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Case work with the mother-dominant family in a child guidance setting

BOSTON UNIVERSITY
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CASE WORK WITH THE MOTHER-DOMINANT FAMILY IN A CHILD GUIDANCE SETTING

A thesis

Submitted by

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CHAPTER I

DELINEATION OF THE SUBJECT

Purpose and Focus

The purpose of this study is to examine case work methods used with those mothers currently in treatment at the Judge Baker Guidance Center who can be described as "dominant" over their families, with particular attention given to similarities in treatment. In order to study the case work and compare its uses with the different mothers, it will be necessary to have some picture of how they function, especially in the family unit.

The questions toward which the study is directed, and which it will attempt to answer, are as follows:

1. What was the nature of the mother's dominance, and how did it manifest itself?

2. What were the central problems these mothers presented to the case worker in the child guidance setting?

3. What case work methods were used?

4. How did they prove helpful, and under what circumstances?

Scope

Certain attitudes and behavior patterns were suggested to define "mother-dominance" as the central emotional problem of a family. These included the mother's exclusive handling of family finances, discipline of the children, school and

recreation plans for the children. If not handled exclusively by her, then all final decisions were made by her rather than by the father or in cooperation with him. In extreme instances, this meant a reversal of roles, with the mother providing support and the father caring for the house and children. In most cases the father was absorbed in his business or other interests and took little active part in family life beyond complying with his wife's demands or plans. It was important to know the mother's attitude toward her husband, that she considered him inadequate, or unambitious, or dependent. It was expected that discipline would be enforced in a rigid, controlling way, and the demands made of the children would be exceptionally high. In short, the mother was the aggressive, initiating, controlling member of the family.

An excellent description of a similar group is given by Mildred Burgum.

> The mothers are aggressive women who dominate the family. Generally they are profoundly conflicted about their femininity which they associate with submission, and either overtly or secretly strive for masculine roles . . . This is true even though in some cases they are poor,sick waifs,desperately floundering for support with deep-rooted never-satisfied dependency needs, out of which the drive for power and dominance grows as a compensation . . . The fathers are dependent, immature, inadequate. They are rarely good providers . . . they lack initiative. In competitive situations they are lost. Their attitudes display . . . infantilism. (They are) . . . sometimes irritable and petulant or given to sporadic outbursts of aggression.[1]

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1 Mildred Burgum, "The Father Gets Worse: a Child Guidance Problem", American Journal of Orthopsychiatry, 12:475 July, 1942.

Selection of Cases and Method of Procedure

Because of the nature of the problem, mother-dominance as a description of a family's emotional equilibrium, it was impossible to locate cases for study through either the intake record or the filing system of the clinic. Instead it was necessary to interview individually the members of the social service department (seven staff workers, nine student workers) and obtain from them those cases which seemed appropriate. Unavoidably this procedure meant that selection of cases was made by subjective decision, although some objectivity attains to the fact that sixteen persons were involved in all, and two opinions contributed to the selection of each case, that of the worker and that of the investigator. In order to obtain the worker's evaluation, only active cases could be selected.

Some limitations were set on the case material at this point. 1) There must have been at least one interview with the father to insure some slight substantiation of the fact that he had withdrawn from the family unit into a passive role, whether because of his own personality structure or because of the aggressive, controlling attitude of his wife. 2) Since particular emphasis was to be placed on the case work treatment, only cases which had been in treatment more than one full year were selected. All families began treatment before January 1952; the longest continual treatment period was six years, beginning in May 1947.

The twenty-one cases decided upon were studied, and all relevant material transferred to a schedule (see appendix I) from which the study was drawn. The material from staff conferences was considered of primary importance, and only the case material on the mothers was studied in entirety. Diagnostic and treatment material on other family members, including the child, was taken solely from the conference record. To preserve confidentiality, all identifying data on the families discussed in the study have been disguised, and all names used are fictitious.

No attempt has been made to prepare an over-all evaluation of the progress these clients made as a result of case work assistance since all the families are still in treatment, although such individual evaluations are possible in the longer cases. Some evaluation of the case work itself, however, as related to the presenting problems of each mother, was necessary in order to treat the original questions posed. The evaluation of individual progress is always a combination of the worker's and the writer's thinking, generally supplemented by opinions recorded in staff conference. That of the case work, its methods and goals, is also a result of combined thinking, often arrived at in discussion between the worker and the writer, and it would be impossible in almost all cases to designate separate sources. In the few instances where the evaluation is solely that of the writer it will be mentioned as such; the final summary and conclusions are, of course, the

writer's own interpretation.

Further limitations appeared as the data were gathered. In many instances case records were incomplete. Whenever this was so, an interview was held with the social worker currently seeing the mother in which recent developments, treatment goals and methods were reviewed. Material varies also in that cases carried by student workers were process-recorded making the case work more clear, while those carried by staff members were generally summarized with focus on the client's development rather than on treatment methods. Thus sources are both recorded and verbal, and although they vary considerably in completeness, all include at least one staff conference and are up to date. A discussion of the records leads to mention of the most serious limitation of all in a study of this kind, the subjectivity of the workers who did the work and recording, and of the writer, who has done the selection of material and its interpretation. Actually the limitation is the reverse, set by the use of language and categories in describing the living experience of case work. But since an approximation must be made in research and study, perhaps the "limits" of the workers' subjectivity can serve as a reminder of the unlimited complexities of case work and the danger of too-easy classification.

Finally, a limitation on the scope of this study has been unavoidable because of the treatment program of the clinic.

The policy of at least one clinic interview with every father, preferably in the first months of treatment, was only instituted one year ago. This fact, combined with the research limitation mentioned above, requiring one interview with the father in every case, produces this last limitation. Because of the focus on treatment methods, long term cases (three to five years) would naturally be the most instructive and valuable. However, it was found that in many such cases the father had never been seen, since when the policy went into effect it was deemed inadvisable to apply it to those families already in treatment for some time. As a result, more than half of the cases included in this study have been in treatment two years or less, and the selection does not accurately represent the total group of mother-dominant families currently in treatment. Nor are the findings as complete and conclusive as they might be, since so many of the long term cases have had to be eliminated.

Value of the Study

One staff worker remarked, when interviewed about those families in her case load suitable for this study, that if she had been asked for the most disturbed mothers she would have mentioned the same names. Certainly there can be no underestimating the seriousness of disturbance which produces, in extreme cases, a reversal of parental roles in almost every aspect of family life. The material presented in Chapter II, drawn from publications, books and periodicals, will show that

interest in the dominating mother is no new development. She has been described, analyzed, educated and treated by psychologists, anthropologists, teachers, analysts and social workers. Yet she is perhaps the particular concern of the child guidance clinic where the severity of her problems so easily blocks progress for her child. In this setting she is the responsibility of the social worker, who is only too familiar with her controlling, aggressive behavior, and aware of the variability and subtlety of its causes and results. It is hoped that this study may bring together a fairly typical group of cases to examine, from the child guidance case worker's specialized point of view, the differences and similarities in "dominance" and in treatment.

The Clinic

A word should be added about the specific clinic setting in which these cases were treated. The Judge Baker Guidance Center operates on an outpatient basis, where individuals in treatment, whether child, mother or father, are customarily seen one hour a week, although treatment plans vary according to the individual's need. Children are accepted for treatment or diagnostic evaluation between the ages of six and seventeen, the decision about the suitability of a case being made by an intake committee. Exceptions are made for families previously treated by the clinic. Few extremely retarded children are treated and no institutionalized cases. The clinic team consists of psychiatrist, psychologist and psychiatric social

worker; limited speech therapy is available. Ordinarily the psychiatrist handles therapy with the child, the psychologist does the testing and the social worker treats the parent, and where necessary interviews the school teacher, doctor, minister, etc. Where both parents are in treatment, they are seen by separate social workers. It is a policy of the clinic, however, that members of the three disciplines should have the opportunity and experience of work with both child and parents, and thus in some cases the social worker treats the child or the psychiatrist sees the mother. Generally in these cases, the social worker receives psychiatric supervision of therapy and the psychiatric fellow receives case work supervision. In some cases the parent may continue seeing a social worker on a more or less regular basis indefinitely, after the child's appointments cease. Within this general framework all treatment plans are flexible, the sole purpose being to assist the child and family in every way.

The Judge Baker Guidance Center was founded in 1917, with the specialized purpose of aiding the Boston Juvenile Court, through study, evaluation and recommendation, in its search for solutions of problems involving juvenile delinquents. In thirty-five years the change in the clinic's function has kept pace with nation-wide changes in the field of child psychiatry. Diagnosis and environmental alteration were found to be insufficient in helping a child modify attitudes and emotional responses, and in the mid-nineteen thir-

ties a program of intensive psychiatric treatment was established. Increasingly, the pre-delinquent child, and the neurotic and deviating child came within the clinic's program, referred by other agencies and by parents themselves. Treatment, too, which extended to include both the child and his mother, has more and more valued the father's cooperation, until now a steadily growing number of fathers are entering treatment. "Today the total procedure is child-family-environment centered".[2]

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2 Thirty-fifth Annual Report, Judge Baker Guidance Center, 1952.

CHAPTER II

SOME THEORETICAL CONSIDERATIONS ON MOTHER DOMINANCE

The Social and Psychological "Role" of Women

In considering the mother who dominates her family as a subject for special study and a problem for special clinical treatment, attention must first be given to the role of woman in our culture, what is expected of her, what she expects of herself, the constantly changing nature of these expectations, and the continuous demand to adjust to them. Since this topic alone deserves careful and extensive research, it can only be touched upon here. However, it is hoped that mention of the subject will emphasize that while mothers included in this study are not struggling solely with cultural and sociological problems, neither are they completely set apart from the "average" modern American mother, but must face many of the same problems as others, whatever their emotional handicap.[1]

In contrast to the general assumption that the feminine role offers steadily increasing opportunity and satisfaction in America, Clara Thompson points to the steadily in-

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1 There were two stock responses when the subject of this study was mentioned. Individuals in the field of psychiatry asked, "Aren't all child guidance cases mother-dominated?" and individuals outside the field of psychiatry asked, "Isn't that the situation in all American families?" These questions point up how broad and hazy is the meaning of the term "mother-dominant". While in the widest sense both questions may be debated at length, in the narrow sense of this paper the answer to both is, "No." In this study, mother-dominance implies a pattern so severe as to be pathological.

creasing frustration it produces. She adds together the fact that women are still discriminated against in many areas of life, that industry has been taken out of the home, that the husband's life no longer centers around the home, and that puritanical ideas still dominate sexual life, with the result that "the position of the present day wife who tries to live in the traditional manner cannot but be one with a constant narrowing of interests and possibilities for development".[2] While new opportunities are indeed available as the old ones diminish, the adaptation of individual women to the change is a slow and difficult process, demanding initiative, since the new "role" is without precedent, and often resulting in compromise. Perhaps the initial reaction, to emulate the male "role" when it seems to offer immediate satisfaction and when the emotional frustrations for a woman are not so quickly perceived, is as much a natural as a neurotic one. The natural reaction to the frustrations later encountered, however, would be further adaptation toward feminine gratification, while the neurotic woman may remain caught in the struggle to compete with the male. The range of adjustment is as wide as the transition is deep; while many women successfully and happily manage their homes in the traditional pattern, others successfully combine careers and home-making, and still others face

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2 Patrick Mullahy, Editor, A Study of Interpersonal Relations, p. 149.

crippling compromises and limitations.

Nor is the role of "mother" any more clearly defined or understood. With the advent of birth control methods the new "illusion is to the effect that unwanted children are less common".[3] In direct contradiction is the traditional illusion that expects a married woman to want a child. If most women can find their way between these two expectations, still some ". . . from neurotic compulsions bear children they cannot love".[4] Furthermore, the myth about the emotional roles of men and women can serve to obscure our thinking. While valid, the association of femininity with passivity and masochism and of masculinity with aggressiveness can be a dangerous over-simplification, under which the domineering mother becomes a freak rather than a deviation. David Levy makes a valuable distinction; he says:

> Theories of femininity, emphasizing especially passive, receptive behavior in women, in keeping with her role in overt sex activity, have embraced all of her functions, and hence have confused feminine and maternal behavior.[5]

Yet maternal behavior, characterized by protecting and giving, is distinctly aggressive, and only because of aggressiveness does it result in masochism in the mother's own orientation. This fact underscores the need for care in discussing the

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3 Ibid. p. 156.

4 Ibid. p. 156.

5 David Levy, Maternal Over-protection, p. 138

neurotic aspects of domineering women, particularly since it is their maternal domination of their families which is under consideration.

The Dynamics of Mother Dominance

In order to discuss the dynamics of the "masculinity complex", it is important first to recall Freud's description of the development of normal femininity. Envious of the male's penis and considering herself castrated by the mother, the female child turns to her father and eventually substitutes for her wish for a penis the wish for a child. Masculine or domineering behavior occurs if this substitution is not satisfactorily achieved: it is a denial of organic inferiority and its unconscious aim is to compete with males for the penis. Freud offers us no explanation as to why this occurs; "We can picture it as nothing other than a constitutional factor: the possession of a greater degree of activity such as is usually characteristic of the male."[6]

Nor does Freud explore the reasons why, in individual cases, this may result in masculine identification with either the mother or father within a great variety of family dynamics. Sexual identification does not take place solely during the phallic period and afterwards, and, especially in cases where it is distorted and unsuccessful, the search leads back to pre-phallic ties. Freud stresses emphatically the strength

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6 Sigmund Freud, New Introductory Lectures on Psychoanalysis, p. 177.

and value of the pre-oedipal attachment of the girl to her mother, and that it contains characteristics of all three phases of infantile sexuality.

Freud's concept of penis envy has been challenged, broadened and explored by recent analysts. While admitting its importance, Helene Deutsch writes that "it seems unlikely that a trauma of external and accidental origin should play a fundamental part in the formation of feminine personality".[7] Instead she feels that full understanding of femininity can be gained only by "investigation of the development of . . . [internal] sexual drives and . . . ego".[8] The real origin of feelings of inferiority, especially in neurotic women, she later concludes,

> is the fact that during a period of biologic development in which the inadequacy of one organ [the clitoris] leads to a constitutionally predetermined transformation of the active tendencies into passive ones, no ready organ [the vagina] exists for the latter . . .[9]

In other words, the girl's functional organlessness is more traumatic than the awareness of the male penis. The hostility and aggression which are aroused by this frustration, and may be set off or increased by penis envy, may be directed against the mother who is held to have wronged the girl, against the father who did not give adequate love, or against herself in

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7 Helene Deutsch, The Psychology of Women, Vol I, p. 226.

8 loc. cit.

9 Ibid, p. 230

guilt about masturbation.

It is not appropriate here to describe the infinite variety of attitude, behavior, and fantasy that is found among women who, as a result of these conflicts, make a greater or lesser masculine identification. Several points need to be kept in mind, however.

First, seldom if ever, is a woman's identification completely masculine. Those who approach it do not marry and raise families. Those who do marry often face great conflict and ambivalence, and it is justifiable to assume that some of this is present as motivation in the decision to seek the help of a child guidance clinic, although perhaps not consciously so. The problem then is really bi-sexuality rather than masculinity, technically speaking, as Florence Hollis points out.[10] Deutsch writes, "What is most ominous is not pure and simple rejection of the mother, but a conflict between rejecting and clinging to her".[11] She adds that if the feminine identification is renouced at the time of the oedipal conflict, there still remains the early, infantile identification, and the rivalry for the father's love.

Second, the confusion about sexual identification cannot simply be dated back to the genital period, no matter how

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10 Florence Hollis, Women in Marital Conflict, Chapter VI.

11 Deutsch, loc. cit. p. 295

much inportance is attributed to the trauma of penis envy. It is true that masculine identification may serve as avoidance of competition with the mother or protection against incestuous feelings in the oedipal situation. But, if a girl cannot satisfactorily identify herself with her mother as a solution to the oedipal conflict, there is reason to assume that development through the anal and oral periods may well have been disturbed as well. Some of the most dominating women have been so crippled in their oral and anal development that any sexual identification is inevitably distorted. Their aggressiveness is a protection against threatening hostile feelings and dependent needs rather than against feminine passivity. Deutsch writes that,

> It is a remarkable fact that the types of neurosis we encounter nowadays with increasing frequency reveal . . . a passive-masochistic, infantile relation to the mother more clearly than did the older types, whose main content was found to be dependence on the father tie and the masculinity complex.[12]

Perhaps the change is not in the neuroses but rather in the perception that beneath the father tie and masculine identification lie threatening narcissistic dependency needs unmet by the mother.

Third, the inevitable expression of a woman's masculine tendencies is through her children, around whom innumerable

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12 Ibid, p. 253. The two types of neuroses here mentioned are strikingly parallel to Groups I and II of this study, cf. Chapter III.

fantasies may center. Not the least of them identifies the child as a part of her own body. Another identifies the child with her father as an object of oedipal wishes.

That the child becomes a part of either parent's neurosis is a common child guidance problem. Karen Horney illustrates it well in her article "Maternal Conflicts", describing through case material how wide the variety of identification and transference onto the child may be: whether of oedipal attachment to the father, fear of the mother, rejection of either parent who takes a submissive, sacrificial role, anger at feeling deserted in favor of a younger sibling. Any or all of these, and many other attitudes, will be found among dominating, controlling mothers.[13] This attitude of the domineering mother toward her children naturally varies as greatly as that toward her parents. Almost all the parental attitudes described by Symonds in his book on the subject [14] can be found in a group of mother-dominated families. Certainly, rejection and ambivalence, as Symonds describes them are the most prevalent. These variously include hostility,

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13 Karen Horney, "Maternal Conflicts," American Journal of Orthopsychiatry, 3:455-465, 1933. cf. also Judith Silberpfennig, "Mother Types Encountered in Child Guidance Clinics", American Journal of Orthopsychiatry, 11:475-484, 1941; and Llewellyn Gross, "Hypothesis of Feminine Types in Relation to Family Adjustment", American Journal of Orthopsychiatry, 20:373 ff, 1950.

14 Percival M. Symonds, The Dynamics of Parent-Child Relationships, Chapters II - VIII.

guilt, withdrawal, excessive control and demand, rigidity, restrictiveness, anxiety, fright and inconsistency. A few cases of over-protective and indulgent rejection can be found.

The particular combination of attitudes manifested depend on a particular mother's reactions to the early experiences mentioned above, and on the nature of her marriage relationship. Unfortunately, case work can seldom trace all the details of the former as does analysis. Burgum [15] describes the latter relationship in these cases as a sado-masochistic one, with the husband striving for dependent gratification as another child. The mother's rejection of the children relieves him of his aggressive-hostile feelings toward them, leaving him free to relate to them in a warm, protecting way, although capitulating to the mother's controls in a showdown.

All the above outlines of attitudes and relationships are at best a framework to which the problems and patterns of individual cases may be added to build the concept of mother-dominance.

Treatment, Problems and Methods

The problems and corresponding theories of treatment of parents in the child guidance setting are both myriad and

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15 Mildred Burgum, "The Father Gets Worse: A Child Guidance Problem", American Journal of Orthopsychiatry, 12:474-485. July, 1942.

fascinating. All of Gordon Hamilton's brilliant summary of them [16] applies in one way or another to treatment of the mother dominant family, and only a few central ones can be touched on here. She writes:

> The objective is to help parents see the connection between their problem and the child's, and if improvement within themselves is not possible, perhaps to help them act out their conflicts in other ways.[17]

The debate about the focus of material with a parent whose child is in psychiatric treatment has been waged these many years, from Madeline Moore in 1933, to Rose Green in 1948.[18] It has been suggested that focus be on the changing of parental attitudes, that all personal material be immediately related to the child's problems, that the aim should be to increase the parent's security as a parent, and that the important thing is the relationship with the parent as a person (rather than as "the guilty party"). Because of the severity of the problem, the latter is of primary importance with dominating mothers whose strong resistance finds a natural de-

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16 Gordon Hamilton, Psychotherapy in Child Guidance, pp. 281-292.

17 Ibid, p. 282

18 Madeline Moore, "The Treatment of Maternal Attitudes in Problems of Guidance", American Journal of Orthopsychiatry, 3:113-127; Almena Dawley, "Inter-related Movement of Parent and Child in therapy with Children", American Journal of Orthopsychiatry, 9:748-754; Wickman and Langford, "The Parent in the Children's Psychiatric Clinic", American Journal of Orthopsychiatry, 14:219-225; Rose Green, "Treatment of Parent-Child Relationships", American Journal of Orthopsychiatry, (AJOO), 18:442-446.

fense in discussion of the child, and whose parenthood is often a tenuous and distorted thing. Hamilton writes,

> If the . . . over-dominating mother is asked to give up her child as love object and so meet head on her own primary problem in the marriage relationship, the result may be overwhelming, unless a supportive relationship is maintained.[19]

However, since the dependent role is in many instances contrary to the role these mothers have chosen, such a transference develops only slowly. In fact they may bring a strong negative transference, especially if their hope is to enlist the clinic in the retention of their control over the child. Even when this hope is not outspoken, treatment of the child is bound to shift and shake the unnatural family equilibrium and will be usually threatening to the mothers. Beneath the hostility which the threat provokes lies the fear of change, fear of looking at themselves. Helene Deutsch describes this aspect of resistance, saying,

> Fear of pain may stem either from excessive masochism or the excessive narcissistic intolerance of the ego, which refuses to accept any discomfort.[20]

Florence Hollis feels that choice of treatment for these mothers depends on the amount of discomfort, the desire to change, the capacity for insight, the depth of the pattern and the external situation. With these in mind, the alterna-

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19 Hamilton, op. cit., p. 291.

20 Deutsch, op. cit., p. 278. Again a parallel may be drawn with this study, the first appearing in the resistance of Group II mothers and the second in that of Group I.

tive goals lie between finding outlets for "masculine" drives and modifying the pattern itself.[21] The immediate relief of initial anxiety, Hirsohn writes, is of especial importance in these cases to avoid withdrawal. Despite a barrage of hostility, intellectualization or politeness from the mother, the worker must recognize from knowledge of the dynamics the deep dependency needs and fears of rejection. He suggests use of direct, concrete advice, or some explanation of causes of similar problems in children so that the mother has something to grasp for support.

Hirsohn's differentiation between support and insight, while oversimplified, bears consideration. He cautions that,

> The domineering, compulsive mother usually does not want intensive treatment involving the recall of earlier childhood feelings and may resent it if the worker makes an attempt to involve her in such treatment.[22]

Nevertheless, since the feelings which she cannot accept in herself are often the reason for her rejection of her child, they must be of concern to the child guidance clinic. The use of supportive techniques described by Schmidl may well lead, over a period of a year or two, to readiness for "insight". He suggests focussing on the social or family situation rather than on the parent as patient, using repressive techniques when necessary, and allowing a strong dependent rela-

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21 Florence Hollis, Women in Marital Conflict, Chapter VI: "The rejection of Femininity".

22 Sid Hirsohn, "Casework with the Compulsive Mother", Social Casework, (June 1951), p. 258.

tionship to form. Following this, the worker may make good use of environmental manipulation, carefully chosen direct suggestions, reassurance and encouragement (all based on knowledge of the parent's feelings and capabilities) and some interpretation, such as the relation between the child's symptoms and the parent's mood.[23]

Later, the degree of insight possible depends on the individual parent and worker. Since these mothers are so preoccupied with concepts of good and bad, Hirsohn suggests a broadening of these concepts, a relinquishing of some parental controls, and a substitution of good rules for poor ones. It is possible to sketch generally the courses treatment may take, as Hamilton has done [24] which, as will be seen, is successful with certain of the domineering mothers.

One gauge of the mother's capacity and eagerness for change in herself and her child is her attitude toward treatment for her husband. While enthusiasm for it may mean a shifting of responsibility or a wish to have him reformed, it may also signify a relinquishing of some of her rigid control. The delicacy and importance of family equilibrium is underscored in Dawley's description of how much it is altered

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23 Fritz Schmidl, "A Study of Techniques Used in Supportive Treatment", Social Casework, December, 1951, pp. 413-419.

24 Hamilton, op. cit., pp. 286-292

by the very act of application for help,[25] and it remains in a state of some flux throughout treatment. In mother-dominated families, Burgum observes that when the mother's attitude improved the father's often became worse, at times adopting the mother's previous attitude. No longer is he able to hide his hostility behind his wife's rejection of the child. Burgum does not discuss treatment plans for this problem. It is hoped that the present study will shed some light on this subject.

Finally, the question arises as to whether case work can really help these women. Hollis states that it can modify,--- but only analysis can change --- the attitudes. Menninger writes that the most self-frustrating course of action is woman's aggression against man. Her function, as he sees it, is the protection of man from his own self-destruction. She is biologically on the side of life, creativity.[26] For those many, caught in this self-frustration and who cannot get or would not wish analytic help, it is worth determining how case work can best be used.

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25 Dawley, op. cit., p. 749

26 Karl Menninger, Love Against Hate, Chapter IV

CHAPTER III

SURVEY OF TWENTY-ONE CLINICAL CASES

General Background

The present ages of the twenty-one mothers under consideration range from thirty-three to fifty, with the average age being forty-one. Nineteen of them are white, two Negro, with one white woman being married to a Negro man. The religious breakdown shows thirteen Jewish mothers, seven Protestant and one Roman Catholic. One mother has an adopted child, actually her niece in treatment, and she is included here because her attitudes resemble those of the other mothers with no more than the usual individual variation.

The income of the families stretches from a marginal one of about forty dollars a week (for four persons) to fifteen thousand dollars yearly. The fathers' occupations include a truck driver, a baker, a bookkeeper, a streetcar conductor, a school teacher, a doctor, a president of a corporation, and a large number of men who are in business for themselves. About half of the families own their own homes, and living arrangements vary from an over-crowded apartment in a slum area to a suburban home in an exclusive residential neighborhood.

The length of treatment of the mothers, with the same, or different, children in treatment, extends from fourteen months to six years, the "year" generally being the

school year from September through June, rather than twelve months consecutively. The average treatment period is about two years, eight months, although this cannot be determined exactly because of variations in treatment plans over the summer months.

Thirteen of the fathers had occasional interviews; one came in with his wife fairly regularly during the first year and spasmodically thereafter; one was seen in treatment for six months but withdrew following transfer; two fathers were treated for one and two years and terminated when both they and their workers felt they no longer needed help; four are now in treatment, having been coming for from three months to three years.

Almost all the mothers have worked outside the immediate home at some time during treatment, either with their husbands or independently. Since in many cases this factor has changed at least once during treatment, and sometimes oftener, any figures are inaccurate. Furthermore, they reveal little about the pattern of conflict or change, since for some mothers it is an improvement to start working and for others an improvement to stop. For what it is worth, however, the present situation shows: Ten mothers working part-time, four assisting their husbands, two holding full-time jobs, one definitely planning to start work, and four mothers neither

employed nor planning to work. Only one mother provides the bulk of the family income, which she has done for the past eight years; her husband is crippled, receives a pension and cares for the home. Generally, the work is clerical, with some domestic work; one woman is a practical nurse, another paints portraits. All are unusually reliable, stable workers and many have held or are holding positions of considerable responsibility.

Of the twenty-two children in treatment, eighteen are male and four female. The boys present ages ranging from six and a half to sixteen and a half, with the average twelve and a half. The girls are now between nine and fifteen, averaging twelve years. A breakdown of ages at referral and present ages is given in Table I.

TABLE I

AGE AT REFERRAL AND PRESENT AGES OF CHILDREN IN TREATMENT

Age in years	Number of children at referral	Number of children at present
5 - 6	1	0
6 - 7	1	1
7 - 8	4	0
8 - 9	5	1
9 - 10	0	2
10 - 11	0	3
11 - 12	2	2
12 - 13	3	2
13 - 14	2	0
14 - 15	1	4
15 - 16	2	3
16 - 17	1	4
Total number	22	22
Average age	10 years	12½ years

It is interesting to note the bi-modal nature of the distribution of ages.

Nineteen of the children were referred by their mothers, three by their fathers. Sometimes the referral was at the suggestion of a friend or relative who knew of the clinic, but more often treatment was suggested by a teacher, school psychologist or traveling clinic, minister, doctor, or another social agency. The symptoms and problems for which they were referred are so extensive and occur in so many different combinations that they are best presented in Table II.

TABLE II

SYMPTOMS AND PROBLEMS OF TWENTY-TWO CHILDREN AT REFERRAL

Symptoms and Problems	Number of males,	females
No friends	16	2
Learning difficulty	9	2
Enuresis	4	2
Minor stealing	6	2
Major stealing, persistent and serious	1	
Stuttering or speech defect	4	
Tics	1	
Obsessive-compulsive behavior	2	
Tantrums	1	1

Symptoms and Problems	Number of males,	females
Thumb-sucking	1	
Hair-pulling	1	
Fire-setting	1	1
Feeding problems	1	1
Sleep disturbances		1
Pathological lying	1	
Withdrawn, anti-social	5	
Outbursts of aggressiveness and cruelty	6	
Defiance		3

The symptoms and problems listed are those presented by the parent at the time of application. All except the last three, withdrawn, aggressive or defiant behavior, were confirmed by the clinical diagnosis; the last three describe the parent's attitude as much as the child's.

It is, of course, difficult to classify parental complaints about attitudes in their children, but interesting to note that whereas no girls were termed aggressive, but rather defiant, no boys were termed defiant, but rather aggressive. There was, in addition to the above, the usual quota of fears, sibling rivalry, hyperactivity and general anxiety. For only fourteen of the children are I.Q. scores available, ranging

from sixty to one hundred forty-eight. Since in re-testing some marked changes occurred, in one instance twenty-five points, and since in most cases it was felt by the psychologist that the performance was below the potential, it is useless to obtain an average. There is a larger number of high scores among the children of those mothers to be classfied in this study as Group III.

In the following discussion of the twenty-one mothers, their attitudes, problems and treatment, the total group has been divided into what appeared to the writer to be three natural sub-groups. Group I consists of five mothers who can be characterized as infantile, immature, subject to powerful, often uncontrollable emotional outbursts, whose defenses are weak and unsteady and who look to the case worker for nurturance and limitations. Only after a long period of supportive help, sometimes as much as three years, were they able to use exploratory or insight-giving case work. Group II is made up of five mothers whose many defenses are repressive and inhibiting, controlling powerful feelings, and who are so caught between these feelings and their control that no therapeutic relationship with the worker is possible since it would threaten the delicate but vital balance. The eleven mothers in Group III, while sharing in various degrees all the problems of the first two groups, were all considered by their

workers capable of using the case work relationship and making readjustments. In the first two groups the nature and severity of the problems suggest the kind of case work needed and there will, therefore, be more focus on the problems than in Group III where case work has more opportunity and scope, among a wider variety of less severe problems. Those areas in which distinction cannot justifiably be made and those attitudes which all the mothers share will be discussed here.

In the area of dynamics it would be satisfying to be able to show that each of these three groups differed from the others in the mother's relationship with her own parents. However, not only is complete understanding of that relationship seldom available to the case worker, but what is available in these cases shows a remarkable absence of pattern. True in three cases in Group II, the woman's mother was dominating and strict and father was ineffectual, though kind. And several women in Group III, described tyrannical fathers who so ruled their wives that their daughters grew fearful of femininity. Yet unconscious attitudes not revealed in case work often contradict conscious ones, and these over-simplifications about early relationships cannot be relied upon for general explanation of present problems. Ordinarily the case worker must follow the attitudes toward early experiences as they appear and change, and the reasons for them may be clearer in one case than another, depending on the repression

and defenses. These cases do, however, bear out one central hypothesis presented in Chapter II, that behind the dominating woman's competition, hostility, dissatisfaction directed toward the male, whether father, husband, son, or all three, lies unresolved conflict and hostile-dependency toward her mother. The question of a woman's identification with her parents and the details of her development in the dominating, controlling "masculine pattern" must be studied individually in case work, if at all.

The most outstanding attitude which all these women share in some degree is their feeling of inferiority and worthlessness. And for all of them this attitude is directly connected with their femininity. One mother, a fourth daughter, said her father had wanted a boy, and she had substituted for him; several spoke of feeling the withdrawal of love at the birth of a younger brother. But more common than such direct competition with a male was a general feeling of desertion or deprivation. In three instances the desertion was a fact, but in others was expressed as "I was the fifth wheel", "the ugly duckling", "I'm all alone, there's no one to help me"; one woman's mother often retired to a cottage named "Kinderlone", "No Children Allowed", another speaks with unhappy pride of being so independent that she went alone on a cruise to South America at the age of sixteen. In an attempt to compensate, many of the group busy themselves to the point of exhaustion with family affairs, both in the immediate fam-

ily and to oblige relatives, later complaining bitterly that their efforts are not appreciated. Where this is not the pattern there is some form of steady, ceaseless activity, in the community or at work. The housework is looked upon as drudgery, slavery, or else is done with fierce compulsion. To a greater or lesser extent, too, these mothers share their moods, alternating between excitement or anger and depression.

In a great many instances the child in treatment was closely connected with the feeling of devaluation, and was rejected as the mother felt she had to reject a bad part of herself, whether the feminine or the masculine side. If the identification with herself was not immediately apparent, it could often be found that the child was linked with someone with whom she had earilier felt identified. It is important to remember that the motherhood of these women as described in the following material is the relationship seen by the clinic with the one child in treatment, and does not necessarily mean that the same attitudes applied to other children in the family. While this was often the case, there are others where one child became a particular outlet for the mother's problems and the other children, as far as is known, made a relatively normal adjustment. In some cases, too, the woman's feeling of inferiority led her to marry a man whom she felt to be her inferior. However, so little is known about the husbands as a group or even as individuals except when they undertook treatment, that any generalization about them is unjustified.

Their wives felt them to be inadequate or distant or passive or dependent, but in each case these facts are at least half a product of the wives' attitudes.

Description of Group I - Five Mothers

These mothers brought to the case worker intense and primitive feelings which in four cases of the five were apparent within a few weeks after the beginning of treatment. These feelings center around anger and aggressiveness, seen in the often unsuccessful struggle to maintain control, the loss of which is equated with insanity. The discipline of their children is extremely inconsistent, since behind it is the fear of hurting or killing the child. Also there is the constant attempted gratification and continual frustration of infantile narcissistic needs. In staff conferences on each of these four cases it was pointed out that both mother and child still considered the child part of the mother's body, a single unit. Thus the child is completely subject to the mother's impulses and needs, her drives for satisfaction or destruction. The following illustrative material was all taken from early in the record, showing initial attitudes and feelings.

> Mrs. Goldberg, when asked by her son how long she was going to live, told him, "forever", if he was a good boy. People live forever if they're happy, and when he was naughty it made her unhappy and then she might die. If he were good, she would live forever. Both mother and child were preoccupied with killing and being killed; both unconsciously held him responsible for her breast cancer. She had two alternatives

in life, which she described, saying that her husband's family suffered from "nervousness" (insanity) while "in my family there is only cancer".

Mrs. Warren (see Chapter IV) spoke of her younger son as her "little girl", said she had always wanted one because girls stayed closer to their mothers. She became panicky when he hurt himself, and claimed that Communist women in the neighborhood exerted an evil influence over him. The older boy had constipation for many years, and his mother gave him constant enemas.

Mrs. Cohen talked often of her son's mishaps in which he "almost killed himself". She wondered early in treatment if there weren't some place she could send him. When he demanded affection, she tried to give it to him but she "couldn't stand it, he hurt her legs when he sat on her lap". She poured out her troubles easily, showing no involvement; she never talked of the children's welfare but of how they affected or inconvenienced her.

Mrs. Hurlburt had gone to work when her son was two "because she loved pretty clothes". She could remember nothing of his developmental history, nor at first his birth date. She early brought up distressing sexual material, was subject to extreme depression and feared psychosis. She described her own mother as "cold, unloving", and was determined to be the opposite with her children. She hated housework and preferred to read or play cards.

The four sons of these women in treatment shared many problems as well. All suffered from extreme anxiety, and were slow in building a relationship with the therapist since it involved separation from the mother and it was necessary to treat them as very young children. All were concerned about killing and being killed, and about survival through eating. They had no clear picture of themselves, but saw themselves as disintegrated, fragmentary. Some compulsive mechanisms or immobilization helped them maintain control. They progressed in treatment as their mothers progressed, but the mothers showed

reluctance to let their sons improve if they felt they were not getting enough help themselves.

There was considerable variation in the presentation of early material. Mrs. Cohen, almost from the first interview, talked of her parents and early experience, but until the worker set limits for her, this only served to increase her anxiety, and make it impossible for her to form a relationship with the worker. Only two years later was she able to bring those early experiences up again and begin to understand and accept them. Rather than early material, Mrs. Hurlburt started almost immediately to discuss confused and uncontrolled sexual material involving herself, her husband, and another woman. It was real progress for her in her second year to handle the situation more firmly and focus her attention away from herself onto her son, but it will be a long time before she can discuss childhood deprivations. Mrs. Warren and Mrs. Goldberg, whose defenses were stronger, both mentioned painful early experiences without affect, denying that they were important. The powerful, anxious, aggressive and dependent feelings were expressed through current material about their husbands or children. In her fourth year of treatment, Mrs. Warren began to work on childhood traumas and rejection; Mrs. Goldberg after two years has not yet begun to do so. In all these cases it seems justifiable to assume serious deprivation in the earliest periods of development.

These women also had excessive fantasies, many of them

paranoid. Their diminution paralleled a strengthening of defenses and only much later (with Mrs. Warren and Mrs. Cohen) did they reappear for controlled exploration. Suicidal thoughts were marked in this group: Mrs. Cohen often threatened to kill herself and once in an outburst of rage beat and scratched herself black and blue. Mrs. Goldberg discussed her suicidal thoughts with her worker. Also, these women do not simply think of themselves as damaged or inferior, but as killers, dangerous and destructive.

Sexual material was presented with little or no hesitation, although taking second place to aggressive drives and destructive fears. For Mrs. Hurlburt, sexual relations were an attempt at infantile closeness; for Mrs. Cohen, they were an effective means of controlling her husband. All four women married to get away from home, and seemed to be searching in marriage for dependency gratifications which had been denied by one or both parents. Mrs. Hurlburt remarked in desperation that her husband's love meant a good deal to her because she had had no love from her mother, and that if her marriage broke up she would just become a bar-fly, for her husband was the "stable element" in her life. However, he was described by the clinic as being "so busy defending his own narcissism that he had nothing to give his boy". Not too much is known about the husbands beyond the fact that they were passive, defensive about themselves, and looked to their wives for strength. Naturally, when both husband and wife hoped to depend on the

other as on a parent for support the other could not give, marital explosions were fairly frequent.

The fifth case in this group differs from the others in the external expression of conflicts. It is included because it was felt by the writer that the mother's early deprivation had been as severe and damaging as for the others in the group, and because treatment suggested by staff conferences resembles that necessary for the others.

> Mr. and Mrs. Lawson and their adolescent son and daughter are all in treatment. The parental roles are almost completely reversed, with Mrs. Lawson working to support the family and Mr. Lawson caring for the home. Mr. Lawson was crippled in an accident eight years ago; however it is evident that the long series of operations which he has undergone since then, for which there was no medical reason, are largely a result of terrible masochism. He was considered by the clinic to be borderline psychotic; he is frank about his dependence on his wife and often allies himself with the children as if he were one of them. For some time Mrs. Lawson worked seven days a week, as if to get as far from her family as possible. She complains that they don't care for her, except as a source of income. She once remarked that she "feels like a man" because she is the one to take the initiative and Mr. Lawson prefers to stay at home. They almost never have sexual relations as Mr. Lawson is seldom able to sustain an erection. Mrs. Lawson is anxious and antagonistic toward her fifteen year old daughter in whom she fears promiscuity, just as she fears sexual impulses in herself.

Like the other mothers in Group I, Mrs. Lawson struggles with control of her aggressiveness and violent feelings; she maintains a superficial defense of intellectualism which breaks down in family tensions when she completely loses control. In her first year of treatment she has discussed her childhood at length, her father's death, her mother's deser-

tion and subsequent foster home and institutional placement. She, too, married to escape, into an inter-racial marriage at that, which made her family disown her. Nor has she hesitated at any time to talk about sexual matters.

Mrs. Lawson is the only mother of the twenty-one, however, who must not only deny her femininity, and suffer the conflicts such denial brings, but who seems to be making an active unconscious effort to adopt masculinity.

Casework with Group I, Mothers

It is evident from the above material that these mothers are difficult indeed to work with, and require time as well as skill.[1] Both cases in the group which have shown some real improvement have been treated for five years. Two or three years may be occupied with relatively superficial, though tremendously important, material, and punctuated with anxiety, hesitation and missed appointments.

The workers had to be prepared and able to accept the mothers' strong, almost headlong dependency without being threatened by it, and being ready and able to meet demands and testing. With the dependency came a resistance, created by anxiety about the strength of feelings rather than by neurotic defenses. The first task was to alleviate this anxiety and the methods used were continued in varying de-

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1 "The very infantile mother who does not assume full responsibility for the child because she has a pattern of behavior which depends on the direction of others requires inexhaustible patience". Hamilton, op. cit., p. 291.

grees throughout treatment. The worker avoided, universalized, or actively helped the mother repress the material about herself which she was unable to handle, and changed the focus to matters outside herself, whether child, household, job, or the like. In those instances where such firm control of the interview was not taken by the worker, the mother either went in repetitive circles or attempted to withdraw because of mounting anxiety. She was helped to talk about herself through the child and find reassurance in a discussion of what constitutes "normal" behavior in children. In these cases such discussion of the child as a defense for the mother is important and needed -- rather than to be avoided -- as in other types of cases. Direct reassurance was used at a certain stage when the mother's fears of psychosis in herself or feeble-mindedness in her child, appeared. But this reassurance was not given until the fears had been verbalized and when the reassurance was justified. Encouragement of and interest in specific activities -- such as housework, finances, recreation, schooling -- all provided a framework of security sorely needed. Direct advice, given for example to Mrs. Warren about how to handle Peter's questions about death, was often carried out verbatum as a kind of experiment. The results helped turn the tide of hopelessness. All the above are, of course, used in some way in all case work. The important point here is that they are used to the exclusion of the exploration of feelings, -- especially hostile ones -- with the specific purpose of

building defenses. The feelings are recognized, accepted and generalized. The danger of acting out or depression is particularly great with these mothers. One worker, who treated two of these cases, placed particular emphasis on the interpretation of the transference, once a relationship had been established. When no other interpretation was possible, this served to reassure the mother that, although she was as yet unable to talk about herself or her feelings about the persons closest to her, she could completely trust her relationship with the worker.

Gradually, these women came to accept to some extent their own ambivalent feelings. The turn toward really exploring their feelings and relating them to past experiences may have been gradual, as with Mrs. Goldberg, or may have depended on an external factor, as for Mrs. Cohen, in having her husband start treatment. In the two longer cases many months were spent viewing and reviewing early feelings and trauma before they were accepted and mastered to any degree. This, of course, called for constant clarification and interpretation of the dynamics by the worker. The relating of this material to current problems with the child helped the mothers keep perspective on themselves, and was useful, too, in helping them accept the child's increased independence, a particular problem in these cases.

The question of what happened to the family equilibrium cannot be answered for the group as a whole. The change

in the mother's relationship to her husband depended on how much of her early experiences she had transferred to him, and how much integration she was able to achieve during treatment. At one point Mrs. Goldberg felt she had "outgrown" her husband, and found herself irritable and "disliking him". Mrs. Warren described her husband as more giving. In the Lawson family, where both parents undertook treatment simultaneously, there is no doubt that the possibilities of treatment for either one singly were more than doubled. There is also the possibility that as they pull themselves together these mothers may take on compulsive, controlling defense mechanisms which would limit their children as well as themselves. Where there was a sign of this it was discussed, but in any event it was preferable to the earlier disintegration.

No generalization can be made either about the outcome of treatment. The growth and stability each one achieves depends on her personality and experiences and her worker's abilities. Mrs. Cohen voluntarily cut down the frequency of her appointments and seems to accept her dependency needs in everyday life more easily. Mrs. Warren has taken a job and is more confident of herself as woman and mother. Mrs. Hurlburt works full-time nursing which gives her immense satisfaction, but in her family continues to fight off depression and struggles to maintain the status quo. It seems possible that the dependent relationship can eventually be relinquished, although very slowly, and perhaps transferred to some degree to

another figure in the woman's life.

Description of Group II - Five Mothers

These five mothers all exhibit rigid, controlling, demanding behavior, especially with their children. Their anxious over-protection covers rejection. They struggle with intense feelings of guilt to the point where their child seems almost to become a sacrifice to atone for the mother's crime. Discipline is subject to the mother's own inner conflict about good and bad. Much energy is devoted to maintaining the compulsive pattern, doing and undoing.

> Mrs. Lillienthal complained bitterly about the family's living arrangements, her need for a maid and her husband's need for a secretary. However, when she got help she spent just as much time instructing them and fussing about how things were to be done, and she fired a secretary within twenty-four hours for incompetence. She couldn't get rid of her son even at night when he would climb into bed with her. She spoke in a steady, tense stream of words, and seldom waited for the answers to her questions. She described herself as being more of a husband to her mother than her father was. She felt love and affection must be bargained for.
>
> Mrs. Rock and her husband had waited five years before having children. Now she shows hostility against her husband that she had to give up work and stay at home, and against her nine year old son for causing her to lose whatever health she had. She was almost triumphant when his enuresis resumed after stopping for a brief period. When he brought home a good report, her response was that she would take away his privileges if it got worse. She often used the phrase, "when Doug was a child" in speaking of him. When he asked for a promised reward he had earned, she refused it, saying that she didn't believe in rewards.
>
> Mrs. Nelson, mother of six, had not wanted a large family. She said about pregnancy, "you know it's inevitable, so you just wish it would hurry up and get over with". She placed tremendous importance on school

achievement and grades. She had tremendous anxiety about all sexual matters, expressed her dislike of bringing up daughters, could never discuss her illegitimate pregnancy when in her teens, or her daughter's illegitimate pregnancy. She hated the poor neighborhood in which they had to live, had never unpacked her household goods in the twelve years they had lived there, refused to associate with her neighbors and encouraged her children to make friends. She undermined her husband's disciplinary measures by giving the children special privileges which resulted in her having ultimate control.

Mrs. Morris had told no one of her three pregnancies until she was seven months along. She had wanted to pick her son up as a baby to feed him but felt it was not allowed. She refused to discuss sexual matters with her children, saying she wanted them to know only the beautiful side of sex. It was never possible to get from her the exact details of her son's delinquent behavior. She flagrantly disobeyed the regulations of the school where he was placed while sincerely insisting that she was cooperating in every way.

Mrs. Sullivan (see Chapter IV) complained about her son's bed-wetting, became so enthusiastic over a few dry nights, that when the wetting started again, as she had been warned it might by the worker, it was a terrible disappointment. She was primarily concerned because of what the neighbors would think. While acknowledging sincerely that it was natural for him at sixteen to have a girl friend, she did everything in her power to put an end to the affair.

The five sons of these women in treatment were all passive and compliant, using many of the same defenses their mothers did, denial, undoing, depersonalization. One boy, a serious delinquent, struggled primarily with the control of aggression, a problem for them all; the others had experienced the oedipal conflict in one way or another, all making some degree of feminine identification. Although with one exception they formed a relationship with the therapist fairly easily, in all cases the prognosis was poor and it seemed impossible

to counterbalance the forces at home. What changes occurred gave only minor relief. All the mothers were, consciously or unconsciously, opposed to any change in their child. For them the child seemed to represent a bad part of themselves which had been discarded as unacceptable. Mrs. Morris remarked that all her children pushed them (the parents) away.

What early history was forthcoming with these mothers, although often important dynamically speaking, could not be used to help them accept their own feelings, since it was subject to the conflict about good and bad in themselves. The same was true of fantasy material, which centered more around their sons than around themselves. They shared with the women in Group I, a picture of themselves as dangerous and destructive.

An area most conspicuous in its absence was the sexual one. All five mothers were extremely reluctant to discuss sexual material and admitted their own fears and inhibitions. All said resentfully they had been given no information or help as girls, but did not discuss their present sexual adjustment in marriage. Mrs. Morris did admit that in more than twenty-five years of married life she and her husband had never undressed before each other. Nor is the relationship between husband and wife any clearer. The mothers complained in most cases that their husbands did not back them up in discipline; Mrs. Lillienthal said that Mr. Lillienthal even challenged her methods in front of the children. The general impression is one of

tremendous distance and separation between husband and wife.

Markedly anal characteristics distinguish these mothers as a group, and it would seem that the problem of control and loss of control is a retreat from unsuccessful or incomplete genital development, and a retreat from any close relationship with man or woman. Two mothers only achieved any real contentment during the summer at the beach when all they did was lie in the sun.

Case Work with Group II, Mothers

These women brought with them a barrage of material, events, details, complaints, and with it tension, anxiety, aggressiveness and even open hostility. These same feelings were manifest no matter what material was discussed, that is, the affect did not vary with the material. They were extremely guilty, and accompanied their complaints about their children with defensive explanations of their handling of them. Despite the amount of material, they seldom could make any connections. In some cases the effort to maintain control was so great that the factual material was seriously distorted. Their defenses were impenetrable and included denial, projection, avoidance, repression, magical thinking, and some intellectualization.

The sum total of all this is that they were unable to form a meaningful relationship with a case worker, whether male or female. Instead they attempted to involve the case worker in the pattern of right and wrong. Mrs. Rock spent

the better part of two years attempting to provoke counter-hostility from her worker and setting up situations for argument. She asked advice, and then either did just the opposite or produced reasons why the advice given was wrong. Everything must be balanced equally, and as she once put it, "Birth is like death". The remarks made by the workers seldom seemed to penetrate. An extreme example of this is Mrs. Nelson, who had had an illegitimate child at sixteen, a fact known to the clinic through the Social Service Index, but never mentioned in three years of interviews. In trying to get her to discuss realistically her daughter's illegitimate pregnancy her worker in desperation finally said, "Well, why did you do it?" and the question, unanswered, brought no more response than if she had said, "Why did you get up this morning?" Mrs. Rock's worker said that her hostility seemed to increase as she felt herself getting closer to the worker. What relationship was formed was a transfer in toto of early hostile-dependent feelings, so that the anxiety about themselves and the awareness of a need for help which some expressed was blocked by fear of giving or receiving anger.

The worker's first task was to explore his or her own feelings about the hostility that these mothers expressed and the frustrations which arose from this negative transference which could not be used and could not be dispelled. While it was necessary to attempt to reach the feelings behind the barrage of material, this was threatening. At the same time

it was impossible for these mothers to move without such exploration. This exploration, or a flat refusal to give advice, was used to handle the either-or situation that these mothers created. It is this writer's feeling that those workers who attempted the methods used for Group I, in relieving anxiety were entirely unsuccessful. Generalization, reassurance, discussions of unusual behavior did not reach these mothers. Focussing on the child in treatment gave relief to anger, but not to anxiety.

Within these mothers' limits a certain amount could be done generally for the child. One worker used a mother's guilt about her child to get her to make school visits and take more of an interest in his activities. The workers were also influential in planning for the children, whether school or camp or recreation. In short, the goal of treatment was to relieve pressure on the child so that he, at least, might have a chance to change.

Description of Group III, Eleven Mothers

The general characteristic of this group is faulty ego structure rather than extreme immaturity as in Group I, or total impairment as in Group II. The problems of those groups are present here, but to lesser degrees. So, too, are modified methods of handling them. There are many ego strengths, which make it possible for these women, with help, to modify some of their attitudes and behavior. They are freer to use both their intelligence and their humor, more

secure to see the relation between their children's problems and their own. What early material appeared was not so charged with emotion that it had to be put aside, but could be used therapeutically. It is possible to distinguish among their problems variations on many familiar themes. While almost all the themes are present in each case, one or two are persistent. These provide the central problem for case work and will be used as the means of subdivision.

Three mothers focussed their problems around the question of control, of themselves and their families, and the danger of loss of control.

> Mrs. Weissman attempted for a long time to control both the interview and her worker, although at the same time becoming increasingly anxious. When the worker set limits and pointed out what she was doing, she was able to see her identification with her son and express her guilt about frequent outbursts of anger. She later touched on her feelings of deprivation, her confusion about sexual roles, and her hostility toward her mother.
>
> Mrs. Woods described the parent-child relationship as a "struggle of wills". She was ambitious and demanding, wanting to reform both her son and her husband, and had once saved the latter's business from failure. At the same time she needed badly to depend on him, and felt that she couldn't.
>
> Mr. and Mrs. Schaeffer have both been in treatment, and for both the expression of hostility and anger is of primary importance. She was extremely guilty about her management of her son, whom she pushed a good deal especially in school.

With Mrs. Weissman, the worker's attitude was largely supportive of her efforts to control herself, although there is no evidence in the record that her hostility was so great

or her defense so poor that exploration of the cause of her anger would have been inadvisable. She gained great relief from talking, but it seems probable that genuine expression of her feeling instead of repression would have been more helpful. Mrs. Woods and Mrs. Schaeffer have both used their dependence on their workers to strengthen themselves and to search for the causes and original objects of their anger.

Two mothers whose defenses were poor struggled with depression or arthritic attacks a great deal of the time, and were threatened by any show of feelings at all.

> Mrs. Sutherland's reaction to any family tensions or disagreements was a wish to withdraw into solitude, which she did in a part-time job. She expended much energy hiding her feelings in silence or in intellectualization, and the major problem for the entire family was that of communication. Later she was able to recognize her fear of the explosion of her anger, and verbalized some of her hostility towards her husband.

> As Mrs. O'Neil (see Chapter IV) slowly and fearfully allowed herself to depend on her worker, she was also less threatened by expressing hostility. Her arthritic attacks were found to be directly connected with both these problems, and it was necessary to approach both of them cautiously, allowing only a little anger to be expressed at a time.

While again the cause of anxiety for these women lay in their angry feelings and fear of expressing them, the case work problem was how to help them without increasing depression or precipitating an arthritic attack. It was particularly necessary for the workers to set limits for these two mothers, and to actively promote a secure, trusting relationship.

The devaluation of themselves as persons, and a fear

of rejection as unlikable, preoccupied two mothers, and was translated into guilt about themselves as poor mothers.

> Mrs. Friedman protected herself from anxiety by a prolonged attempt to intellectualize, a defense used by the entire family. When her son asked a question, he was told to "look it up in the encyclopedia". It was only when confronted with the meaning of her use of psychological terminology that she could relax, and compare her worries about her son with those about herself. She dwelt at length on childhood and adolescent feelings of inferiority, gradually building a more realistic and satisfying picture of herself.

> Mrs. Baker was excessively dependent on external appearances, and material security. She herself is distinctly Negroid, but her husband and adopted daughter, although Negro, could both pass for white. For her, color differences are all-important, representing the acceptable and unacceptable. She is aggressive and patronizing in her manner and has not yet become involved in a case work relationship.

Both these women used strong defenses, intellectualization and concern with outward appearance, to protect themselves from fears of being damaged. Both had fantasies about their children becoming delinquent, which they also feared in themselves. With Mrs. Friedman it was possible finally to explore these fears. Mrs. Baker has shown extreme resistance, in breaking appointments and discussing superficial material. It is felt that until the child's adoption is final and it is impossible for her to be taken away, Mrs. Baker will not be secure enough as a mother to relate to her worker.

Disturbances of a sexual nature troubled two mothers.

> Mrs. Eckdahl (see Chapter IV) had created an extremely seductive relationship with her adolescent son, and at the same time could not tolerate the sexual demands her husband made. She said she felt "like a hybrid", and was clearly bewildered about sexual roles.

She is a boyish person who has identified herself with an older brother.

Mrs. Bernstein's conscious problem was with her intense guilt and her need to be punished. Unconsciously she had acted out the oedipal situation during her mother's absence from the home from her fourth to eleventh years. "People do not ever believe that my father is my father. They sometimes think we are husband and wife". Her father still looks to her to take full responsibility in the family. She also harbored resentment against her children for having increased, during pregnancy, her severe hearing loss.

While very different in dynamics, both these women have strong antagonistic feelings toward their fathers. Mrs. Eckdahl has not yet expressed them, but has been able to talk quite directly about the relationship with her son. Mrs. Bernstein did show her antagonism toward her father, but never talked directly of the sexual nature of their relationship, resolving many of the oedipal conflicts indirectly. Both workers had to take great care in the handling of these discussions that they did not become too anxiety-provoking.

The central problems which the last two mothers presented to the case workers cannot be classified with any of the above, although generally these women share the attitudes of the dominating mother.

Mrs. Stanley's worker wrote of her, "She seems unusually naive in her reluctance to question herself and most of her activity or pattern of behavior". She came to depend on her worker, expressed ambivalence and hostility, and eventually much attention was given to her need to form exclusive, absorbing friendships with a homosexual flavor with a woman. But this was all carried on indirectly, and never did she discuss these feelings or problems directly.

The worker's interpretations bore fruit, in that Mrs.

Stanley's attitudes and behavior changed somewhat. But at best she discussed herself only through her daughter, and much of the time gossiped from one thing to another, denying the worker's suggestion that the topics might be connected. This work has a character all its own in that, while it is in no sense "insight therapy", it brought results.

> Mrs. Olstein was exceptionally fearful about her son, and for this reason was restrictive and watchful of him. She feared having damaged him as she felt damaged herself. She made good use of her relationship with two women workers to replace the hostile-dependent one she had had with her mother.

There is some question as to whether this is a mother-dominant family since Mrs. Olstein's relationship to her husband and the child not in treatment appear to be happy and without conflict. She is the only one of the twenty-one mothers whose behavior toward her child could be called over-protective-rejecting. She seemed genuinely accepting of her feminine role and did not need to occupy every hour with activity. She made excellent use of case work, and it was necessary for both the women workers only to summarize and clarify, for she was eager to explore the problems at hand. Many of her conflicts about dependency were satisfactorily resolved, but no clear picture of her relationships with men was obtained. She was anxious about transfer to a male worker, expressed considerable hostility, and recently withdrew from treatment following her father's death, so that this aspect of her conflict will never be clear.

Among the children there is also more ego integration than in the earlier groups, but no distinctive traits or problems that can be pointed out.[2] Only one child showed severe deprivation on an oral level. Many struggled with the control of aggressive feelings and disintegrated pictures of themselves, and the confusion of activity-passivity, masculinity-femininity was very great. Most had little difficulty relating to the therapist, and the overall picture shows slow but steady progress.

The mothers experienced conscious conflict about their motherhood, and were guilty about their desire to withdraw from family life or to be more independent. While they found the responsibility a burden, at the same moment they wished they could enjoy it. They were able to recognize the inconsistency of their discipline fairly readily, once secure in the case work relationship.

While a stream of complaints about their husbands was expressed by most of them at some time, the undercurrent of loneliness and bewilderment was evident at the same time. The most frequent dissatisfaction was that their husbands withdrew from family life, taking no authority and leaving it all to them, a complaint which it is difficult to distinguish from the mothers' lack of confidence in themselves as mothers.

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2 See Percival M. Symonds, op.cit., pp. 96-97 for an interesting discussion of the effects on the children of the combination of dominating mother and submissive father.

Case Work with Group III Mothers

The initial resistance which these mothers feel to treatment may spring from their fear of loss of control over themselves or their child, or from the implications treatment has for them of inadequacy, or from guilt over their rejection or ambivalence about their child. The workers were able, either directly or indirectly, to get at the anxiety these feelings created by a discussion of their feelings about treatment. At the same time the workers made clear the nature of the treatment plan, setting the limits for the mothers so that they were freer to recognize the need for help. All this may have taken place over a long period of time in conjunction with other things.

In most cases the mothers spent considerable time early in the contact focussing on the child in treatment, and defending their own behavior with the child. Gradually, the workers explored the exact nature of the misunderstandings, the mothers' expectations and hopes for the child. Finally, the child's problems were related to the mother's own experiences and attitudes. During this transition, support was given through discussion of child development, and direct advice where needed to help with plans for the child. The aim, of course, was increased awareness for the mother of her own involvement. Feeling that they could depend on the case worker, it was easier to express hostility, whether toward husband, child, or parents, at times even toward the worker.

It was important that the workers be able to use this constructively. For example, one worker used it as proof that anger did not kill, but that relationships can be strengthened by it. The mother needed to know, too, that her worker was prepared to set limits on her hostility. If the worker avoided, as sometimes happened, the expression of hostility the danger of depression or of acting out increased.

Naturally, many of these themes, which are being discussed consecutively here, appeared simultaneously throughout the treatment. Their intensity and importance varied with the individual mother, and how they were handled varies with the worker. In some cases the interpretation of transference was particularly noticeable in the record; in others it was used only occasionally. The maintainance of constructive defenses was also important, as were discussions of environmental problems and family relationships. Despite the worker's efforts to help a mother see how she herself genuinely felt, such efforts would be fruitless without awareness of the other themes, especially how her child and husband felt. It was also possible in most instances to use early material as it was brought up to further the growth of understanding and acceptance. And throughout treatment specific, tangible assistance was given where needed, whether tutoring, school or camp arrangements, advice about giving sex information, or discussion of how to manage the housework economically.

With the expression of hostility, if the worker did

not allow this to be too threatening, a mother recognized her own ambivalence. The exploration of hostility lead to consideration of the attitudes of those persons against whom it was directed, and the mother's fear of being rejected or hurt by them. Her feelings of being unloved and unlovable, inferior, inadequate began to show themselves directly, where before they showed indirectly as in the guilty feelings about handling her child. Often the causes for these feelings could be touched upon, whether parental attitudes or the birth of a sibling or the like. In some cases childhood fantasy could be compared with reality. In this material the relationship with the worker was of tremendous importance. The experience of being accepted as valuable by the worker gave tangible reason for giving up the devalued image. Here was someone who neither rejected nor made impossible demands. This was, in short, the corrective experience.

Only when her feelings about herself had been touched upon and clarified was it possible for these mothers to truly consider their feelings about their child or husband. The expectations of, or fears about, themselves conditioned their expectations of, and fearsabout, family members. This was especially true of parental acceptance or repression of a child's hostility. It automatically produced guilt and counter-hostility if the parent was identified with the child in feelings of deprivation. Only in recognizing her own dependency needs, which she tried to master by control and authority,

and in having them met in the case work relationship, could she accept the dependency needs of her children and her husband.

Many readjustments seemed to take place naturally after attention had been given to the self-image. Some mothers stopped work, others began to work; some mothers hired maids, others fired them, as they realized that gratification of their own needs meant more satisfaction for the whole family. Mrs. Bernstein, for example, put her foot down and refused to go on taking responsibility for all her in-laws, and is planning to start working. The worker's help was needed here in planning what was realistically possible, and in discussing the meaning of these changes both to the mother and her family.

Particularly important, was the marital relationship. Although the fathers' attitudes were vital throughout treatment, they were especially so as this realignment of forces took place. The variety of relationships was immense. Mr. and Mrs. Schaeffer made of treatment a shared experience, the realignment taking place continuously. Mr. Woods was also in treatment, and was found to be struggling with neurotic problems so that his wife's worker attempted to help her accept the need for her to be the strong and steady member of the family. Mrs. Friedman's worker felt that his (Mr. Friedman's) defenses were so limited and important to him that it would be unwise to suggest that he see a social worker. The ad-

justments made in the O'Neil family (see third case study in Chapter IV), while very minor, were a good example of how tension could be eased and the husband drawn more closely into family life. Mrs. Stanley is another example: she gradually began to depend more on her husband, and became terribly upset over an incident which she interpreted as withdrawal. At the worker's insistence she talked it over with him and later reported their relationship had never been better. In all cases it was imperative that the worker take the family's emotional balance into consideration, and in most that something active be done as well. This may have been to arrange treatment for the father in a few cases, or to discuss his personality and attitudes with the mother in order to clarify her own feelings and expectations. In no case was the aim a reversal of roles, a turning-upside-down of the earlier equilibrium. The mother remained the stronger of the two parents, and the result of treatment was greater acceptance of each other within this balance.

This review of case work with Group III, mothers is a collection of the work and progress of the entire group. It may, therefore, sound overly optimistic. Individual cases may not cover all the material suggested above, or may focus on one particular aspect for a long period of time. Even with these mothers who are more able and ready to change than the first two groups, as much as two years may be spent helping

them overcome resistance, recognize ambivalence and accept a therapeutic relationship.

CHAPTER IV

PRESENTATION OF CASE MATERIAL

The following four cases presented in detail, one each from Group I, and II, and two from Group III, have been selected as good examples of the points made about the groups generally in Chapter III. They have been in treatment longer than the average case, in order to illustrate as many of the problems which arise during treatment as possible.

A Case from Group I

Both sons in the Warren family have been treated at the clinic: Arnold, now thirteen, from 1949-1951, and Peter, now six and one half, for the last eighteen months. Thus, Mrs. Warren, thirty-six, has been seeing the same case worker for the better part of five years, during which time, Mr. Warren, thirty-eight, was seen only once. For a long time the family's economic situation went from bad to worse, since for two years, Mr. Warren, apprenticing as a carpenter, was unable to join the union. Recently, he has taken a job as a truck driver, is earning more, and the family is making every effort to save enough to move to the country from its crowded city apartment.

Arnold and Peter, boys of superior intelligence, were both struggling with intense aggressiveness, which served to cover up fear of being hurt. Arnold formed a relationship with his therapist only after a year of distrustful testing and later made some progress in social relations, although he developed a learning problem at the same time. Peter's outbursts of violence and savage cruelty, and incessant activity and climbing have lessened considerably. He has made an effort to control himself and now plays better with other children.

Mrs. Warren identified Arnold with the bad, aggressive, rejected side of herself, to such an extent that they were almost one unit. Peter was connected for her with her own mother's death which she interpreted as necessary for Peter to live. She had trouble keeping consistent control over the boys, being fearful that they would get killed. At times she was sure women in the neighborhood had an "evil influence" over Peter. She was not close to Mr. Warren whom, she flatly stated, she

had not loved when she married him. In a family crisis, however, she said the family drew closer together, and recently she has described him as much more giving. He does not seem a very adequate person -- withdrawing from the family into his work or to sleep. A severe childhood trauma, the loss of one eye at the age of six when struck by an automobile while walking with her mother, is the focus of all Mrs. Warren's emotional problems. She interpreted the accident as a punishment to her mother for hating her, and wanting to kill her. Her father, who died when she was four, had done a great deal with her. This, she felt, her mother resented.

Mrs. Warren, according to her worker, "flung herself into the relationship . . . with a heavy, meek, masochistic sort of dependency". At the same time she missed many appointments. She reported remarkable changes when she did come in, was anxious and depressed after missing appointments, but could only manage biweekly interviews throughout the three years. Gradually, she expressed her anxiety about her aggressive feelings toward women (she had no friends whatsoever, imagining that women hated her) which the worker accepted, over and over again, interpreting that she was fearful of rejection. In the second year she mentioned the accident for the first time, without affect. She brought out her fear of being abnormal, psychotic, and, following the worker's direct reassurance, she relaxed considerably. She was able to use direct advice about handling Peter, accepted reassurance that her injury had not affected Arnold in any way, and that it was possible to get angry with the children without killing them. She continued to describe tremendous improvement in herself and Arnold, expressed only extremely positive feelings toward her mother, some hostility against her father, was unable to discuss Arnold at all except in terms of herself, and was quite ill after deciding to terminate Arnold.

Six months later she reapplied for Peter and said that for herself this time it would not be necessary to go "down to the very bottom" as they had done before. She now seemed much more confident. Also, the economic situation of the family had improved. Almost at once she turned to material on her own childhood: her awareness of her mother's guilt about the accident, her feeling that it meant her mother hadn't wanted her, and her happy memories of her father. The worker helped her express her sense of loss at her father's death, and linked many of her recollections to Peter's behavior. Mrs. Warren in turn went on to connect her guilt about her mother's death with Peter's birth, and her fear of Peter's dying with her fear of punishment for her hostility toward her mother. She made good use of suggestions about handling Peter's fears of dying, made a real effort to talk things over with her fam-

ily and neighbors instead of fighting, became more firm and consistent in her discipline and accepted the worker's interpretation of Peter's behavior with concern and relief. All this took place in about four month's time.

Suddenly, she seemed to gain new perspective on herself and talked about how upset and sick she had been over the previous years in a grief reaction to her mother's death. She made renewed efforts to face her many fears all of which the worker explored and discussed with her, relating them to reality -- how her mother had really felt about her -- and immediate situations to be faced. In attempts to master the accident she learned to drive and was able to explain another accident to her children. She undertook a diet, was delighted to lose her temper at a neighbor justifiably and not to feel she should die of guilt, and made a close friend. While her gruesome dreams continued, and her paranoid fantasies returned with occasional fears of being deserted, she continued to progress, reviewing her adolescent feelings of inferiority and stupidity, and every few weeks returning to a discussion of the accident. Recently, she suddenly took a part-time job and underwent quite a transformation, becoming animated, happy and well-dressed, although at the same time more severe with Peter. For the first time, she really seemed to grasp the worker's interpretation that both she and Peter turn their aggressions onto themselves, and now is more and more able to discuss her conflict about dependency and fear of killing people by getting close to them.

Interpretation

This case, while typical of Group I, in that very powerful threatening feelings were expressed from the beginning, does not show the repressive method necessary when early material or fantasy appear too soon. Mrs. Warren interpreted her accident as punishment by her mother for her oedipal wishes toward her father which she may have felt killed him. She projected her own hostility against her mother onto her in order to be able to live with her tremendous guilt. Her mother's death at the time of Peter's birth made Mrs. Warren treat him as a kind of sacrifice in appeasement for the old feelings

of hostility.

Aware of this, and of the ever-present danger of depression and paranoia, the worker concentrated her efforts on the difficult task of helping Mrs. Warren form a dependent relationship with a woman. She offered tangible help in advice about Peter, direct reassurance about her fears of abnormality, gave permission for the expression of hostility, and did not challenge Mrs. Warren's insistence of nothing but affection for her mother. The only interpretation offered, concerning her fear of rejection, was aimed at easing and deepening the relationship and carried with it the most meaningful reassurance. Arnold was so much an integral part of Mrs. Warren's bad, angry, guilty self that through three years the worker had to exercise patience and offer the strongest support to her unsteady defenses, accepting even her unreal flight into health. She wrote near the end of that time,

> "I have been so alarmed by the kind and degree of upsets she has that I haven't tried to get into her underlying feelings about her mother, her feelings about her own children being boys, any sexual material, or the matter of her eye injury, and unless these problems are worked through, I think she will remain extremely disturbed".

In the second eighteen months it was possible to deal with all these things, at least partially, because Peter was more separated from her than Arnold. Use was made of the early material not only to discover its effects on Mrs. Warren's personality, but as related to her sons, husband, and neighbors. At the same time that she gained insight through

exploring and discussing early material, she was helped to change present attitudes and behavior patterns for new ones. The worker utilized not only the dependency transference in clarification and interpretation, but also all the important current relationships of Mrs. Warren's life, a method which will enable her eventually to terminate treatment. There is still some work to be done about the marriage relationship, to help Mrs. Warren in her understanding that to be strong does not mean being completely independent or severe, and to be dependent does not mean being in danger of being killed or killing.

A Case from Group II

The Sullivan family, consisting of Mr. Sullivan, forty-eight, his wife, forty-four, George, sixteen and one half, and Michael, fifteen, live in an apartment building which the family owns in a residential area. Mr. Sullivan earns a good salary as a bartender, often working overtime so that he is seldom at home. Mrs. Sullivan supplements the income doing domestic work by the day. They are devout Roman Catholics and both boys are in parochial school where George excelled until recently. He has been in treatment at the clinic for two years, referred for nocturnal enuresis which has never ceased since infancy, and thumb-sucking, nail-biting, and hair-pulling which began shortly after Michael's birth. He is a passive, compliant boy, fearful of aggression, especially from his mother, anxious about his own mental integrity, and with strong homosexual elements resulting from feminine identification. His many defense mechanisms include repression, avoidance, denial, and depersonalization. Recently, he has allied himself increasingly with Michael in defiance and independence of his mother. The enuresis has stopped only for short periods at a time.

Mrs. Sullivan's concern about the bed-wetting was based on the inconvenience it caused her, and her shame about what her neighbors would think. The rigid daily schedule and rules she had devised for both boys showed no awareness of

their needs or attitudes, but was based on her high valuation of school success. She described George as a finicky eater, but felt that the things he liked best were bad for him. She became over-enthusiastic when he had a few dry nights, so that the next wet one was a terrible disappointment. When cautioned by her worker that it would take time for George to change, she immediately turned to complaining about his thumb-sucking which "makes her so mad she could scream". Neither parent had given their sons any sex information; when George asked about babies at twelve his mother said she didn't know. She summed up the relationship by saying, "I can get around George and have him do whatever I want. I build him up, tell him how good he is. It always works". Mr. Sullivan was no help in talking with the boys, his wife complained, although rejecting the suggestion that she might help him express himself by saying he confuses her. She obviously avoided talking of her marriage, and couldn't remember the wedding date.

With the boys, Mrs. Sullivan was attempting to be as strict as her parents had been with her. She grew up in a poor family in Ireland, the oldest of six children, and having much responsibility for her siblings. Her mother was strict, often beating the children; her father, a much older man, was kind and gentle. She led a secluded, lonely life, never going back to school after having stopped when her father was taken ill. She was never given any sex information and found the subject frightening; she smoked secretly from fourteen to sixteen years for which her parents would have killed her if they had known. She stopped by using will power, thinks George should stop wetting the same way, and that her husband and Michael are weak to continue smoking. Despite an unhappy childhood she prefers to associate with Irish-born women with whom she can talk about the past, feeling that American-born women look down on her.

Mrs. Sullivan talked freely with a strange lack of affect other than annoyance. She was concerned about what the clinic would think of her and defensive about her handling of the boys. The worker met her many questions always on the level of the feeling behind them, and although she relaxed slightly, her denial of any emotion in any situation, including a tumor operation, continued. Her superficial reasonableness and cooperation were contradicted by misleading distortions in conversations with George, and continued reliance on magical thinking.

Once the clinic's purpose had been clarified with George, Mrs. Sullivan talked more of herself, showing how identified she was with him, and in the oft repeated phrase, "Aren't I awful?" revealed her fear of the hostility within

her. Gradually, her fantasies of having castrated George came out in her feelings that he needed to be circumcised, or that he had an extra kidney which should be removed. She insisted on a physical exam although he had had many. The worker at one point discussed George's knowledge of sex with her, after which she suddenly decided it was time for him to grow up, but the change of attitude was so sudden it had a punitive, depriving effect.

In the fall, George was conforming (and the wetting no longer bothered his mother) so she wished to stop his treatment and send Michael who was defiant and rebellious. In all these situations -- regarding George's school work, independence, having a girl friend -- the worker's careful, patient attempts to help Mrs. Sullivan accept change were to no avail. In one interview she described how she had treated both boys as girls when they were little, with long curls and dolls, recognizing that she had wanted a girl. She cancelled the following three appointments.

Interpretation

Mrs. Sullivan's struggle with the control of her own resentment was so intense that everything -- relationships and reasonableness -- was subject to it. She presents the picture of a rigid, controlling, castrating woman, deeply confused about her own sexuality and that of her two sons. She illustrates particularly well the impossibility of working with such women on a rational level, making it clear that their unreliable behavior, so despicable if they are held responsible, is actually a result of tragic deprivation and frustration. Her worker commented that her guilt did not seem to match her hostility, that she did not have enough guilt to make use of help. Certainly the neurotic pattern offered satisfactions as George sensed when he said, "If I stopped wetting, you'd have nothing to complain about." In any event, the unsolved problem is how to reach her real

feelings, how to form a therapeutic relationship. A great effort was made. The worker consistently met the feeling tone behind her words, set definite limits on her expression of hostility, and did not explore the violent fantasies, supporting her defenses while attempting to help her deal with reality problems. When George drew away from her, allying himself with his brother and father (who seemed to respond positively) Mrs. Sullivan was particularly in need of support, for her acceptance of the change was at best intellectual. Should the goal be simply a slight widening of the path she has laid out for her sons? She has seldom missed an appointment in two years. Would more appointments, perhaps in psychiatric therapy if she could accept it, give her enough security to break this hostile-dependent, doing-undoing trap in which she is caught?

First Case from Group III

Mrs. O'Neil, forty-five, referred her daughter, Elizabeth, fourteen, three and a half years ago following an episode of minor stealing from a grocery store with another girl, and because of defiance and disobedience at home. The family, white, Protestant, also includes Mr. O'Neil, fifty-one, a streetcar conductor, and John, nine. They have a marginal income with only enough for necessities, and live in a shabby rented frame house in a poor, overcrowded city neighborhood. Elizabeth, who also had temper tantrums and fought constantly with her brother, had few friends because of her need to be best at anything she tried. She was found to have a good hold on reality but to be limited emotionally by extreme anxiety, confusion about sexual roles and a picture of herself as a dangerous, damaging person. She was a resourceful, reliable child who has in treatment made a much happier feminine identification.

Initially, Mrs. O'Neil's attitude toward Elizabeth

was resentful and complaining; she described John as a completely satisfactory, conforming child, and was clearly threatened by her daughter's defiance and need for affection. It was later apparent that Elizabeth only too closely resembled her mother at the same age. Mrs. O'Neil grew up the second of four children of parents who were extremely strict and uncompromising. She was the only one who openly rebelled against the regime. The parents preferred her beautiful younger sister whom she hated and often wished dead. Following the sister's early death at twenty-one years, Mrs. O'Neil often felt she must have caused it, and was guilty as well about the death of a college teacher whom she had intensely disliked. She did not finish college but went to New York, took an office job, became the office supervisor and was eventually fired for being "too bossy". She completed Normal School but could not find a job and worked as a domestic for some time, which she felt was degrading. She married Mr. O'Neil because he was "alone and unwanted the way she was", and she thought she might as well do her own housework as someone else's. She had had practically no education about sex, a subject she still finds upsetting; she associated pregnancy with illness as a girl, and her first attack of arthritis came after Elizabeth's birth, a second one after John's. At the beginning of treatment the marital picture was of an impatient, rigid, demanding, unhappy woman, married to an unambitious, passive, patient, easy-going man.

Mrs. O'Neil seemed a sad and pathetic person indeed when first seen at the clinic. Slight, careworn, faded, and shabby, she was also so crippled with arthritis that it was a struggle to climb the two flights of stairs to her worker's office. In three years of a close, helpful relationship, her worker has found the connection between unexpressed anger and the crippling pain so consistent that when Mrs. O'Neil recently came in stiffened up, the first question the worker asked was, "What are you angry about?" In the beginning, however, the danger of increasing the arthritis or causing depression was grave. Aware of her need for defenses, the worker did not directly approach Mrs. O'Neil's deep anxiety about being in any way dependent, or expressing hostility. After six months she brought up her feeling of responsibility for her sister's death, following which the arthritis became worse. She was unable to get to the clinic for several months and the worker made many home visits. Convinced of the worker's interest, she relaxed a little, and was able to have her interviews on the first floor of the clinic instead of insisting on climbing the stairs. As she recognized her identification with Elizabeth, needing acceptance and affection, she also recognized John's shortcomings. The worker offered specific suggestions about setting limits for Elizabeth instead of

giving in to her as Mrs. O'Neil had given in to her older sister, and used discussion of Elizabeth's confusion about sexual identification to further Mrs. O'Neil's acceptance of her own femininity. The worker noted a change in her appearance, she gained weight and a new sparkle, and talked appreciatively of her husband's buying things for her which previously made her guilty. Suddenly she found she could climb the stairs, and could talk about her fear of anger, her jealousy of her sister, and resentment of authority. She was no longer fearful of injury coming to the children, and expressed genuinely positive feelings for Elizabeth.

The second winter of treatment she attended a mothers' group at the clinic which, for her, was not very successful since she became involved in rivalry with the other women for the attention of the doctor in charge, and much of her time with her own worker was spent unravelling this situation. This last winter most of the interviews have centered around her feelings about Mr. O'Neil and the marriage. In the fall she complained bitterly about his lack of ambition, and the poor support he provided for the family. She also thought her friends were hesitant about inviting them out together. The worker faced with her directly the kind of man he is, unambitious, easy-going, passive, also bringing up his many good points, and wondering whether the problem of going out wasn't Mrs. O'Neil's shame rather than her friends'. Elizabeth, too, was remarking on her father's weaknesses, and at the worker's suggestion, Mrs. O'Neil talked with her about it, saying that all people have weak points, and that all men are not like her father. This seemed to consolidate Mrs. O'Neil's own loyalty, and with the worker she spent a great deal of time trying to figure out how to readjust the family balance. She found that she could insist on certain things which were realistically important, such as a washing machine, and now moving to the country, and that her husband would comply and cooperate. It is almost as if she is pulling him along with her into a new life.

Interpretation

Once more the dependent relationship is of great importance, as important as Mrs. O'Neil's conflict about it is deep. Only a year of testing out, and several months of home visits sufficed to build it. Her other deep conflict, the expression of hostility, was handled only a little at a time over the three and a half years of treatment. While very

little early material was brought up, this case is an excellent example of the manipulation of current material and current relationships to help change attitudes. By talking of Elizabeth's conflicts about femininity, Mrs. O'Neil's own anxiety is lessened and with direct encouragement from the worker she experiments, so to speak, with a new relationship with Elizabeth, and discovers for herself that it is not too dangerous to be close. Most important she is more able to accept her husband as he is. Ideally, it might have been best if he could have been seen at the clinic, too. There is reason to believe that he would have welcomed the opportunity. Since this was not possible, the worker had to use more indirect, but perhaps ultimately more meaningful, ways to help readjust the balance. It took longer, of course, and meant that Mrs. O'Neil had to think through her own feelings and aspirations more deeply. One advantage was that Elizabeth was included in the new understanding and acceptance. The goal with Mrs. O'Neil, as with so many of these mothers, is to help her be strong without being bitter, paralyzed, or punitive.

Second Case from Group III

Carl Eckdahl, fifteen and one half, was referred two years ago because of his habit of wearing a costume of white drapery around the house every afternoon and evening. He was also withdrawn, cruel, quarrelsome, and unable to make friends. He lives with his family, Mrs. Eckdahl, forty, Mr. Eckdahl, forty-nine, and sister Virginia, twelve, in a small town where his father teaches physical education in the high school, earning only a very moderate salary. Mrs. Eckdahl also taught

Physical education until two years ago, and now occasionally substitues. The Family now and then goes on outings together which are always planned and arranged by Mrs. Eckdahl.

Mrs. Eckdahl describes Carl's withdarwal as beginning when he was eight or nine, the same time at which his parents gave up encouraging him in athletics; at the same time his mother began a practice of wrestling with him, which she stopped only "when he started winning". He was found in therapy to have tremendous anxiety about instinctual drives which he controlled by extreme denial. He saw women as atrractive but destructive and men as incomplete and inadequate, and was confused about his own identification. It was difficult to form a relationship with him since he controlled the threatening situation by silence. Recently, he has made real progress, abandoning his robes, joining a boy's club, and gettin a part-time job.

That the relationship between Carl and his mother was a highly seductive one was obvious. He often put his arm around her and held her hand, always hitting her or twisting her arm before letting go. After supper he liked to put his head in her lap or on her shoulder, again with the accompanying act of twisting. Mrs. Eckdahl showed little concern about his draping himself, and was more upset about his fights with Virginia.

Mrs. Eckdahl grew up on a farm, the youngest of five children, four girls and a boy. She idolized her brother and followed him everywhere, helping both him and her father with the farm work. As a result, she can now repair a car and do carpentry, but hates housework. The family was not well off and there was much work for all of them in order to survive. Her father is described as stern and selfish; he punished his wife if the children were bad. Although Mrs. Eckdahl is sympathetic and appreciative toward her mother, she cleary is fearful of being like her. When her brother left home in resentment of his father's domination, Mrs. Eckdahl took over his chores. The Eckdahls went together all through college, though when they married it was because Mrs. Eckdahl figured "she had better settle down". For several years they enjoyed many sports together, but now the relationship has been going from bad to worse. They seldom do anything together, or even talk together; Mrs. Eckdahl does not welcome sexual relations at all and feels that that is all her husband wants. She is irritated by his slow ways, his sweeping generalizations which close any discussions, by his having to be prodded to take any responsibility around the house. She has urged him to change jobs, for while the present one is secure, it offers no advancement and doesn't

pay well. He agrees he should change but does nothing. Mrs. Eckdahl has tried to pretned affection but found it didn't work. She has at times considered separation.

From the beginning, Mrs. Eckdahl was eager and enthusiastic about getting help, although a useful therapeutic relationship was formed only slowly as are all her relationships with women. She focussed at once on her marriage, with a stream of complaints about her husband, at first expressing frustration and later loneliness and bewilderment. Mr. Eckdahl wanted her to be a "clinging vine", she said defiantly, and she couldn't be. Gradually, the emphasis changed to her own confusion about sexual roles. She was trying to be both father and mother to the children which, she realized, must be confusing to them, and which made her feel "like a hybrid". She turned to Carl, wondering why he didn't do what she expected, and later saying maybe she was the crazy one, not he. In a discussion of testing results, it was necessary for the worker to point out Carl's anxiety about his closeness to his mother, but any direct interpretation of this relationship was avoided.

From this subject, Mrs. Eckdahl turned to talking about her own family, her need to conform to her father's wishes and the self-sacrifice involved. The worker's attempts to draw out discussion of her relationship to her brother were not successful. In the second year, Mrs. Eckdahl showed growing awareness of the sexual nature of her relationship with Carl, and finally this was discussed directly. So far, however, she seems unable to do anything about it. The excess physical contact continues, although without the gesture of violence at the end. Mrs. Eckdahl also recognized that it stemmed partially from her turning away from her husband but made no effort to reach out to him. He has just recently started treatment, and since then his sexual demands on her have lessened, so she says, and she reports a more friendly, relaxed atmosphere between them. He has also made more of an effort to share things with Carl. Mrs. Eckdahl is still fluctuating between the ferocious activity with which she attacks her housework -- as if to punish herself -- and depression which is always there if she stops. Her worker talked with her about getting a maid, saying there was no reason why she should do housework if she hated it, but she must, at present anyway, do it herself.

Interpretation

Mrs. Eckdahl brought many valuable traits to the case work relationship. She has a quick sense of humor, and a

genuine desire for help that has made her regular in appointments. She is intelligent and able to make connections for herself, between thoughts and between interviews.

Her behavior is almost manic-depressive in quality and her ego-integration is poor, so that her worker has had to be careful not to let her go too fast. Especially with regard to the sexualized relationship with Carl, the worker pursued a delicate course between not dismissing and not pushing the issue. It was handled by the worker's asking non-judgemental questions with which Mrs. Eckdahl did as much as she could. In conference it was suggested that she used both that relationship and her marriage as defenses and that the important thing to explore was her feelings about her father and brother, but this is still in the future. It appears that she really wants her husband to be a brother to her rather than husband, and the repressed sexual impulses have been directed toward Carl, a less threatening object. She feels that if she allows her husband any control at all, he will walk all over her as her father did. It is much too early to know whether or not, with all three in treatment, Mrs. Eckdahl will be able to make a more satisfactory feminine identification and accept her husband as a sexual partner.

CHAPTER V

SUMMARY AND CONCLUSIONS

Before summarizing the findings of this study, a distinction made at its beginning should be repeated. The women herein described are not representative of the mythical "American mother" who is so often accused of having ruined her children by her domination of them. They are, rather, struggling with attitudes rooted in unhappy childhood experiences which make them incapable of being happy in the roles of wife and mother. Whatever cultural and social problems exist are superimposed on this more or less pathological pattern. In addition, many women seen in child guidance clinics reveal conflicts about their femininity and exhibit rigid, domineering or over-protective behavior in their families. However, in this group of twenty-one mothers the confusion about sexuality is the central problem with which they must deal, and because of its severity, it becomes the central problem with which their families too must deal.

The most obvious, and most important, finding was already foretold in the literature on the subject. These women desperately need someone on whom they can depend; their "domination" covers fear of being rejected, fear of hurting and being hurt. They have been unable, or afraid, to identify themselves with femininity and accept its more passive, receptive gratifications. This makes the protective, giving

function of motherhood extremely difficult for them.

The original questions posed in Chapter I, can serve as the focus of a summary.

1. What was the nature of the mother's dominance and how did it manifest itself?

It was expected, as described on page 1, that dominance would be manifested in rigid, controlling, exacting behavior toward both husband and children, accompanied by bursts of temper when faced with excessive disagreement or frustration. Conflict about sexuality and extremely strong defenses seemed inevitable.

These qualities were indeed found among sixteen mothers, with many different variations on the theme. The energies of five were so absorbed in maintaining some kind of balance within themselves and their families that they were unable to use the outside relationship with a case worker. One mother, whose impulse was to withdraw from her family into solitude, substituted the "struggle of wills" for any more satisfying family relationship. Intellectualization protected one mother from her fears; another, whose character defenses were poor, suffered arthritic attacks. For all the expression of anger was dangerous; some tried to repress it entirely and suffered the consequences, others nullified it in the compulsive doing-undoing pattern. Several mothers seemed to be forced to continue and intensify the domineering pattern because they were not getting satisfying emotional support from

their husbands.

It was not expected, however, to find five mothers whose development was so immature that they lacked adequate defenses, and whose dominance was therefore that of impulse. Their lack of control of their own instinctual drives governed their households, in contrast to the over-control of the other mothers.

2. What were the central problems these mothers presented to the case worker in the child guidance setting?

Two problems are recurrent throughout the material, control versus loss of control and dependence versus independence. They are inextricably woven together, but in very different ways. For the Group I, mothers dependence is of supreme importance, and with it being controlled, or limited, by the worker. Independence means loss of control, and possible psychosis. The Group II mothers are caught between their isolated independence and the control they hope it guarantees, and their fear of loss of control which for them occurs with dependence. The Group III mothers, in many instances, identified dependence with loss of control but were not so threatened that they had to deny their own need for dependence and could not accept the limits set by the worker. These conflicts carry over directly into the parent-child relationship which is of particular concern to the child guidance clinic. Loretta Cass has suggested an equation, ". . . the degree of

conflict in the parent-child relationship is a function . . . of the awareness the parent has for the child's attitudes [and his own] and of the degree of parental control exerted by the parent".[1] In other words, awareness and control are at opposite poles in the parent-child relationship, awareness producing positive identification and a minimum of control, and control producing negative separation from a minimum of awareness. The problem facing the child guidance social worker, then, is the increase of parental awareness of the child's attitudes through increased awareness of their own.

3. What case work methods were used?

4. How did they prove helpful, and under what circumstances?

These will be considered together, the usefulness of each method in particular circumstances being discussed following mention of the method itself, under the general division of "supportive" and "insight-giving" methods. For effective use of any case work methods, a relationship with the worker which is to some extent dependent is necessary. The unusual importance of a dependent relationship to the dominating mother has been emphasized before in this study, and can be emphasized again. A statement about one mother made in staff conference applies to them all, "She needs

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1 Loretta Kekeisen Cass", "An Investigation of Parent-Child Relationships in Terms of Awareness, Identification Projection and Control", American Journal of Orthopsychiatry, 22:307, April, 1952

mothering". Some, of course, need it more than others, and some can use it more profitably than others. The need for it and the ability to use it determine the case work methods which the worker chooses in treatment. Among the Group I mothers, the need for a dependent relationship was so great that only strengthening, supportive methods could be used for a long time, as preparation for exploration and increased insight. The hostile-dependency which characterized the Group II mothers' relationships to a case worker was so strongly ambivalent that only a few relief-giving measures were possible. For the third group, the need for dependency was not as great as for Group I, and not as threatening as for Group II, so that both supportive and insight methods were used simultaneously.

One supportive method used was what the writer terms "specific" support. This includes all kinds of environmental manipulation, direct advice about handling problems, reassurance, encouragement, and general discussion of personality development. These tangible evidences of support were particularly helpful to the Group I mothers who needed all they could get to help them pull themselves together. In many cases they welcomed the worker's activity on their behalf and made good use of advice. On the other hand, such support did little to relieve the group II mothers. Direct advice could not be followed, or else was fitted into the compulsive pattern. Encouragement and reassurance, no matter how carefully given,

seemed to threaten these women. Only efforts to make environmental changes for the child in treatment could really be considered useful. While many types of "specific" support were used with the Group III mothers throughout their treatment, it was impossible to pick and choose which would be useful. The mothers were able to make many adjustments and plans on their own after discussing them with the worker.

A second method is the setting of limitations within the interview situation, in contrast to the permissive, accepting attitude. Again the Group I mothers were most in need of limitations, and when these were not set became anxious. The active repression of childhood or fantasy material helped in the unification of the personality and in the construction of adequate defenses. It is perhaps easily overlooked that the Group II mothers needed limitations set for them as much as any of the others. The case worker's reaction, in working with someone with rigid defenses, is to attempt to explore the feelings being held in check, using caution, reassurance and warmth. But permissive acceptance was only threatening to these women. The firm setting of limits in interview and treatment, and regular review of this structure, might make it possible for these mothers to relinquish some of the controls they have had to impose on themselves for safety. While efforts were made to limit the expression of hostility or anxiety, there is no evidence in the records that such continuous structuring of the treat-

ment situation was carried on over a period of time. With Group II, again some limitations were set as they were needed, depending on how anxious the mother was about her own ability to maintain self-control.

The interpretation of transference served to support the mothers in several instances. The Group I mothers sometimes involved their workers in their fantasies or distortions, which could have made further work impossible as well as increasing anxiety if it had not been interpreted. This was not done with the Group II mothers, whose fantasies, while equally intense, were more deeply repressed. Nevertheless the transference was obviously strong, and the question of whether its interpretation would have brought relief or not must be left open. Generally, such interpretation did not seem to be necessary with the third group.

The method of manipulation of emotional attitudes marks the transition from supportive to insight-giving case work. The Group I mothers' need for dependency was used later in treatment to clarify the feelings of deprivation and rejection; their anxiety about a child's aggressiveness helped them to discuss their own. Only a little such manipulation was possible in Group II, specifically the use of guilt about a child to help the mother take a more active interest in his activities. The attitudes of the Group III mothers were used to increase understanding within the family unit, whether of the child's behavior or of the father's

personality problems.

In discussing the insight-giving methods used with dominating mothers, those in Group II must be omitted altogether. Although they brought up much powerful material it could not be used. The mothers in Group I were helped by these methods only after very long periods of supportive help, sometimes as much as three years. Group III mothers made the best use of the worker's clarification or interpretation, some with outstanding success.

Clarification was used extensively. A good example of its use with the Group I mothers was in the review of early traumatic experiences, one a desertion, another an accident, which were recalled again and again by the mothers in attempts to master them. Gradually, it was possible for the workers to define more clearly the woman's reaction to those experiences to clarify her attitudes toward the other persons involved and relate the experience to present attitudes. Much clarification of fantasy was needed among these mothers as well. Most of the clarification with Group III mothers was done with current material, for example relating a woman's attitude toward her mother to that toward her child, or verbalizing her feelings about herself as inferior.

Very little interpretation was undertaken. Perhaps this was because the relationship and the meeting of dependency needs was so all-important for these mothers, and, if properly handled, in itself brought what changes case work

could effect.

In conclusion, it is interesting to glance back, with this study in mind, to the literature reviewed in Chapter II. It seems to the writer that the analytic discussions of the dynamics of mother-dominance accurately described the mothers considered here. Furthermore, the recent material on general child guidance treatment problems included those which arose in the treatment of these cases. Since no studies in case work specifically on this subject have been published to the writer's knowledge, no comparison or differences are possible. However, it is the writer's opinion that this study gives more reason to think that case work can offer help to these mothers than did Hollis's study, possible because the treatment described here was so much longer than that given the women she studied. Also, the changes among the fathers resulting from adjustments made by their wives were, in these cases, less catastrophic than in those presented by Burgum, perhaps because the clinic's work is now family centered from the beginning.

Finally, it must be remembered that no woman maintains a position of rigid dominance over her family without a reason for doing so, and without tension, pain and the sacrifice of intimacy and understanding. She needs help, no matter how greatly she is threatened by it or how resistant she is to it. This study demonstrates that help is available in the case work relationship; the task of making such help increasingly effective, and more acceptable to more mothers, lies always ahead.

Approved:
Richard K. Conant
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Dean

APPENDIX I

Schedule for case material

I. Names and ages of family members, underlining child now in treatment:

Child's age at beginning of treatment:

Date of beginning of treatment:

Pattern of interviews with family, including completeness of record:

Brief description of mother, father and child:

Family status, race, religion, father's occupation, income and living arrangements:

Child's problem:
Referred by
Precipitating events
Mother's attitude at time of application
Symptomatology, level of development, diagnosis and treatment material, from staff conference only.

II. Mother-child relationship, including mother's presentation of developmental history, mother's identification of child with other family members, mother's attitude toward child's friends, schoolwork, therapist, evidence of over-protection or rejection.

III. Mother-father relationship, including management of finances, use of leisure time, management of discipline, sex relations.

IV. Other material on mother, personality and early history, including significant relationships with her mother and father, early trauma and insecurity, physical difficulties and general attitude toward woman's expected role in our culture.

V. Other material on father, pertinent to study, including his identification of child, attitude toward treatment, and relevant early relationships and trauma.

VI. Cultural, environmental, educational, religious factors of importance to the study.

VII. Treatment of mother

VIII. Evaluation by research worker.

1. General impressions of work, results, quality.
2. How adequate is the history on mother?
3. Was there a change of attitude?
4. Was there a change in family equilibrium, if so what?
5. Additional thoughts about how to help this mother.

BIBLIOGRAPHY

Books

Deutsch, Helene, The Psychology of Women. Volumes 1 and 2. New York: Grune and Stratton, 1944.

Hamilton, Gordon, Psychotherapy in Child Guidance. New York: Columbia University Press, 1947.

Hollis, Florence, Women in Marital Conflict. New York: Family Service Association of America, 1949.

Levy, David, Maternal Overprotection. New York: Columbia University Press, 1943.

Menninger, Karl, Love Against Hate. New York: Harcourt Brace and Co., 1942.

Mullahy, Patrick, Editor, A Study of Interpersonal Relations. New York: Hermitage Press, 1949.

Sayles, Mary Buck, The Problem Child at Home. New York: The Commonwealth Fund, 1928.

Symonds, Percival M., The Dynamics of Parent-Child Relationships. New York: Bureau of Publications, Teachers College, Columbia University, 1949.

Periodicals

Burgum, Mildred, "The Father Gets Worse: A Child Guidance Problem", American Journal of Orthopsychiatry, 12:474-485, July, 1942.

Cass, Loretta Kekeisen, "An Investigation of Parent-Child Relationships in Terms of Awareness, Identification, Projection and Control", American Journal of Orthopsychiatry, 22:305-313, April, 1952.

Dawley, Almena, "Inter-related Movement of Parent and Child in Therapy with Children", American Journal of Orthopsychiatry, 9:748-754, October, 1939.

Dunbar, Flanders, "Symbiosis of Parent and Child", American Journal of Orthopsychiatry, 22:809-824, October, 1952.

Green, Rose, "Treatment of Parent-Child Relationships", American Journal of Orthopsychiatry, 18:442-446, July,1948.

Gross, Llewellyn, "Hypothesis of Feminine Types in Relation to Family Adjustment", American Journal of Orthopsychiatry, 20:373-381, April, 1950.

Hirsohn, Sid, "Casework with the Compulsive Mother," Social Casework, 32:254-261, June, 1951.

Horney, Karen, "Maternal Conflicts", American Journal of Orthopsychiatry, 3:455-463, October, 1933.

Moore, Madeline, "The Treatment of Maternal Attitudes in Problems of Guidance", American Journal of Orthopsychiatry, 3:113-127, April, 1933.

Newell, H. W., "Psychodynamics of Maternal Rejection", American Journal of Orthopsychiatry, 4:387-401, July, 1934.

Schmidl, Fritz, "A Study of Techniques used in Supportive Treatment", Social Casework, 32:413-419, December, 1951.

Silberpfennig, Judith, "Mother Types Encountered in Child Guidance Clinics", American Journal of Orthopsychiatry, 11:475-484, July, 1941.

Wickman, Katherine M. and Langford, William S., "The Parent in the Children's Psychiatric Clinic", American Journal of Orthopsychiatry, 14:219-225, April, 1944.

Pamphlets

Thirty-Fifth Annual Report, Judge Baker Guidance Center, Boston, Massachusetts, 1952.