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The disobedient child: a study of children brought for treatment to the Providence Child Guidance Clinic with the complaint of disobedience at home

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THE DISOBEDIENT CHILD

A Study of Children Brought for Treatment
to the Providence Child Guidance Clinic
with the Complaint of Disobedience at Home

A thesis

Submitted by

Ann Drucker

(A.B., Hunter College, 1940)

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

1957

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CHAPTER I

INTRODUCTION

The Problem

A rather large and perhaps significant number of children each year are brought to the Providence Child Guidance Clinic by mothers whose sole or major complaint is of disobedience at home. The term disobedience is not the only one used. Words such as unmanageable, rebellious, defiant, or hard to get along with are employed. However, in almost all of the cases studied, the mothers themselves or with the advice of their physicians are responsible for taking the child to the clinic. There are few referrals by an agency, school, or police.

The characteristics of the child, of the mother, and of the family, and the characteristics of the contact with the clinic in this type of case form the central problem of the thesis. Some attention is paid as well to the apparent success of the treatment in the cases studied and the probable value of such treatment within the framework of child guidance clinics.

Why the Problem was Chosen

The problem was chosen for study partly because of the possibility that it represents a disturbed parent-child relationship in pure form. The possibility that the term disobedience might instead be a parent's way of describing some other symptom of behavior with which she is not familiar was also considered. In general, no external pressure forced the family to ask the help of the clinic. No feeling of urgency was

induced by teachers or by the neighbors, and no anti-social acts of consequence were committed by the child in the community.

A few comments by English and Pearson¹ are of some significance in this respect:

There is a type of parent who is completely unconscious of his hatred of the child. Some time early in the child's life he became conscious of his hate and dislike for the child and felt horror at having such - to him - unnatural feelings. This reaction of horror caused him to repress his feelings of hatred from consciousness. . . . The child of such a parent is in a worse situation than if the parent openly and consciously rejected him, and the effect on him is more serious.

Later they comment on disobedience² (the underlining is the writer's and not the authors'):

Each adult and each child has his own personal code and any violation of that code by himself or others is regarded as naughtiness. For one, disobedience is the deadly sin . . . From the adult's point of view, naughtiness consists in the rebellion of the child against the code, i.e., the real sin lies in the rebellious unwillingness of the child to conform. . . . When the child loves his parents or, more accurately, when they love him, he tries to conform to their code and later to the code of the social organization.

No matter what the conclusions, the problem of the disobedient child warrants considerable study because it clearly is a recurring source of an appreciable number of new cases each year. Any light which can be shed on its fundamental nature as evidenced by the record of its treatment in the past should be of some help in the future.

Scope of Study

An effort was made to cover the full range of such cases coming to

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1. O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, pp. 110-111.
 2. Ibid., pp. 243-245.

the clinic by selecting a sufficient number for analysis. Closed cases were chosen to obtain a reasonably complete picture for the intake period from January 1, 1950 to May 31, 1952. The thirty cases for this time interval were a manageable number for study. Since these thirty cases constitute all of the cases coming with this problem during this time period, they should give a valid picture of this clinic's experience with such cases at this time. Certainly, however, firm conclusions would demand a far more extensive set of data than was available. A much more detailed investigation of a number of child guidance clinics over many years would be required.

Method of Study

The procedure followed was to read rapidly through the case records for those cases listed in the intake book for the period selected as coming with the problem of disobedience or its equivalent. After this preliminary skimming of the material, a series of questions was drawn up which it was felt could be answered with some completeness. In order to determine the special characteristics of this group of cases the following research questions were asked:

In what ways are these cases different from the average run of clinic cases?

What are the social characteristics of the families coming to the Child Guidance Clinic because of this problem?

What are the characteristics of the child's position within the family and of his or her relations with the parents?

What are the characteristics of the clinic contact with regard to the parents' attitudes toward the clinic and the situation at termination?

With these questions in mind a schedule was devised for extracting

relevant data from the case records. The items on this schedule were as follows:

- child's name, case number, date of intake
- source of referral, problem as stated at intake
- child's age, sex, color, ordinal place in sibling group, I.Q., school grade
- physical and other symptoms
- sibling's ages and sex
- abbreviated psychological findings
- father's age, color, ethnic origin, religion, occupation, education
- mother's age, color, ethnic origin, religion, occupation, education
- marital status, members of household
- attitude of mother to child, mother to clinic, mother to husband
- attitude of father to child, father to clinic, father to wife
- number of clinic interviews, reason for termination, status at termination
- brief summary of any other important aspects of the case

After some trial and error and much careful consideration, a method of analyzing the data was evolved which might at first glance seem obvious. The child was taken as the key and divisions were made along the lines of sex and the broad periods of a child's life: pre-school from 3 through 5 which includes children in the oedipal stage of development, latency from 6 through 11, and adolescence from 12 on.

Agency Background

The Providence Child Guidance Clinic is a private agency. Its

financial support comes primarily from the United Fund, formerly the Rhode Island Community Chest. The mode of operation is similar to that of child guidance clinics elsewhere. A team work type of service is offered combining the efforts of a psychiatrist, psychologist and a psychiatric social worker. Generally the psychiatrist works with the children who are accepted for study at the clinic. The psychologist evaluates the personality of the child and the level of intelligence at which the child is functioning. He also attempts to determine the child's potential ability. The psychiatric social worker usually works with the parent. Occasionally the social worker may help in the direct treatment of the child as well if the disturbance is not too severe. Also, the psychiatrist may at times treat a badly disturbed parent.

As there is so great a shortage of personnel trained to provide treatment, the waiting list for the clinic is, of necessity, quite long. No matter how the referral is made, by a physician, school, or other agency, the parent must telephone personally before the name of the child will be placed on the waiting list. At this time an attempt is made to explore other resources in the area and so eliminate those cases which can best be handled elsewhere.

In the first, or intake, interview which follows, the caseworker explores the situation in detail with the parent to be certain that it falls within the province of the clinic. At this time the mother usually comes alone. The family and other environmental background is obtained. A major effort is made to have the parent understand what she can expect from the clinic and what the clinic expects of her. Some attempt is made to assess and handle her feelings around coming to the clinic.

After the intake interview there is an intake conference during which the staff decides whether or not to accept the case, which workers are to be assigned to the various members of the family, and along what lines the treatment might profitably be undertaken. At this time any pertinent medical or psychological information which is available from other sources may be presented. The clinical psychologist usually determines at this point which tests will be most helpful. In addition to psychometric tests, other psychological tests such as the Blackie pictures or the Rorschach Ink Blots may be given to evaluate the child's personality structure and to determine more fully the area and extent of personality damage.

If the child is accepted an appointment is scheduled with the psychologist during which the child is seen alone. When the results of the tests are available a brief conference of the three members of the team is held to discuss and evaluate the test findings. At this point certain cases may not be accepted for further treatment. For example, if the child is severely retarded the parent will be advised of this and referred to the program for retarded children for guidance. Another type of situation arising is the case of the child whose problems are due primarily to organic brain damage. If the family is basically accepting and there is little emotional difficulty involved the child may be referred back to the family physician or pediatrician. In some few cases it is found that the child is essentially normal but is reacting to an abnormal situation in his environment or in his family relationships. These families are usually referred to a family agency for counseling.

Cases where treatment is not instituted but where only a diagnosis has been made are called Diagnostic. During the period of this study the percentage of diagnostic cases dropped from slightly under 50 per cent to approximately 20 percent. (See Appendix, Figure 2).

The drop is perhaps due to increased skill in the intake process where unlikely cases are eliminated. It may also be due in part to the fact that sources of referral are becoming increasingly aware of the types of cases which can best be handled at a child guidance clinic. Also, and perhaps most important of all, there has been a change in emphasis within the clinic itself from diagnostic cases to treatment cases.

In those cases accepted for treatment a series of weekly interviews is scheduled, the child with the psychiatrist and the mother with the social worker. As treatment progresses, the mother is helped to appreciate the connection between her problem and the child's problem. "With the young child, generally speaking, the child's problem is the same as that of the mother."³ Some of her undesirable defenses are removed in a gradual manner as she obtains partial insight into her own motivations and behavior. At the same time her ego is strengthened to help her meet her true life situation. Deep therapy is not practiced. As Gordon Hamilton states: "Just as the child patient has to know that we do not think him all bad, so does the adult need to have his strengths as a parent accredited."⁴

3. Gordon Hamilton, Psychotherapy in Child Guidance, p. 283.

4. Ibid, p. 284.

Primary emphasis is on the child with the full realization, however, that the parent is a key part of the clinical problem. In the words of Rogers:

. . . a sharp contrast to the earlier policy of child guidance clinics where the task of altering parental attitude was often turned over rather casually to the social worker as a secondary measure, while the psychiatrist applied his superior skill to what seemed to be the nub of the situation, the child himself.⁵

A voluntary fee system of one dollar per thousand dollars of annual income for each visit provides a little financial support for the clinic. Its main function, however, is to involve the parents more closely with the work of the clinic and help to obtain their active participation. The fees may be altered freely to meet the actual financial situation of the client.

Weekly staff conferences are held to share the thinking of the psychiatrist, psychologist, and social worker and to evaluate the effectiveness of the treatment. Plans for the future are decided by mutual agreement after the exchange of factual information. These conferences are important for all concerned and are of especial value to the social workers and psychiatrists in training.

In summarizing the agency background for the purpose of this thesis greatest stress should be attached to the persistence which must be demonstrated by the parent before treatment starts, the psychological testing which determines the degree of disturbance of the child, and the separate although coordinated treatment of mother and child.

5. Carl R. Rogers, The Clinical Treatment of the Problem Child, p. 180.

CHAPTER II

GENERAL RELATION OF THE CASES STUDIED
TO THE CASE LOAD OF THE CLINIC

Valid conclusions cannot be drawn nor an adequate understanding of the problem be obtained without an appreciation of how the cases under study fit into the pattern of all of the cases of the clinic. Here it must be recalled that all of the accepted cases of "disobedience" were studied over an intake period of about two and one half years. Comparison should therefore be made with all clinic cases accepted in the same time interval. Figures 1 through 4 (see Appendix) are drawn as a frame of reference against which one can view the thirty cases.¹

As may be seen from Figure 1, the clinic accepted approximately five hundred new cases in the time interval under consideration, January 1, 1950 to May 31, 1952. Of these, as shown on Figure 2, about two thirds were treatment and one third were diagnostic cases. Therefore the thirty cases studied represent almost one tenth of all the new treatment cases accepted by the clinic. The disobedient child is clearly an important problem for the clinic but is by no means an overwhelming one.

A comparison of the sources of referral of the thirty cases examined with the total caseload is of considerable interest.

1. The data for these graphs were supplied by Mr. Kennison T. Bosquet, psychologist for the Providence Child Guidance Clinic, to whom the author is greatly indebted.

TABLE I

DISTRIBUTION OF SOURCES OF REFERRAL
IN THE THIRTY CASES STUDIED

Source of Referral	Number of Cases
Physician	12
School	2
Agency	4
Self	6
Other Clients	3
Relatives	2
Friend	1
Total	30

In the clinic caseload as a whole, as indicated by Figure 3 in the Appendix, referrals by schools and other agencies accounted for forty to fifty per cent of the total cases, referrals from physicians accounted for thirty per cent, and self referrals accounted for only thirteen per cent. The remaining, approximately ten per cent of cases, were referred by miscellaneous sources including one to three per cent court referrals.

In the thirty cases studied, forty per cent of the cases were referred by physicians. This accounted for twice as many cases as in any other category. Only twenty per cent of referrals were made by schools and other social agencies. This is less than half of the similar category in the total clinic caseload. Twenty per cent of the cases studied were self referred and another twenty per cent were referred by friends and relatives.

It should be repeated here that it is the policy of the clinic to accept only those cases where the parent himself asks for an interview.

Thus, for example, if a doctor telephones or writes to refer a case he is asked to tell the parent to apply himself. Very rarely does the clinic initiate the contact. In this sense all referrals are to a certain extent self referrals. However, there may be more coercion in some types of situations than others. The parent of a child who is a school behavior problem may be forced by the school to attend the Child Guidance Clinic whether he wants to or not by the threat of expulsion of the child from school if the parent does not comply. As school problems were ruled out and only disobedience toward the parent was considered, such compulsion did not apply in these cases. Therefore, motivation for coming to the clinic might be said to be good in that it indicates the parent's own desire for help with his problem. To explain the other sources of referral, it usually appeared that the parent had consulted the doctor or teacher or friend and had been advised to come to the Child Guidance Clinic.

The average number of interviews per case is shown in Figure 4 for the complete caseload. With minor exceptions, the psychologist sees each child once. The number of interviews by the psychiatrist may be equated to the number of times the child was seen after the psychological testing, and the larger number of interviews by the social worker to the number of times the mother was seen. The difference of one interview as between psychiatrists and social workers in the years up to 1950 corresponds to the intake interview by the social worker. The larger difference in more recent times reflects both a tendency toward holding a termination interview with the mother alone and some treatment of both mother and child by the social worker. All indications are that in respect to the number and

distribution of interviews the group studied does not differ so very significantly from the rest of the caseload of the clinic. The thirty mothers had a total of 180 interviews or an average of six interviews per case. As can be seen from Figure 4 the average number of interviews for each mother in the total caseload of the clinic was six also.

The immediate conclusion resulting from the general comparison is that the "disobedient" group takes a full ten per cent of the effort of the clinic and so warrants a rather complete study.

CHAPTER III

THE CHARACTERISTICS OF THE CHILDREN

As described previously, the first problem encountered was to determine a workable method of analyzing and correlating the data. The division by sex and by age group (three to five, six through eleven, twelve on) was a logical one to try and proved remarkably successful.

TABLE II
AGE AND SEX DISTRIBUTION

Age	Boys	Girls
3 - 5	9	0
6 - 11	12	3
12 - 14	3	3
Total	24	6

The outstanding characteristics of the group of children is that the boys outnumber the girls by four to one. This must be contrasted with the general clinic average of two to one in line with most child guidance clinics. Note further that there are no girls at all in the youngest group but there are nine boys.

The next point to be considered was the ordinal position of the children in their sibling group. The children were divided into only (living) child, first born, intermediate child, last or youngest child. For the purpose of the study the only child was taken to mean the only

living child. He may have been the first born with succeeding siblings who died or he may have been the second or third child born with previous siblings deceased. First born child in this classification does not include only children but means first born child with one or more younger siblings. Also, the term last child indicates the youngest child with at least one older living sibling.

TABLE III

ORDINAL POSITION IN SIBLING GROUP
ACCORDING TO AGE AND SEX

Ordinal Position	Boys				Girls			:Group :Total
	:3-5	6-11	12-14	Total	:6-11	12-14	Total	
Only child	: 3	3	0	6	: 2	0	2	: 8
First child	: 4	6	0	10	: 1	2	3	: 13
Intermediate	: 2	2	1	5	: 0	1	1	: 6
Last child	: 0	1	2	3	: 0	0	0	: 3
Total	:			<u>24</u>	:		<u>6</u>	: <u>30</u>

Table III indicates the overwhelming predominance of first born and only children in the group under study, twenty-one out of the total of thirty. Interestingly enough, in the boys' group no adolescent boy falls into this category. Of the three adolescent boys two are youngest children and one is intermediate. Although three is a very small number from which to draw any conclusion it seems likely that being a first born or only child is not a significant feature in adolescent disobedience among boys. Two of the three adolescent girls are in the first or only category while one is not and so the situation is obscure for them.

It is significant to note that two-thirds of the boys, or more than

half of the cases studied, were first born or only boys from three through eleven years old.

An examination of the I.Q.'s of the children shows that they tend appreciably toward the high side. This is not unexpected as the clinic normally does not accept retarded children. Nevertheless there are a sufficient number of children with I.Q.'s below ninety to indicate that intelligence is not of primary consequence with respect to intake.

TABLE IV

I.Q. RANGE OF THE THIRTY CASES OF DISOBEDIENCE

I.Q. Range	Boys			Girls			Group Total	
	3-5	6-11	12-14	Total	6-11	12-14		Total
60 - 69 Borderline	1	0	0	1	0	0	0	1
70 - 79 Dull	0	2	0	2	0	0	0	2
80 - 89 Dull normal	1	1	0	2	0	1	1	3
90 - 110 Normal	2	3	1	6	2	0	2	8
111 - 120 Superior	2	2	2	6	0	2	2	8
121 - 140 Very superior	1	2	0	3	0	0	3	3
Not tested	2	2	0	4	1	0	1	5

Out of the thirty children studied, five were not tested. The reason for this is not clear. Occasionally, in the case of a very young child, the child may be too hyperactive to be tested and the mother may have broken her contact with the clinic before a repeat test could be scheduled.

In the case of older children recent testing may have been performed elsewhere but not recorded in the clinic record.

Of the twenty-five children tested, twelve or almost half are in the superior or very superior range. Another ten children are in the dull normal to normal range and only three are in the dull to borderline level of intelligence.

Perhaps of greatest importance in characterizing the group is the fact that few of the children were severely disturbed. This may be attributed in part to the nature of the problem at referral. Disobedience is not looked upon as a serious behavior disturbance by the clinic although it may cause parents much distress. Often disobedience may be the child's reaction to unrealistic demands placed upon him by the family. In these cases disobedience may be considered a healthy manifestation of the child's developing personality. In other words, while the mother is bringing the child to the clinic to make him conform to her impossible standards, the clinic in turn attempts to educate the mother toward more realistic goals. In other cases the child is reacting in a fairly normal way to rejection on the part of the parent. These children are apt to suffer some personality disturbance as a result of the rejection they have experienced in the past.

An attempt to assess the degree of disturbance of the children was made. Evaluations by the psychiatrist or psychologist were available in the majority of the case records. Where no direct statement was made, reports of the psychological test findings were used. Of the five cases in which no testing was done the psychiatrist's evaluation of the child was taken in three instances. The other two cases were considered as unknown

because no clear statement appeared. Although the term normal covers a wide latitude, whenever the term was employed by the psychiatrist or psychologist to describe the child, the child was considered as normal for the purpose of this study. In the two instances where the psychiatrist described the child as normal but the test findings showed some emotional disturbance the child was listed as moderately disturbed.

From Table V which follows it may be seen that one-third of the children studied were considered normal, one-half of the children were only moderately disturbed, and but one-tenth were severely disturbed.

TABLE V

DEGREE OF DISTURBANCE IN THE DISOBEDIENT CHILDREN

Degree of Disturbance	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	5-11	12-14	Total	
Severely disturbed	1	2	0	3	0	0	0	3
Moderately disturbed	2	6	2	10	2	3	5	15
"Normal"	5	4	1	10	0	0	0	10
Unknown	1	0	0	1	1	0	1	2

A few of the comments found in the records will help in the understanding of the children in the three to five year old sub-group. Gerald Benjamin¹ is described as a "normal" child. Mrs. Benjamin's complaints

1. All names used are fictitious. (See Table XXII for actual case numbers and assumed names).

are classed as petty and due to expecting too high a standard of obedience. Morris Brand is termed a normally aggressive child; Edward Carter is said to have no need for psychiatric treatment. The exception is Robert Ames who was pre-psychotic although described by his mother as simply confused by his environment of too many bosses at home. It is worth noting that this is the only case of "disobedience" in this age group which was really far worse and in which the wrong description was not merely a semantic difficulty.

Boys in the latency period are described in the case records in terms which indicate greater disturbance for most than appears in the younger group. As Irene M. Josselyn states²: "Tremendous respect is due the child who meets the demands society places upon him during the latency period. On the whole he does better than the adults around him." Harvey Ingrian had been in the Bradley Home for Disturbed Children for some time. Murray Joyce is said to be infantile with little control over emotions, hostile and aggressive. On the other hand, Douglas Milne was so well adjusted that the psychiatrist felt there was no need for him to come to the clinic. Charles Mallory likewise was only mildly disturbed although described by his mother as demonstrating gross misbehavior. The attitude of both parents was so poor that Charles had to be placed at Lakeside Shelter to prevent the mother from having a complete nervous breakdown. Two boys in the latency period were considered severely disturbed. According to test results George Herrick had such poor personality integration that there was the possibility of mental illness in his later life.

2. Irene M. Josselyn, Psychosocial Development of Children, p. 17.

Thomas Hunt, in addition to his difficult behavior at home, had many psychosomatic complaints such as fainting, chest pains, lack of appetite which the psychiatrist felt were an indication of serious disturbance in a boy of nine.

Adolescent boys seem to fall into the moderately disturbed to normal category. Michael Doyle is called a normal adolescent although he was functioning in school at a lower level than his superior I.Q. would warrant. Paul Ericsson was called moderately disturbed because the test findings showed him to have deep feelings of inadequacy as well as repressed hostility although the psychiatrist felt he was not in need of psychiatric help. Henry Foster was moderately disturbed in that he was lazy, listless, and always tardy. He also had no outside interests.

The adolescent girls, although also listed in the moderately disturbed category, exhibit more serious symptoms than the adolescent boys. Evelyn Robbia is cruel to cats, picks on younger children, and wets her bed, in addition to being unmanageable. Mary Appleton shows strong feelings of inadequacy and has difficulty in accepting her femininity because of an unresolved oedipal conflict. Sylvia Camp screams defiance of her parents, forges their names on her report card, lies, steals from her parents. Nevertheless, although they have serious problems, the girls would not be classed in general as severely disturbed.

CHAPTER IV

THE FAMILY CHARACTERISTICS

The background and social position of the family generally are of significance in the behavior and attitudes of its members. Ethnic origin, religious background, and education of the parents all have their influence on a child. It might be expected, therefore, that the disobedient child would appear in a family having certain well defined characteristics. For example, Helene Deutsch in writing of the oral component of motherli-¹ness brings out differences in attitude and behavior.

. . . overemphasis on eating is especially typical of Jewish women. Another example is the hostess, she directs her oral-motherly giving to more distant objects. This type is more frequent among French and Slavic women. The ascetic New England women often denies herself this kind of motherly satisfaction with regard to her own children, preferring to feed the hungry and needy.

As will be seen from the tabular data which follows, considerable differences exist between the families under study. Also, it is not always wise to draw firm conclusions when a pattern does emerge. As an illustration, it should be noted that all of the families were white. However, the colored population in Rhode Island is less than two per cent of the total population² and two per cent of thirty cases is less than one case.

Many of the case records did not provide a clear description of the ethnic and education background of the family. To a certain extent, the

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1. Helene Deutsch, The Psychology of Women, Volume two, Motherhood, p. 20.
 2. 1956 Providence Journal Bulletin Almanac, p. 69.

information on religion and on occupation are indicative in these respects. For example, if the man is employed in a professional occupation it may be taken as an indication that he has a higher educational background than the unskilled laborer.

Table VI gives the father's occupation and compares the distribution with the available figures³ for the entire state in 1950.

TABLE VI
OCCUPATION OF FATHER AND COMPARISON WITH
ALL MALES IN RHODE ISLAND (1950)

Occupation	Number	Percentage	Number in Rhode Island ³	Percentage
Professional	4	13	13,984	7
Own Business	4	13	22,814	11
Clerical and Sales	7	23	27,800	14
Skilled Labor	8	27	44,985	22
Semi-skilled labor	5	17	57,326	29
Unskilled	0	0	33,467	17
Unknown	<u>2</u>	<u>7</u>	<u>-</u>	<u>-</u>
Total	30	100	200,376	100

The families coming to the clinic with the complaint of disobedience have a greater percentage of professional fathers and a smaller percentage of semi-skilled and unskilled laborers than exists in the population as a whole. An appreciable number, however, are in the lower and middle income occupations. When the natural tendency of higher income families to

3. 1956 Providence Journal Bulletin Almanac, p. 84.

seek medical and other professional help is taken into account, there seems to be no strong correspondence between disobedience and the occupation of the father.

A very marked deviation of the clinic clients from the general population⁴ appears in the analysis of their religious background, Table VII.

TABLE VII

RELIGIOUS BACKGROUND INCLUDING COMPARISON WITH
THE GENERAL POPULATION IN RHODE ISLAND

Religion	Number	Percentage	Number in Rhode Island ⁴	Percentage
Roman Catholic	10	33	474,000	59
Protestant	11	37	107,000	13
Jewish	6	20	27,000	3
Armenian Apostolic	2	7	?	?
Mixed	1	3	?	?
Unaffiliated	0	0		
Total	30	100		

All main religious groups are represented, so that disobedience does not seem to be restricted to any one religious background. It is significant that the Catholic percentage is well below that in the state as a whole, but likely that this group often seeks counsel elsewhere. The relatively large percentage of Jewish families coming to the clinic because of disobedience as compared to the percentage of Jewish families in the state is of interest. The percentage of Jewish families in the total clinic

4. 1956 Providence Journal Bulletin Almanac, p. 50.

caseload is unknown since this information is not recorded in the Intake book. Disobedience may be more common among Jewish children or Jewish parents may react more strongly to their children's disobedient behavior.

The points of greatest importance in the family are likely to be those listed in Tables VIII through XII. Marital status of parents, attitude of the wife to the husband and the husband to the wife, attitude of the mother and of the father to the child all provide the emotional climate in which the child is reared.

Table VIII gives the marital status of the parents in a form which permits analysis of the children as a whole and by sub-groups. The categories Separated and Divorced are lumped together in the Appendix Tables XXIII through XXVIII to enable all information to be displayed conveniently. Much friction indicates that the parents are together but quarrel openly and bitterly.

TABLE VIII
MARITAL STATUS OF PARENTS

Status	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Together	5	7	1	13	2	1	3	16
Much Friction	2	3	0	5	0	1	1	6
Separated	1	0	0	1	1	0	1	2
Divorced	0	0	2	2	0	1	1	3
Remarried	1	2	0	3	0	0	0	3
Total				24			6	30

Approximately half of the families fall into the categories of much friction, separated, divorced, and remarried. Emotional maladjustment of children is to be expected in such homes. In many of the case records there is evidence of the troubles which are attendant upon the absence of the father in the early years of childhood. Military service in the second World War is a factor of importance in the period under consideration. Gordon Hamilton states:⁵

Whether or not the fatherless boy (beyond the nursing period) is worse off than the fatherless girl is not precisely known, but in child guidance one observes that the boy who has had little or no opportunity to form wholesome identifications with his father continues to have great difficulty.

In-law difficulties also crop up in an appreciable number of the cases. Overly helpful grandmothers and grandfathers appear frequently in the case records as do interfering or dependent aunts and uncles.

On the other hand, half of the girls and a little more than half of the boys do come from families in which the parents are together and friction between them is not a major problem.

A word of warning is needed before proceeding to the tables of parental attitudes. Essentially, all of the information on the attitude of the father was given by the mother. She alone was seen by the clinic in almost all of the cases. How much of the presumed attitude of the father is simply projection by the mother is most difficult to determine. Likewise, how much of the unknown or don't know listing is due to the mother and how much to the lack of questioning or of recording by the

5. Gordon Hamilton, Psychotherapy in Child Guidance, p. 215.

social worker is also in doubt. Some very interesting patterns do emerge nevertheless.

TABLE IX

ATTITUDE OF WIFE TO HUSBAND

Attitude	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	2	1	0	3	0	0	0	3
Ambivalent	4	3	1	8	2	0	2	10
Rejecting	2	3	1	6	0	0	0	6
Unknown	1	5	1	7	1	3	4	11
Total	24				6			30

TABLE X

ATTITUDE OF HUSBAND TO WIFE

Attitude	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	2	1	0	3	0	0	0	3
Ambivalent	1	0	1	2	0	0	0	2
Rejecting	3	6	1	10	2	1	3	13
Unknown	3	5	1	9	1	2	3	12
Total	24				6			30

There is some difference between the girls and the boys in Tables IX and X. Neither parent is listed as accepting toward each other for the

girls. The large number of "unknown" entries is disturbing but the pattern of rejection is beginning to emerge. If the youngest group of boys is omitted, only one wife and one husband remain under "accepting." Reference to Table XXV of the Appendix gives the entry Fr for both. The key Table XXII shows that Malcolm Fremont's parents accept each other. They both reject Malcolm, however, as shown by the Fr entry under Rejecting in Table XXV for both mother's attitude to child and father's attitude to child.

The attitudes of the parents toward the children is summarized in Tables XI and XII. Obviously there is an infinite range in the quality of parental attitudes toward each other and toward their children. However, in order to simplify matters for the purposes of this study, the terms accepting, ambivalent, and rejecting were chosen to delineate three broad classifications into which most parental attitudes could be grouped. These terms are commonly used by the social worker, psychologist, and psychiatrist in describing parents in the case records and wherever possible, their value judgments were used. In general, the term rejecting covers parents who are also described in such words as hostile, bitter, angry, overly critical or punitive. The term accepting includes parents who are also described as being warm, loving, kindly, and sincerely interested in helping their children. The word ambivalent indicates mixed feelings of acceptance and rejection. Ordinarily one might assume that the majority of parents bringing their children to the clinic could be placed in the category ambivalent. However, as will be seen in the tables, the majority of parents in these cases are rejecting. In a few cases where there were no definite statements made by any member of the team concerning parental

attitudes the writer was able to formulate a judgment from the recorded material. However, when the recorded material was insufficient to evaluate the parental attitudes they are listed as unknown. Individual children may be traced in Tables XXIV through XXVIII by reference to the key Table XXII which lists each child and underlines the letters of his last name which appear in the detailed tables. It is helpful to be able to find out from Table XXIV that in the youngest group of boys, the three accepted by their mothers and the three accepted by their fathers represent five boys. Edward Carter who is accepted by his mother is rejected by his father while Robert Ames and James Sampson are in the reverse position. Only Morris Brand is accepted by both parents. The summary tables which follow do give a fairly valid picture because the situation is so clear for many of the groups.

TABLE XI

ATTITUDE OF MOTHER TO CHILD

Attitude	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	3	1	0	4	0	0	0	4
Ambivalent	2	4	3	9	1	1	2	11
Rejecting	4	7	0	11	2	2	4	15
Unknown	0	0	0	0	0	0	0	0
Total				24			6	30

TABLE XII
ATTITUDE OF FATHER TO CHILD

Attitude	Boys				Girls			Grand Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	3	1	0	4	0	0	0	4
Ambivalent	1	1	0	2	0	0	0	2
Rejecting	2	8	2	12	3	3	6	18
Unknown	3	2	1	6	0	0	0	6
Total				24			6	30

On an overall basis as given in Tables XI and XII, although the pattern of rejection is clear, there are a fairly large number of entries under ambivalent and accepting. When looked at in detail, as explained previously, it is seen that acceptance of the child by one or both parents is restricted almost entirely to the youngest group of boys. Such acceptance is almost completely absent in all other groups. The father's attitude is listed as rejecting toward all the girls and unknown or rejecting toward all except two boys six years of age or more. While it should be remembered that the father is seen through the eyes of the mother, the pattern of rejection is overwhelming for all except the youngest boys. Figure 5 is a plot of the pattern for the boys in which acceptance and rejection appear explicitly but ambivalence or unknown attitude does not. Complete or 100 per cent rejection means that both parents rejected all the children in the one year age bracket plotted as a bar on the

graph. Fifty per cent rejection means that half of the combined mothers and fathers for the one year age bracket are listed as rejecting. In general, for each one year bracket (3-4, 4-5, ... 14-15), the per cent rejection (or acceptance) is 100 times the total number of parents listed as rejecting (or accepting) the children in the one year bracket divided by the total number of parents or twice the number of children.

Acceptance and rejection are balanced until the age of six. After this, rejection is extremely marked. The pattern for the girls is not plotted because it is completely one-sided. Ten of the twelve parents were rejecting; the two remaining were ambivalent.

CHAPTER VTHE CHARACTERISTICS OF THE CLINIC CONTACT

The attitude of the parents toward the clinic is mixed as shown by the summary Tables XIII and XIV.

TABLE XIIIATTITUDE OF MOTHER TO CLINIC

Attitude	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	4	5	2	11	1	1	2	13
Ambivalent	1	3	0	4	0	0	0	4
Hostile	3	1	1	5	2	2	4	9
Unknown	1	3	0	4	0	0	0	4
Total	24				6			30

TABLE XIVATTITUDE OF FATHER TO CLINIC

Attitude	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Accepting	3	3	1	7	1	1	2	9
Ambivalent	0	0	0	0	0	0	0	0
Hostile	2	1	0	3	1	0	1	4
Unknown	4	8	2	14	1	2	3	17
Total	24				6			30

The mothers are seen to be on the accepting side in their contact with the clinic. However, nine are listed as hostile. This is a relatively large number when the purely voluntary nature of the contact is considered. Of those fathers for whom sufficient information is available, a higher percentage was on the accepting side but a large number, over half, is in the unknown category. Here again it is mainly the mother speaking and in all probability expressing the sentiment she feels is appropriate under the circumstances. There may be some contradiction in the concept of a father rejecting his daughter completely but accepting the clinic.

The detailed Table XXIV (Appendix) presents a more illuminating picture of the parents' attitude toward their children as compared with their attitude toward the clinic. For example, Morris Brand, whose parents accept him and each other, has a mother who is hostile to the clinic. His father is accepting. Avery Pushkin's parents both accept the clinic but his father rejects him and his mother is ambivalent toward him. It does not appear that the attitude of the parents toward the clinic can be predicted from their attitude toward each other or the child.

As the mother in most cases is equally or more disturbed than the child, the number of interviews with the mother are listed in Table XV. A rather large number of mothers, fourteen in all, went to the clinic four times or less. Only four were seen ten or more times and each of them had a child in the latency period.

TABLE XV
NUMBER OF INTERVIEWS WITH MOTHER

Number	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
1 - 4	6	6	1	13	0	1	1	14
5 - 9	3	4	2	9	1	2	3	12
10	0	2	0	2	2	0	2	4
Total				24			6	30

In the examination of Table XV it should be kept in mind that the average number of interviews for all cases coming to the clinic during the period of study was approximately six, Figure 4. The average for the cases of disobedience is exactly six.

Table XVI compares the intelligence of the child with the number of interviews with the mother. The trend is quite marked. The mothers of five of the six children with I.Q.'s below 90 were seen less than five times. The mothers of eight of the eleven children with I.Q.'s above 110 were seen five or more times.

TABLE XVI

COMPARISON BETWEEN INTELLIGENCE OF CHILD
AND NUMBER OF INTERVIEWS

Number of Interviews	: Below 90	: I.Q. 90 - 110	: Above 110	: Unknown	: Total
1 - 4	5	2	3	4	14
5 - 9	1	4	6	1	12
10	0	2	2	0	4
Total	6	8	11	5	30

A study of Tables XXIV through XXVIII of the Appendix confirms, or at least does not contradict, this tendency of more interviews for the more intelligent cases in each of the sub-groups. The twelve boys from six to eleven provide a rather clear illustration. Mrs. Ingrian and Mrs. Locke were seen fifteen and eleven times respectively. Their children Harvey and Arthur have I.Q.'s of 117 and 131. Mrs. Knox is an exception because she was seen only four times and her son John had an I.Q. of 126. John, however, was only six years old and does not fit in with the pattern of rejection which is displayed so strongly in this latency group. Comparison with the three through five year old sub-group indicates that he is more in line with them. On the low end of the scale, the mothers of the three boys with I.Q. below 90, Mrs. Fremont, Mrs. Herrick, and Mrs. Joyce, were each seen five times or less. Of course, the trend of number of interviews with intelligence is not complete but it is strong enough to be beyond the possibility of random distribution. The reason

is by no means obvious. A guess would be that the higher the intelligence, the stronger the feeling of the psychiatrist and the social worker that progress can be made or is being made.

Perhaps the most interesting phase of this study lies in the manner of termination of the clinic contact and the status of the case at termination. These are summarized in Tables XVII and XVIII.

TABLE XVII

WHO TERMINATED THE CASE

Terminated by:	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Clinic	8	2	2	12	2	1	3	15
Mother	1	4	1	6	1	2	3	9
Mother-Clinic	0	6	0	6	0	0	0	6
Total	24				6			30

TABLE XVIII

STATUS AT TERMINATION

Status	Boys				Girls			Group Total
	3-5	6-11	12-14	Total	6-11	12-14	Total	
Unimproved	5	4 $\frac{1}{2}$	2	11 $\frac{1}{2}$	2	2	4	15 $\frac{1}{2}$
Moderately improved	1	5	0	6	1	1	2	8
Improved	3	2 $\frac{1}{2}$	1	6 $\frac{1}{2}$	0	0	0	6 $\frac{1}{2}$
Total	24				6			30

As may be seen, few cases were terminated by mutual consent of the clinic and the mother. There are always many unmet needs which the clinic simply does not have time to explore or to work through because of the continual pressure of more urgent cases.

The termination of treatment is always related to the original request and its shared reformulation with the client. If a new treatment goal is formulated later, one may proceed, but one does not hold cases open to see if something will happen.¹

Here it should be noted that eight of the nine cases in the three through five sub-group were terminated by the clinic. Rejecting mothers often will terminate when success appears possible. As expressed by Hamilton:²

"If the parents derive secondary gains from the fact that their children are not getting well, as soon as treatment begins to show results it is likely to be abandoned."

It is probably not coincidental that all six of the mutual terminations fall in the latency sub-group of boys. Of these only one, Arthur Locke, is rated as improved. As shown in Table XXV, Arthur was rejected by his mother but accepted by his father.

The question of status at termination or movement and the means of evaluating the success of treatment is a highly controversial one. In the words of Hunt and Kogan:³

Movement is a concept analogous to growth . . . Caseworkers have defined no such static, cross-sectional variables as height or weight with respect to which their clients can be measured at opening and closing, and from which amount of movement might be derived.

-
1. Gordon Hamilton, Theory and Practice of Social Casework, 2nd Ed., p.79.
 2. Gordon Hamilton, Psychotherapy in Child Guidance, p. 315.
 3. J. McV. Hunt and Leonard S. Kogan, Measuring Results in Social Casework, p. 26.

The record for the thirty cases is not impressive even when the case-worker's comments are taken at face value. As shown in Table XVIII, half of the cases were unimproved at termination in the eyes of the worker. The symbol 1/2 indicates that in one case the child was considered as improved and the mother not. When the natural tendency to look on the brighter side of life is taken into account and when the case records are studied in more detail the picture is measurably worse. In many instances the child benefited considerably from the treatment and the mother did not retrogress. The case was closed as improved or moderately improved. There is more than a little doubt of a brighter future for a pre-adolescent with a strongly rejecting mother and father whose attitude is basically unchanged by the course of treatment. Hamilton puts it quite strongly:⁴

One does occasionally find children who make tremendous strides in their adjustment, irrespective of any outward sign of change in the mother, although this must usually follow a long treatment process.

A look at Table XXV and Figure 5 demonstrates the enormous difficulty against which the clinic must struggle and the small chance of extensive successes.

On the other hand, adolescents have sufficient ego strength in some instances to go a long way on their own. Anna Freud describes the changes as the child grows older:

4. Gordon Hamilton, Psychotherapy in Child Guidance, p. 313.

The ego of the early infantile period was undeveloped and indeterminate, impressionable and plastic under the influence of the id; in the pre-pubertal period, on the contrary, it is rigid and firmly consolidated. It already knows its own mind. ⁵

Only two of the six adolescents showed any improvement, however.

A more quantitative comparison between the status at termination and some of the possibly relevant factors is given in Tables XIX, XX, and XXI which follow. As might be expected, the majority of children rejected by their mothers show no improvement. Three out of the four who are accepted show some improvement. However, as shown in Table XIX some rejected children are listed as improved and one accepted as unimproved.

Table XX indicates a strong trend toward greater success of treatment with higher intelligence of the child and small success with low intelligence. Five of the six with I.Q.'s below 90 are listed as unimproved. All of the improved cases are in the normal or above normal group. There is here, too, some danger of wishful thinking. The outstanding case in which the mother was greatly strengthened and where she worked out a series of good solutions to many of her very real problems did in fact involve a boy of average intelligence, Henry Foster. Also five of the eleven in the above normal group ended in the unimproved category.

Table XXI seems to show no strong trend of status at termination with number of interviews. It is true that almost two-thirds of those cases having a small number of interviews remained unimproved but it must not be forgotten that half of the total cases were unimproved. One-third of the cases seen an average number of times remained unimproved while at the

5. Anna Freud, The Ego and the Mechanisms of Defense, p. 161.

other end of the scale one-half of those cases seen ten or more times demonstrated no movement.

TABLE XIX

COMPARISON BETWEEN STATUS AT TERMINATION
AND ATTITUDE OF MOTHER TO CHILD

Attitude	S t a t u s			Total
	Unimproved	Moderately Improved	Improved	
Accepting	1	1	2	4
Ambivalent	5	4	2	11
Rejecting	9½	3	2½	15
Total	15½	8	6½	30

TABLE XX

COMPARISON BETWEEN STATUS AT TERMINATION
AND INTELLIGENCE OF CHILD

Intelligence	S t a t u s			Total
	Unimproved	Moderately Improved	Improved	
Unknown	3½	1	½	5
Below 90	5	1	0	6
90 - 110	2	4	2	8
Above 110	5	2	4	11
Total	15½	8	6½	30

TABLE XXI

COMPARISON BETWEEN STATUS AT TERMINATION
AND NUMBER OF INTERVIEWS

Number of Interviews	S t a t u s			Total
	Unimproved	Moderately Improved	Improved	
1 - 4	9½	2	2½	14
5 - 9	4	5	3	12
10 -	2	1	1	4
Total	15½	8	6½	30

CHAPTER VISUMMARY AND CONCLUSIONS

Within each sub-group of sex and age, the pattern for the "disobedient" child is well defined and may be summarized fairly concisely. It is interesting to note that no girls under the age of six were brought to the clinic for this problem although there were nine boys through five.

Boys from three through five (a total of nine)

The pattern is first or only children with parents whose attitudes range from acceptance to rejection toward each other and the child. There were generally a small number of interviews which were terminated by the clinic with some improvement in almost half the cases. The children were not severely disturbed initially.

Girls from three through five

No cases.

Boys from six through eleven (a total of twelve)

The pattern is again of first or only children but now with strongly rejecting parents who make the prospect of continuing improvement after termination questionable.

Girls from six through eleven (a total of three)

Just as for the boys in this age group, the pattern is of first or only children with strong rejection by the parents. Little if any success, even of transient nature, was achieved through treatment despite a relatively large number of interviews.

Boys of twelve and older (a total of three)

No first or only children appear and the pattern is one of

ambivalence and of absence of the father. The boys are not badly disturbed. Marked success was achieved in one of the three cases, no success in the treatment of the other two.

Girls of twelve and older (a total of three)

Once again first or only children appear in the now familiar very strong pattern of rejection. There is small likelihood of successful treatment.

No very satisfactory answer can be given to the question of what is the pattern of the child's behavior that causes parents to come to the clinic complaining of disobedience. Fundamentally it is the mother who controls the situation and not the child. Therefore the pattern varies from completely normal behavior, through the usual mild disturbances of childhood, to the strong disturbances induced by the parents through their rejection. On the whole, however, the children as a group do not seem so different from typical children everywhere.

The question about the characteristics of the clinic contact and the associated controversial one of movement is of the greatest importance from a psychological and from an administrative point of view. It is also least likely to be answered properly. The data of Table XVIII does tempt one to assert that clinic effort is not likely to be very successfully spent on cases involving "disobedience" in its pure form. If an initial interview establishes that the pattern matches the standard ones described previously in this Chapter, a child guidance clinic may not be very effective. Apparently, psychiatric help is not needed for most of the youngest group of boys. The overpoweringly strong pattern of rejection for the older children of both sexes will nullify the treatment

of the child unless the parents are treated successfully as well. Unfortunately, a relatively small number of visits will have little influence on an adult woman's unconscious goals. Her behavior pattern rarely can be modified appreciably when her hostile feelings are so strong. It need hardly be pointed out that the father's attitude is most unlikely to be altered in absentia. In individual cases where there is a partial or complete acceptance of the child by one or both parents and when the child is disturbed, the clinic can function in its usual effective manner.

The validity of any conclusions based upon as few as thirty cases is always suspect unless corroborated by other studies of overlapping nature. Here it is of interest to look back twenty years, or so. Carl R. Rogers in 1939 reviewed the work of Helen L. Witmer and her students as reported in "The Outcome of Treatment in a Child Guidance Clinic," Smith College Studies in Social Work, Volume 3, June, 1933, pages 399 - His conclusions and those of Miss Witmer seem so pertinent today and are so relevant to the findings of this thesis that they are worth quoting at length. In Mr. Rogers' words¹

In a notable group of studies . . . Miss Helen Witmer and various graduate students at Smith College have brought to light facts which are of basic importance. In these studies a group of 197 children's cases from the Institute of Child Guidance, New York City, was examined to determine the factors associated with the success or failure of the child's adjustment at the time the case was closed. A further study of each case was made several years after the clinic contact in order to determine the later degree

1. Carl R. Rogers, The Clinical Treatment of the Problem Child, p. 180.

of success or failure and the factors associated with this final result. The greatest part of their findings was negative. Such items as the child's age at the time of clinic study, the sex, school placement, ordinal position in the family, even the child's symptomatic behavior, showed no relationship to the outcome of treatment, as judged by the Institute staff at the time the case was closed. Intelligence showed but a slight relationship with outcome. The nationality or religion of the child, the economic status of the home, the size of the family -- these too were of no help in predicting the outcome. But when ratings were made of the marital adjustments of the parents, of the emotional tone of the home, or of the behavior and attitudes of the parents toward the child, it was discovered that these less tangible factors bore a striking relationship to the clinic's success in dealing with the child. In the home where the parents were finding satisfaction in their married life, where the home atmosphere was free from strife and friction, and where parents had a normal degree of affection for the child, it was possible to overcome the child's difficulties in the overwhelming majority of instances. But when the reverse of these conditions prevailed the results were consistently poorer, in some instances the majority of the cases being failures. This was in spite of the fact that the Institute workers had been aiming to improve these very conditions, seemingly without success. With justification Miss Witmer concludes her study with the remark that "the findings of this paper thus lend weight to the mental hygiene hypothesis that parent-child relationships are of fundamental importance in determining personality development, and at the same time they suggest that the methods of therapy generally employed are not very successful in remedying the more serious difficulties that arise out of family maladjustment.

Twenty years later the situation is closely the same although the job of altering basic parental attitudes is taken far more seriously.

In the crucial matter of success of treatment Miss Witmer's findings do seem to apply. However, it must not be thought that the pattern of the characteristics of children within each sub-group of sex and age as described in this thesis are in contradiction to the findings of Miss Witmer. The predominance of first born and only children, the preponderance of boys as compared to the usual clinic caseload, the parental attitude of ambivalence toward the youngest boys, the parental attitude of

rejection toward the older boys and still stronger rejection toward the girls, the apparent slight correspondence of the child's intelligence with length of treatment and success at termination, all simply characterize the group and sub-groups. The groups are clearly recognizable according to the data and their description may be of value in determining future intake policy of the clinic.

Accepted
Katherine Spencer
5-14-57

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APPENDIX

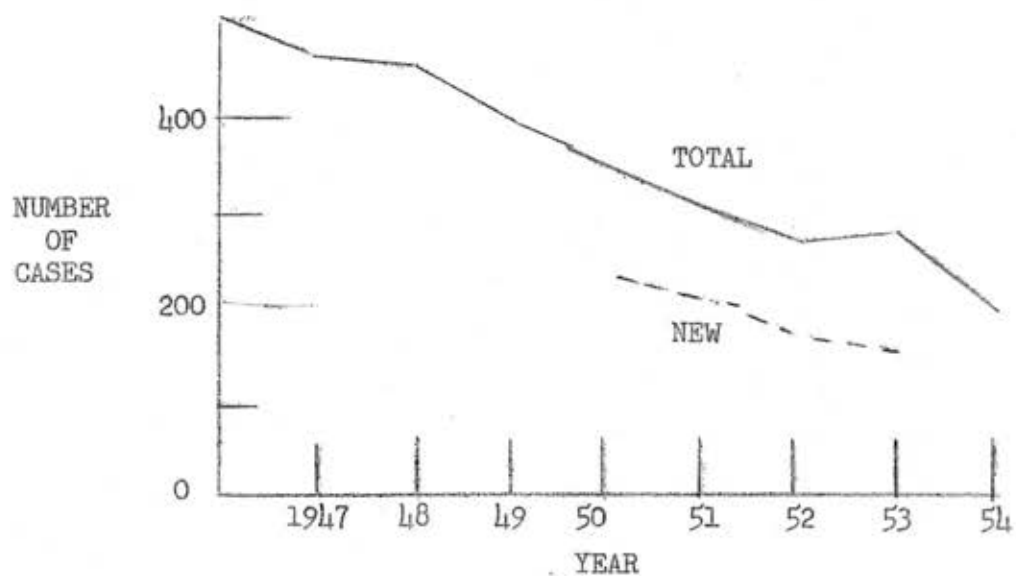


FIGURE 1 CASE LOAD OF THE CLINIC FROM 1946 TO 1954

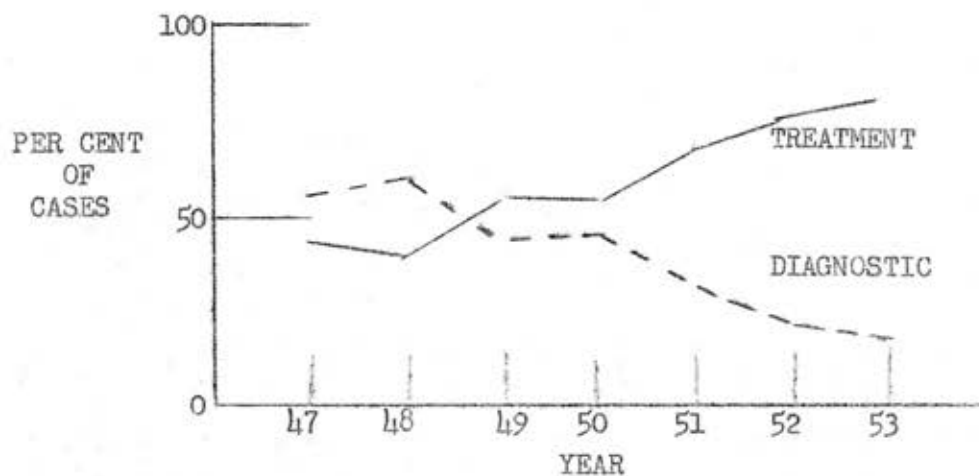


FIGURE 2 CLASSIFICATION OF CASES AS DIAGNOSTIC OR TREATMENT

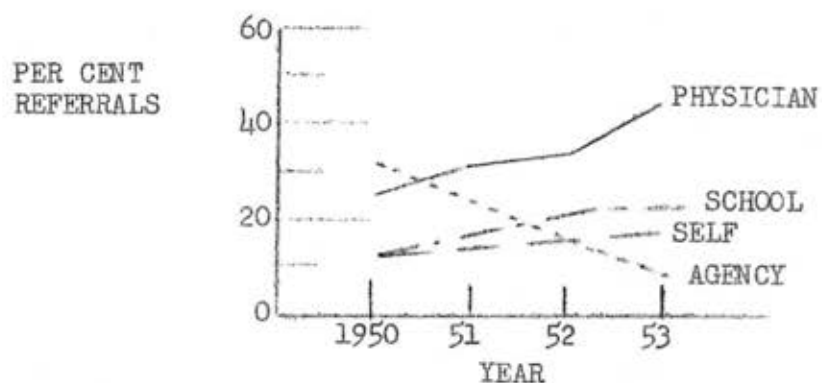


FIGURE 3 REFERRAL SOURCES FOR ENTIRE CASELOAD OF CLINIC 1950 TO 1953

Note: The 10 per cent not accounted for are miscellaneous including 1 to 3 per cent court referrals.

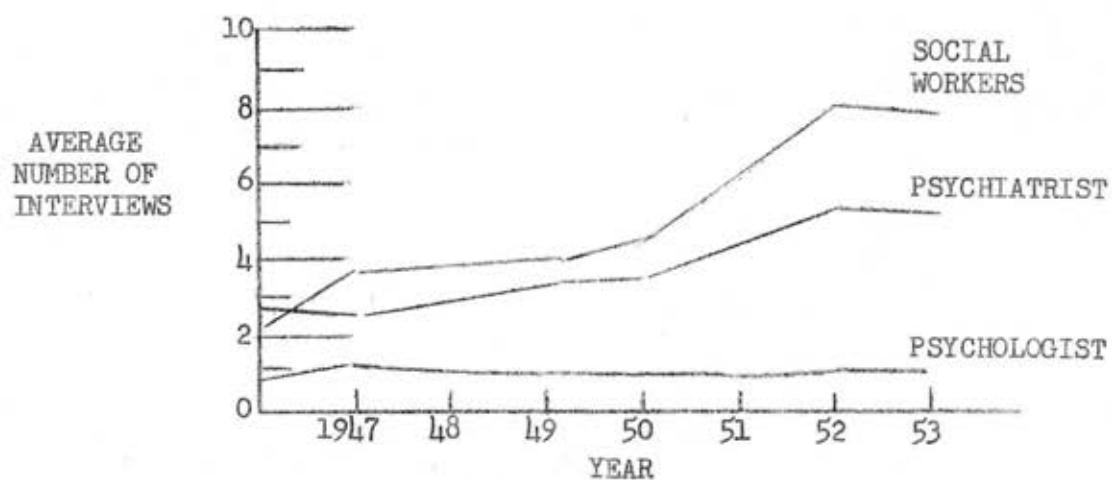


FIGURE 4 AVERAGE NUMBER OF INTERVIEWS FROM 1946 TO 1953

The data on the Providence Child Guidance Clinic were furnished by Mr. Kennison T. Bosquet whose help is here gratefully acknowledged.

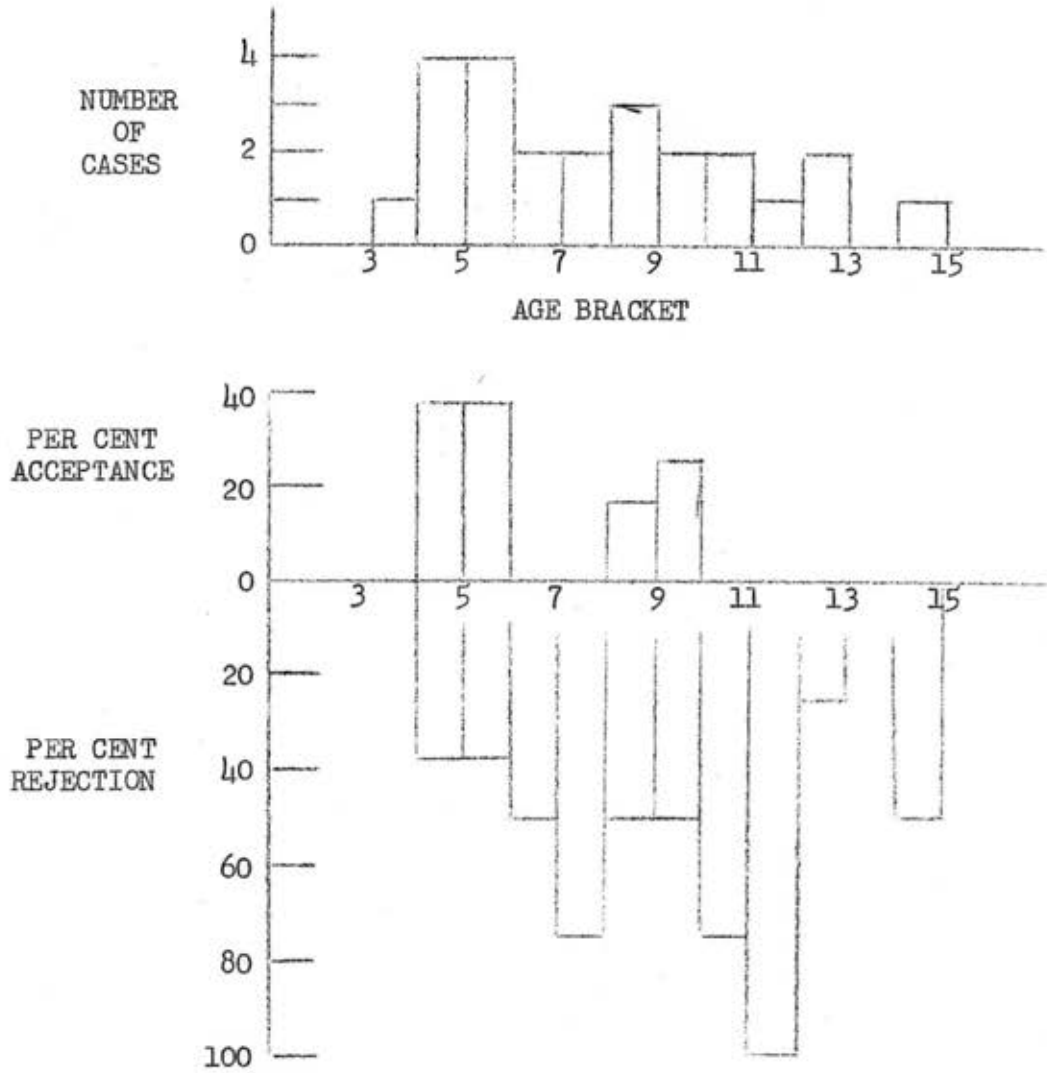


FIGURE 5 THE PATTERN OF REJECTION FOR THE BOYS YEAR BY YEAR

Note: The girls were all rejected by at least one parent and most were rejected by both. No girl was accepted by either parent.

Per cent rejection (acceptance) is $100 \times \frac{\text{sum of parents listed as rejecting (accepting)}}{\text{twice the number of cases for the year bracket}}$.

EXPLANATION OF TABLES IN APPENDIX

Table XXII lists the actual case numbers assigned by the Providence Child Guidance Clinic and the corresponding fictitious names assigned each case for description or tabulation in the thesis. The first or first two letters of the fictitious last name are underlined to indicate that these letters will be used in subsequent tables to designate a particular child. In this way, the tables permit a detailed analysis of the data since each child can be clearly identified.

All thirty cases are summarized in Table XXIII. The position of numbers in each row and column has a consistent meaning. For example, the set for the first or only child in the ordinal place in Sibling group reads:

$$\begin{array}{cc} 7 & \\ 9 & 3 \\ 0 & 2 \end{array}$$

which means:

7 boys.. 3 - 5	
9 boys.. 6 - 11	3 girls..6 - 11
0 boys .. 12 and over	2 girls.. 12 and over

Tables XXIV through XXVIII give the same information as Table XXIII for each of the sub groups according to age and sex. In addition, each child is listed by his identifying letter(s).

TABLE XXII

ACTUAL CASE NUMBERS AND ASSUMED NAMES

Number	Name	Table	Sex	Age at Intake	
1)	6449	Robert Ames	XXIV	M	5 1/2
2)	6584	Mary Appleton	XXVIII	F	13
3)	6603	Gerald Benjamin	XXIV	M	3
4)	6636	Morris Brand	XXIV	M	4
5)	6645	Sylvia Camp	XXVIII	F	12
6)	6647	Edward Carter	XXIV	M	4
7)	6678	Amy Davidson	XXVII	F	9
8)	6696	Michael Doyle	XXVI	M	14
9)	6705	Etta Dreiser	XXVII	F	7
10)	6732	Paul Ericsson	XXVI	M	12
11)	6747	Peter Firdusi	XXV	M	10
12)	6728	Henry Foster	XXVI	M	12
13)	6882	Malcolm Fremont	XXV	M	8
14)	6922	Frank Gage	XXV	M	7
15)	6952	Dimitri Gorgas	XXV	M	10
16)	6959	Anthony Guarneri	XXIV	M	5
17)	6989	Jayne Heifetz	XXVII	F	7 1/2
18)	6993	George Herrick	XXV	M	8
19)	6998	Thomas Hunt	XXV	M	9
20)	2885	Harvey Ingrian	XXV	M	11
21)	7022	Murray Joyce	XXV	M	8
22)	7036	John Knox	XXV	M	6
23)	7063	Arthur Locke	XXV	M	9 1/2
24)	7060	Charles Mallory	XXV	M	6
25)	7066	Douglas Milne	XXV	M	7
26)	7082	Walter Peskoff	XXIV	M	4 1/2
27)	7089	Avery Pushkin	XXIV	M	5 1/2
28)	7127	Evelyn Robbia	XXXIII	F	12
29)	7166	Carl Rush	XXIV	M	4 3/4
30)	7112	James Sampson	XXIV	M	5

TABLE XXIII

SUMMARY OF ALL THIRTY CASES

I.Q.	: Below 90	: 90-110	: Above 110	: Do not know
	: 2	: 2	: 3	: 2
	: 3 0	: 3 2	: 4 0	: 2 1
	: 0 1	: 1 0	: 2 2	: 0 0
Ordinal Pl. in Sibling Group	: First or Only	: Intermediate	: Last	:
	: 7	: 2	: 0	:
	: 9 3	: 2 0	: 1 0	:
	: 0 2	: 1 1	: 2 0	:
Marital Status	: Div. Sep. Dec.	: Together-Frict.	: Together	: Remarried
	: 1	: 2	: 5	: 1
	: 0 1	: 3 0	: 7 2	: 2 0
	: 2 1	: 0 1	: 1 1	: 0 0
Mother's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: 4	: 2	: 3	: 0
	: 7 2	: 4 1	: 1 0	: 0 0
	: 0 2	: 3 1	: 0 0	: 0 0
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
	: 3	: 1	: 4	: 1
	: 1 2	: 3 0	: 5 1	: 3 0
	: 1 2	: 0 0	: 2 1	: 0 0
to Husband	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: 2	: 4	: 2	: 1
	: 3 0	: 3 2	: 1 0	: 5 1
	: 1	: 1	: 0	: 1 3
Father's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: 2	: 1	: 3	: 3
	: 8 3	: 1 0	: 1 0	: 2 0
	: 2 3	: 0 0	: 0 0	: 1 0
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
	: 2	: 0	: 3	: 4
	: 1 1	: 0 0	: 3 1	: 8 1
	: 0 0	: 0 0	: 1 1	: 2 2
to Wife	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: 3	: 1	: 2	: 3
	: 6 2	: 0 0	: 1 0	: 5 1
	: 1 1	: 1 0	: 0 0	: 1 2
Movement	: Unimproved	: Moderate Impr.	: Improved	:
	: 5	: 1	: 3	:
	: 4 1/2 2	: 5 1	: 2 1/2 0	:
	: 2 2	: 0 1	: 1 0	:
Number of Interviews (mother)	: 1 - 4	: 5 - 9	: 10	:
	: 6	: 3	: 0	:
	: 6 0	: 4 1	: 2 2	:
	: 1 1	: 2 2	: 0 0	:
Terminated by	: Clinic	: Mother	: Mother-Clinic	:
	: 8	: 1	: 0	:
	: 2 2	: 4 1	: 6 0	:
	: 2 1	: 1 2	: 0 0	:

TABLE XXIV

BOYS FROM THREE THROUGH FIVE...A TOTAL OF NINE

I.Q.	: Below 90	: 90 - 110	: Above 110	: Do not know
	: <u>Am</u>	: <u>Br</u>	: <u>Be</u>	: <u>G</u> <u>Pe</u>
	: <u>Pu</u>	: <u>R</u>	: <u>C</u> <u>S</u>	
Ordinal Pl. in Sibling Group	: First or Only	: Intermediate	: Last	
	: <u>Am</u> <u>Be</u> <u>Br</u>	: <u>G</u>	: <u>S</u>	
	: <u>C</u> <u>Pe</u>			
	: <u>Pu</u> <u>R</u>			
Marital Status	: Div. Sep. Dec.	: Together-Frict.	: Together	: Remarried
	: <u>Am</u>	: <u>Be</u> <u>Br</u>	: <u>G</u> <u>Pe</u>	: <u>S</u>
	: <u>C</u>	: <u>Pu</u>	: <u>R</u>	
Mother's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Am</u>	: <u>Be</u>	: <u>Br</u>	
	: <u>R</u> <u>S</u>	: <u>Pu</u>	: <u>C</u> <u>G</u>	
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
	: <u>Am</u> <u>Br</u>	: <u>Pe</u>	: <u>Be</u>	: <u>G</u>
	: <u>R</u>		: <u>C</u> <u>Pu</u> <u>S</u>	
to Husband	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Am</u> <u>Be</u>	: <u>C</u> <u>Pe</u>	: <u>Br</u>	: <u>G</u>
		: <u>Pu</u> <u>R</u>	: <u>S</u>	
Father's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>C</u>	: <u>Be</u>	: <u>Am</u> <u>Br</u>	: <u>G</u> <u>Pe</u>
	: <u>Pu</u>		: <u>S</u>	: <u>R</u>
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
	: <u>Am</u>		: <u>Be</u> <u>Br</u>	: <u>C</u> <u>G</u> <u>S</u>
	: <u>Pe</u>		: <u>Pu</u>	: <u>R</u>
to Wife	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Am</u>	: <u>Be</u>	: <u>Br</u>	: <u>G</u> <u>Pe</u>
	: <u>C</u> <u>Pu</u>		: <u>S</u>	: <u>R</u>
Movement	: Unimproved	: Moderate Impr.	: Improved	
	: <u>Am</u> <u>Be</u>	: <u>G</u>	: <u>Br</u>	
	: <u>Pe</u>		: <u>C</u> <u>S</u>	
	: <u>Pu</u> <u>R</u>			
Number of Interviews (mother)	: 1 - 4	: 5 - 9	: 10 -	
	: <u>Am</u>	: <u>Be</u> <u>Br</u>		
	: <u>G</u> <u>Pe</u>	: <u>C</u>		
	: <u>Pu</u> <u>R</u> <u>S</u>			
Terminated by	: Clinic	: Mother	: Mother-Clinic	
	: <u>Am</u> <u>Be</u> <u>Br</u>	: <u>Pe</u>		
	: <u>C</u> <u>G</u>			
	: <u>Pu</u> <u>R</u> <u>S</u>			

TABLE XXV

BOYS FROM SIX THROUGH ELEVEN.....A TOTAL OF TWELVE

I.Q.	: Below 90	: 90 - 110	: Above 110	: Do not know
	: <u>Fr</u>	: <u>Go</u>	: <u>Ga</u>	: <u>Fi</u>
	: <u>He</u>	: <u>J</u>	: <u>Hu</u>	: <u>I</u>
		: <u>Mi</u>		: <u>Ma</u>
Ordinal Pl. in Sibling Group	: First or Only	: Intermediate	: Last	:
	: <u>Fi</u> <u>Fr</u> <u>Ga</u> <u>Go</u>			
	: <u>He</u> <u>Hu</u>	: <u>J</u>	: <u>I</u>	
	: <u>L</u> <u>Ma</u> <u>Mi</u>	: <u>K</u>		
Marital Status	: Div. Sep. Dec.	: Together-Frict.	: Together	: Remarried
		: <u>Go</u>	: <u>Fr</u> <u>Ga</u>	: <u>Fi</u>
		: <u>He</u> <u>I</u>	: <u>Hu</u> <u>J</u>	: <u>Mi</u>
			: <u>K</u> <u>L</u> <u>Mi</u>	: <u>Ma</u>
Mother's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Fi</u> <u>Fr</u> <u>Ga</u>	: <u>Go</u>		
	: <u>I</u>	: <u>He</u> <u>Hu</u>	: <u>J</u>	
	: <u>L</u> <u>Ma</u> <u>Mi</u>	: <u>K</u>		
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
		: <u>Ga</u>	: <u>Fi</u> <u>Fr</u>	: <u>Go</u>
		: <u>He</u>	: <u>Hu</u> <u>I</u> <u>J</u>	
	: <u>K</u>	: <u>Mi</u>		: <u>L</u> <u>Ma</u>
to Husband	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Go</u>	: <u>Ga</u>	: <u>Fr</u>	: <u>Fi</u>
	: <u>He</u> <u>I</u>	: <u>Hu</u>		: <u>J</u>
		: <u>Mi</u>		: <u>K</u> <u>L</u> <u>Ma</u>
Father's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Fi</u> <u>Fr</u> <u>Ga</u> <u>Go</u>			
	: <u>He</u> <u>Hu</u> <u>I</u>			: <u>J</u>
	: <u>Ma</u>	: <u>Mi</u>	: <u>L</u>	: <u>K</u>
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
			: <u>Fr</u>	: <u>Fi</u> <u>Ga</u> <u>Go</u>
			: <u>I</u>	: <u>He</u> <u>Hu</u> <u>J</u>
	: <u>K</u>		: <u>L</u>	: <u>Ma</u> <u>Mi</u>
to Wife	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>Go</u>		: <u>Fr</u>	: <u>Fi</u> <u>Ga</u>
	: <u>He</u> <u>Hu</u> <u>I</u>			: <u>J</u>
	: <u>Ma</u> <u>Mi</u>			: <u>K</u> <u>L</u>
Movement	: Unimproved	: Moderate Impr.	: Improved	:
	: <u>Fi(m)</u> <u>Fr</u>	: <u>Ga</u> <u>Go</u>	: <u>Fi</u> (b)	
	: <u>I</u> <u>J</u>	: <u>He</u> <u>Hu</u>		
	: <u>Ma</u>	: <u>Mi</u>	: <u>K</u> <u>L</u>	
Number of Interviews (mother)	: 1 - 4	: 5 - 9	: 10 -	:
	: <u>Fi</u> <u>Fr</u>	: <u>Ga</u> <u>Go</u>		
	: <u>J</u>	: <u>He</u> <u>Hu</u>	: <u>I</u>	
	: <u>K</u> <u>Ma</u> <u>Mi</u>		: <u>L</u>	
Terminated by	: Clinic	: Mother	: Mother-Clinic	:
		: <u>Fi</u>	: <u>Fr</u> <u>Ga</u> <u>Go</u>	
	: <u>He</u>	: <u>Hu</u>	: <u>I</u>	
	: <u>J</u>	: <u>K</u> <u>Ma</u>	: <u>L</u> <u>Mi</u>	

TABLE XXVI

BOYS OF TWELVE AND OLDER...A TOTAL OF THREE

I.Q.	: Below 90	: 90 - 110	: Above 110	: Do not know
		: <u>F</u>	: <u>D</u> <u>E</u>	:
Ordinal Pl in Sibling Group	: First or only	: Intermediate	: Last	:
		: <u>F</u>	: <u>D</u> <u>E</u>	:
Marital Status	: Div.Sep.Dec.	: Together-Frict.	: Together	: Remarried
	: <u>D</u> <u>E</u>	:	: <u>F</u>	:
Mother's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
		: <u>D</u> <u>E</u> <u>F</u>	:	:
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
	: <u>D</u>	:	: <u>E</u> <u>F</u>	:
to Husband	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>D</u>	: <u>F</u>	:	: <u>E</u>
Father's Attitude to Child	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>D</u> <u>F</u>	:	:	: <u>E</u>
to Clinic	: Hostile	: Ambivalent	: Accepting	: Do not know
		:	: <u>D</u>	: <u>E</u> <u>F</u>
to Wife	: Rejecting	: Ambivalent	: Accepting	: Do not know
	: <u>F</u>	: <u>D</u>	:	: <u>E</u>
Movement	: Unimproved	: Moderate Impr	: Improved	:
	: <u>D</u> <u>E</u>	:	: <u>F</u>	:
Number of Interviews (mother)	: 1 - 4	: 5 - 9	: 10 -	:
	: <u>E</u>	: <u>D</u> <u>F</u>	:	:
Terminated by	: Clinic	: Mother	: Mother-Clinic	:
	: <u>E</u> <u>F</u>	: <u>D</u>	:	:

TABLE XXVII GIRLS FROM SIX THROUGH ELEVEN...A TOTAL OF THREE

I.Q.	: Below 90 : : :	: 90 - 110 : <u>Dr</u> <u>H</u> :	: Above 110 : : :	: Do not know : <u>Da</u> :
Ordinal Pl in Sibling Group	: First or Only : <u>Da</u> <u>Dr</u> <u>H</u> :	: Intermediate : : :	: Last : : :	
Marital Status	: Div.Sep.Dec. : <u>Da</u> :	: Together-Frict : : :	: Together : <u>Dr</u> <u>H</u> :	: Remarried : : :
Mother's Attitude to Child	: Rejecting : <u>Da</u> <u>Dr</u> :	: Ambivalent : <u>H</u> :	: Accepting : : :	: Do not know : : :
to Clinic	: Hostile : <u>Da</u> <u>Dr</u> :	: Ambivalent : : :	: Accepting : <u>H</u> :	: Do not know : : :
to Husband	: Rejecting : : :	: Ambivalent : <u>Da</u> <u>H</u> :	: Accepting : : :	: Do not know : <u>Dr</u> :
Father's Attitude to Child	: Rejecting : <u>Da</u> <u>Dr</u> <u>H</u> :	: Ambivalent : : :	: Accepting : : :	: Do not know : : :
to Clinic	: Hostile : <u>H</u> :	: Ambivalent : : :	: Accepting : <u>Dr</u> :	: Do not know : <u>Da</u> :
to Wife	: Rejecting : <u>Da</u> <u>H</u> :	: Ambivalent : : :	: Accepting : : :	: Do not know : <u>Dr</u> :
Movement	: Unimproved : <u>Da</u> <u>Dr</u> :	: Moderate Impr. : <u>H</u> :	: Improved : : :	
Number of Interviews (mother)	: 1 - 4 : : :	: 5 - 9 : <u>Da</u> :	: 10 - : <u>Dr</u> <u>H</u> :	
Terminated by	: Clinic : <u>Dr</u> <u>H</u> :	: Mother : <u>Da</u> :	: Mother-Clinic : : :	

TABLE XXVIII GIRLS OF TWELVE AND OLDER...A TOTAL OF THREE

I.Q.	: Below 90 : <u>R</u>	: 90 - 110	: Above 110 : <u>A</u> <u>C</u>	: Do not know
Ordinal Pl. in Sibling Group	: First or Only : <u>C</u> <u>R</u>	: Intermediate : <u>A</u>	: Last	:
Marital Status	: Div.Sep.Dec. : <u>R</u>	: Together-Frict. : <u>A</u>	: Together : <u>C</u>	: Remarried
Mother's Attitude to Child	: Rejecting : <u>A</u> <u>C</u>	: Ambivalent : <u>R</u>	: Accepting	: Do not know
to Clinic	: Hostile : <u>A</u> <u>C</u>	: Ambivalent	: Accepting : <u>R</u>	: Do not know
to Husband	: Rejecting	: Ambivalent	: Accepting	: Do not know : <u>A</u> <u>C</u> <u>R</u>
Father's Attitude to Child	: Rejecting : <u>A</u> <u>C</u> <u>R</u>	: Ambivalent	: Accepting	: Do not know
to Clinic	: Hostile	: Ambivalent	: Accepting : <u>C</u>	: Do not know : <u>A</u> <u>R</u>
To Wife	: Rejecting : <u>R</u>	: Ambivalent	: Accepting	: Do not know : <u>A</u> <u>C</u>
Movement	: Unimproved : <u>A</u> <u>R</u>	: Moderate Impr. : <u>C</u>	: Improved	:
Number of Interviews (mother)	: 1-4 : <u>R</u>	: 5 - 9 : <u>A</u> <u>C</u>	: 10 -	:
Terminated by	: Clinic : <u>R</u>	: Mother : <u>A</u> <u>C</u>	: Mother-Clinic	: