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The significance of the presenting problem in a child guidance clinic

BOSTON UNIVERSITY
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THE SIGNIFICANCE OF THE PRESENTING PROBLEM IN A CHILD GUIDANCE CLINIC

A thesis

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CHAPTER I

INTRODUCTION

This is a study of the significance of the presenting problem in a child guidance clinic as studied in relation to the maternal attitudes of mothers of latency age boys with enuresis. Two groups of families of a latency age child were studied. One of these groups mentioned enuresis as a presenting problem, while, in the other group, although enuresis was present it was not mentioned as the presenting problem.

The presenting problem is that behavior about which the parent is most concerned and for which she seeks help at the time of referral. There may be present many other problems about which the parent may have little concern or awareness. Increasingly in psychiatric clinics it is felt that the significance of the patient's problem to him and the explaining of this in the present life situation is most productive for further treatment. The mother's description of the presenting problem will suggest her attitude to the symptom and to the child, and be related to the possibilities for treatment.

Although the focus of this study is on the presenting problem, the mother's attitude to her son and to his symptom was examined. This was considered necessary since the behavior of young children is largely determined by the emotional climate in which they live. The climate reflects the attitude which the mother has to these children. The mother's attitude is felt to be of great importance because of the recognition of the interdependance of the child and his mother; the child is still

developing and hence very sensitive to his environment.

In considering the presenting problem and maternal attitudes it was felt desirable to consider a symptom which these boys displayed as their adaption to inner conflict. The symptom of enuresis was chosen since this is a symptom frequently observed in children referred to a child guidance clinic. Also when this symptom is found in latency age boys the mother-child relationship is suggested as crucial.

In this study twenty families with latency age enuretic boys have been selected from the population of the clinic between the years 1955 - 1959. In each case the following areas were examined: background characteristics; duration of the symptom and mother's attitude to it; mother's attitude to her own childhood, her husband, her son and her son's problem; in addition, her attitude to change and who would do the work.

The setting of the study is the Douglas A. Thom Clinic for Children. This is a child guidance clinic situated in Metropolitan Boston. The clinic generally services children between the ages of five and twelve having emotional problems. It studies and treats these children and their families.

CHAPTER II

THEORETICAL CONSIDERATION

This is a study of the significance of the presenting problem in a child guidance clinic, as it relates to maternal attitudes toward latency age boys with the symptom of enuresis.

Increasingly in all psychiatric clinics, adult as well as child, there has been a shift from the securing of a long and involved social history to the emphasis and importance of the presenting problem. In child guidance clinics this is the symptom which the mother notes as most important. Perlman states:

> The problem is the client's problem and his impetus is to get help with it as he sees and feels it. The problem as the client sees it may truly be the central problem or it may be the peripherol one on which he has centered his concern. Whichever it is, common sense tells us that, since we can help with a problem only through the person that has it, we must, at least at first, start with the troubled person's center of concern, with what he feels is crucial. Sometimes the caseworker is so clear in his own mind that the problem the client presents is not the "real" one, or he is so eager to present his own speculations about the problem's sources, that he starts to focus upon the area of his, rather than the client's interests. When this happens, he may find that he has gained full comprehension of the problem but has lost the person whose problem it is.[1]

In child guidance, the problem which the mother presents is the child's. However, particularly with the very young child, the mother-child relationship is of basic importance in the child's development;

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[1] Perlman, Helen. Social Case Work, page 28.

and in treating an emotionally disturbed child, the mother is always included in the treatment plan.

Hamilton observes that:

> During the first twenty-five years of child guidance the etiology of symptomatic behavior has been pursued, and the startling discovery has been made that parental attitudes are significantly causal.[2]

Brody[3] in discussing the relationship of the mother to her infant states that the contributions of psychoanalysis to the understanding of the mother-infant relationship centers about one theme: the frequent prevalence in both partners of an unconscious struggle for the achievement of libidinal and aggressive aims toward each other. This unconscious struggle is characterized by numerous conflicts which may be manifested more or less overtly - and this is brought further along with the finding of the Group for the Advancement of Psychiatry Pamphlet that:

> Gradually as the child experiences minimal and hence tolerable frustrations of his basic needs and is satisfied repetitively by the mother he more actively turns toward her with increasing confidence and patience.[4]

In considering the mother's attitudes, however, we must remember that her attitudes are derivatives of her own early experience and as Hamilton states that:

> Serious rejection usually stems from the original experience now carried over to a 2nd generation. It is

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[2]Hamilton, Gordon, Psychotherapy and Child Guidance, p. 8.

[3]Brody, Sylvia, Patterns of Mothering, p. 89.

[4]Group for the Advancement of Psychiatry Report, #38, p. 318.

> not this child that the mother rejects but this child has touched off her feeling of being unloved by her own parents.[5]

Therefore really the mother's attitude to her own child can only be understood through a study of the mother's own experience. Wichman and Langford state:

> Conflicts in feelings in early relationships are later reflected in the parent's relationship with the child. The pressures, the over-meticulous care or neglect bear a relation to those which figured conspicuously in the parent's own home earlier.[6]

It may seem that in discussing the mother-child relationship that stress has been laid on the relationships in the pre-latency period. However, even in latency, when the boy turns somewhat more from the parental environment and the oedipal period to school and his peers his parents nevertheless continue to be of great importance to him.

Josselyn states that:

> He cannot feel safe in this new world he is exploring unless he can also feel assured that when anxiety or frustration becomes unbearable he can return to the primary relationships that gave him security before.[7]

and again that the "serious problems of this age group, however, are the problems that result from the failure of earlier childhood."[8] If the child has not satisfactorily passed through

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[5] Hamilton, Gordon, op. cit., page 277.

[6] Wichman and Langford, "Parents in a Children's Psychiatric Clinic" Journal of Orthopsychiatry, vol. XLV, p. 220.

[7] Josselyn, Irene M., Psychosocial Development of Children. Family Service Association of America, p. 75.

[8] Ibid., p. 77.

the earlier stages of development with sufficient emotional satisfaction the effect may show up in latency. Hamilton states:

> If the parental situation has not been worked through the child is still struggling with his primitive impulses and is still confused in his identifications.[9]

In addition, although often these problems have persisted for sometime, because of the child's close association with his family, his difficulties have not shown up until latency when he moves out from the family group to form broader relationships.

Therefore in treating the symptomotology of the latency age child one must consider the parents in order to help the child. It is in this area of the parental relationships, and the interaction of the parents with the child, that the social worker is particularly active.

However, although we are well aware of the parental relationships, and the importance of the mother's attitude as significant, we must in child guidance deal with the mother in the beginning. In casework it is axiomatic that we begin where the client is and explore his problem as he sees it. The emphasis is on what the mother thinks the problem is, for as a client gives the meaning a situation holds for her, this becomes the beginning of treatment. The mother starts with the presenting problem of the child and the worker considers "the symptom and the attitude which the mother has to it, not in the light of what led up to this attitude, but around the area of the fact that the mother has such an attitude in

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[9] Hamilton, Gordon, op. cit. p. 214.

her present behavior."[10]

In child guidance in the beginning of the relationship experience we explore the ideas of the parent regarding the child, and the attitude of the parent to the child. No limit is set on the problem and "it is recognized that the feelings of the mother and her anxiety around the problem are of primary importance."[11] We might say, in other words, during the application and diagnostic interviews it is crucial for the social worker to listen to the presenting problem as the mother perceives it and her feelings around it.

In this study we are concerned with maternal attitudes and feelings around the symptom of enuresis both when it occurs as a presenting problem and when it is part of, but not, the presenting problem. Then it seems important to look at some of the literature on enuresis.

Enuresis which Webster defines as involuntary emission of urine, is discussed by English and Pearson who state that:

> Enuresis is a condition in which the child who has been toilet trained or has passed the age where toilet training should be completed wets himself during the day or the bed at night. Since toilet training is not expected to be complete before the age of three and a half, any wetting before that time cannot be called enuresis; nor can the term be applied to the occasional accident that all children have even after that time; nor to the incontinence which is only a minor symptom of some other illness such as pyelitis.[12]

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[10] Aptaker, Herbert. Causality and Treatment. American Journal of Ortho-psychiatry, vol. IX, p. 387.

[11] Coleman, Short and Herschberg. Intake Interviews in Children's Cases. American Journal of Orthopsychiatry, #105, p. 183.

[12] English, O.S., and Gerald Pearson, Emotional Problems of Living, pp. 212-213.

There seems to be no quarrel with consideration of children over three and a half and in fact most of the material deals with children over six years. However, when continued beyond six it does indicate that something has gone awry with the child's development and Michaels states that:

> Both from our studies and from our clinical experience there seems to be no doubt as to the great importance of enuresis as one of the most significant indicators of disharmony within the personality.[13]

However, even among those who agree that enuresis is psychological in origin there are a variety of causes offered. Mohr[14] claims the reason of poor training, Bakwin[15] the wish of a neglected child to gain attention, and MacGuinness[16] who claims that wetting is an expression of antagonism against parental domination of children otherwise submissive in their behavior. Pearson finds that "enuresis present from birth is the commonest type,"[17] and some factors are given as low socio-economic families, limited intelligence, and poor training. Enuresis sometimes occurs after a dry period, this usually follows an "up-setting" experience, regression to a more infantile level, and a third factor is the desire for revenge.

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[13] Michaels, Joseph J. and Sylvia E. Goodman, "Enuresis and Age of Cessation in 1000 Neuropsychiatric Patients," American Journal of Orthopsychiatry, vol. IX 1/39, p. 63.

[14] Mohr, A. J. and E. H. Waterhouse, "Neuroses in Children" American Journal of Disturbed Children, vol. 27, 1929.

[15] Bakwin, Harry, "Enuresis in Children", Journal of Pediatrics, vol. 145, 1928.

[16] MacGuinness, "The Treatment of Enuresis in Children," Medical Clinic North America, vol. 19, p. 286, 1935.

[17] Pearson, Common Neuroses of Children and Adults, p. 120.

This would indicate that as Margaret Gerard found from a review of the literature that:

> Enuresis is not a clinical entity to which one can ascribe a single cause.[18]

Dr. Gerard found in a study of 72 cases referred to the psychiatric service over a period of 7 years that 7 were found to wet for psychical causes. Of the remaining 65, only 4 could be ascribed to faulty training, and the other 61 showed definite diagnosible psycho-genic causation. Again among these 61, 5 coincided with the arrival of a sibling with other regressive symptoms, 8 others had never responded in training and evidenced various degrees of a stubborn and aggressive behavior. This was in response to rejecting attitudes of parents. The remaining 46 presented neuroses, in each of which was found a distinct and similar clinical syndrome and in which enuresis was only one of the symptoms. This Gerard found "according to our experience" probably represents the most common cause of enuresis. Here wetting occurred during sleep or unconsciousness and was therefore true enuresis.

Further Gerard found that the manifest attitudes of boys and girls among these enuretics were consistent but differed strikingly. Since this study deals with mother's attitudes toward latency age boys, Dr. Gerard's findings in regard to boys will be considered here. She found the boys to be passive, retiring, and self-depreciatory. They were slow and dawdling in daily activity, and school achievement was below that expected

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[18] Gerard, Margaret, "Enuresis a Study in Etiology" Journal of Orthopsychiatry, vol. IX, January, 1939, p. 130.

from their intelligence quotient. As to their personality patterns which were neurotic, the boys indicated a fear of women as dangerous persons who could injure them. Therefore they defended against this fear by identification with the woman and avoidance of the active male role.

Since these consistent neurotic patterns appeared in such a large number of cases studied, Dr. Gerard questioned, then, what were the experiences of these children which led to the emotional conflict for which solution was found in this symptomotology. In her study the mother-son relation is suggested as crucial:

> The boys, in turn conceiving the female role as dangerous to the man, may accept the mother's rejecting attitudes as corroboration of evil intent, and they attempt to avoid the danger also by identification, but with the woman not with the man, and by denying their masculinity.[19]

Therefore it would seem most valuable to study the attitude of mothers to their sons, which developed this response.

Sears, Macoby, and Levin[20] in their study of 379 mothers in child rearing practices report that: "Three things were related to late persistence of bedwetting." One was the severity of toilet training and another the mother's affectional warmth. Both of these were related to the amount of emotional upset during training.

These readings in Pearson[21], Gerard[22], and Sears, Macoby and Levin[23],

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[19] Gerard, Margaret, M.D., "Enuresis, A Study in Etiology". The Emotionally Disturbed Child, p. 136.

[20] Sears, Macoby and Levin, Child Rearing Practices, p. 131.

[21] Pearson, op. cit.

[22] Gerard, op. cit.

[23] Sears, Macoby and Levin, op. cit.

indicate that a child's problems, i.e., the specific symptom of enuresis, is the result of the interaction with his family environment but primarily his interaction with his mother.

This will be of particular impact again to the social worker since the mother's attitude to the symptom will reflect what responsibility she does take in this area and how much the symptom disturbs her. Also since the mother's attitudes are integrated into her personality the way she relates to her son will be the way she will relate to the worker. Perlman says:

> They (the attitude of obedient, helpless, approval-seeking, resistant, or defying) can be understood as behavior that is symbolic of relationships to other potent persons in the client's past or present life.[24]

The issue to be considered in this study concerns the importance of the presenting complaint. This is an important focus in working with people, and particularly for the social worker in a child guidance clinic. As the mother tells us the presenting complaint and its history she pictures her concern about the symptom, and how willing she is to work toward altering it. The social worker is concerned with encouraging a relationship within which the mother may work toward solving her problem. In the early relationship, when the mother first presents the problem, she may reveal her attitude to treatment, what she expects of the clinic, the responsibility for the problem, and the possibility of change.

The presenting complaint here considered is enuresis. In addition to

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[24] Perlman, Helen, Op. cit., p. 31.

considering the mother's attitude to this complaint, the areas which authorities look at as crucial when studying enuresis were examined. These specific areas include the mother's unconscious rejection of her son and, the mother's attitude toward her husband as it is reflected in her attitude to her son.

CHAPTER III

METHODOLOGY

Purpose of the Study

The purpose of this study is to examine the significance of the presenting problem in a child guidance clinic, and further concerns itself with maternal attitudes toward latency age boys with enuresis. Two groups of mothers were studied, one group mentioned enuresis as the presenting problem while the other group did not, although enuresis was present. The sample was selected on the basis of the problem presented by the mother at the time of her initial telephone call to the Douglas A. Thom Clinic for Children. The cases studied were seen through the years 1955 - 1959.

The Setting

The Douglas A. Thom Clinic for Children was founded in 1921 (then named the Habit Clinic for Child Guidance) as one of the pioneering clinics in this country and in the world. At that time the program consisted of diagnostic studies of the child in his social milieu, and treatment in the form of advice and suggestions to the parents. Under the influence of psychoanalytic work with children, the newly organized Thom Clinic began to apply psychotherapeutic techniques to the child himself.[1] With this new interest in dynamic psychology, caseworkers began to treat parents for their own problems. Caseworkers questioned the wisdom of the approach

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[1] The Douglas A. Thom Clinic for Children, Inc. Annual Report for the year 1957, Boston, 1957, p. 8.

however. They maintained that parents should be accepted in the role in which they present themselves to the clinic not as informants, nor as patients, but as individuals who are troubled about a relationship in which they are involved. The child guidance worker then took as his task the fostering and enhancing of the parent's strength in deciding to help the child, and helping the parent to support the child's psychological growth as it received fresh impetus from psychotherapy.[2] Thus in the 1940's there evolved the traditional child guidance pattern of weekly psychotherapy for the child and casework for the mother.

While this continues to be a major part of the clinic's program, the clinic has extended its function by providing consultation services to other agencies in the community (i.e. nursery day care centers). Furthermore, as other agencies in the community began to treat children with a mild neuroses and situational upsets, the clinic began to absorb in its caseload an increasing number of seriously disturbed children, and multi-problem families, which required years of intensive treatment. Through the stimulation of these difficult cases, the clinic developed its emphasis upon the "family diagnosis", and experimented with new types of treatment for these families.[3] The family study is now used in assessing the treatability of more disturbed families, and in guiding treatment plans and techniques.

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[2]Witmer, Helen Leland, Psychiatric Interviews with Children. New York: Commonwealth Fund, 1946.

[3]Annual Report for the year 1957. The Douglas A. Thom Clinic for Children, Inc. Boston, 1957, p. 12.

The "chronic problem family" which is a current concern of many community agencies, precipitated the clinic's research study on families of antisocial children. This reflects the clinic's concern in providing optimum service to its families, and also, perhaps, lending assistance to other community agencies in their work with these difficult-to-treat families.

Intake Policy and Procedure at the Douglas A. Thom Clinic for Children

All of the procedures at the Thom Clinic from the time of referral to final disposition have the two major aims of acquiring a most thorough understanding of, and to give optimum service to, each family.[4] Recognizing that psychotherapy is not a panacea, the clinic attempts to select only those families who can benefit from and utilize the services available.

> We consider the Thom Clinic to be primarily a study and treatment center for emotionally disturbed children. Of the children referred to us, we treat all whom we believe we can treat from the standpoints of our estimate of their pathology, and of willingness and ability of their parents to permit change in their child, and from that of the capacity of our clinic facilities.[5]

The selective and therapeutic process begins at the point of the telephone referral, the first step in the intake process at the Thom. Although these initial calls usually last only ten or fifteen minutes, a skilled and sensitive social worker can make a significant beginning in understanding the family structure, the areas in which breakdown of functioning have occurred, and the strengths of the situation.[6] Having

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[4] Ibid., p. 16.

[5] Ibid., p. 11

[6] The Douglas A. Thom Clinic, Inc. Annual Report for the Year 1957, (Boston), p. 20.

elicited enough information, the worker begins to formulate a tentative diagnosis, and give consideration to whether this client is at the appropriate agency.

If it is obvious that the client is not eligible for the services of the clinic, the worker can direct the referral to a more suitable source at this point. The intake policy includes the following principles:

1. Age: generally, children between the ages of five and twelve are accepted. However, the child younger than five years and the child in early adolescence are also eligible.

2. Residence: generally, the family must live in the greater Boston areas which are members of the United Fund. Families residing outside of these areas and in communities where psychiatric child services (state or private) are not available are also eligible.

3. If the problem is principally a physical one, the case is referred to a hospital setting.

4. Severely disturbed children (e.g., certain psychotics) may be referred elsewhere, i.e., to a private psychiatrist, residential treatment center, psychiatrically-oriented day school, etc.

5. Persons with sufficient financial resources available, and who are also not willing to wait for a clinic appointment, are encouraged to seek private treatment. The determination of fees is based on a "sliding scale" fee schedule.

The worker taking the intake call records the information in the Intake Book. Each referral that is not referred elsewhere, is presented in the Intake Committee meeting, with enough information to formulate a tentative diagnosis and prognosis. The Associate Director presides over these meetings and the members include the clinic social workers and a staff psychologist. The worker who took the call has the responsibility

of conveying to his colleagues the tone of the client, his feelings about help, as well as the nature of the problem. The decision of the Intake Committee is then recorded in the Intake Book. If the referral is accepted, the worker who took the call will notify the parent or referring agency of the decision. If the parents of the child have not yet contacted the clinic (in the case of an agency referral) they will be encouraged to do so, since it is important that the parents show a genuine interest in getting help for the child.

At this point, the name is placed on the appropriate waiting list for assignment: application interview, reevaluation, or research study. The application interview is a joint interview, and the workers initial contact with the two parents. The joint interview is an important step in the process of securing first-hand knowledge of the parent's attitudes toward help, their complementary strengths and frailties in their interrelationships, what part each has in the child's problem, and what resources are present in the family with which to work.[7] Following this initial appraisal of the total family unit, the diagnostic study is initiated, with the mother ordinarily seen by a social worker while the child is seen by a psychiatrist in three interviews. The father is then seen at least once by a social worker or psychiatrist. The purpose of the diagnostic study is to formulate a diagnosis of the parents and the child; to assess the family member's motivations and abilities to involve themselves in the helping process.

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[7]The Douglas A. Thom Clinic, Inc., Annual Report for the year 1955, (Boston).

To cope with the increasing number of disturbed families that were referred to the Thom Clinic in the early 1950's, the psychiatric family study was devised. In this, an attempt is made to appraise the personality of each parent and the disturbed child, with particular emphasis upon their dynamic interrelationships. The psychiatrist sees both parents together (and at times, in separate interviews), and spends a few sessions with the child alone. The aim of this study is to establish a balance in the family unit and to facilitate optimum functioning for all the members.[8] While the family study is applied principally to the more disturbed families referred to the clinic, this focus on the dynamics and equilibrium of the family unit is at the core of the diagnostic thinking at the Thom.

> It was found that all children in emotional trouble do not profit from psychiatric treatment, that treatment for one or two members of a family may so change the family equilibrium that the child's improvement cannot long be maintained in the face of increasing stress for other family members.[9]

Consultation is another form of treatment at the clinic. Intensive treatment cases have been followed by consultations at regular monthly or bimonthly intervals when it was felt that a child and parent have reached a plateau level of progress, and yet require continued guidance, observation, and support to stabilize the progress they have made. This may also serve to prepare a family for later intensive treatment, or for referral to another agency for a different kind of help.

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[8] Ibid.

[9] Ibid., p. 15.

The Sample Selection

Since the intake book outlines the child's problems as seen by the mother, it was from this book that the cases for this study were first selected. The intake book was investigated for the years 1955 - 1959. Here is listed the name of the child and the presenting problem. The majority of the clinic's population is latency age so this area presented no difficulty. Proceeding backwards from the year 1959 cases of boys were selected in which the symptom of enuresis was given as the first problem.

Next the cases were reviewed as to which discipline was responsible for the application and diagnostic interviews. Those completed by a social worker were selected. Each case which came up in order and met the criteria of age, sex, symptom, and who in addition were living with their natural parents were chosen.

The comparative ten cases were selected in the same manner except that in the consideration of the symptom these cases were considered on the basis of enuresis being present but not the first problem.

Following the selection, the face sheet information, referral data, and diagnostic study was applied to a schedule. The data were collected in each case on information given by the mother about herself, her family situation, the child and his problem, and the mother's attitude toward the child, toward his symptom, and toward involving herself in the helping process. The information that the mother gave about her own early life and her feelings about it were also explored in an attempt to see if there is any relation between what happened to the mother as a child and what is happening to her own child. No attempt was made to follow these

cases into treatment or final disposition.

In this study the following aspects will be considered, in relation to the presenting problem and the mother's attitude to it: the homogeneity of the background information in the two groups; then, the history of the symptom including the mother's attitude to it. In this latter area consideration will be given to a comparison, in the two groups, of how the symptom was handled. Following this a comparison of the mother's attitude to her own early life and then that of her son. Finally the mother's attitude toward help will be examined with the focus on her attitude toward change and who will do the work.

CHAPTER IV

DATA PRESENTATION

The data that will be discussed is first, the background data presented by the parents at the time of the application interview, when the parents discuss for the first time, at the clinic, the child's problem and the family situation.

In this chapter PRESENTING will represent the group in which enuresis was the presenting problem and OTHER the group where enuresis was present but was not the presenting problem.

In both groups the majority of mothers were in the 29 - 39 age bracket and of the Jewish religion. This is indicative of the general population at the clinic where the majority of the mothers are in their mid-thirties, and, in 1953, a study made indicated that forty-three per cent of the clinic population was Jewish, thirty per cent Protestant, and twenty-one per cent Catholic.[1]

All of these boys were living with their natural parents and in only three instances were there others than the natural family living in the household. This occurred three times in the PRESENTING group. In one home there was a paternal grandfather present, in another a paternal grandmother and in the third a maternal grandmother

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[1] The Douglas A. Thom Clinic for Children, Inc. Annual Report, 1953, page 7.

The following table, Table 1, illustrates the relation in both groups of age of mother and the religion of the family.

TABLE 1

AGE OF MOTHER AND RELIGION

PRESENTING Age	Catholic	Jewish	Protes-tant	OTHER Age	Catholic	Jewish	Protes-tant
20-29	1	-	-	20-29	-	-	-
29-39	-	6	2	29-39	1	6	1
39-49	-	1	-	39-49	-	1	-
49-59	-	-	-	49-59	-	1	-

Tables 2 and 3 indicate the relationship in both groups in age of mother, first, to her education and then to the fathers.

TABLE 2

AGE OF MOTHER TO OWN EDUCATION

PRESENTING Age	Grammar	High	College	OTHER Age	Grammar	High	College
20-29	-	1	-	20-29	-	-	-
29-39	1	4	3	29-39	1	4	3
39-49	-	-	1	39-49	-	1	-
49-59	-	-	-	49-59	-	-	1

TABLE 3

AGE OF MOTHER TO FATHER'S EDUCATION

PRESENTING Age	Grammar	High	College	OTHER Age	Grammar	High	College
20-29	-	-	1	20-29	-	-	-
29-39	-	3	5	29-39	-	3	5
39-49	-	1	-	39-49	-	1	-
49-59	-	-	-	49-59	-	1	-

In the matter of income the members of the OTHER group had on the whole a slightly higher income. This is shown in Table 4.

TABLE 4

INCOME OF GROUPS

Group	$3,000 - $5000	$5,000 - $7000	$7,000 to $10,000	Over $10,000
PRESENTING	5	3	-	2
OTHER	1	5	3	1

In the matter of income, however, during a recent study at the clinic it was estimated that, in general, parents presenting themselves at the Thom clinic appear to underestimate their income, so that it could be speculated that the majority would fall into the middle income group of $5000 to $7000, or lower middle class.

Regardless of income the mothers of both groups of children were not employed outside the home except for one mother in the PRESENTING group. In this instance the mother had an M.A. in Education, and taught part time in night school. This was a family where the income was small, and insufficient, since the father attempted to maintain the family by buying and selling ladies handbags on commission.

In considering the father's occupation, the following prevailed as shown in Table 5.

TABLE 5

FATHER'S OCCUPATION

Group	Unskilled	Semi-skilled	Salesman	White Collar	Professional
PRESENTING	1	1	4	2	2
OTHER	2	1	3	1	3

As noted from Table 5 at least half of the fathers were semi-skilled or white collar workers. In the professional category, the PRESENTING group included a business executive, and a bank officer. The OTHER group included a contractor, a dentist, and an engineer.

As stated before all of these boys were in the latency age group ranging from 6 years to 11. The PRESENTING group tended to have younger boys than the OTHER group. This is noted in Table 6.

TABLE 6

AGE OF BOYS

Group	6	7	8	9	10	11
PRESENTING	2	3	1	4	-	-
OTHER	2	2	2	1	2	1

As to position in the family more than half the boys in each group were first children. This is shown in Table 7.

TABLE 7

ORDINAL POSITION

Group	1	2	3
PRESENTING	6	3	1
OTHER	7	2	1

Table 8 shows that in no instance were these boys only children.

TABLE 8

NUMBER OF OTHER SIBLINGS

Group	1	2	3	4	5	6
PRESENTING	4	5	1	-	-	-
OTHER	6	2	1	-	-	1

At least three-quarters of the families, however, came from families of no more than three children, which indicates further similarity in these groups of children.

Table 9 examines the age to grade in school. Appropriate age to grade indicates any boy who was within twelve months of the age considered average, in our culture, for grade, i.e. six years for grade one, etc. Any boy more than twelve months above the age considered average was considered inappropriate.

Table 9 shows an additional similarity in the two groups, since more than half in each group were situated appropriately. This is somewhat different than many children in the clinic who are so absorbed in their inner conflict that they have little energy to expend on learning.

TABLE 9

RELATIONSHIP OF AGE TO GRADE

GROUP	Appropriate age to grade	Inappropriate age to grade
PRESENTING	6	4
OTHER	7	3

Of those boys in inappropriate grades the retardation was very slight, in two instances in the PRESENTING group all 4 were repeating one grade, but 2 were age 9 and in the fourth grade, one 7 in the second, and a fourth almost 10 and in the third. In the OTHER group there were three one grade behind but, in addition, were doing poorly.

Thus in background characteristics the PRESENTING group and the OTHER group are strikingly similar. Most of the mothers of both groups are in the age range 29-39, and more than half are of the Jewish religion.

In addition these mothers had at least a high school education and four in each group had a college education. The fathers' education was similar and the majority were employed above the semi-skilled class, either as salesmen, white collar workers or professionals.

More than half the boys were first born; all had siblings and the majority were in the appropriate grade to age of boy.

Information about the Symptom

Even before the application, at the time of referral, it is of concern to the social worker to know the community source that referred the family. In this sample the majority of children in both groups were referred by the family doctor, one in the PRESENTING group was self-referred. Table 10 shows the source of Referral.

TABLE 10

SOURCE OF REFERRAL

Group	Pediatrician	Doctor and Medical Clinic	School psychologist	Other Social Service	Other psy.	Self	Friend
PRESENTING	3	3	1	1	1	1	-
OTHER	3	-	3	2	1	-	1

Many of these families had previously consulted their family physician about this problem even when the eventual referral had come from the school psychologist. Another psychiatric source frequently consulted was a child guidance clinic in the same community which treats younger children.

The precipitating factor which finally got the child to the clinic was not clearly established although the presenting problem is significantly different in each group. In the PRESENTING group enuresis is listed

as the first and most disturbing symptom while in the OTHER group it is mentioned, but little concern is shown. The all pervading concern is for some other symptom. This is shown in Table 11.

TABLE 11

PRESENTING PROBLEM

Group	Enuresis	Poor School Work	Immature	Phobia	Aggressive	Nervous
PRESENTING	10	-	-	-	-	-
OTHER	-	4	3	2	1	-

Of the mothers of the boys in the PRESENTING group who listed Enuresis only three mentioned additional problems. Two of these mentioned poor school work, and one that her boy was also immature. With the mothers of the OTHER group enuresis was mentioned only as an after-thought but in addition to the presenting problem two mothers mentioned that their child was nervous and another that he was immature.

Table 12 shows the number of children who had previously been trained, and those who had not. Here the term -never trained- is used to indicate those boys whose mothers cannot recall their having control over emission of urine at night for a period of at least a year. Recurrence indicates those boys whose mothers recall that they did have control over emission of urine for at least a year and then reverted to wetting. Table 12 is shown on page 28.

In both groups although the mothers expressed differing views on the importance of the symptom their children's response to training had evidently been the same.

TABLE 12

DURATION OF SYMPTOM

Group	Never trained	Recurrence
PRESENTING	7	3
OTHER	7	3

The mothers in the PRESENTING group used many methods of punishment to correct the symptom. Table 13 indicates the many methods of punishment used by the mothers in this group in order to correct the symptom. Here the term "physical punishment" indicates the use of physical force such as spanking. "Withdrawal of love" is behavior on the part of the mother characterized by lack of response or verbalization of great disapproval. "Nagging and scolding" is behavior on the part of the mother characterized by reiteration in a whining or strident voice disapproval of the child's actions. "Praise" is as defined by Sears, Macoby, and Levin, "a symbolic reward implying approval or affection."

Mothers' Attitudes

TABLE 13

MOTHERS' ATTITUDE TO SYMPTOM

PRESENTING GROUP Mother	Physical Punishment	Withdrawal of love	Nagging and Scolding	Praise
1	-	1	1	-
2	1	1	-	1
3	-	1	-	-
4	-	1	-	-
5	1	1	1	-
6	1	1	-	-
7	1	-	1	-
8	-	1	-	-
9	-	1	-	-
10	-	1	-	-

In the OTHER group mothers ignored the symptom except that two used praise.

In the PRESENTING group a withdrawal of love would be a mother who constantly told her son it was all his fault and ridiculed him for wetting, another who shamed her child, another told the child she did not love him because he was bad and that he would grow up and go to jail.

In the OTHER group, in ignoring the symptom, one mother said that she felt it was cruel to wake up her boy at night to go to the bathroom, another reported she had a washing machine, and the doctor said he would stop before he was married, while a third thought that it was hereditary in her son since his father wet the bed until he was eight and the paternal grandmother until she was twenty.

It was then felt important to look at whether these mothers had made any prior attempts to solve the problem and to relate this to the duration of the problem.

This seems important since one would feel that prior attempts to change the situation would indicate a desire for change. See Table 14.

TABLE 14

PRIOR ATTEMPTS BY MOTHERS

PRESENTING Source	Never Trained	Recurrence	: OTHER	Never Trained	Recurrence
Pediatrician	2	1	:	2	-
Social Service	1	-	:	-	-
Psychiatric Clinic	1	-	:	-	-
Medical Clinic	2	1	:	-	-
School Psychologist	1	-	:	-	-
None	-	1	:	-	-
Friend	-	-	:	-	2

In the OTHER group of mothers they had done little to cope with the symptom of enuresis except in two instances to consult their pediatrician and in two instances to consult with friends. However, they had endeavored to cope with other presenting problems which they considered more crucial. In two cases of phobia the mothers had previously consulted other mental health clinics and in two cases, of the child being very immature, the mothers had consulted a pediatrician. However, the six other mothers were pressured into consultation by others. One stated that the Y.M.C.A. worker stimulated her into considering her son's difficulty, four were motivated by school counsellors and one by a social worker at the clinic where the mother was receiving treatment for her own personality problem. All of these mothers showed ambivalence as to whether their son had a problem.

In regard to the symptom many of the families in both groups had consulted their family pediatrician, and the majority in the OTHER group had been referred by other than medical sources. The symptom of enuresis was the presenting problem in all the PRESENTING group but was not in any of the OTHER group. However, the results were exactly the same for both groups although the symptom had been handled differently.

Table 15 indicates the mothers' attitude toward her own schooling. For this Table and hereafter in this chapter, the terms of "accepting," "ambivalent", and "rejecting", shall be understood to mean:

> Accepting is a positive recognition and permission for the needs of another.
>
> Ambivalent is feeling positively and negatively at the same time toward the needs of another.
>
> Rejecting is the withdrawing of libidinal investment in the needs of another.

TABLE 15

MOTHERS' ATTITUDES TO SCHOOL

Group	Accepting	Ambivalent	Rejecting	Unknown
PRESENTING	4	2	-	4
OTHER	3	-	3	4

As is seen four members of each group did not speak of their school at all.

An example of the attitude of acceptance was one mother who said: "I did well in school", of ambivalence "I'm not sure I did well", and that of rejection as "School was always miserable, I couldn't learn anything".

Less than half of the mothers spoke of their attitude to their peers. In each group four mothers spoke of attitude to peer relationships. In the PRESENTING group one was accepting, two ambivalent, and one rejecting. In the OTHER group one was ambivalent, and four were rejecting.

Table 16 shows the attitudes of the mothers to their own childhood. In this Table and hereafter in the chapter the terms "happy", "overprotective", and "unhappy" will be understood to mean:

> Happy indicates an appropriate gratification of ego needs.
>
> Overprotective indicates a need to shelter the child unrealistically from environmental influences.
>
> Very unhappy indicates very little gratification of ego needs.

Table 16 appears on page 32.

TABLE 16

MOTHERS' ATTITUDES TO HOME

Group	Happy	Ambivalent	Over Protective	Very Unhappy
PRESENTING	3	1	1	5
OTHER	3	2	-	5

In the PRESENTING group those mothers who spoke of their childhood as happy said, "mother was wonderful, and father an angel; I had five devoted sisters; we were a very affectionate family": those ambivalent as "mother was wonderful, but my brother got all attention;" to rejection where a a mother reported she was punished severely, had two feeble minded brothers, and a very depriving mother.

In the OTHER group, an example of happy was the mother who said her mother was wonderful and she had a close family, while the ambivalent spoke of her home being "generally good but I was a dopey kid who conformed too much". And the rejecting as "my mother was alcoholic I sometimes had to go and find her, and bring her home; my father and mother went years without speaking and I was the go-between."

In mothers' attitudes to their sons, their attitudes towards school, peers, and home were again looked at. This is shown in Table 17.

TABLE 17

MOTHERS' ATTITUDES TO SON'S SCHOOL

Group	Accepting	Ambivalence	Rejecting
PRESENTING	5	3	2
OTHER	2	2	6

Here there is a great divergence, and this can be partly explained by

the fact that the presenting problem in the OTHER group frequently involved school difficulties. In the diagnostic interviews six mothers in this group mentioned acting out in school, repeating a grade, disliking to go to school, and being "kicked out".

In Table 18 the mothers' attitude to her son's peers is shown.

TABLE 18

MOTHERS' ATTITUDES TO SON'S PEERS

Group	Accepting	Ambivalent	Rejecting	Unknown
PRESENTING	3	5	1	1
OTHER	-	2	6	2

Here again more than one-half of the mothers in the OTHER group saw their sons as unable to get along well with others their age. The most positively that any mother spoke about this was "he would like to have friends but it's hard work for him." The six mothers whose attitude was rejecting said he has no friends, he rarely plays with anyone, and the kids call him stupid.

Table 19 indicates the mothers' attitude to their sons at home.

TABLE 19

MOTHERS' ATTITUDES TO SONS AT HOME

Group	Accepting	Ambivalent	Overprotecting	Rejecting
PRESENTING	1	1	6	2
OTHER	1	5	4	-

It is interesting here that, in each group, in only one instance were

the mothers accepting. This was indicated by the PRESENTING mother who saw her child as a genius, and the OTHER mother who said he was extremely generous, always well mannered, and never aggressive. In the groups in which the mothers overprotected their children there were elements of rejection "I feed him and care for him but sometimes he makes me so mad and I fly off the handle." Another mother told of dressing her boy although he is nine years old, but then said, "he couldn't do anything right." In the actual rejection in the PRESENTING group one mother said, "he repulses me, I wonder if he is crazy". At birth, she said, she told the doctor she was afraid she didn't like this child and he still exasperates her with very repulsive manners.

Only in the area of attitudes in the home is there sufficient data to relate the mother's attitude to her own childhood in her home and her attitude to her son.

In the PRESENTING group the mother whose own childhood was acceptable was accepting of her son. The mother who was ambivalent about her own childhood was overprotective of her son. In the five cases where the mother spoke of her own mother as rejecting, in three instances she overprotected her son, and in two she rejected him.

In the OTHER group, of the three mothers who described their own childhood as acceptable, two were overprotective of their son, and one was ambivalent. Two mothers who expressed feelings of ambivalence about their own childhood were ambivalent or overprotective of their sons. Of the five mothers who were rejected at home three mothers were overprotecting, one accepting, and one ambivalent.

Since the mother's attitude to her son is sometimes a reflection of

her attitude to her husband it is interesting to look at this manifestation. Hamilton questions: "How much is the parents' distructiveness directed toward the child and how much is displaced from another person - the husband for instance."[2] This is shown in Table 20.

TABLE 20

MOTHER'S ATTITUDE TO HER HUSBAND

Group	Accepting	Ambivalent	Rejecting
PRESENTING	5	3	2
OTHER	3	5	2

One accepting mother spoke of her husband as "a wonderful husband and an ideal father, we see eye to eye on everything." One mother whose attitude was ambivalent said: "I don't respect him much but he lets me do as I please." The mothers who spoke of rejection spoke frankly. One said, "My husband is self-centered and insensitive; he is critical of me. We have a poor marriage."

In Table 21 the mothers' attitudes to their sons in relationship to their attitudes to their husbands is shown.

TABLE 21

MOTHERS' ATTITUDES TO THEIR SONS TO THOSE TOWARD THEIR HUSBANDS

Attitude to son	Accepting		Ambivalent		Rejecting	
	PRESENTING	OTHER	PRESENTING	OTHER	PRESENTING	OTHER
Accepting	-	1	-	-	-	-
Ambivalent	-	2	-	1	1	2
Overprotective	4	-	2	4	1	2
Rejecting	1	-	1	-	-	-

[2]Gordon Hamilton, Psychotherapy and Child Guidance, p. 283.

Here the attitudes of ambivalence and overprotection prevail both in the mother's attitude to her husband and to her son, which suggests feelings of hostility.

Where the mother placed responsibility for the problem was then explored. This is shown in Table 22.

TABLE 22

MOTHER PLACED RESPONSIBILITY FOR PROBLEM OF ENURESIS

Group	Self Blame	Confusion	He can't help it	Child's Fault	Physical
PRESENTING	4	2	1	3	-
OTHER	1	2	3	2	2

In Table 23 is shown the mothers' accepting of the symptom.

TABLE 23

MOTHERS' ACCEPTANCE OF SYMPTOM OF ENURESIS

Group	Acceptable	Fairly Acceptable	Fairly Unacceptable	Unacceptable
PRESENTING	-	2	3	5
OTHER	4	6	-	-

It is noted that the definition acceptable can be illustrated by the mother who said, "bed wetting is no problem, his father wet the bed until older; this is natural for boys," and fairly acceptable as "I don't like it but I can tolerate it." Fairly unacceptable as, "I don't like it, because I think he is lazy," and unacceptable as "I am disgusted at a wet bed. It is repulsive to me and makes me nervous; it is so much extra wash."

It is noted that in the OTHER group the enuresis was either acceptable or fairly acceptable in all cases. This appears to be because the

mothers were greatly concerned about the presenting problem which in this group was not enuresis and could then accept the enuresis. They expressed this in "he will outgrow it", - "his brother won't eat, that's worse;" "it's because of his room phobia," and "I am concerned about his school work."

Following this the mother's attitude to change was explored. This is shown in Table 24.

TABLE 24
MOTHERS' ATTITUDES TO CHANGE

Group	Possible	Fairly Possible	Fairly Impossible	Impossible
PRESENTING	4	5	1	-
OTHER	4	3	2	1

Table 25 shows mother's attitude to who will do work.

TABLE 25
MOTHER'S ATTITUDE TO WHO WILL DO WORK

Group	Clinic Will	Ambivalent	I will
PRESENTING	6	1	3
OTHER	6	4	-

In each group more than half felt that, by some magic of the clinic, all would be worked out. Such expressions as "I want to told what to do - like you are neglecting your child and you should devote half an hour a day to him", or "find out what is wrong and tell us"; "it is all in your hands"; or the ambivalent who say "I don't know if he has a problem, the Y.M.C.A. says he has"; "I'm not a psychologist, I don't know;" or those

who were willing to involve themselves and said, "I need help myself" or "tell me how I can be at fault."

The mother's attitude to change was then compared with who will do work, and this is shown in Table 26.

TABLE 26

MOTHER'S ATTITUDE TO CHANGE COMPARED TO WHO WILL DO WORK

PRESENTING				OTHER			
Attitude	Clinic	Ambivalent	I will	Attitude	Clinic	Ambivalent	I will
Possible	-	1	3	Possible	4	-	-
Fairly Possible	6	-	-	Fairly Possible	2	1	-
Fairly Impossible	-	-	-	Fairly Impossible	-	2	-
Impossible	-	-	-	Impossible	-	1	-

CHAPTER V

SUMMARY AND CONCLUSIONS

This has been a study of the significance of the presenting problem in regard to the maternal attitudes toward enuretic latency age boys. The study was confined to the application and diagnostic interviews in a child guidance clinic. A comparison was made between two groups of mothers; one group mentioned enuresis as a presenting problem; the other, although enuresis was present, did not mention it.

The first area explored was the background characteristics. It was seen that the mothers in both groups were between 29 and 39 years of age; that more than half were of the Jewish religion, and that the education of the fathers and mothers of both groups was similar. In general, too, because of the income and job status of the father one would consider these families to be lower middle class. These characteristics not only revealed similarity between the two groups but were similar to the general clinic population. All of the boys were of the latency age but the OTHER group tended to be somewhat older than the PRESENTING group. None of the PRESENTING group was over nine years of age but the OTHER group had two ten-year-olds and one eleven.

This, however, does not seem significant since these boys are still in the age range of latency and would be concerned with similar problems relative to this time in their lives.

More than half of the boys in both groups were first children. It might be conjectured that, therefore, the age of the mother was younger in

these boys' early years. In addition the newness of her role might lead to insecurity which would influence her handling of these children. However, we have no information as to how these mothers felt about their pregnancy and subsequent motherhood, and therefore little on which to base this.

All of these boys had siblings, three-quarters of both groups came from families of three children which also is indicative of the general clinic population. Most of the children were in appropriate grade for their age. All of this information indicates a homogeneity of background characteristics.

The next area explored was the symptom. The first point looked at was the source of referral and there the majority of the PRESENTING group had been referred by a medical clinic. The majority of the OTHER group had been referred by another community resource, the school psychologist, or other psychiatric or social service sources. This may be because of the attitude of the mother to the problem. The possibility is that where the mother saw the crucial problem as enuresis she had first, in general, consulted a medical source. Where the crucial problem was seen by her as a phobia, poor school work, or immaturity she had usually been pressured into coming to the clinic by another community source.

The symptom of enuresis was the crucial problem in the PRESENTING group and for the OTHER group poor school work, immaturity, or a phobia. Where enuresis was the important issue the mothers had attempted to manage this in many ways, but where it was not the issue they had done very little about it. However, this difference in handling and attitude had the same outcome. Seven boys in each group had never acquired training and with three boys in each group wetting was a recurrence. This would seem to

indicate that enuresis was serving to relieve an inner conflict and therefore responded little to either excessive attention, or none at all, on the part of the mother.

Following this the mother's attitude to the symptom was explored and it is here that there is great divergence in each group. In the PRESENTING group where the mother saw enuresis as the important issue she had tried to treat the symptom in numerous ways. Almost all awakened the boys at night; shamed them, physically punished them; rewarded them, and two eventually bought euretones. Their concern about the symptom pervaded their attitude to their sons. In the OTHER group although these boys were enuretic also there was an almost complete lack of effort on the mother's part to change the behavior of her son in this area. Her attitude was that the symptom was inherited, or due to some other problem which if removed, would lead to the cessation of enuresis. This divergence of attitude was further confirmed in the area of whether these mothers considered the symptom acceptable or unacceptable. In the PRESENTING group three-quarters of the mothers considered the symptom fairly or totally unacceptable, whereas in the OTHER group the mother considered the symptom acceptable or fairly acceptable.

These findings would be important to the social worker in a child guidance clinic since although basically the attitude of the mother to her son may be the same, her attitude to the symptom is different. She will then be helped only if the worker realizes that "This first center of concern is not necessarily the basic problem; it is rather the one the client finds uppermost in his anxiety at a given time. The caseworker must start

with the client where he stands."[1] It is important to explore what the mother feels is critical rather than to push the boy and his mother into categories because the child shows symptoms of enuresis.

The next area covered was the mother's attitudes first to her own childhood and then to her boy's. This was done in three areas, school, peer relationships and home.

Material about the mother's attitude to her own schooling and her peers was available from 6 mothers in each group. In the PRESENTING group more than half of them were accepting of school while of the number in the OTHER group was divided equally between accepting and rejecting. These mothers' attitudes to their sons' schooling was somewhat comparable. The mothers in the PRESENTING were accepting of half of their boys in the areas of school and only rejecting of two, while the OTHER group of mothers were rejecting of 6 in the area of school. In the mothers' remembrances of their own home life half the mothers in both groups remembered their own home life as very unhappy. Three of the ten remembered life in their own homes as very happy but this is questionable and is perhaps due to their inability to express hostility to their own parents, for in most instances these home relationships sounded too idyllic. Regardless of their attitudes to their own home relationships these mothers were largely overprotective or ambivalent to their boys. This raises the question of unconscious rejection and bears out Gerard's findings in a number of the

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[1] Perlman, Helen. op. cit., page 30.

mothers of enuretic boys studied by her, "The largest number of mothers of the neurotic boys were on the whole unconscious of their rejection but the attitudes were disclosed by their mechanism of overcompensation evidenced in their behavior toward their sons. These women were excessively over-solicitous and fearful of injury of the patient, as well as constantly supervising and directing him in all his activities."[2]

In the PRESENTING GROUP 6 mothers were overprotective, and several spoke of dressing their sons even at 8 years, of being nervous about them at all times as "they are so precious." In the OTHER group the mothers also were overprotective but were somewhat more ambivalent about it. Gerard's findings of the relationship of mothers to their husbands and to their sons, however, was not borne out here. "In several instances the boys were identified with a consciously rejected husband and these mothers admitted that they could not love the particular child as much as the others because of the resemblance to the unloved husbands."[3] This does not appear in the sample in this study since only two mothers in each group openly rejected their husbands although at least half were either ambivalent or rejecting. The two who openly rejected their husbands were ambivalent or overprotective of their sons.

The mothers' perception of their sons' ability to change and of who will do the work was next explored. This was in relation to the symptom. The results remained primarily the same in both groups. In both groups

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[2]Gerard, op. cit., page 138.

[3]Gerard, op. cit., page 138.

the majority of mothers felt that their sons' ability to change was at least fairly possible and more than half felt the clinic would do the work. This, however, is frequently found in the general clinic population. Mothers first applying often have a magical belief in the omnipotence of the clinic. However, in the PRESENTING group at least 3 mothers were able to face their own involvement at this early stage of treatment. None of the mothers in the OTHER group were able to do this.

It appears, therefore, that the most striking difference in these groups is in the area of the mother's attitude to the symptom, whether she considered it crucial or not. This should be of interest to social workers in considering parents as they come to the clinic, and in meeting the mother where she is and where she is willing to start in treatment.

It is basic in beginning the application and diagnostic process in child guidance that "we notice and accept rather than explore."[4] Frequently the mother has waited a long time to get to the clinic and is fearful of what will be expected of her. The caseworker's task is to form a relationship for without this she cannot work. The worker's first task is to listen without reservation to the mother's presenting problem; that is why she has come. Also, unless the worker listens she does not know the precise nature of the problem. Only if the worker can listen comfortably and openmindedly for the mother to present her problem in her own way can the mother begin to relate productively.

Scientifically caseworkers know that people can more easily ask for

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[4] Hamilton, Gordon, Social Case Work, p. 29.

help if they project their difficulties on an external factor - here the child's problem. The mother must project her attitude away from herself as she proceeds to the attitude being her's. However, her attitude to the presenting problem as she portrays it will show the worker her attitude to her child and to the worker.

It is important to remember that the mother comes for help with the child and is not, in the beginning, asking for help in her relationship to the child. The child guidance clinic's very structure gives her a defense. Caseworkers are naturally oriented to work with the mother in a disturbed parent-child relationship, but this assumption is erroneous. The mother first thinks of the symptom rather than her relationship to the child and, classically, continues to present the child's problem far into the relationship. If the worker fails to stick with the problem as the mother presents it, but shifts the focus to another area for the sake of the work involved, this will appear to the mother as rejection of herself and the child.

Initially it is known that in general the mother comes to the clinic feeling guilty around her own involvement and anger at the necessity for coming to the clinic. She can more easily express these feelings around the presenting symptom. If the worker refuses to acknowledge the presenting problem and to shift the areas of guilt and hostility the mother may become so frightened or angry that she will act out her rejection and fail to return. In a child guidance clinic, it is the worker's task to free the mother to allow her son to receive help.

It is clear from the small sample in this study the different meaning which enuresis has to these two groups of mothers. Whatever each

mother shares as the presenting problem is the place at which the case-worker should start. This is basic and yet is apt to be forgotten in getting on with the work of the particular agency in which the worker finds himself. The general acceptance of this is noted in the movement of child guidance clinics who are no longer interested in long history taking with the mother but in the problem as it incapacitates the mother-child-relationship today.

A next step in consideration might be a study leading to an examination of the reason why one group of mothers presents this symptom and another does not. It might be speculated that familial patterns in some instances lead to an unquestioning acceptance of this symptom.

APPENDIX

APPENDIX

SCHEDULE

I. BACKGROUND CHARACTERISTICS

1. Age
2. Appropriateness of school grade
3. Health
4. Nationality Background
5. Religion

II. COMPOSITION OF HOME

1. Ordinal Position
2. Other members related
3. Other members unrelated
4. Siblings

III. SOCIO-ECONOMIC

1. Income
2. One or Both Parents Working
3. Educational Background of Parents
   a. Grammar School
   b. High School
   c. College
4. Father's type of Job
   a. Unskilled
   b. Semi-skilled
   c. Skilled
   d. Professional

IV. SYMPTOM

1. Duration

a. Always

b. Recurrence

2. Prior Attempts to Solve

a. Other Social Service

b. Other psychiatric service

c. Consultation with physician

d. Discussed with friends

V. HOW THEY GOT TO CLINIC

1. Method of referral

a. Self

b. Doctor

c. Others

2. Precipitating Factor

VI. MOTHER'S ATTITUDE TO OWN CHILDHOOD

1. School

a. Accepting

b. Ambivalent

c. Rejecting

2. Recreation

a. Accepting

b. Ambivalent

c. Rejecting

3. Peer Group

   a. Accepting

   b. Ambivalent

   c. Rejecting

4. Home

   a. Accepting

   b. Ambivalent

   c. Overprotection

   d. Rejection

VII. MOTHER'S ATTITUDE TO SON

1. School

   a. Accepting

   b. Ambivalent

   c. Rejection

2. Recreation

   a. Accepting

   b. Overprotecting

   c. Ambivalent

   d. Rejecting

3. Peer Group

   a. Accepting

   b. Overprotecting

   c. Ambivalent

   d. Rejecting

4. Home

a. Accepting

b. Overprotection

c. Ambivalent

d. Rejecting

VIII. MOTHER'S ATTITUDE TO HUSBAND

a. Accepting

b. Ambivalent

c. Rejecting

IX. HOW PROBLEM HANDLED

1. Physical Punishment

2. Withdrawal of Love

3. Isolation

4. Praise

X. MOTHER'S ATTITUDE TO SYMPTOM

1. Acceptable to unacceptable

2. Responsibility

a. Others b. Own Fault

3. Change

a. Possible impossible

b. I will do work

c. Clinic will do work

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