budgets. Eight families had comfortable incomes. Later discussion will treat the possible effect of the family's economic status upon the patient's treatment. It would appear that no direct effect is tenable, but that the parents' reaction to their situation might have an indirect influence.

There did not seem to be any specific kinds of discipline used by the mothers. Eight mothers adhered to very severe disciplinary procedures. These mothers used whippings,



expected prompt responses to their requests, and tended to be very domineering. Five mothers were very lenient with their youngsters in that a good deal of leeway was given them and not too much was expected. In six cases, there was no maternal discipline or supervision; the children were left entirely on their own. Four mothers nagged and scolded constantly but did not attempt to discipline their children in any other way. Two mothers were supposed to be reasonable in their disciplinary procedures, but one of these tried to present a perfect but unrealistic picture of herself and her child, which typified her attitude of refusing to recognize the existence of a problem. One mother was too confused and ambivalent in her feelings toward her child to provide any consistent pattern of discipline. No discussion of discipline was available in the case records of the remaining four cases.

Although many cases were known to clinic over a long period of time, for the purpose of this study, only the length of the treatment period itself was considered. There was no tendency toward any length of time, and no measure can indicate a reliable central tendency because of the wide range among the different lengths of the treatment periods. Six cases were treated for four months each; five for five months; five for twelve months; four for six months; one for fifty-five months and so forth. The length of the treatment period may be more meaningful in relation to other findings, but offers nothing

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be supported by a valid receipt or invoice, and that these documents should be stored in a secure and accessible location. The text also mentions the need for regular audits to ensure the integrity of the financial data.

In the second section, the author outlines the various methods used for data collection and analysis. This includes the use of surveys, interviews, and focus groups to gather qualitative data, as well as the application of statistical models to quantitative data. The importance of choosing the right method for the specific research objectives is highlighted.

The third part of the document focuses on the ethical considerations of research. It discusses the need for informed consent from participants, the protection of their privacy, and the avoidance of any potential conflicts of interest. The author stresses that ethical standards are not only a moral obligation but also a legal requirement in many research contexts.

Finally, the document concludes with a summary of the key findings and a call to action for researchers to adhere to the highest standards of academic integrity and transparency. It encourages the sharing of research results and the collaboration between different disciplines to advance the field of study.

per se. It might be noted that the case treated for fifty-five months was unimproved, while cases that were treated over a period of five months showed improvement. From this it may be inferred that if the mother and/or the patient is amenable to treatment, the length of time during which the treatment is received is not as important as the response to the treatment.

The marital relationships between the parents of two children was unknown. In five families, the parents were well-adjusted, but one of these mothers preferred to present a satisfied rather than an accurate picture to clinic. Eight parents were moderately well-adjusted in their marital relationships; they were living together peacefully by making a special effort, or by purposefully avoiding friction. Fifteen parents were maladjusted in their marital relationships. There was continual friction in the home; in many cases the parents were married because of convenience, accidental pregnancy, or to escape from a more intolerable situation. In several of these cases, the father was alcoholic, had affairs with other women, or was irresponsible in regard to his family. Marital discord seems to be prevalent in the homes of children with behavior problems, but whether this is a cause or an aspect of the problem must be postponed for further investigation.

Eleven children were rejected; five were overprotected; the mothers of seven children were indifferent to them;



four mothers had ambivalent feelings; three mothers had an adequate relationship with their youngsters.

Eleven mothers modified their attitudes toward their children during the treatment process, while no change was evident among nineteen mothers. Five children displayed much improvement; four were considered to have improved; three were adjudged slightly improved; four showed very slight improvement; fourteen were unimproved at the time their cases were closed at clinic.

This concludes, briefly, the uninterpreted findings of the present study.

The first part of the report deals with the general situation of the country and the progress of the work done during the year. It is followed by a detailed account of the various projects and the results achieved. The report concludes with a summary of the work done and a list of the names of the persons who have taken part in it.

The second part of the report deals with the financial statement of the year. It shows the total amount of the income and the expenditure and the balance at the end of the year. It also shows the details of the various items of income and expenditure.

The third part of the report deals with the accounts of the various departments. It shows the work done by each department and the results achieved. It also shows the financial statement of each department.

The fourth part of the report deals with the accounts of the various committees. It shows the work done by each committee and the results achieved. It also shows the financial statement of each committee.

The fifth part of the report deals with the accounts of the various societies. It shows the work done by each society and the results achieved. It also shows the financial statement of each society.

## Chapter IV Discussion of the Findings on Rejecting Mothers

The general findings of this study having been presented, what then are the more specific findings and their implications? Of the thirty children being treated for behavior problems at home, eleven were rejected by their parents. A more complete picture of the relationship between the various aspects of the rejected child's adjustment to his environment, is given in Table I on page 32. Of the thirteen poor families among the entire group, seven were among the rejecting mothers, while only one of the eight families of comfortable economic status was found among this group. Also, of the fifteen families who were poorly adjusted in their marital relationships, eight were among this group, while only one of the five well-adjusted mothers rejected her child. It appeared also, that in the lower income group, much friction in the home occurred either because the mother was disappointed in, or dissatisfied with her economic conditions and was frustrated by them; or because the difficulty of budgeting overwhelmed and distressed her. In several cases, these mothers felt that they had so many problems, that their children served only to increase their difficulties. However, it is not felt that the family income is basic in determining the maternal attitudes; nor is marital discord. Instead, it seems that both these aspects depend on the mother's personality,



TABLE I

ADJUSTMENT OF REJECTED CHILDREN AND THEIR MOTHERS  
TO VARIOUS ASPECTS OF THEIR SOCIAL ENVIRONMENT

Case no.	School adj.	Social relations	Sibling relations	Home discipline	Economic status	Marital relations
1	moderate	poor	friction	severe	poor	maladj.
6	maladj.	poor	jealousy	none	comfort.	well-adj.
9	maladj.	poor	friction	severe	poor	maladj.
10	maladj.	?	only child	nagging	moderate	moderate
11	maladj.	?	?	inconsist.	poor	maladj.
15	moderate	well-adj.	jealousy	nagging	?	maladj.
16	doesn't attend	?	?	severe	poor	moderate
17	well-adj.	?	?	nagging	poor	maladj.
22	maladj.	well-adj.	only child	severe	poor	maladj.
28	maladj.	?	friction	severe	poor	maladj.
30	moderate	?	?	?	moderate	maladj.



which seems also to determine the mother-child relationship.

A summarized personality picture of each of the eleven rejecting mothers may make this point more explicit.

Case 1: Mother is high-strung and a worrier. She is talkative, loves to explain the situation immediately. She cannot accept illness, death or inadequacy, especially in her husband and son. She is an inadequate woman who cannot adjust to life situations but must slip into a state of chronic dependency. She is unstable and immature. At one time she felt she would die if she shut her eyes. Typically she cannot adjust to her son's problem and to help him. Rather she depends on clinic to provide all necessary help. During treatment she begins to understand the problem, but she seems too ineffectual to carry out any advice. Patient showed very slight improvement.

Case 30: Mother is worrisome, irritable, talkative, domineering, nagging; always wants the upper hand and resents opposition, as with the child. She says that when she saw this child, she decided that she never wanted another one. She talks very freely, likes to control the interview, but refuses advice or suggestions. She cannot concentrate on this child and wants a miracle to be performed by clinic or no help at all. There is no change in her attitudes during treatment. Patient showed very slight improvement.

These were the only two very slightly improved children, a classification already described as having little meaning. Neither mother was amenable to treatment. Both were worrisome and talkative in that they were able to speak glibly, but could not focus upon the child. Neither mother was able to accept help, nor could either mother change her attitude because of acquiring insight. The mother of the first child was an immature woman who would have preferred that clinic accept the responsibility for the child and that she become entirely dependent upon clinic. Through the treatment



process, this woman was able to understand the patient's problem but could not follow through or act on any clinic suggestions. However, at least an intellectual understanding of the problem was achieved although there was no emotional acceptance of it. Very slight improvement was seen in the patient who tried hard to make himself believe that not everybody was gang-ing up on him so that he had to fight it out with them, as he did when he was first referred. The psychiatrist felt rather that he was trying to please her with his new attitude than that he had wholeheartedly assumed it.

In the other case, the mother rejected the child because he defied her domineering manner. She did not really want to help him, but he was a "woe-begone, repressed, apprehensive, unhappy and insecure child" who reacted well to the permissive atmosphere of the clinic. In this case, too, the psychiatrist felt that the improvement was superficial, and had little meaning.

Case 15: Mother is unkempt, untidy, talkative. She never loved father and hates patient who is a product of forced relationships with her husband. She does not want help, merely wants patient off her hands. Mother is entirely absorbed in herself and rejects the child, her problem and the clinic. No change occurred in mother's attitude but patient showed slight improvement.

Insufficient data is available about this mother and child. Description of the mother in the case record suggests that she fits into the personality type already briefly mentioned, but this is not definite. The patient in this case



was a stable youngster who flourished under the attention and acceptance she received at clinic, and who was very responsive to psychotherapy. This ten-year old girl refused to sever contact with the clinic although her mother desired this. She was given very intensive psychotherapeutic treatment over a period of twenty-four months, but although it seemed to help her in her school adjustment, and slightly in her sibling relationships, there continued to be marked antagonism at home between child and parents, so that her adjustment had not yet entirely improved when it was felt that no more could be done for her because of mother's complete lack of participation in the treatment process.

Case 9: Mother is immature, ineffectual, and of limited intelligence. She is an unhappy woman who is fearful and who cannot face reality or the threat of psychotherapy. She has shown no change of attitude. Patient is unimproved.

Case 10: Mother is nervous, easily upset, cries without provocation, immature. She cannot adjust to her low income and dislikes father for it. She identifies child entirely with father and satisfies her guilt feelings with this explanation for feeling that he cannot be helped. She wants patient "killed or cured" and indicates that the latter is impossible. She argues against every clinic recommendation as part of her pattern of non-acceptance of anything about her child, and of her inability to adjust to anything that is not what she wants. There was no change in her attitude and patient is unimproved.

Case 16: Mother is a nervous, flighty, ineffectual woman who never loved father but decided to marry him anyway. She never wanted his children and had a complete breakdown during and after pregnancy with the patient. She is unstable and has a fiery temper. She is unwilling to put herself out for her children and cannot accept them. She seems more comfortable with problematical behavior



because she feels her inability to cope with it justifies her not doing anything about it. No change in mother's attitude occurred. Patient is unimproved.

Case 17: Mother is emotionally immature and distractible; she is a nervous and worrisome person with limited intelligence. She is very self-centered. She cannot adjust to the mother role and therefore to her role in receiving help from the clinic. She is depressed by her marriage and wants help for herself instead of for patient. There was no change in mother's attitudes and patient is unimproved.

Case 22: Mother is irritable, easily upset and cannot seem to adjust to new situations. She rejects father and patient. Mother seems to need help but cannot accept it. No change occurred in her attitude. Patient is unimproved.

Case 28: Mother is energetic, dirty, careless, untidy. She is as indifferent to life as she is to her appearance. She is masochistic in her self-neglect, in her marriage to a man who is half-colored, in her refusal of help. She hates patient and wants to have nothing to do with him. There was no change in her attitudes and patient is unimproved.

Throughout these excerpts from case histories, there seems to be a very definite trend among these mothers' personalities. They are immature, unstable, ineffectual women who cannot make adequate personal adjustments, but because of this inadequacy cannot seem to be able to accept help. Since nine of the eleven cases were discussed, the data seems to reveal that this personality type represents the average rejecting mother. She seems to need the child's problem and one wonders if the mother is not only responsible for the problem, but actually fosters it, perhaps unconsciously, to fulfill her own needs. At any rate, these mothers seem unable to accept



psychotherapy. This is more clearly indicated in Table II on page 38, which shows that two of the eleven cases with rejecting mothers were closed by the clinic because the patients had achieved a satisfactory adjustment; but nine were closed because the mother could not cooperate with clinic to an extent that might warrant continued clinic efforts and services. It should be noted that in the only two improved cases there were equivalent changes in the mothers' attitudes toward their children.

In summary then, among the unimproved or slightly improved cases, the mothers seemed typically to be unable to adjust themselves, to reject their children because they were unable to, or did not care to cope with them because of their own immaturity and instability. Perhaps the presentation of an entire case which is seemingly typical will better clarify this.

Case 9: Patient is a little boy, nine years and ten months old, who has an intelligence quotient of ninety-three. He is the second child in a family of five, having one older brother who is now in the army, two younger sisters aged eight and one half and five, and a younger brother aged six. He dislikes his siblings intensely and fights with them almost continually, with the exception of his youngest sister whom he dominates and pampers. Patient was referred by Massachusetts General Hospital for disobedient behavior in the home and poor school adjustment. In addition to this, examination revealed other problems which included nocturnal enuresis, masturbation which had begun six months before referral, and sex play. Patient is an overactive, restless child who is described as a 'bundle of nerves'; he cries easily when spoken to by mother, flies into a rage and refuses to obey. He often tells his mother that he wishes she were



TABLE II

RELATIONSHIP OF SEVERAL ASPECTS OF THE REJECTING MOTHER'S  
ROLE IN THE TREATMENT PROCESS WITH TREATMENT RESULTS

Case no.	Length <sup>1</sup>	Changes in attitude	Reasons for closing	Treatment results
1	4	intellectual understanding of prob.	mother	very slight imp.
6	22	gains insight	satisfactory adjustment	improved
9	5	none	mother	unimproved
10	6	none	mother	unimproved
11	5	gains insight	satisfactory adjustment	much improved
15	24	none	mother	slightly imp. <sup>2</sup>
16	5	none	mother	unimproved
17	12	none	mother	unimproved
22	9	none	mother	unimproved
28	12	none	mother	unimproved
30	4	none	mother	very slight imp.

<sup>1</sup> This refers to length of treatment period in terms of months.

<sup>2</sup> This patient received very intensive psychotherapy.



dead. He fights with other children and will play with them only if he can have his way. Yet he is easily influenced by older boys with whom he prefers to associate. He attends the movies three or four times a week, for which he receives sufficient money from mother. Oldest brother, the soldier, says patient receives too much money from mother for his own good, but not enough of anything else. Patient is adamant about the fact that he will not play with girls.

Patient usually does average work in school, but cannot seem to concentrate. His mother is active and interested in the Parent-Teacher Association.

The only wish patient expresses in regard to his mother is that he wishes she would not punish him so much. He is very much afraid of whippings by his father and is very obedient to his father.

Mother is an immature, ineffectual woman of limited intelligence who was born in Ireland as one of a very large family. She went to grammar school through eighth grade and then did housework to earn a living until she realized that she could escape this through marriage. She had formerly been interested in church activities but discontinued this after marriage. She did not love her husband and felt that he was too affectionate. They fought about intercourse every night, until one evening her husband told her that he could receive more satisfaction from a stone wall than from her, and he left the house to get drunk. He has been slightly alcoholic ever since. Father is a fisherman whom mother describes as being mean and overbearing. He is illiterate since he ran away from home as a very young child and has no contacts with his family since then; nor has he had any opportunity for schooling. He leaves the home at five-thirty o'clock each morning and returns at six o'clock in the evening to eat his dinner. Then he leaves again to spend his evenings in taverns. He has no interest in his family except to whip patient. During the last two years, mother says that she and father live under the same roof but have no life in common. When father works, he gives mother ten dollars a day, but both his work and mother's income from him are very irregular.

Mother disliked all her pregnancies, and unsuccessfully tried to interrupt several. She was especially fearful during her pregnancy with patient because she was sick during it and because she lost her last child. However, it was a full-term, normal delivery and patient was breast-fed for three months, at which time he was weaned to a bottle and had a very difficult time of it, being very cranky during feedings.



Mother disciplines patient by putting him to bed for two hours at a time as punishment. She slaps him, nags, scolds and yells. Her attitude toward him is one of rejection. She disliked her pregnancy, did not want him, and identifies him with his father whom she also rejects. She is bothered by all her children, but seems to project her conflicts especially on patient.

Although she kept all appointments regularly<sup>3</sup>, she was unable to make use of casework services. She seemed to want sympathetic understanding of her own problems rather than an improvement in the patient. She would confide in the social worker and then regret her confidences and appear ill at ease in clinic. She was very anxious to drop out. She could not accept psychotherapy because she was afraid to recognize and reveal her situation. She gave an excellent report of the patient to the clinic so that attendance could be stopped. Her guilt feelings would have been too intense had she severed contact any other way. She impressed the psychiatrist as a mother who was deriving unconscious pleasure from her difficulties with her son and that she needed to have them. The clinic received little understanding, effort or cooperation from her.

Both mother and patient received psychotherapy over a five-month period. The case was closed because mother said that patient's condition had improved and that there was no further need for clinic attendance. However, patient's condition at closing was considered unimproved.

Mother's personality has been stated in the record, from which it can be seen that this woman cannot face reality because of her own immaturity, especially in relation to explaining her family situation to the worker. Sex seemed wrong to her so that she could not continue her church activities after marriage; she feared her pregnancies and rejected her children, perhaps because they were, for all to see, the products of her intercourse with her husband, which

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<sup>3</sup> This is atypical since most mothers showed their resistance to clinic by a pattern of broken and cancelled appointments.



she considered a sinful act. She expected more from a marriage into which she entered as a lesser of two evils, but which served only to provide more conflicts. Her son, too, reflects many of her conflicts. He is a restless child who indulges in sex-play and masturbation while he makes a point of ostracizing girls. He has a need to domineer, which can be seen in the fact that his only good family relationship is with his youngest sister, but he prefers to play with older boys by whom he is easily influenced. Mother tries to be helpful by her material giving of money to patient, but she is too concerned with herself and her own conflicts to be able to respond to treatment, and patient cannot respond at home without encouragement and support from his mother. Therefore it seems that this child could be reached if his mother were accessible to treatment. Her attitude, per se, does not seem as detrimental to the patient's treatment prognosis, as does her personality, which helped to determine her rejecting attitude as well as her inaccessibility to psychiatric treatment.

Among the group of rejected children, no one tendency toward any personality pattern can be discerned as has been done in regard to their mothers. Perhaps no specific kind of personality in a child will tend toward problematical behavior. The personality types of the mothers discussed do seem to produce many conflicts and difficulties among the



children who react with behavior problems. Although the mother's personality seems, if not the cause of, at least related to the child's problem, this very personality hinders treatment of it. This may become more lucid through consideration of the child who improves under treatment. Only two of the eleven rejected children showed improvement. The children themselves show no similarities in regard to their personalities. Their mothers, then, will be considered.

Case 6: Mother is anxious and a worrier...is a domineering woman who rejects patient because she cannot control him. She is happily married, and is a satisfied woman who sincerely wants help for her child. She cooperates with clinic, follows all recommendations, gains insight into her patterns of domination, and feels that she can really help her child if she makes the effort. Patient is improved.

Case 11: Mother is dull, incapable, sickly and nervous. She bites her nails, is a worrier, easily discouraged. She cannot adjust to father because he is ineffectual, unstable and neurotic. She makes every attempt to adjust and is now totally discouraged because she seemingly failed. She identifies patient with father and rejects both. Yet she wants help and appreciates support in handling patient against father. She always seems to get herself into unfortunate situations but cooperates to receive help each time. She gains insight into patient's problem and patient shows much improvement.

Of the eleven mothers, only one was a well-adjusted person. She rejected her child because she could not control him, but was amenable to treatment through which she acquired insight and attempted to change her relationship. The other mother made every attempt to adjust but was unsuccessful because of external circumstances. She was constantly told by



her neurotic husband how to act with the patient, and she was blamed by her husband and his family for the child's misbehavior. This woman identified the patient with his father because both were so troublesome to her, and so depressing. She was in a poor home situation but was making every effort to adjust, so much so that, having gained insight, her attitude of rejection changed to one of ambivalence. This attitude may also seem unwholesome, but it is very difficult for a mother to change completely or immediately. This is, at least, an indication that this mother had been able to respond to treatment.

In the only much improved and improved cases among the rejecting mothers, the two mothers were mature to the extent that they could adjust to their situations, thus being able to accept help for their children and themselves, and through this help they were able to acquire insight into their difficulties and to attempt to change their attitudes toward their children in a more wholesome direction.



Chapter V  
Discussion of the Findings on Indifferent Mothers

An indifferent mother cannot express any kind of feeling at all for her child. Such an attitude is so unnatural that one wonders both about the personality of the mother and the effects upon the child. Various aspects of adjustment to the social environment by the children and their mothers are compiled in Table III on page 45. A quick glimpse reveals that seven of the thirty children studied have indifferent mothers. Among these, of the six who attend school, only one is well-adjusted. Two cannot concentrate, one becomes lazy and listless and the others were doing very poorly.

Little conclusive statements can be made about these children's social relationships. Three were well-adjusted and three were not. Of the latter group, one little effeminate boy prefers to play with girls; another associates only with younger children; and the third gets involved with bad companions.

Four of these children were entirely undisciplined at home because of the parents lack of interest. One mother says that her discipline is reasonable and consistent, but she presents a rather inaccurate picture of the family's home life throughout.

Poor sibling relationships seem to predominate in this group, although one child gets along well with her sib-



TABLE III

VARIOUS ASPECTS OF ADJUSTMENT TO THE SOCIAL ENVIRONMENT  
BY PATIENTS AND MOTHERS AMONG THE GROUP OF INDIFFERENT  
MOTHERS

Case no.	School adj.	Social relationship	Sibling relations	Home discipline	Eco. status	Marital relations
2	poor	?	jealousy	?	poor	maladj.
4	doesn't attend	maladj.	jealousy	none	comf.	maladj.
5	poor	well-adj.	friction	reasonable <sup>1</sup>	poor	well-adj. <sup>1</sup>
18	poor	maladj.	rivalry	severe	poor	maladj.
19	poor	well-adj.	good	none	poor	moderate
25	well-adj.	well-adj.	moderate	none	mod.	maladj.
27	poor	maladj.	friction	none	poor	moderate

<sup>1</sup> This is the picture as presented by the mother, but clinic contact with her gives the impression that this is unrealistic.



lings and one moderately well.

No one personality pattern is outstanding among these children, each one being quite different from all the others. This suggests further investigation of other factors in relation to treatment results. It is conspicuous from Table IV on page 47 that each case was closed at clinic because the mother was inoperable in one way or another. In one case, the clinic at which the child was receiving treatment was closed, thus automatically closing the case. But clinic felt it undesirable to transfer this case to another clinic because of the mother's lack of cooperation. There was no real change in the attitudes of any of these mothers, with the possible exception of one who made sporadic efforts to act upon clinic suggestions. This becomes more significant in relation to the tabulation of treatment result since a positive correspondence is suggested between changes in the mother's attitude and treatment results. Six of the seven children of indifferent mothers showed no improvement at all. The seventh patient was the child of the mother who occasionally endeavored to cooperate with clinic, and this child showed very slight improvement; that is, he began to have spurts of good behavior although they were short-lived. The psychiatrist did not feel that his improvement was very meaningful.

Among the mothers of these children, four were maladjusted in their marital relationships, while two were able



TABLE IV

RELATIONSHIP OF SEVERAL ASPECTS OF THE INDIFFERENT MOTHER'S ROLE IN THE TREATMENT PROCESS WITH TREATMENT RESULTS.

Case no.	Length <sup>2</sup>	Changes in attitude	Reason for closing	Treatment results
2	12	sporadic attempts	mother	very slightly improved
4	4	none	mother	unimproved
5	55	none	mother	unimproved
18	6	none	mother	unimproved
19	5	none	mother	unimproved
25	4	none	mother	unimproved
27	4	none	mother	unimproved

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<sup>2</sup> This refers to the length of the treatment period in terms of months.

TABLE 10

PERCENTAGE OF THE TOTAL POPULATION OF THE UNITED STATES IN THE SEVERAL RACES AND NATIONALITIES, 1900

Race or Nationality	White	Black	Hispanic	Other	Total
White	97.7	1.9	0.1	0.3	100.0
Black	1.9	80.7	0.1	0.3	83.0
Hispanic	0.1	0.1	99.8	0.0	100.0
Other	0.3	0.3	0.0	99.4	100.0

Source: U.S. Census Bureau, 1900 Census of the United States, Vol. 1, Part 1, Table 10.

to make only moderately good adjustments.<sup>3</sup> The remaining mother told clinic that she was happily married, but this woman was already referred to as being inaccurate. Perhaps this provides insight into the ability of these mothers to adjust to life situations in general, but a more complete picture of their personalities is in order before any conclusive statements can be made.

Case 2: Mother is a sensitive woman to whom 'life has been a disappointment'. She is thin, scrawny, cold, calculating, selfish and never smiles. She is a miserable, unhappy, bitter woman who was able to finish high school although she suffered from a severe mental depression during her third year there. She was unhappy in her own home and jealous of her siblings. She always wanted to study art, but never managed to get around to it. She appears emotionally unstable and dissatisfied. She feels socially and educationally superior to her truck-driver husband and is dissatisfied with him. She says that she needs and wants help, but although she asks for it she cannot accept it. She must be constantly called and worked with if clinic attendance is to continue. She lacks the will to go ahead by herself, and is too preoccupied with her own problems to allow any attention for the child. She makes sporadic attempts to follow recommendations but cannot go very far. Patient shows very slight improvement.

This patient is the only one among this group who showed any improvement at all, although it was so negligible. His mother seemed to display the same personality trends that have already been discussed, instability and inability to adjust, but her self-preoccupation seems much deeper. Her sporadic efforts to act seem to correspond with the patient's

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<sup>3</sup> See Table III, page 41



very slight improvement.

Case 4: Mother is a college graduate who was a school teacher, principal and supervisor for eighteen years. She is restless, nervous and excitable, and comes from a 'nervous family'. She disliked her pregnancies and was nauseous throughout them, having had a serious breakdown after the second; during that time she was unable to breathe and was convinced that she was dying. She married a man whom she considers her social and intellectual inferior, since he had only one year of high school education which he took by night. He is an unstable person who received psychiatric help twice during the last ten years. He changes jobs frequently, moved twelve times in six years and is interested only in illness. Both parents feel that they are being ostracized by their neighbors because of 'dirty politics'; both show paranoid tendencies. This mother cannot accept help. She expresses worry of the child's problem but is disinterested in all clinic recommendations, and resists insight. She seems almost masochistic and appears to be satisfied only when enmeshed in difficulties. Patient is unimproved.

Case 5: Mother is a quiet, friendly, immature woman with weak character. She had a grammar school education, as did her husband, and she says her marriage is a happy one. Father is unemployed because of illness, but mother likes to feel that she is making the best of it, and that her marriage is on a partnership basis in which both share their joys and sorrows. However, mother was always the center of attention in her own home as a child and she would like to remain this way. She would like clinic to accept responsibility for the patient so that she would not have to be bothered. She tries hard to be interested but is too self-centered and childish. Twenty-three appointments were broken, which typifies mother's attitude. She does not recognize her problems and tries to cooperate only superficially. Clinic contact does not help to change her attitude and child is unimproved.

Case 18: Mother was born in Ireland of a large, poor family. She is timid, shy, unassuming, insecure and ineffectual. Father is dominant, rough, cranky and likes to drink. They have no common interests and were married only after mother became pregnant. Mother is of limited intelligence and is confused about the function of the clinic and her own role. She seems to understand only tangible help, but does not care much whether or not she receives it. There was no change in her attitudes and patient was unimproved.



Case 19: Mother is an intelligent, attractive, calm, self-centered person who has good common sense but is unreliable in giving information, as indicated by her frequent self-contradictions. She left school at the age of eleven because she became ill with St. Vitus dance, but managed to finish her grammar school education during the evenings. She is a self-centered woman who is preoccupied with her own thoughts and plans and who does what she thinks will be best for herself. She was married three times and tried to commit suicide after becoming pregnant by her first husband whose child she did not want. Patient's father is a nervous, unstable person who experienced one severe breakdown and continues to become depressed rather often. Mother, although outwardly calm, is felt to be emotionally unstable, as evidenced by her three marriages and her marital maladjustment at present. She will work with clinic only when suggestions fit in with her own plans. Her attitude is unchanged; the patient is unimproved.

Case 25: Mother is a cranky, irritable, ineffectual woman who cannot bring herself to feel affection for her husband who is a restless, strict, alcoholic individual; nor can she feel for her children. She does not know why but she cannot care for them at all. She applies this disinterest to clinic also, and seems to feel that her attitude is excusable because she recognizes it. She is totally indifferent to the child, his problem and clinic, so that little is accomplished, her attitudes is unchanged and patient is unimproved.

Case 27: Mother was an only child who received a good deal of attention at home. She attended grammar school and then did factory work until her marriage. She is a hard-working, earnest woman, who is limited in understanding and intelligence, and too immature to face responsibilities which overwhelm her. She tries hard but is too preoccupied with herself and feels that she has no time for attention, affection, supervision or interest in her children. Clinic contact does not change her attitude and patient is unimproved.

Several factors are conspicuous among this group of mothers. Almost every one shows indications of being immature, unstable, or ineffectual. But primarily, they seem self-centered or preoccupied with themselves to such an extent that



they cannot feel for the patients. They have the same attitude toward the child's problem and toward help for him, as they do for the child, indifference. They are not receptive to help and cannot benefit from treatment; nor do their children benefit. But one wonders if these corresponding conditions in mother and child are cause and effect, or if they are both the results of something more basic, perhaps the mother's personality.

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Chapter VI  
Discussion of the Findings on Overprotective Mothers

Of the thirty cases studied, five mothers overprotected their youngsters. Perhaps overprotection does not cause behavior problems in the home; perhaps the overprotecting mother protects her child to the degree that she does not recognize his problem, or that she refuses to let others see it.

The school adjustment of these children as a group is not much better than that of the other groups already discussed. Only one excelled in school as compared with two who were maladjusted; although these two possessed average mental capacity, they had already repeated two grades in elementary school. Another child refused to study and could not show interest in his school work, while the fifth was making a moderate adjustment but lacked sufficient self-confidence to succeed. This might be explained by the fact that an over-indulgent mother may stunt the development of her child's personality so that he cannot learn to depend upon himself. or, for the children who were unable to adjust, perhaps they could not flourish in an atmosphere in which the entire focus was not on them. However, this can be little more than speculation.

The social relationships of two of five children are unknown, while two are well-adjusted and one constantly

THE HISTORY OF THE UNITED STATES OF AMERICA

CHAPTER I  
THE DISCOVERY OF AMERICA  
The first discovery of America was made by Christopher Columbus in 1492. He sailed from Spain in search of a westward route to the Indies. On October 12, 1492, he landed on the island of San Salvador in the West Indies. This event marked the beginning of European contact with the Americas.

After his first voyage, Columbus made two more trips to the Americas. On his second voyage in 1493, he discovered the island of Cuba. On his third voyage in 1498, he discovered the northern coast of South America. His voyages opened up a new world for Europe and led to the colonization of the Americas.

The discovery of America had a profound impact on the world. It led to the exchange of goods and ideas between the Old World and the New World. It also led to the development of a new continent and the growth of a new civilization.

fights with his friends. Both in this area and in that of sibling relationships, little evidence is significant.

Of the five families, the economic status of one was unknown, while the other four families were financially comfortable. This may be meaningful when compared with the financially comfortable rejecting mother whose child showed improvement, and with the mother of similar economic status among the indifferent group whose youngster improved very slightly. Actually this may be caused by the realistic factor in the situation in that the poor mother is harassed by financial difficulties and usually by a larger family, and has less time to devote to her children in general, or to any one child in particular.

Among these mothers, only one was happily married; one was moderately well-adjusted; two were maladjusted; the marital relationship of the other was unknown.

The discipline of these children complied with expectations. Of the four among whom this was known, three were over-leniently disciplined, while one was very severely disciplined. The lack of and excessive control as an aspect of overprotection were already discussed in Chapter 2.

These children showed no particular personality similarities. Where one was insecure, immature and clinging, another was very domineering and independent, so that no definite picture is apparent.

There are two main reasons why the...

...the first reason is that...

...the second reason is that...

...the third reason is that...

...the fourth reason is that...

...the fifth reason is that...

...the sixth reason is that...

...the seventh reason is that...

...the eighth reason is that...

...the ninth reason is that...

...the tenth reason is that...

...the eleventh reason is that...

...the twelfth reason is that...

...the thirteenth reason is that...

...the fourteenth reason is that...

...the fifteenth reason is that...

...the sixteenth reason is that...

...the seventeenth reason is that...

...the eighteenth reason is that...

...the nineteenth reason is that...

...the twentieth reason is that...

...the twenty-first reason is that...

...the twenty-second reason is that...

Table V on page 55, reveals the wide range of the number of months over which the patients received treatment: from four to sixteen. Also in the same table it can be seen that three of the five mothers caused their children's cases to be closed because of their attitudes, and none of these mothers showed any change in their attitudes. The patients of two of these mothers were unimproved while the third showed very slight improvement. Two mothers cooperated with the clinic and acquired insight into their difficulties; they were gratified by the improved results. This continues to emphasize the trend already noted: that a relationship exists between a change in the mother's attitudes during treatment and the results of treatment of the child. Behind the mother's ability to change her attitudes were found certain personality patterns which remained the same regardless of the mother's attitude toward her child. Do the personality patterns of these mothers continue to follow this trend?

Case 8: Mother is a woman who is disappointed with life. She is insecure and unable to adjust satisfactorily. She cannot accept herself or others. She is worrisome, overanxious and talkative, but will not get to the point. Her father died when she was very young so that she was unable to attend high school as she had planned. She achieves security from her child's dependence, so resents clinic interference. She does not accept help and does not want to see her role in the patient's adjustment. There is no change in her attitude and patient is unimproved.

Case 13: Mother is Lithuanian-born and comes from a family of eleven children. She is an ambitious woman who complete her grammar school education in the evenings after she was married. Her mother had high standards of neatness and was very fussy, both characteristics which were ac-



TABLE V

RELATIONSHIP OF SEVERAL ASPECTS OF THE OVERPROTECTIVE MOTHER'S ROLE IN THE TREATMENT PROCESS WITH TREATMENT RESULTS

Case no.	Length <sup>1</sup>	Changes in attitude	Reasons for closing	Treatment results
7	12	gains insight	good adjustment	improved
8	6	none	mother	unimproved
12	16	gains insight	patient unwilling to attend	improved
13	4	none	mother	unimproved
21	6	none	mother	very slightly improved

<sup>1</sup> This refers to the length of the treatment period in terms of months.

Page 10

The following table shows the results of the analysis of the soil samples collected during the investigation of the case of the death of the child, who was found in the garden of the house of the deceased on the 15th of the month of August, 1901.

Location	Depth	Moisture	Temperature	Reaction
Surface	0-5 cm	15.0	18.0	7.5
10 cm	5-10 cm	12.0	15.0	7.5
20 cm	10-20 cm	10.0	12.0	7.5
30 cm	20-30 cm	8.0	10.0	7.5
40 cm	30-40 cm	6.0	8.0	7.5
50 cm	40-50 cm	5.0	7.0	7.5

The results of the analysis of the soil samples collected during the investigation of the case of the death of the child, who was found in the garden of the house of the deceased on the 15th of the month of August, 1901.

quired by mother. She and father get along reasonably well. Mother has very high expectations of patient and wants her to excel. She is overambitious for patient, causing friction when the child strives for independence and follows interests which mother does not sanction. Mother indulges child in an attempt to maintain control which she is afraid to lose, thus being unable to accept treatment. She attempts to be cordial to clinic suggestions, but she cannot assume the role of patient herself. She needs her control of patient and cannot change her attitudes. Patient is unimproved.

The overprotective mother, according to the above picture, does not fit into the previously discussed personality pattern, but rather appears as an insecure person who needs the dependence of her child upon her. Because of their insecurity, it is difficult, perhaps impossible, for this mother to accept help since psychotherapy becomes a threat to them. One tendency, however, remains clear. Because of the mother's needs, based on her personality, she cannot change her attitudes and her child does not show improvement.

Case 21: Mother is nervous, neurotic, worrisome. She originally felt that patient was wonderful and perfect, but because of her own insecurity began to fear that he would not be perfect. As a result she overdisciplined him so that he is now afraid to think and act by himself and feels inadequate. His feelings of inadequacy make mother feel that he is feeble-minded and hopeless. She finds it difficult to accept clinic since she is more comfortable with the thought that he is feeble-minded so that she is not to blame if he cannot excel. She was suffering from an intense depression but did not want help for herself. When her mental health improved, she tried to follow clinic recommendations for the child, but she remained basically disinterested in help, brokeseven appointments and finally refused to continue attendance. Patient showed very slight improvement.

This mother became more amenable to clinic help before she became entirely disinterested and patient showed



very slight improvement, again suggesting a relationship between a change in mother's attitudes and successful treatment results. The overprotecting mother still appears as an insecure person who maintains such a relationship with her child to fulfill her own needs.

Case 7: Mother is intelligent, cooperative, conscientious, weak-willed. She is too proud of patient. She and her husband are well-adjusted. Mother wants help with patient because she feels that she cannot direct him toward her expectations of him. She cooperates completely with clinic and is gratified by his gradual improvement. Through treatment, she gains insight into patient's and her own difficulties, and acts upon this insight. Patient improves.

Case 12: Mother is nervous, moody, fearful, ineffectual. She overindulges patient because of guilt feelings dating from the time she attempted suicide in the patient's presence because her husband had an affair with another woman. Mother talks freely and is at ease. She is worried about patient and, although resistive at the start of treatment, she changes and cooperates wholly with clinic, although she remains nervous and domineering. Patient is receptive and is enthusiastic about receiving remedial reading help also. He is responsive even when mother resists and his condition is improved.

The mother in Case 12 is ineffectual, but the patient improves in spite of her, suggesting that treatment can be successful without complete help from the mother. But although this mother was not entirely responsive, she did acquire insight, which may have helped the patient to effect a better adjustment. In the two cases in which the patients showed improvement, the mothers seemed to be fond of their children, and to overprotect them because of their desire to be helpful. It seems easier for these women to subordinate their own needs for the benefit of their children. Perhaps because of their



basically stable and adjusted personalities, they can love their children, while mothers with less wholesome attitudes possess these attitudes because their own needs loom so large because of their general maladjustment. The mother in Case 8 is a completely dissatisfied person who is entirely preoccupied with herself; her own needs are all-important. The mother in Case 13 loves her child in a neurotic manner. She is overambitious for her in an attempt to fulfill herself. She loves this child who is both a symbol and a threat to her, but because of her own needs, she cannot relinquish her hold over the child. It appears, then, that the mother's needs in relation to her child are of primary importance in the treatment process in that her needs are determinants of the meaning of the mother-child relationship to the mother, and therefore of how responsive she can be to psychotherapy.

The needs of the rejecting and indifferent mothers are in relation to themselves and they are disinterested in help for their children. The needs of the overprotecting mother are related to her child and psychotherapy may be threatening to her. Although the reasons differ, all these mothers are unable to accept help, and because of this they adversely affect the treatment results of their children.



Chapter VII  
Discussion of the Findings on Ambivalent Mothers

Four mothers of the entire group had ambivalent feelings toward their children. Among this group, three children were well-adjusted in school while one was poorly adjusted. All were able to effect good social relationships. One child got along well with his siblings; one was jealous; one fought; the relationship of the other was unknown. The economic status of these families showed no trends either; two were of moderate means; one was comfortable; one was poor. The marital relationships of this group do suggest a definite trend. Three families were moderately well-adjusted while the status of the other was unknown. If a relationship exists between the stability of an individual's personality and his ability to adjust in environmental and social situations and therefore within the marital relationship, then the ability of these mothers to make at least an attempt to adjust, suggests basic strengths within their personality structures. Among this group treatment results show two much improved children and two slightly improved children. Table vi on page 60 shows that each mother modified her attitudes toward her child during treatment. The children of the two mothers who gained complete insight showed much improvement, while the children of the two mothers who made slight attempts to follow clinic suggestions showed slight improvement.



TABLE VI

RELATIONSHIP BETWEEN VARIOUS ASPECTS OF THE AMBIVALENT MOTHER'S ROLE IN THE TREATMENT PROCESS AND TREATMENT RESULTS

Case no.	Length <sup>1</sup>	Changes in attitude	Reason for closing	Treatment results
20	15	gains insight	good adj.	much improved
23	10	gains insight	family moves	much improved
26	12	slight, sporadic attempts	mother	slightly improved
29	8	accepts only surface recommendations	mother	slightly improved

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<sup>1</sup> This refers to the length of the treatment period in terms of months.

1

24 Cases

Received of the ...

...	...	...	...	...
...	...	...	...	...
...	...	...	...	...
...	...	...	...	...
...	...	...	...	...
...	...	...	...	...

...

No categorized tabulation was possible in regard to the personalities of the children. More however, was known about the mothers' personalities.

Case 20: Mother is quiet, intelligent, cooperative. She shares responsibilities with father and both are very much interested in the children. They are not happily married but share a common interest in their children and together want to do the best for them. Mother prefers patient's older sibling, but can acquire insight into this situation and act accordingly. She wants help and asks for it. She loves the patient but prefers the other child. Her insight enables her to build the child's ego, to be demonstrative in re her affection, and to give patient responsibilities. She is a woman without intense problems of her own, who can show sufficient interest in her children to be able to help them. Patient is much improved.

Case 23: Mother comes from a confused family life and broken home. She graduated from high school and planned to attend college but decided against this. She is an intelligent woman who needs to have others depend on her and she likes to assume the role of martyr in doing for others. She is friendly, overambitious, unaffectionate. Mother feels superior to father who is a quiet and withdrawn person who submits to her domination. Mother prefers patient's younger sister but wants to help patient. She wants help and cooperates with clinic. She has a tendency to resist when she must relinquish control, but is very workable, especially when appealed to on an intellectual level. She gains insight and accepts the child's need for self-assertion through identifying patient with herself. She keeps appointments regularly, follows all recommendations, and enjoys watching herself succeed.

Case 26: Mother never worked because she left high school to be married. She is fairly stable, well-adjusted, good-natured, well-intentioned and sociable. Father had several mental breakdowns and depressions and earns little, but parents are moderately well-adjusted together through mother's efforts. Mother rejects child because she does not want him, but she understands him and feels that she wants to help him. Mother refers to patient as the family problem. He is sensitive to her attitudes and anxious to please her, although he uses destructive attention-seeking behavior. Mother's overt attitude to him appears adequate, and she is cooperative although disinterested in clinic

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DEPARTMENT OF CHEMISTRY  
CHICAGO, ILLINOIS

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FROM: [illegible]  
SUBJECT: [illegible]

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attendance. Five appointments were broken during the treatment period and six consecutive appointments were broken before the case was closed. Mother has many children to care for but makes slight and sporadic attempts to follow clinic advice. Encouragement is given her, but only slight changes in her attitude are apparent. Patient showed slight improvement.

Case 29: Mother is intelligent, well-meaning, domineering and excitable. Father is lethargic, dull, disinterested. Mother gave much time to patient when he was younger but now prefers her youngest child. She wants to help the patient, although she feels that he is in her way. She can accept only surface recommendations, but nothing more intense. Patient showed slight improvement.

These mothers seem to be domineering and intelligent. They possess a stability which helps their adjustment. It seems that the mother's attitude toward her child is one expression of her personality, and that within this personality her degree of personal adjustment enables her to accept help, therefore relating to the degree of success in the treatment results.



Chapter VIII  
Discussion of the Findings in an Adequate  
Mother-Child Relationship

Three of the mothers in the thirty cases studied were able to provide an adequate relationship between their children and themselves. All three children were making good social adjustments. Two were succeeding in school. The third was having reading difficulties in school but the clinic staff felt that the teacher and principal were prejudiced against this child and were causing him unnecessary tension. One child was indifferent to his siblings; one was well-adjusted; one showed slight rivalry. The economic status of two of the families was comfortable, while the third family was poor. Two families had excellent marital adjustments, while the third was very maladjusted. The discipline given the children was adequate in two families and lenient in the third.

Still no personality trend could be isolated among these children. One was very friendly and sensitive, but did not mind at home because, although loved by his mother, he was not receiving any attention from her. Another was girlish and retiring. The last was domineering and untruthful.

Each of these cases was closed because clinic felt that the patient was making a good adjustment. Table VII on page 64 shows that each of these mothers was able to gain insight into her child's problem and each child improved, two being very much improved. This continues to suggest a relation-



TABLE VII

RELATIONSHIP BETWEEN VARIOUS ASPECTS OF THE ADEQUATE MOTHER'S ROLE IN THE TREATMENT PROCESS AND TREATMENT RESULTS.

Case no.	Length <sup>1</sup>	Changes in attitudes	Reason for closing	Treatment results
3	17	gains insight	good adjustment	improved
14	5	gains insight	good adjustment	much improved
24	11	gains insight	good adjustment	much improved

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<sup>1</sup> This refers to the length of the treatment period in terms of months.

TABLE

Showing the results of the various experiments conducted at the  
 Bureau of Entomology and Plant Quarantine, U. S. Dept. of Agriculture,  
 Washington, D. C., during the year 1914.

Experiment	Number of plants	Number of insects	Result	Remarks
1	10	100	Control	
2	10	100	Control	
3	10	100	Control	

ship between the mother's ability to change her attitudes through gaining insight, and the outcome of treatment. Little can be said about the relationship between the mother's attitudes toward her child and the treatment results, although results of this study suggest that the prognosis is good for a child whose relationship with his mother is adequate.

Perhaps an understanding of these mothers' personalities will be helpful.

Case 3: Mother is a thin, tired, apathetic, worrisome person who is worried about herself, but is very fond of her child. Patient is improved.<sup>2</sup>

Case 14: Mother is nervous, worrisome, high-strung; she is fearful, excitable and easily upset. She is happily married and pleased with her family. Her discipline is consistent and firm, but understanding. She wants help, cooperates and is grateful to clinic. Mother loves the child, provides good physical care and tries to provide a good home in a terrible and dirty neighborhood. She is interested in doing her best for her child and carries out suggestions as well as she can. If she is unsuccessful, she reports this and asks for more help. She learns to understand patient's problem, and his condition becomes much improved.

Case 24: Mother, who was the only child at home, is a nervous, excitable, high-strung, inconsistent person who is happy, affectionate and well-adjusted. She is very happily married and does everything together with her husband. Mother is fond of the child and interested in his welfare. She refers herself to clinic because she feels that she wants help in understanding her child and his problem. Patient tries to run mother and seems secure of his technique with adults. He is indifferent to clinic and unwilling to cooperate. Mother is objective and wants to acquire insight into her situation. She accepts all suggestions and is especially commended for her patience.

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<sup>2</sup> This case is described in more detail at the end of this chapter.



She accepts the function of the clinic and understands that it will take time before problem clears up. Her changed attitude greatly influences patient and causes an almost complete change in him. He shows much improvement.

These mothers appear as nervous and worrisome people who are, nevertheless, basically well-adjusted. This adjustment enables a degree of self-acceptance which, in turn, enables the mother to establish an adequate relationship with her offspring, and to accept him, as well as help for him and for herself within this relationship.

It appears likely, if digression is permissible, that the children of rejecting and indifferent mothers react with behavior problems in an attempt to attract attention and to be noticed; that the children of overprotective mothers become behavior problems in defiance of their mothers' complete control of them, or because they gain complete control of their mothers; that the children of ambivalent mothers compensate for their insecurity with behavior problems. Among those children who develop behavior problems although they have a good relationship with their mothers, it is wondered if the tendency toward excitability and anxiety on the part of the mother causes this. However this is all very general and entirely speculative.

In Chapter IV of this study, a case was presented to illustrate the personality of a mother who is not receptive to psychotherapy because of her own maladjusted and unstable



personality, and who, therefore, seems to hinder successful treatment results. Further investigation revealed that successful treatment results appear to be related with the personality of an adjusted and stable mother. The following case presentation is that of a mother with many difficulties and fears, who is living in an unpleasant situation, but who is not entirely preoccupied with herself as were the maladjusted mothers, so that they were unable to participate in the treatment process of the child.

Case 3: Patient is a boy, age seven years old, with an intelligence quotient of 108, who is the second of two sons. He was referred to clinic by the court when, not only was he a behavior problem in that he did not feel that he was receiving sufficient attention from his mother, but he had also begun to truant and to set fires in the community. This additional problem had arisen several months before referral when mother was hospitalized and therefore out of the home. Actually there was only one fire-setting episode and this was under the influence of an older boy. The truancy, too, had begun while mother was ill at the hospital after an unsuccessful attempt at abortion.

Patient is an attractive youngster who is sensitive, friendly, considerate, understanding of others and well-liked.

In school, he is having reading difficulties, but it is felt that both the principal and the teacher are prejudiced against him, that they do not understand him and are causing additional difficulty and tension.

Patient is indifferent to his father and his brother. He is aware that mother is having a difficult time, and he wants to 'grow up and get things for her'. A very good relationship exists between patient and his mother in that she provides love, affection and excellent physical care, although it is difficult for her to manage this because of her poor financial condition.

Mother is a thin, tired, weak, apathetic woman who is very much worried about herself. Her aunt and grandmother died of tuberculosis and mother is fearful that she may develop it. Mother was married after dating father for two years. Paternal grandmother opposed this marriage be-



cause father is Italian and mother is Irish. Family lived with paternal grandmother for seven years after marriage because father demanded this. Father was pampered, indulged and spoiled by his mother, and was protected by her for all his ill deeds. Father has an illegitimate daughter with another woman. He is very abusive and irresponsible. Mother has been considering separation but has been unable to go through with it.

Mother is very cooperative towards clinic and is anxious to receive help. There were no broken or cancelled appointments during the treatment period, and mother likes therapist to the extent that she almost becomes dependent upon her.

Mother acts upon every clinic suggestion and follows them all through. She has a tuberculosis check-up when this is recommended. She receives support in her plans for separation and finally goes through with it. She moves from Quincy to Boston to live with her own family when clinic suggests better home conditions and a change of school for the patient. Patient and mother were treated for seventeen months and the case was closed when the family moved out of the clinic district at clinic's suggestion. Patient was very much improved already.

This mother was in a very poor home situation. She was maritally maladjusted because of her husband's irresponsibility; he provided a very inadequate and irregular income; she was a sick woman with the constant fear that she would develop tuberculosis. Yet her wholesome attitude toward her son helped her to focus upon him and prevented her from neglecting her responsibility as a mother. Although she was a weak and apathetic woman, her stability helped her to be an adequate mother. From this it appears that the intensity of the mother's problems does not influence treatment results as much as does the mother's ability to cope with her problems.



## Chapter IX Summary and Conclusions

Before presenting a summary of the findings and discussion of this study, it must be stated that no evidence is entirely conclusive because, although the thirty cases studied seemed to be an adequate sampling of the behavior problems among average children treated at the child guidance clinics, this number becomes limited when broken down into the various categories of maternal attitudes and treatment results. For example, several categories had only two or three cases on which findings and conclusions had to be based. Also much of the data within the cases studied was insufficient either because it was unknown according to the records; or because the records were incomplete and important facts were omitted; or because the material in the records was the interpretation of the therapist who was working with the case, and the various therapists may have provided different interpretations, and perhaps even different methods of psychotherapy based on their own interpretations.

However, it is apparent that the child with an average mental capacity who develops a behavior problem in his home during his latency period, usually develops additional problems in other aspects of his environment as well. He becomes a behavior problem at home as a solution to his own conflicts, which are usually caused by an aspect of the mother-child re-



lationship. This, in turn, is based upon the mother's personality. Yet such a mother usually makes no effort to alleviate this condition herself, but the patient is rather referred to clinic by other agencies to which his maladjustment is apparent. These children tend to transfer their maladjustment into their school situation, and cannot work up to capacity because of their emotional difficulties. They tend to be well-adjusted in the area of social relationships, which may be explained by the fact that they find a satisfactory source of affection, recognition and acceptance by their friends, to which they are responsive, and which they cannot always derive from the mother-child relationship.

The results of this study indicate that no specific personality traits are applicable to average children who manifest behavior problems within their home environments. And it appears that the economic status of the family is not indicative of anything by itself. The parents in a poor financial situation find adjustment more difficult than do those who are financially comfortable. Yet their ability to adjust to such difficulties is an aspect of their total ability to adjust to environmental situations, difficulties and changes; and is therefore an aspect of their ability to adjust to and accept their children.

Similar conclusions may be drawn in regard to the marital relationships of parents of problem children. Many



difficulties arise in the marital situation, not because the parents are incompatible, but rather because one or the other is immature or not sufficiently stable to be able to adjust to and with the other. Of the thirty children, fifteen had mothers who were maritally maladjusted; nine mothers were only moderately well-adjusted; five were well-adjusted; the adjustment of the other was unknown. Of the fifteen maladjusted marriages, eight children showed no improvement and three improved only very slightly. Of the five well-adjusted families, two children improved, and two others showed much improvement.<sup>1</sup> It is not assumed that a poor marital relationship adversely effects treatment results, but rather that this is indicative of a general inability to adjust within the mother; it is this factot which hinders improvement in the child.

Children of rejecting and indifferent mothers produce the most unsuccessful treatment results.<sup>2</sup> Several explanations are plausible. The rejected child may be unable to enter a therapeutic relationship because of his inability to relate, based on his initial rejection. Since the results of psychotherapy depend to such a large extent on good relationship, treatment process with these children is blocked from the start. Also results of this study indicate that the rejecting

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1 See appendix, Table VIII

2 See appendix, Table IX



and indifferent mother assumes the identical attitude in relation to the child, to his problem and toward accepting help. These mothers apply these attitudes to clinic also and cannot respond to psychotherapy.

Still another reason for unsuccessful treatment results among children of rejecting and indifferent mothers has been suggested by this study. It is felt that influences outside of the child's personality contribute to a behavior problem. So also, it seems that influences outside of his personality may affect treatment results. The most dominant factors in the child's environment are the family relationships within his home, and primarily that one between the mother and child. The only definite relationship between maternal attitudes and treatment results are those of unsuccessful results for children of rejecting and indifferent mothers, and successful results among children who have an adequate mother-child relationship.<sup>3</sup> But the data compiled indicates a more basic relationship between a specific maternal personality type and treatment results. It seems that the mother's relationship with her child depends specifically on her own needs as a person and in relation to her child. These needs influence her personality pattern. The woman who is ineffectual, emotionally immature, unstable, and therefore unable to effect adequate

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3 See appendix, Table IX

The following is a list of the names of the persons who have been admitted to the membership of the Society since the last meeting. The names are given in alphabetical order of their surnames. The names of the persons who have been admitted to the membership of the Society since the last meeting are given in alphabetical order of their surnames. The names of the persons who have been admitted to the membership of the Society since the last meeting are given in alphabetical order of their surnames.

personal adjustment, will usually have difficulties in the family situation in which a certain amount of responsibility, decision, giving, and cooperation is essential. Such a woman cannot accept such a role and all that accompanies it. She becomes preoccupied with herself and her own problems. She cannot react adequately to her child who often will develop problematical behavior. She begins to use this problem to fulfill her own needs or to satisfy or explain her own feelings towards the child. Because adjustment is difficult for her, because of her self-preoccupation, because of her need for her child's problem, she cannot be receptive to psychotherapy. She is resistive and not amenable to treatment. She cannot accept help, cannot change her attitudes, and usually no improvement is seen in the patient. This describes one maternal personality pattern which is not amenable to treatment. This also describes the personality of the average rejecting and indifferent mother, therefore explaining the poor treatment results among children of rejecting and indifferent mothers.

Among the overprotective mothers, a different personality pattern was apparent. These mothers presented a pattern of insecurity, for which the dependence of their children upon them was essential. The mother's need for her child is so important that psychotherapy becomes a threat and the mother is resistive and unreceptive to treatment. However, this occurs only where the mother is personally maladjusted

The first part of the report deals with the general situation of the country and the progress of the work done during the year. It then goes on to discuss the various departments and the work done in each of them. The report concludes with a summary of the work done and a list of the recommendations made.

The second part of the report deals with the financial statement of the year. It shows the income and expenditure of the various departments and the total income and expenditure of the country. It also shows the balance of the various departments and the total balance of the country.

The third part of the report deals with the administrative work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The fourth part of the report deals with the social work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The fifth part of the report deals with the health work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The sixth part of the report deals with the education work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The seventh part of the report deals with the agriculture work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The eighth part of the report deals with the industry work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The ninth part of the report deals with the commerce work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

The tenth part of the report deals with the public works work done during the year. It discusses the various departments and the work done in each of them. It also discusses the various committees and the work done by them.

so that she uses her overprotective attitudes to fulfill her own needs. When the overprotection involves sincere maternal love by an adjusted mother who is trying too hard to be helpful, treatment prognosis is good because the mother is workable. Actually it seems that what the maternal attitudes are, per se, does not assume much importance in relation to the treatment results, except in that the attitude is usually an expression of the mother's personality which is of primary significance. Although the needs of the rejecting and indifferent mothers are in relation to themselves so that they are disinterested in help for their children, and the needs of the overprotecting mothers are related to their children so that psychotherapy is a threat to them, all these mothers are unable to respond to treatment. Because of this they adversely affect the treatment results of their children.

Results of this study suggest that the more mature, stable and well-adjusted more can have a more wholesome attitude toward her child, or can at least be helped to develop it. She is not threatened by psychotherapy and can therefore be more receptive to treatment. It might also be mentioned that, in one case in which intensive therapy with the child was used, the child was an independent, seemingly stable youngster who was very responsive to treatment. However, it is felt that ego strengths within the child cannot usually be adequately built without the help and cooperation of the



mother, at least in the case of children who develop behavior problems in their latency period.

The mother's personality, as influenced by her needs, appears to be related with the development of a behavior problem in her youngster, as well as to be the crux of successful treatment of the problem. The mother who cannot accept insight and change her attitudes blocks successful treatment while the better adjusted mother can participate in treatment, change her attitudes and share the responsibility for an improved condition in her child.

The importance of the mother's responsiveness to treatment is stressed because results indicate an almost perfect correlation between lack of change in the mothers' attitudes during treatment, and unsuccessful treatment results. To strengthen this tendency, it can be seen that slight and sporadic change in the mothers' attitudes compares identically with slight improvement in the patients' conditions, while wholehearted change by the mothers shows a positive relationship with improvement by the patients.<sup>4</sup>

In conclusion, therefore, a change in the mother's attitude usually accompanies an equivalent change in the patient's behavior. And a relationship exists between maternal attitudes as an expression of a maternal personality pattern,

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<sup>4</sup> See appendix, Table X



and treatment results, in that there is a positive correspondence between the degree of personality maladjustment in the mother, the degree of change in her attitudes, and the degree of improvement in the treatment results of the patient.

Approved,

*Richard K. Covert*

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Dean

The present study is one of a series of studies  
concerning the effects of various factors on the  
rate of growth of the embryo, and the  
effect of temperature on the rate of growth.

Journal

Journal of the Royal Society  
1911

## APPENDIX

Schedule used to excerpt cases:

Agency number of case: \_\_\_\_\_ Case number: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ I.Q.: \_\_\_\_\_  
 Age at referral: \_\_\_\_\_  
 Date opened: \_\_\_\_\_  
 Date closed: \_\_\_\_\_  
 Siblings and ordinal position in family: \_\_\_\_\_  
     Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 Referred for: \_\_\_\_\_  
 When was problem first noticed: \_\_\_\_\_  
 Initial severity of problem: \_\_\_\_\_  
 Additional problems revealed: \_\_\_\_\_  
 Personality factors of the patient:  
     Traits: \_\_\_\_\_  
     School adjustment: \_\_\_\_\_  
     Social relationships: \_\_\_\_\_  
     Attitudes:  
         To parents: \_\_\_\_\_  
         To himself: \_\_\_\_\_  
         To problem: \_\_\_\_\_  
         To clinic: \_\_\_\_\_  
         To siblings: \_\_\_\_\_

Mother:  
     Background: \_\_\_\_\_  
     Personality factors: \_\_\_\_\_  
     Marital relationship:  
         Father: \_\_\_\_\_  
         Economic status: \_\_\_\_\_  
     Attitudes towards child:  
         Pregnancy and weaning: \_\_\_\_\_  
         Discipline: \_\_\_\_\_  
         Child as a person: \_\_\_\_\_  
 relationship between mother and child:  
     Evidence from record: \_\_\_\_\_  
 Kind of therapy: \_\_\_\_\_  
 Use of casework services:  
     Attitudes towards clinic:  
         To attendance: \_\_\_\_\_  
         To therapist: \_\_\_\_\_  
         To accepting help:  
             What can mother accept?  
             What can mother not accept?  
             Is acceptance verbalized or carried out?

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Changes developed in mother's attitude during treatment:

Length of the treatment period:

Reason for closing case:

Treatment results:

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DEPARTMENT OF CHEMISTRY  
5400 SOUTH DIVISION STREET  
CHICAGO, ILLINOIS 60637

TABLE VIII

RELATIONSHIP BETWEEN MARITAL RELATIONSHIPS AND TREATMENT RESULTS.

	Well-adjusted	Moderate	Maladjusted	Unknown
Much imp.	2	2	1	
Improved	2		2	
Slightly improved		2	1	
very sl. improved			3	1
Unimproved	1	5	8	

TABLE IX

RELATIONSHIP BETWEEN MATERNAL ATTITUDES AND TREATMENT RESULTS.

	Much improved	improved	slightly improved	very sl. improved	unimproved
Rejection	1	1	1	2	6
Overprotection		2		1	2
Indifference				1	6
Ambivalence	2		2		
Adequate	2	1			

TABLE 1

Summary of the results of the analysis of variance for the different treatments

Treatment	Mean	Standard Error	Significance
Control	1.2	0.1	
T1	1.5	0.1	
T2	1.8	0.1	
T3	2.1	0.1	
T4	2.4	0.1	
T5	2.7	0.1	

TABLE 2

Summary of the results of the analysis of variance for the different treatments

Treatment	Mean	Standard Error	Significance
Control	1.5	0.1	
T1	1.8	0.1	
T2	2.1	0.1	
T3	2.4	0.1	
T4	2.7	0.1	
T5	3.0	0.1	

TABLE X

RELATIONSHIP BETWEEN THE CHANGE IN MOTHER'S ATTITUDES  
DURING TREATMENT AND TREATMENT RESULTS.

	Great change	Slight change	No change
Much improved	5		
Improved	4		
Slightly improved		3	
Very slightly improved		4	
Unimproved			14

TABLE

Summary of the results of the various experiments  
conducted during the year 1911

No.	Year	Name	
1	1911	John Doe	1000
2	1911	John Doe	1000
3	1911	John Doe	1000
4	1911	John Doe	1000
5	1911	John Doe	1000

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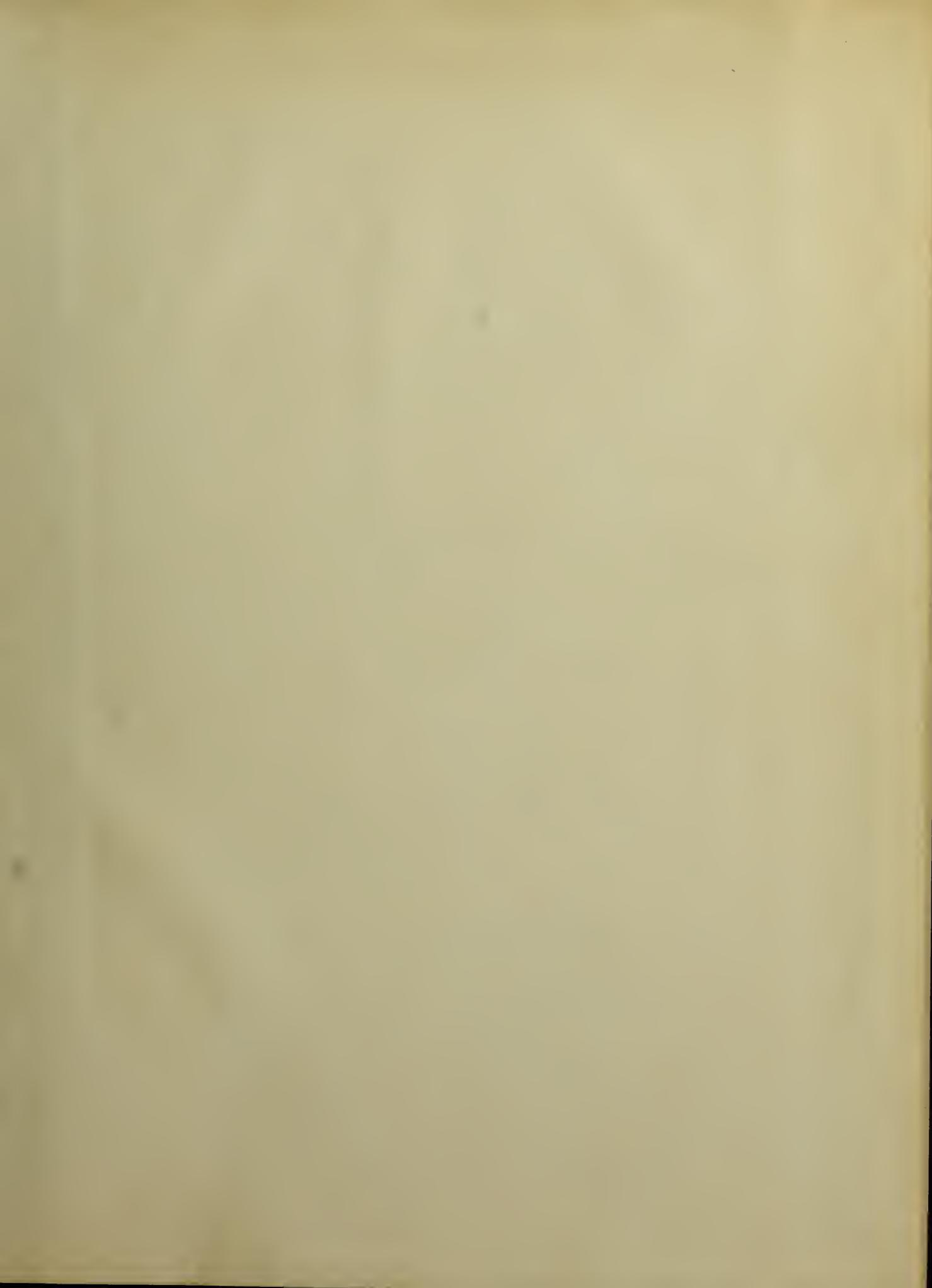
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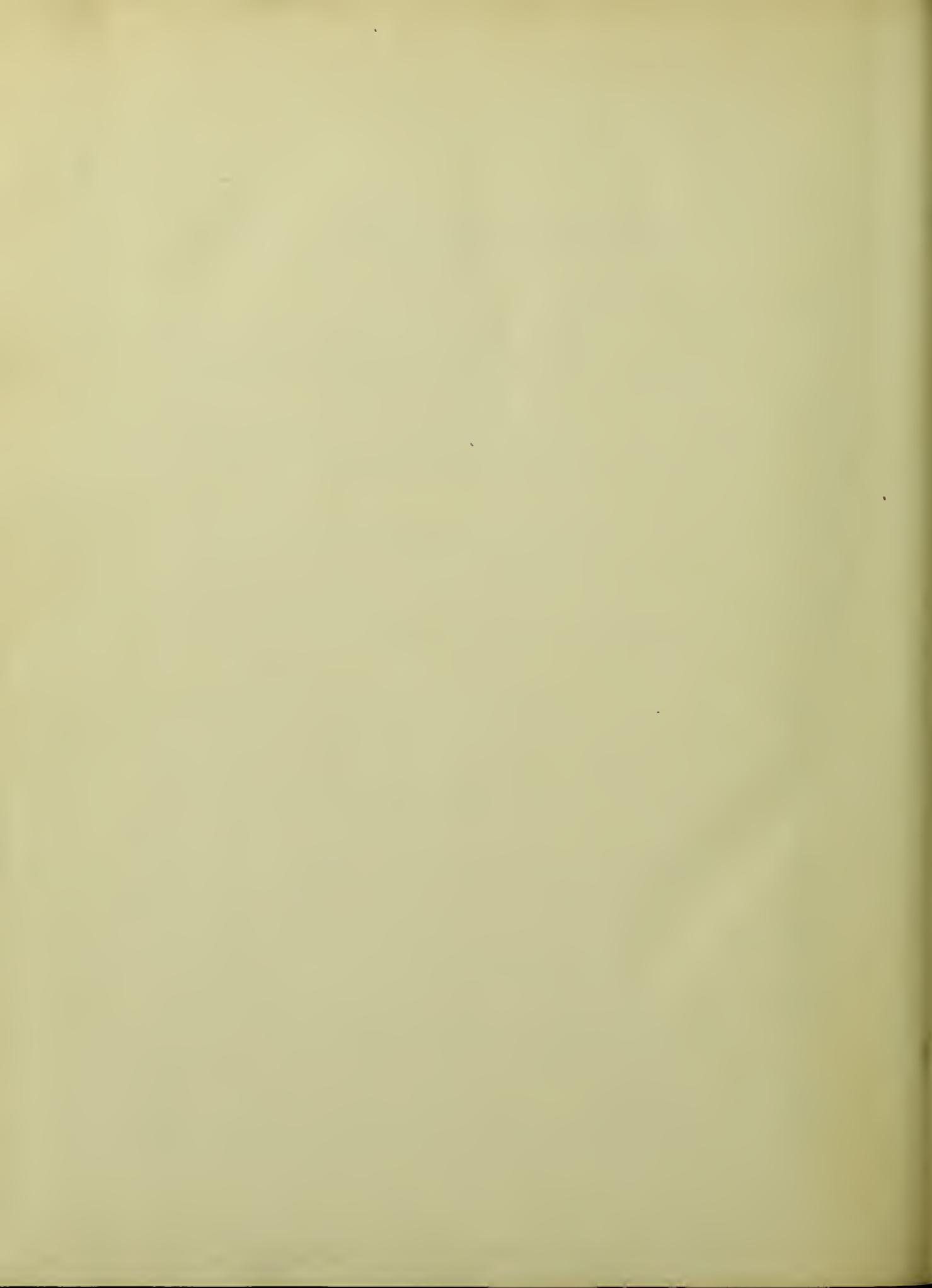
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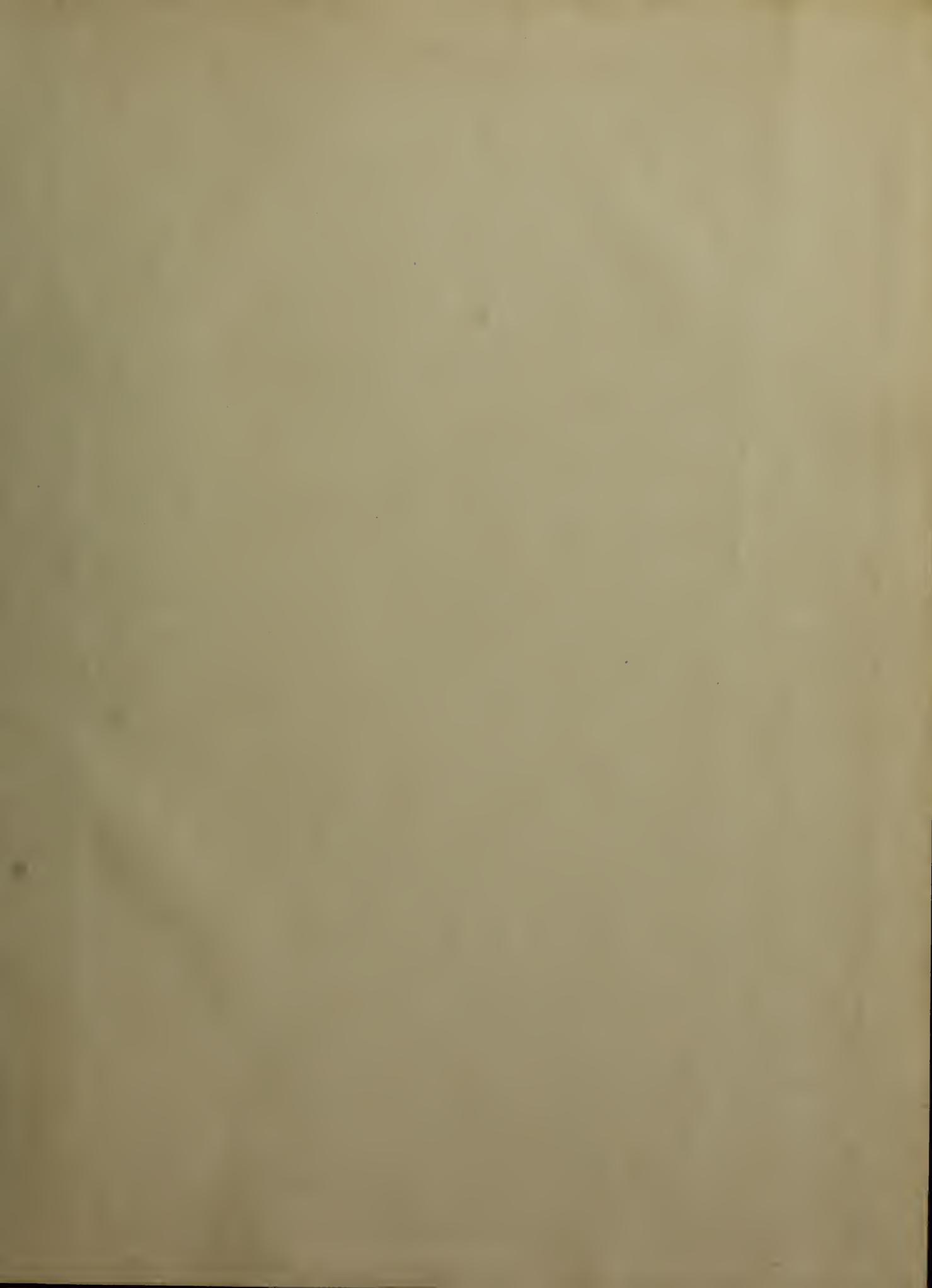
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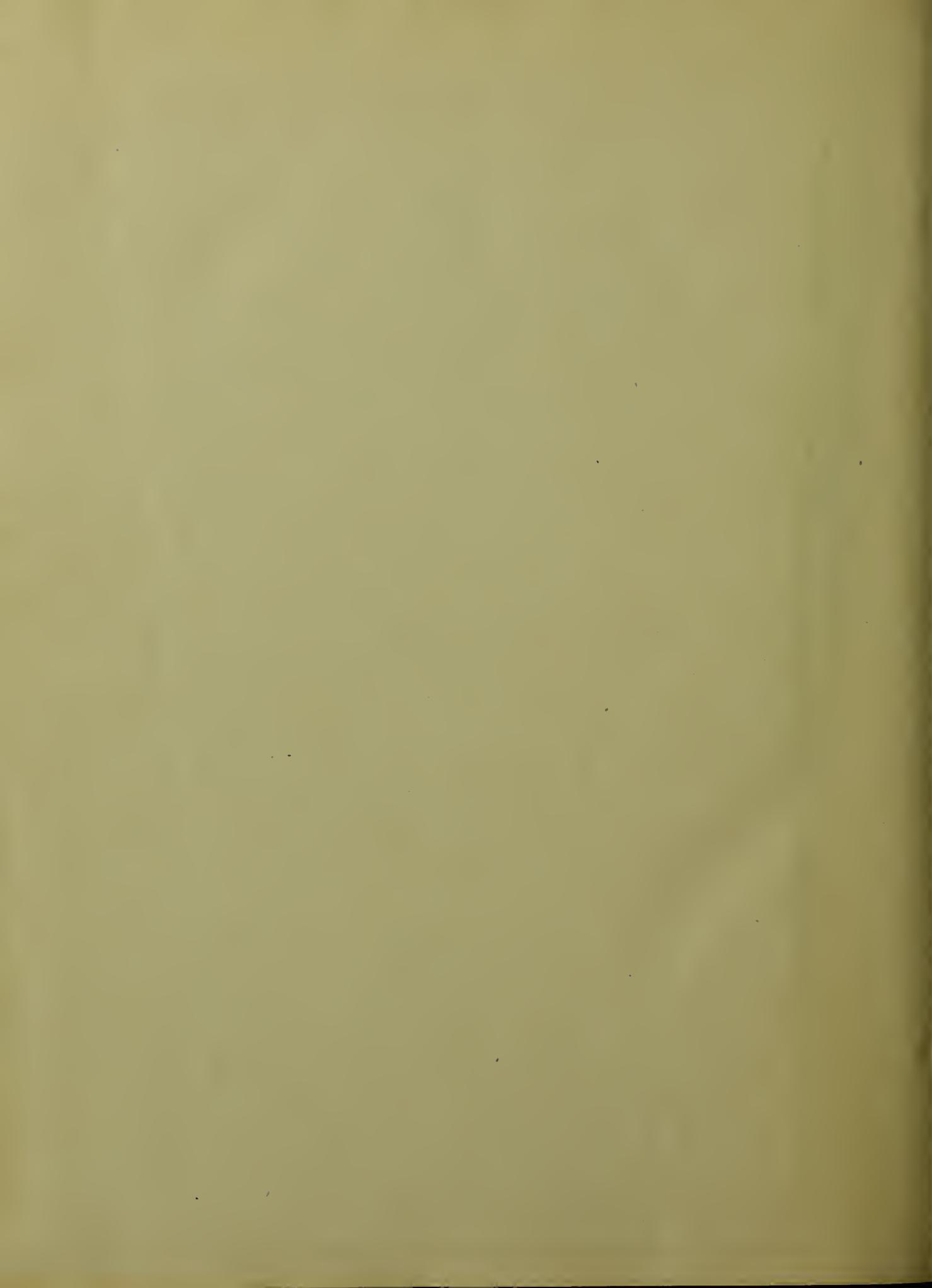
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