1951

Influential factors in the acceptance of child guidance help by mothers of preschool children: a comparative study of factors in the emotional adjustments of mothers who have accepted child guidance help with the problems of their preschool children, as compared to those mothers who have allowed these problems to continue unaided until the school years.

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Boston University

http://hdl.handle.net/2144/10797

Boston University
INFLUENTIAL FACTORS IN THE ACCEPTANCE OF CHILD
GUIDANCE HELP BY MOTHERS OF PRESCHOOL CHILDREN

A Comparative Study of Factors in the Emotional
Adjustments of Mothers Who Have Accepted Child
Guidance Help with the Problems of Their Pre-
School Children, as Compared to Those Mothers
Who Have Allowed These Problems to Continue Un-
aided Until the School Years.

A Thesis

Submitted by
Robert Harold Nee
(A.F., Boston University, 1949)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1951
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INTRODUCTION

In recent years, it has been recognized that efforts to prevent emotional illness are most effective when applied in early childhood, and that correction of patterns of adjustment in later periods becomes increasingly difficult. It has also been recognized that the close involvement of the child with his parents, especially with his mother, makes treatment of the mother an almost inevitable concomitant of the treatment of the child.\(^1\) The knowledge of the importance of the mother-child relationship, and the more favorable outcome of treatment in early childhood, has brought many problems to the child guidance setting. The emotional problems of the mother which seem to be interfering with her healthy adjustment to the personality of the child are, also, frequently seen as responsible for the time of referral of the child, and the use made of clinic services.

The possibility of treatment of the emotionally disturbed child of preschool age has long been acknowledged. As early as 1929, Lowrey\(^2\) felt that the mental hygiene problems of the preschool child were not particularly different from those of any other age group, and that service to this child

\(^1\) George S. Stevenson and Geddes Smith, *Child Guidance Clinics*, p. 91.

might well be incorporated in child guidance programs. It is
only in recent years, however, perhaps stimulated by the men-
tal health programs of the early forties, that the demand for
such service has begun to reach its just proportions.

The Worcester Youth Guidance Center, where this study is
being conducted, has kept pace with the demand for such ser-
vice and during the course of its thirty years in operation
has treated successfully many of these younger children. In
recent years, however, the preschool child has come to assume
a sizeable proportion of the agency's caseload, and indica-
tions are that this group will increase in years to come.
During the six year period between January, 1945 and January,
1951, approximately seventy children under five years of age
were accepted for treatment, two-thirds of this group having
been accepted during the latter half of this period.

Expansion of service, and refinement of techniques to
meet this increasing demand, however, is no guarantee that
mothers of preschool children will accept the help offered
them after they have been accepted for treatment. Many
mothers reject treatment following acceptance, whereas others
continue to wait months, even years, after the onset of the
child's symptoms to seek help from any source at all.

Purpose of Study

The purpose of this study is to examine the emotional
adjustments and attitudes of mothers who have accepted help
for their preschool children as compared with mothers who have waited until a later period to accept help although the symptoms of their children arose in the preschool period. This study will attempt to answer the following questions:

1. Is it a different type of mother who refers her child at the period of onset of symptoms, and what is the nature of the difference?

2. Is there a relationship between the time of referral and the mother's attitude toward the child? If so, what is the nature of this relationship?

3. What are the attitudes of mothers toward child guidance help for their preschool children?

As the mothers occupy a most important position in the treatment plan of the child by necessity of their involvement in treatment, an understanding of their attitudes and the factors involved in the time of the child's referral, might afford diagnostic clues toward defining casework services for the two groups of mothers.

Source of Data

This study is based upon the agency's case recordings, for the most part, and will include all cases of children under five years of age who were referred for treatment during a two year period, between July, 1948 and July, 1950. A total of twenty-nine cases were found to have been referred during this period. For the purpose of this study, all cases in which the mother was not interviewed three or more times were excluded because it was felt that the material was inadequate for the study of mothers' emotional adjustments and
attitudes, especially attitudes toward the prolonged treatment process itself. Also, excluded were cases in which it had been definitely determined that the children were mentally defective, and one case in which a child was referred because her behavior was interfering with the treatment of a spastic disorder. These latter cases were excluded because they did not meet the criteria for comparative study. The remaining cases, thirteen in all, were then matched individually with cases of children over five years of age of the same sex and with similar symptoms of preschool onset, and having been referred during the same time period as the cases of children under five years of age.

**Limitations**

In some instances, summary recording was found to have been used. Thus, one of the limitations of this study lies in the amount of subjectivity of case recordings and the lack of verification of data. Inasmuch, too, as the study is confined to a limited time span of the Worcester Youth Guidance Center, the findings will refer specifically to this agency, although, perhaps general inferences may be drawn to situations that do not differ in essential factors from the setting that is being studied.
II METHOD OF STUDY AND DESCRIPTION OF MATERIAL

The Worcester Youth Guidance Center has three classifications of service to the community: treatment, consultation and diagnostic. Diagnostic service is the psychological study of a child, often with collateral interviews with the child's mother, for the purpose of arriving at a diagnosis. Consultation is that service offered to mothers and members of other agencies who are dealing with a "problem child." The child is not seen in treatment. Treatment is a service offered to both mother and child, and individual workers are assigned each. Assignment of cases is flexible; the child's therapist may be a psychiatrist, psychologist or social worker, but mother's worker, for the most part, is a social worker.

Method of Study

In this study, cases were used only in which treatment was afforded both mother and child. The material used was obtained from the recorded interviews with the mothers; the treatment sessions with the children; the recorded summaries prepared by the workers for a diagnostic conference after both mother and child had been in treatment approximately six weeks; and from teaching conferences at which two of the cases used in this study were presented. At these conferences, the entire staff participated, and only those conclusions in which there was a general agreement among staff members were
severity of emotional disorder and of different personality structures, regardless of similarity of symptoms, became apparent. This danger was diminished by establishing a diagnostic criterion which would approximate as nearly as possible equality of severity of disorder and which would embrace a picture of the child's personality patterns.

In establishing this criterion, the diagnosis as recorded by the child's therapist has been used, but as the Center has found no one standard psychiatric classification of children's disorders entirely adequate, it has been necessary to redefine some diagnoses in accordance with the classification selected for use in this study.

Definitions of Classifications

Gordon Hamilton's diagnostic system has been found most useful in classifying cases because the criteria she has established in terms of the child's personality patterns are clearly defined and applicable to the cases being studied. For the purpose of discussion, the diagnoses of the children studied have been grouped in the same manner as Miss Hamilton presents them, under the somewhat modified titles of: (1) The Extremely Aggressive Child, (2) The Anxious Child, and (3) The Severely Disturbed Child.

The diagnoses used in this study are as follows:

1. The Extremely Aggressive Child

PBD Primary Behavior Disorder

Included within this group are extremely aggressive children who act out their impulses freely. They have a deficient super-ego and exhibit a high degree of self-love. Because of their narcissism, these children have difficulty relating to others. Their behavior evidences a pattern of trying to provoke. They anticipate punishment for their actions, but have no understanding of its meaning, and consequently try to avoid it.

A total of five children under five years of age presented personality patterns as defined by this diagnosis, and they were individually matched with five children over five years of age in accordance with the aforementioned criteria who also presented the personality patterns of the Primary Behavior Disorder. Two cases illustrative of this group are those of Martin B. and Vance D. which are matched cases.

Case #1 Martin, age three years and five months, was referred by his mother for temper tantrums, destructive behavior, and eating and sleeping difficulties. Mrs. B. complains that he "goads" her to anger by throwing food on the floor, up-setting drawers and beds in retaliation for her restrictions, and kicking both her and his sister without provocation.

Case #2 Vance, age seven years and four months, was referred by his mother who complained that he has been a behavior problem since birth. He is "aggressive, stubborn, and destructive." He shows a great deal of hostility towards his parents. He calls them names and takes offense at the slightest opposition to his wishes by flying into a temper. He yells, throws things, and gnashes his teeth when he is displeased.

In treatment, both of these children were found to have little capacity for control. They had little guilt feeling
concerning their hostility, rather considering it to be a logical response to their environment. They showed little depth in affect, and had established only superficial relationships. For them, people were objects to be feared.

2. **The Anxious Child**

Whereas the primary behavior disorder is a direct reactive disturbance to a child's environment, the anxious child already has to some extent, an internalized conflict. This group includes the diagnoses of psychoneurotic, anxiety type, and psychoneurotic with conduct disorder.

**Pn,A Psychoneurotic, Anxiety Type**

Within this group are children who have repressed their impulses with a resultant internalized conflict which is frequently expressed in symptoms such as tics, enuresis, stuttering, and the extreme of psychosomatic illnesses. These are fearful children who present a pattern of anxiety; overtly, in withdrawal, shyness, or worrying, and; disguised, in nightmares or covert fears.

**Pn,CD Psychoneurotic with Conduct Disorders**

Children bearing this diagnosis are those who present symptoms of anxiety described in the above group along with behavior disorders suggestive of the primary behavior disorder. They are distinguished from this latter group, however, in that their predominant personality patterns are fraught with anxiety. They also have an awareness of the social consequence of their behavior, and frequently have a very strict superego.

Six children of preschool age fell into the broad classification of "The Anxious Child." Three were diagnosed psychoneurotic, anxiety type, and three psychoneurotic with conduct disorders; all six were matched individually with cases of
children over five years of age with the same diagnoses. An example of each type is as follows:

Case #10 Owen K., age ten, was referred by his mother at the suggestion of the school. Owen was a severe stutterer, and his mother complained that he was shy and withdrawn with other children and that he had been doing poorly in school. He bites his fingernails, sucks on the back of his hand, and is restless in sleep, often complaining of nightmares.

This picture of inhibition of impulses was borne out in Owen's contacts with the clinic. He was found to be an anxious, unhappy boy. He was very self-conscious about his speech and consequently avoided social contacts with others. He had many fears, and presented personality patterns definitive of the diagnosis psychoneurotic, anxiety type.

Case #11 Bob R., age four years and three months, was referred by his mother who complained that he wouldn't go out to play, and if he did, he fought with other children. He was described as destructive in his play. He cries a good deal, complains of nightmares almost every night, and gets colds frequently. He also has asthma-like attacks in which he has difficulty breathing.

Although Bob was able to establish a relationship with the therapist, his capacity for rapport was found to be limited by his anxiety. He had many fears and frequently spoke of being chased by wolves. For the most part, however, his emotions were inhibited, and his aggression was felt to be directed against himself rather than others. Because he was a behavior problem as well as a very anxious youngster, he was diagnosed psychoneurotic with conduct disorder.
3. **The Severely Disturbed Child**

Within this group, Miss Hamilton\(^2\) includes cases of severe psychoneuroses, psychosomatic disorders, marginal psychoses, and psychoses. Two cases of preschool children were found to be severely disturbed and have been diagnosed at the Center as "Atypical Child" or "Autistic Child". As the personality patterns of these children differ from those described by Miss Hamilton, these two children and their matched cases will be thought of as "Atypical".

At **Atypical Children**
The personality patterns of these children seem to differ more in degree than in kind from those disorders already defined. These are emotionally disturbed children whose disorders are so severe as to hamper functioning in many areas of life. They show functional deviations in intelligence, motility, speech development, achievement, or relationships to parents and others in their environment. They may deviate in one of these areas, or in several interacting areas. They have a very weak ego development, indicating fixation and emotional deprivation at an early period in their development.

As the two cases of preschool children, and their matched cases of two children of school age, show varying degrees of disorder, all four cases will be presented as illustrative of this group.

Case #23 Laura M., age four years and four months, was referred by both father and mother because they feared that she was retarded. Mrs. M. complains that Laura gets into everything; is hyperactive; won't play with other children; pulls other children's hair, and; talks babyish.

\(^2\) Ibid., pp. 98-123.
Although Laura tested at the borderline level of intelligence, the score attained was not felt to be indicative of her potential intelligence because of the presence of obvious components of emotional blocking. There were many factors, such as her general alertness, responsiveness, facial expressions, sentence structure and vocabulary usage during treatment sessions which seemed to indicate average intelligence.

Case #24 Carrie K., age six years and one month, was referred by her mother at the suggestion of the school. Carrie had spent three terms in the public school kindergarten because she was felt to be "slow" and unready for first grade. Mother felt that she had always been slow and complained that she was unpredictable, sweet and affectionate at one time and obstinate and stubborn at others. Carrie, a very quiet child, was the object of teasing by other children and seemed to accept ostracism. She "day dreamed" a good deal, and cried often without any apparent reason.

In treatment, Carrie was found to have average intelligence on informal testing. She presented a picture suggestive of the "Atypical Child" as defined, and for the purpose of this study has been matched with Laura M.

As will be noted from the descriptions of Laura and Carrie, the principal area of deviation affected by their emotional disorder was that of intelligence. More severe deviations are seen in the following two cases of Tommie R. and Gerry K.

Case #25 Tommie R., three years and four months of age, did not talk; had temper tantrums; and was afraid to go to the toilet. Mother stated that he stopped talking at the age of two when a sibling was born. Since that time,
he has not attempted to talk and has refused to leave the house. Although trained at an early age, he continued to have diurnal and nocturnal enuresis. He was afraid of the toilet, dogs, and strangers.

Case #26 Gerry L., a six year old boy, was referred by his mother because she feared that he would not do well in school. Gerry was in kindergarten where his bizarre behavior was apparent to teachers and children alike. Gerry made up meaningless sentences; did not talk coherently, and; went for long periods of time without speaking at all. He was afraid to go to the toilet, and was afraid of germs and babies. He shook his hands compulsively, and would not play with other children.

Both of these children were considered to have adequate intelligence, but because of emotional disturbances were seen to be functioning at earlier levels. Their realities were completely distorted by deep and threatening fears.

No attempt has been made to uncover the etiology of the various disorders which have been discussed, but the writer will attempt to relate these disorders to the factors in the emotional adjustments of their mothers. (See Chapter III, Section B).

Where two or more children over five years of age met all the established criteria for matching with a preschool child, duplication of other factors, such as the ordinal position of the child in the family and the economic background of the family, was attempted. Thus, a female child of preschool age who was diagnosed a primary behavior disorder, and whose mother referred her because she had temper tantrums and was aggressive with other children, was matched with a female
child over five years of age whose mother referred her for similar symptoms of preschool onset, and who was also a primary behavior disorder. Both of these children were "first" children and both came from families having the same yearly income. In one case, however, the mother waited to seek help after the child had started school. The question, therefore, arose as to why one mother failed to recognize, or chose to ignore, symptoms of emotional disorder whereas another mother sought help relatively early in the period of onset. This is a question of differences in the personalities of the two mothers, and of differences in their attitudes toward the child and his symptoms.

**Description of Material**

All the children studied were living in their own homes, and with the exception of one case both the mother and father were in the home. In the one exception, the father had deserted. Four girls and nine boys under the age of five were found to have been referred during the period of study. With their matched cases, a total of eight girls and eighteen boys were studied in this thesis. As will be noted in Table 1, the cases of children under five years of age have been assigned odd numbers and their matched cases of children over five years of age have been assigned even numbers in sequence. Table 1 illustrates the distribution of cases with reference to descriptive criteria.
TABLE 1.

DISTRIBUTION OF MATCHED CASES WITH REFERENCE TO DESCRIPTIVE CRITERIA.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Sex</th>
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<th>Sources of Referral</th>
<th>Yearly Income of Family</th>
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<td>6.1</td>
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</tr>
<tr>
<td>26</td>
<td>M</td>
<td>6.0</td>
<td>1</td>
<td>Mother</td>
<td>$3000</td>
</tr>
</tbody>
</table>

*Ordinal Position of the Child in His Family.
The ages of the preschool group range from three years and one month to four years and seven months with an average age of three years and eight months. The ages of the school group range from five years and six months to ten years with an average age of seven years and two months. In all cases, the child's mother was directly responsible for the child's referral, but frequently she came at the insistence of someone else. In such cases, the source other than the mother has been noted in Table 1. Six of the mothers of children of school age came at the suggestion, or insistence, of another source, whereas only two of the mothers of preschool age children required the suggestion of another source.

No significance was attached to the yearly income of the child's family. This factor was used merely as additional criteria for matching.

It was found that eight of the preschool children were "first" children, and five "second" children. In the comparative group, seven of the children were "first" children, five "second" children, and one was the fifth child. In this latter case, the child was the youngest child in a family with four married siblings. He and his mother lived alone and to all intents and purposes, he was an only child.

Table 2 lists the symptoms of major complaint to the mothers of individually matched cases along with the psychiatric diagnoses for each set of matched cases. Ten children of the total group fell into the classification of the
Table 2.
DISTRIBUTION OF SYMPTOMS AND
PSYCHIATRIC DIAGNOSES OF MATCHED CASES.

<table>
<thead>
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<th>Matched Case Nos.</th>
<th>Symptoms of Common Complaint to Mothers</th>
<th>Psychiatric Diagnoses</th>
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<tbody>
<tr>
<td>1 - 2</td>
<td>Temper tantrums, Unmanageable, Destructive, Aggressive.</td>
<td>PBD</td>
</tr>
<tr>
<td>3 - 4</td>
<td>Temper tantrums, and Aggressive with other children.</td>
<td>PBD</td>
</tr>
<tr>
<td>5 - 6</td>
<td>Doesn't get along with other children, Temper tantrums, Destructive.</td>
<td>PBD</td>
</tr>
<tr>
<td>7 - 8</td>
<td>Uncontrollable Behavior, Will not mind.</td>
<td>PBD</td>
</tr>
<tr>
<td>9 - 10</td>
<td>Aggressive toward mother, Temper tantrums</td>
<td>PBD</td>
</tr>
<tr>
<td>11 - 12</td>
<td>Nightmares, Won't go out to play, Destructive, Cries frequently.</td>
<td>Pn,CD</td>
</tr>
<tr>
<td>13 - 14</td>
<td>Infantile speech, Disobedient, Enuresis.</td>
<td>Pn,CD</td>
</tr>
<tr>
<td>17 - 18</td>
<td>Stuttering, Unhappy.</td>
<td>Pn,A</td>
</tr>
<tr>
<td>19 - 20</td>
<td>Tics, Extremely Nervous.</td>
<td>Pn,A</td>
</tr>
<tr>
<td>21 - 22</td>
<td>Nocturnal Enuresis</td>
<td>Pn,A</td>
</tr>
<tr>
<td>23 - 24</td>
<td>&quot;Mentally retarded&quot;, Babyish, Obstinate.</td>
<td>Atypical</td>
</tr>
<tr>
<td>25 - 26</td>
<td>Does not talk, Many fears, Refuses to leave house.</td>
<td>Atypical</td>
</tr>
</tbody>
</table>
extremely aggressive child; twelve in the group of the anxious child; and four were classified as severely disturbed children.

The first questions that suggest themselves are: Do the emotional adjustments of the mothers of children of preschool age differ from mothers of children of school age, and do the emotional adjustments of mothers differ in relation to the nature of the emotional disorders of their children? The writer will attempt to answer the first question in Section A of Chapter III, and the second question in Section B of Chapter III.
III FACTORS IN THE EMOTIONAL ADJUSTMENT OF MOTHERS

Treatment of mothers at the Worcester Youth Guidance Center is, for the most part, focused on the mothers' own emotional problems. They are encouraged to elaborate their feelings regarding their own experiences as a means of becoming more conscious of their underlying motivations. The premise underlying this approach is that a healthy parent-child relationship is very much dependent upon the healthy emotional adjustment of the mother. In speaking of the need for the involvement of mothers in the treatment of their children, Marjorie Stauffer has said:

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

In treating mothers, staff members have noted any number of factors in the emotional adjustment of mothers as contributing to unhealthy parent-child relationships. The writer has selected for examination those factors which seem to occur most persistently as significant in the emotional adjustment of the mothers under study. These include: (1) their early emotional experiences, (2) their current relationships to

their parents, (3) their personality needs, (4) their manifest feelings, and (5) the nature of their marital adjustments.

The first factor studied was the emotional background of the mothers' early life experiences. No one will deny that these experiences affect later emotional adjustments, and Flugel\(^2\) feels that the structure of the parent-child relationship is partially determined by the fact that when an individual becomes a parent, partially forgotten and outgrown emotions and tendencies which he had experienced in his own childhood are now directed upon his child in the same way as he had directed them upon his parents. The question under consideration here is: What is the nature of these early emotional experiences as revealed by the mothers' own feelings, and do these experiences differ significantly between the two groups of mothers being studied?

I  Early Emotional Experiences

The experiences of the mothers studied revealed three groupings which of necessity are somewhat broad. It was felt that limited categorization would blur the emotional tone of these experiences.

1. An Experience of Rejection
Within this group were placed those mothers who experienced rejection in childhood. Some expressed the feeling that their mothers or fathers did not love them, or that they were misunderstood and lonely during childhood.

Others revealed having had a traumatic experience in childhood which would necessarily involve feelings of rejection. These experiences included parental abuse, neglect, separation and death.

2. An Experience of Rigid Controls
These mothers were reared in homes of rigid control. Their early emotional experiences were characterized by inhibited emotions, strict training, and harsh discipline. In the few instances where mothers interpreted these early experiences as ones of rejection, they were placed in that group rather than in this one.

3. An Experience of Understanding and Warmth
The early emotional experiences of these mothers appeared to be those of a stable parent-child relationship, characterized by understanding and affection between parents and children.

To further elaborate the mothers' feelings about their parents and the emotional responses they direct toward them, the mothers' current relationships with their parents were studied. If, as Flugel\(^3\) has said, parents tend to direct the feelings and emotions toward their children that they formerly directed toward their parents, the mothers' relationships with their parents might appear significant in their relationships with their children.

II Relationship to Parents

Although the parents of many of the mothers studied were dead, it was found that the mothers continued to express feelings of dependency and hostility toward them. Therefore, all

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3 Ibid., p. 161.
expressed feelings of their relationships with their parents, whether the parents were living or dead, were grouped in the following categories:

1. A Stable Relationship
   These mothers manifested no feelings toward either parent which appeared to be affecting their present emotional adjustment. Their relationships seemed to be stable in that they were emotionally independent of their parents.

2. A Dependent Relationship
   Mothers were considered dependent if there was any evidence that they permitted a parent to dominate them, or if they felt the need for parental advice regarding small details. In cases where parents were dead, these mothers expressed great longing for a parent.

3. A Hostile Relationship
   Mothers were considered to have such a relationship to their parents if they expressed their hostility openly, or if they revealed it by their associations in interviews.

III The Personality Needs of the Mothers

That the personality needs of the parents, especially those of the mother, have a decisive influence on the development of the child is borne out by Stella Chess\(^1\) who feels that parents tend to gratify their needs through the demands they make on their children. In substance, she says that the demands made upon a child are a reflection of the demands of society, modified by the particular needs of the parents through whom they are transmitted. In all the divergent patterns these demands assume, parents are seeking security

through gratification of their own needs. When such demands fail to take into account the child's personality needs, the child's development is hampered and the parent-child relationship suffers.

A study of the personality needs of mothers as they relate directly to the child would constitute an intensive analysis of case material. Therefore, the writer has selected for examination only those personality needs that were made obvious by the treatment relationship. Those selected, however, appeared to be significant in the parent-child relationship.

1. A Need for Dependency and Affection
   Mothers who seemed to have an unusual need for affection were placed in this group. These mothers had strong dependent needs which evidenced themselves in the treatment relationship.

2. A Need for Perfection
   Within this group fell mothers who held rigid, set views and standards. In the treatment relationship, these mothers were impatient with the slow treatment process, and sought direct advice in an attempt to overcome the "imperfections" in their children.

3. A Need for Social Approval
   The mothers in this group seemed to have an unusual need for group approval and differed from those showing a need for dependency and affection in that their need for approval was superficial and impersonal, gratified by social affairs and club interests.

IV Manifest Feelings

This classification is meant to portray the characteristic feelings of mothers as exhibited in their ordinary life
situations in an attempt to discover whether the observable feeling states of the two groups of mothers differed.

1. **Feelings of Inferiority and Inadequacy**
   Mothers who were insecure and self-incriminating in manner and conversation, or who expressed feelings of inadequacy, were included in this classification.

2. **Feelings of Domination**
   Mothers who evidenced an unusual need to dominate were classified under this heading. In most instances, these mothers were the dominant family member, and tolerated no interference with their plans.

3. **Feelings of Hostility**
   Included in this group were those mothers who evidenced a persistent pattern of bitterness and hostility. Frequently, mothers have covered their fears and anxieties with hostility, but after a relationship of mutual understanding was established this broke down. This was not true of these mothers.

V. **The Marital Adjustment**

The marital adjustment of parents is frequently thought of as an index of the emotional adjustment of parents, and it cannot be denied that the emotional tone of a marriage is reflected in the parent-child relationship. Flugel believes that one of the most important factors contributing to a healthy parent-child relationship is the happiness of the relationship between the two parents. He feels that in cases where marriage is unsuccessful that there is likely to be an excessive overflow of emotions in the direction of the child. For this reason, it was deemed important to study the

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5 Flugel, op. cit., p. 174.
the nature of the mothers' marital adjustments.

1. An Adjustment Based on A Neurotic Attachment
   Within this group were placed those mothers whose adjustment was that of a masochistic relationship with a cruel and abusive husband, or the attachment of a passive, dependent husband to a domineering woman with obvious masculine identifications. Many of these attachments were marked by warmth and affection or by conflict and discord, but they have been classified separately because they were felt to be more precarious with obvious implications for the parent-child relationship, especially in the child's identification with parents.

2. An Adjustment Marked by Warmth and Understanding
   These mothers gave no indication that they were in any way dissatisfied with their marital relationships. They shared mutual interests and responsibilities with their husbands and had made a satisfactory sexual adjustment.

3. An Adjustment Marked by Conflict and Discord
   These mothers expressed dissatisfaction and complained of their husbands' lack of consideration, lack of interest, or infidelity. Some contemplated separation or divorce.

Section A. Factors in the Emotional Adjustments of Mothers of Preschool Children and Mothers of School Children.

It seemed probable that not all the factors studied would have the same significance for both groups of mothers, or that the factors of significance would emerge clearly in all cases. In order to determine with any definiteness the basic differences between the emotional adjustments of mothers of children under five years of age and mothers of children over five years of age who have accepted treatment, a much larger sample of statistical maneuverability would have to be used. However, on the basis of the relatively small samples
used for comparative study, it has been possible to indicate differences in personality patterns and tendencies between the two groups. Table 3 illustrates the differences in the various factors in the emotional adjustments of mothers in Group I (mothers of children under five years of age) and mothers in Group II (mothers of children over five years of age).

**TABLE 3.**

**COMPARISON OF FACTORS IN THE EMOTIONAL ADJUSTMENTS OF MOTHERS**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Early Emotional Experiences:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejection</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Rigid Controls</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Understanding</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>II Relationship to Parents:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Dependent</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Hostile</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>III Personality Needs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependency</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Perfection</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Social Approval</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>IV Manifest Feelings:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inferiority</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Domination</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Hostility</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>V Marital Adjustment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurotic Attachment</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Marked by Warmth</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Marked by Conflict</td>
<td>1*</td>
<td>4</td>
</tr>
</tbody>
</table>

*Mother separated from husband who deserted her.
It was possible to obtain information regarding the early emotional experiences of only eleven of the mothers in Group I. Seven of these eleven mothers had expressed feelings of rejection, six of the seven having suffered the trauma of parental death along with their rejection. In contrast, only one mother in Group II had a rejecting experience in childhood and none of them suffered emotional trauma. Conversely, only four mothers in Group I experienced a childhood of rigid parental controls, whereas eight mothers in Group II had such an experience.

The mothers' relationships to their parents showed a wider dispersion than their early emotional experiences in both groups, and does not appear to be significant in relation to differences between the two groups. It seemed significant, however, in terms of the parent-child relationships of the total group of twenty-six mothers that only four had a stable relationship with their parents. These four mothers were in Group II.

Ten of the mothers in Group I had an apparent personality need for dependency and affection in contrast to only four mothers who evidenced this need in Group II. Three of the mothers in Group I evidenced a need for perfection in contrast to seven mothers in Group II.

Along with their personality needs, the manifest feelings of the mothers showed the greatest significant difference between the two groups. Nine of the mothers in Group I
had feelings of inferiority and inadequacy in contrast to only three of the mothers in Group II. Likewise, only three of the mothers in Group I manifested feelings of domination whereas nine of the mothers in Group II manifested this feeling.

A study of the marital adjustments of the two groups of mothers was found to be less significant than some of the other factors studied. Six of the mothers in Group I had made a marital adjustment based on a neurotic attachment, and four mothers in Group II had such an adjustment. Six of the mothers in Group I had a marital adjustment marked by warmth and affection, and five of the mothers in Group II had a similar adjustment. The one mother whose marriage was tabulated as marked by conflict in Group I was separated from her husband. He had deserted her prior to acceptance of treatment for her child. Four of the mothers in Group II had marital adjustments marked by conflict and discord.

Upon further examination of the cases, it was noted that eight of the mothers of the total group had been diagnosed as having had "neurotic disorders" which had necessitated psychiatric treatment. These disorders included "nervous breakdown", psychosomatic disorders, and excessive fears. Of the eight mothers having had these disorders, five were mothers in Group I and three were mothers in Group II.

On the basis of these limited findings, a descriptive analysis of the prominent personality patterns and tendencies
of mothers in Group I revealed that they experienced emotional rejection in childhood with the trauma of parental death; that they manifested feelings of inferiority and inadequacy with a strong need for affection and dependency. Such a woman is Mrs. J. who has been selected for presentation as typical of this group.

Case #9 Mrs. J. applied for help with her three year old daughter, Betty, who she complained had temper tantrums, and was negativistic, unmanageable, bold, and boisterous. She wet the bed three or four times a week and was a very restless sleeper.

In treatment, Mrs. J. revealed that both her parents died when she was eleven years old. She and a younger sister lived in an orphanage until she completed high school, at which time she was forced to live with her grandmother by lack of any other alternative. She resented her grandmother very much and described her as an elderly, strict, domineering and cold person who rejected her and complained of having the responsibility of two young girls.

Mrs. J. worked for ten years as a secretary after high school. Then, dissatisfied with the loneliness of her life, she joined the WAC's and married her husband after a three month courtship in service. Following her discharge from the service and the birth of Betty, Mrs. J. lived with Mr. J.'s family for a time, and initially projected the blame for Betty's behavior on them, claiming they spoiled her as an infant.

She described herself as an "introvert" and stated that she becomes panic-stricken in large groups. She felt inferior to others and frequently said that she made a very inadequate mother. She did not want any more children because she did not feel that she could handle them.
Through the casework relationship, Mrs. J. gained considerable relief by finding an outlet for pent-up emotions, and by developing an emotional awareness of her motivations. At the close of treatment, she was pregnant and looked forward to the future with a good deal of confidence.

In this case, as in many of the cases, Mrs. J. found in acceptance of treatment an understanding relationship after having experienced rejection by her parents and grandmother. She was confused about her role as a mother and was unable to give of herself in her relationship with Betty. Her confusion and strong feelings of inadequacy were obviously important factors related to her acceptance of treatment. At the same time, the material suggests that there was a sensitivity to Betty's needs and unhappiness, growing out of her own early and later experiences of unhappiness.

A descriptive analysis of the mothers in Group II who have waited months, or years, after the onset of the symptoms of their children to accept help, revealed a rigidly controlled mother who was reared in an atmosphere of inhibited emotions and strict training. She was seen to have an unusual need for perfection with manifest feelings of domination. She was seen to resent any interference with her plans, and frequently demanded intellectual achievement from her children. Mrs. B., whose case has been selected for presentation was felt to be typical of this group.

Case #20 Mrs. B. referred her son Henry, age five and a half, who, she complained was an extremely nervous child. He had been stammering since
the age of three, and since the age of four had a prominent facial tic. Prior to application for treatment, Mrs. B. had consulted a physician because Henry was doing poorly in kindergarten.

Mrs. B., a thirty-one year old woman, was an only child. She felt that as a child she usually got her own way from her parents, but that she had to adhere to quite strict standards. When she was three, her father was confined to a wheel chair until his death from multiple sclerosis. She remembered him as being a strict person and recalled that he used to reach her with a ruler if she disobeyed him.

When she was five, her mother had a judge pretend to arrest her for running away. She did not feel that she was unhappy as a child, however, as she felt that every child needed a strict training.

After her father's death when Mrs. B. was in her teens, her mother went to work and she had "to shift for" herself. At the age of seventeen, she went to work. She had not planned to marry, but her mother was so controlling that she decided she would be better off married and "on her own."

She married a rather passive, dependent man, and continued to work for six years before having children. She had four children, and maintained very rigid training schedules even when the children were infants. Discipline was severe and she insisted upon handling this as she felt that she could do it better than Mr. B.

Mrs. B. did not permit her husband to handle any of the management of the children because she felt that his childhood training was so poor. She felt that he had been brought up "without authority" and felt that he was an "after-thought" of his parents because they were in their fifties when he was born.

She placed the blame for Henry's disorder on Mr. B., on Henry himself, and on the neighborhood in which they lived. She recognized no flaws in her methods or standards, and often
in interviews took a superior attitude in
telling her worker of her ability to do
things right.

Mrs. B. is a rigid, controlling person who has a strong need
for perfection. Her early emotional experience was one of
inhibited emotions and rigid controls which she has incorpor-
ated into her own standards. Her manifest feelings of domi-
nation are felt to be the result of having been dominated,
and also an expression of strong masculine identifications.
It was felt that her referral of Henry came about because his
 tic and stammering represented a flaw in her methods, and
because his growing independence in his identification with
Mr. B. became a threat to her need for domination.

To recapitulate, the prominent differences in the person-
ality patterns of the two groups of mothers appear in their
early emotional experiences, their personality needs, and in
their manifested feelings. The mother of the preschool child
is, for the most part, an emotionally confused person who has
a strong need for affection and dependency with manifest feel-
ings of inferiority and inadequacy, having had an emotional
experience of rejection in childhood. In contrast, the mother
who waits until the school period to refer her child presents
a picture of a rigid, well-controlled person who has had an
early emotional experience of parental control. She mani-
fests feelings of domination and has a need for perfection.
She tends toward compulsiveness, and frequently is the
dominating family member.
Section B. Factors in the Emotional Adjustments of Mothers of Aggressive Children and Mothers of Anxious Children.

In an attempt to find out if the personality patterns and tendencies of the mothers studied differed in relation to the personality patterns of their children, the factors studied in their emotional adjustments have been regrouped into the diagnostic groups of: Mothers of Aggressive Children and Mothers of Anxious Children. As only four children were classified as severely disturbed, and as there is less known of the mothers of these four children, no attempt has been made to relate the personality patterns of these mothers to the personality patterns of their children. Table 4 is a comparative analysis of the tabulated totals of the emotional factors of the ten mothers of aggressive children and the twelve mothers of anxious children.

As an unequal distribution of cases fell within the two groups, the total of each emotional factor is relative to the total number within the group. Because of this distribution and the limited sample for each group, it is impossible to compare the groups. It was felt, however, that qualitative conclusions might be drawn regarding the relationship between the factors studied in the emotional adjustments of the mothers and the personality patterns manifested in their children's disorders.
TABLE 4.

FACTORS IN THE EMOTIONAL ADJUSTMENTS OF MOTHERS OF AGGRESSIVE CHILDREN, AND MOTHERS OF ANXIOUS CHILDREN

<table>
<thead>
<tr>
<th>Factors of Emotional Adjustment</th>
<th>Mothers of Aggressive Children</th>
<th>Mothers of Anxious Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Emotional Experiences:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejection</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Rigid Controls</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Understanding</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Relationship to Parents:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dependent</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hostile</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Personality Needs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependency</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Perfection</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Social Approval</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Manifest Feelings:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inferiority</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Domination</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Hostility</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Marital Adjustment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurotic Attachment</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Marked by Warmth</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Marked by Conflict</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

The personality patterns and tendencies of these two groups of mothers are less apparent than those of mothers of children under five years of age and mothers of children over five years of age. The most prominent factors, however, still appear in the early emotional experiences, personality needs, and manifest feelings. Of the ten mothers of aggressive children, seven have an unusual need for dependency and
affection, and seven of the ten have manifest feelings of inferiority and inadequacy.

The factors in the emotional adjustments of mothers of anxious children are less prominent in relation to the number of the sample. Eight of the twelve mothers, or two-thirds of this group, had an early experience of rigid parental control and inhibited emotions. Seven of the twelve evidenced a need for perfection and seven manifested feelings of domination.

The factors in the emotional adjustments of the four mothers of severely disturbed children revealed no common factors for comparison with the other groups. In many instances, information was found lacking in one or more of the categories. With these mothers, it is difficult to relate their own emotional experiences and problems to those of their children because of the nature and depth of the disorders involved. These mothers are frequently so threatened by their children's disorders that they seek to explain them in terms of organic involvement or feeblemindedness, and frequently only face their own emotional involvement after the children show progress.

In summary, it must be said that no conclusions can be drawn regarding the relationship between the factors studied in the emotional adjustments of the mothers and the personality patterns manifested in their children's disorders. There seems to be a tendency for mothers of aggressive children to
have a personality need for dependency and affection with manifest feelings of inadequacy, and for mothers of anxious children to have had a childhood experience of rigid parental controls with a personality need for perfection and manifest feelings of domination. Valid conclusions, however, would emerge only from a study of larger samples of equal distribution.
IV THE MOTHER-CHILD RELATIONSHIP

The importance of the early emotional experiences of a child was suggested in the previous chapter by examination of some of the experiences in the lives of the mothers being studied. Table 3 showed that many of the mothers who had suffered early emotional deprivation, also had a great need for dependency and love, and manifested feelings of inadequacy. Likewise, it was noted that the mothers whose experience had been over-restrictive were reacting with feelings of domination and were evidencing a need for perfection. Although no attempt has been made to directly relate the personality needs and manifest feelings of the mothers to their early life experiences, such a relationship is suggested by Symonds¹ who says:

The attitude a person takes toward himself grows out of the attitude which parents showed toward him when he was little. Parents who are serene and who show confidence in a child will engender in that child similar serenity and confidence in himself. Similarly, parents who show anxiety about a child will give him feelings of insecurity and inferiority. Courage and self-reliance in an individual stem originally from the fact that his parents provided security for him while he was growing up.

Turning now to the mothers' relationships to their children, one might question whether the children are reacting through their emotional disorders to repetitive patterns

in the mothers' own experiences. In an attempt to uncover this, as a possible differential between the two groups of mothers studied, an examination has been made of the mother-child relationships in terms of the mothers' attitudes toward their children.

An attitude has been defined by Dr. Frederick Allen\(^2\) as "an externalization of one's own feelings." In substance, he says that it is the way one reacts to situations and people, as well as the way one relates himself to reality. It has a genetic background, a definite purpose, and reason for existing. He feels that an attitude is the mother's symptom just as lying, stealing and temper tantrums might represent the symptoms of the child.

Using this definition as a guide, a description and an evaluation of the mothers' attitudes have been sought by examining their behavior in relation to their children, or the ways in which they react to their children. No attempt has been made to uncover the genetic backgrounds of the attitudes as the question under consideration is: Do the attitudes of the mothers of children under five years of age differ from those of mothers of children over five years of age.

In determining attitudes, the behavior patterns of the mothers in their relationships with their children were examined as revealed in their treatment relationships. For the most part, this information had to be sought from material of their early treatment contacts because of the many changes and modifications achieved during the treatment process. The following three groups of attitudes were found to embrace the behavior patterns of the mothers studied.

1. **Inconsistent**
   Mothers whose behavior toward the child was predominantly one of inconsistency, alternating between warm responses and abrupt impatience, were placed in this group. These mothers were frequently seen to have a need for perfection or intellectual achievement which overpowered positive feelings when the child did not meet this need. They objected to the child's behavior rather than to the child himself. (The behavior patterns of four of the twenty-six mothers were classified as inconsistent.)

2. **Overtly Hostile**
   Mothers were considered overtly hostile if they were openly antagonistic to the child. These mothers criticised their children unduly and disciplined them severely. A few expressed the wish to be rid of the child, and others complained that the child interfered with their activities. These mothers objected to the child himself. (Eight of the twenty-six mothers studied were placed in this group.)

3. **Unconsciously Hostile**
   The behavior of the mothers who were classified as unconsciously hostile to their children was characterized by guilt. They were over-indulgent and were unable to be firm. Their attempts at constructive discipline, although many, were pathetic, ending in frustration for both mother and child. These mothers were extremely anxious in their
relationships with their children. (Of the twenty-six mothers, fourteen were classified as unconsciously hostile.)

Table 5 illustrates the break-down of these attitudes in terms of the two groups of mothers.

**TABLE 5.**

**COMPARISON OF ATTITUDES OF MOTHERS OF PRESCHOOL AGE CHILDREN AND MOTHERS OF SCHOOL AGE CHILDREN.**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistent</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Overtly Hostile</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Unconsciously Hostile</td>
<td>10</td>
<td>4</td>
</tr>
</tbody>
</table>

The most striking difference between the two groups of mothers appears in those who were found to be overtly hostile toward their children and those found to be unconsciously hostile toward their children. In Group I, only two of the mothers were found to be overtly hostile, whereas six of the mothers in Group II had this attitude. On the other hand, ten of the mothers in Group I were found to be unconsciously hostile toward their children as compared with only four of the mothers in Group II.

As the feelings of mothers, both positive and negative, are often powerfully stimulated and reinforced by an unconscious process by virtue of which the child is identified with a loved or hated object of significance in the mother's
past, an attempt has been made to further clarify the attitudes of the mothers by determining the nature of their identifications of their children. As it was felt that a mother may also identify the child with herself, a three-fold classification was established of those who identify the child with a hated object, those who identify the child with a loved object, and those who identify the child with themselves. It was found impossible to discover the identifications of six mothers, but as it was possible to determine the identifications in ten cases of each group, the following categories were used for comparison of the two groups.

1. Identifies the Child With Hated Object
   Mothers were considered to identify their children with hated objects if they expressed the feeling by verbalization or direct association that both the child and the hated object had similar characteristics.

2. Identifies the Child With Loved Object
   Mothers were considered to identify their children with loved objects if they pointed out this identification by word or association.

3. Identifies the Child With Self
   Mothers were considered to identify their children with themselves if they felt that the child had characteristics like theirs, and thought the child felt as they did.

In relating the objects with whom the mothers identified their children, to the mothers' individual attitudes toward their children, no significant relationship could be determined because of the limited number of cases used. Certain

3 Flugel, op. cit., p. 160-163.
pattern tendencies appear, however, which might have significance in a broader study of attitudes and identifications. Table 6 illustrates the identifications of ten mothers within each group.

**TABLE 6.**

**IDENTIFICATIONS OF CHILDREN BY MOTHERS OF PRESCHOOL AGE CHILDREN, AND BY MOTHERS OF SCHOOL AGE CHILDREN.**

<table>
<thead>
<tr>
<th>Identifications</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>With a Hated Object</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>With a Loved Object</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>With Themselves</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Of the two mothers in Group I who identified their children with hated objects, one was inconsistent in her behavior toward the child, and the other was overtly hostile. All four mothers in Group I who identified their children with loved objects were unconsciously hostile, and all four in this group who identified their children with themselves were also unconsciously hostile in attitude.

With reference to mothers in Group II, the six mothers who identified their children with hated objects were overtly hostile; the two mothers who identified their children with loved objects were unconsciously hostile; and of the two who identified their children with themselves, one was overtly hostile and one was inconsistent.
The ramifications of the relationship between the identifications of the child, and mothers' attitudes manifested in their behavior toward the child seem to be many, but the pattern of tendency seems to be that mothers who have identified their children with a hated object are overtly hostile to the children; mothers who have identified their children with loved objects are unconsciously hostile to them. This latter relationship seems paradoxical on the surface until one examines the original love relationship, the meaning it has for the mother and the guilt it has aroused in her. Likewise in grasping the significance of the relationship between the varied attitudes of mothers who identify their children with themselves, one must look to the mothers' attitudes toward themselves. Are these mothers hostile toward themselves, or do they identify their children with themselves in an attempt to find compensation for their own failures? These are questions which cannot be answered in this limited study. However, in terms of the two groups of ten mothers, the differences of objects with whom the mothers identified their children seem relatively significant.

As shown in Table 6, two mothers in Group I identified their children with hated objects in contrast six mothers in Group II. In Group I, four mothers identified their children with loved objects and four identified their children with themselves, whereas in Group II, two mothers identified their children with loved objects and two with themselves.
The following cases are presented as illustrations of the three types of behavioral attitudes examined in this study, but will to some extent point up the identifications of the mothers as well.

The first case, that of Mrs. E., is illustrative of a woman who was inconsistent in her behavior toward her child and who identified the child with herself.

Case #10 Mrs. B. referred her daughter Dorothy, age eight, complaining that she was a behavior problem and that she had severe temper tantrums. Another problem of concern to mother was Dorothy's refusal to go to school.

Mrs. E., a thirty-eight year old woman, had a good deal of pride in her past achievements having been a school teacher for a number of years. She had worked with gifted children and seemed to be sensitive to children's feelings. In her relationship with Dorothy, she showed capacity for positive feelings, but this was often overpowered by her perfectionism and the emphasis she put on intellectual achievement. She had sent Dorothy to nursery school when she was three and a half years, and she had taught her to read before the age of five.

Mrs. B. was one of five children with three sisters and a brother. She contrasted her childhood experience with those of children today by saying that she had been taught to respect authority whereas mothers of today give in to their children too much. She felt a good deal of competition with her sisters and had a strong drive to do well in the teaching profession. She received a lot of self-esteem for her work and said that she postponed marriage because of this.

She married when she was thirty-one and her husband was seven years her junior. She found little real satisfaction in her marriage and seemed to regret that her achievements were in the past. She identified Dorothy with herself.
in an attempt to compensate for the failure she felt she was making at marriage. She put pressures on Dorothy to succeed, but at the same time showed a sincere, warm interest by allowing her to help in the home and by sharing activities with her.

In the course of treatment, with the relieving of her pent-up feelings of hostility toward her husband, Mrs. B. gained some insight into her inconsistencies and dissatisfaction about being a woman. She was able to use her teaching ability more constructively with Dorothy and put fewer demands on her.

The case of Mark M. is illustrative of a mother who is overtly hostile to her child, and who identifies him with a hated object.

Case #13 Mrs. M. brought her son Mark to the Center primarily because he was disobedient to his parents. She complained that Mark, age four years and seven months, also had infantile speech and nocturnal enuresis. She said that she felt he was disobedient to annoy her, but did not know why this was. She insisted upon obedience, usually using physical punishment to enforce her demands, except when they were in public places.

Mrs. M. was found to be a tense, nervous, little woman who was openly hostile to Mark. She stated that she wished he were a girl, and said that she had thought of adopting a girl. She saw all boys as noisy, bullying, and dirty, and men were "quiet, non-talkative creatures who have to be told everything."

Little is known of Mrs. M.'s early life except that her mother was a strict disciplinarian. In spite of this, Mrs. M. was very much attached to her mother. She had complete contempt for her father, however, and spoke of him as a nonentity. Her relationship with all men was one of domination.
Mrs. M. had fears surrounding childbirth and has had two children by cesarian section. The second child lived only a few days. She had fallen prior to this birth and had a good deal of guilt about this in view of the fact that the child was a boy and she had wanted a girl. She emphasized the suffering she had experienced at both births and was very resentful about them.

Mrs. M. identified Mark with her husband and she demanded submission from both. On one occasion at the clinic, Mark refused to pick up his hat so she took him to the lady's room and beat him soundly "to show him he couldn't behave that way."

Although Mrs. M. identified Mark with Mr. M., specifically relating similarity of characteristics they held in common, her identification of him was more generalized to include all men who were hostile figures to her. She resented her feminine role and reacted by proving that she was stronger than men.

An exaggerated case of the mother who is unconsciously hostile toward her child is that of Mrs. L. who identifies her child with a loved object.

Case #1 Mrs. L. applied for clinic help with her son Martin when he was eighteen months old, complaining that he was unmanageable, and that his aggressive behavior had been a source of irritation to her since his birth. At this time Mrs. L. was in treatment with a psychiatrist and acceptance was deferred until Martin was three years and four months old at which time Mrs. L. reapplied for help.

Mrs. L. was reared in a family situation of great discord. The second youngest of four girls, she took responsibility for keeping the family together during periods when her mother or father would leave the home. Being the largest and least attractive of the girls,
she felt forced into a position of subservience in the family. Having actually experienced neglect and rejection at the hands of an indifferent mother, she nevertheless idealized her and was unable to express any hostility toward her.

She identified Martin with her eroticized father who was an alcoholic. She verbalized hostility toward her father, but recalled that father used to treat her as "his boy", and she remembered fondly that her interests were always masculine in imitation of him.

Mrs. L. was unable to exercise any controls with Martin and was noted to be getting satisfaction from his erotic play with her silk stockings. She was openly seductive toward him and used to sleep with him and dress in front of him. She had many neurotic fears about his well-being and feared that she might do him physical harm.

Mrs. L.'s relationship with Martin was seen to be guilt-laden because its eroticized nature, and the impulses it reactivated in her relationship with her father. Because of the "forbidden" aspect of her relationship with her father, she had been unable to express hostility toward her mother. Most of the mothers who were found to be unconsciously hostile toward their children did not act out their early conflicts to the extent that Mrs. L. did, but all revealed anxiety in their relationships with their children, and their behavior toward the children was one of helpless indulgence.

In summation, it is felt that although no specific inferences may be drawn from the mothers' identifications of their children, that attitudes they manifested by their behavior patterns reveal significant differences between the
the two groups of mothers studied. A large majority of the mothers who accepted treatment for their children of pre-school age revealed a behavior pattern of unconscious hostility manifested by a mother-child relationship of anxiety and guilt. The largest group of mothers of children over five years of age who deferred treatment of their children until a later period fell into the category defined as overtly hostile, but there was found to be no outstanding concentration of these mothers in any one of the three attitude groups.
V  MOTHERS' ATTITUDES TOWARD TREATMENT

Having established tentative differences of factors in the emotional adjustments of the two groups of mothers and in their attitudes toward their children, two logical questions arise. Are these differences predictive of a specific attitude toward the treatment situation, and do the attitudes toward treatment differ significantly between the two groups of mothers?

In an attempt to answer these questions, the attitudes of the mothers toward treatment in the initial phase of its process have been studied. They were found to be of four different types.

1. Those who did not want to participate in treatment. Three of the total group of twenty-six mothers expressed the feeling that treatment should revolve around the child, and they did not want to involve themselves in the treatment process except to receive direct advice in handling the child.

2. Those who were ambivalent toward treatment. At times these mothers seemed sincerely interested in getting help for themselves as well as for their children, and at other times, preferred not to bother with it. Fourteen of the twenty-six mothers seemed to be ambivalent toward treatment.

3. Those who sought help for both child and self. Four mothers expressed the feeling that they needed help with their own problems as desperately as the child did. They expressed feelings of inadequacy and blamed themselves for the child’s problem. They felt guilty about their part in the problem, and helpless about how to alter their methods of handling the child.
Those who assumed an understanding, responsible attitude toward treatment. Five of the mothers showed an understanding of their role in the problem situation, and related it to the difficulty the child was having. These mothers spoke frankly to the worker and participated actively in interviews and in the treatment plan outside the clinic itself.

Table 7 is a break-down of these attitudes as they were distributed between the two groups of mothers.

**Table 7.**

**Comparison of Mothers' Attitudes Toward Treatment**

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not want to participate in it.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ambivalent toward it.</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Sought help for child and self.</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Wanted treatment and took understanding, responsible attitude.</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 7 indicates that more than half of the mothers in both groups during the first phase of treatment either did not want to participate in it or were ambivalent toward it. Whereas only seven of the mothers in Group I fell into these two attitude groups, ten of the mothers in Group II were so classified. Four of the mothers in Group I sought help for both themselves and the child, whereas none of the mothers in Group II expressed a desperate need for help with their
own problems. Only two of the mothers in Group I and three of the mothers in Group II were able to take an understanding, responsible attitude during the initial phase of treatment.

Except for those four mothers who sought treatment for both the child and themselves, the mothers' attitudes toward treatment were not found to be predictable by the factors in the emotional adjustments of the mothers, or by their attitudes toward their children. The four mothers in Group I who sought help for themselves as well as for their children had certain factors in common. All four were mothers of children under five years of age; all four had a need for dependency and affection; all four manifested feelings of inferiority and inadequacy; and all four were found to be unconsciously hostile toward their children. Examination of these cases individually revealed that they were sensitive to the needs of their children, but were unable to meet these needs because of the anxiety and guilt that pervaded their relationships with their children.

In summary, it must be said that examination of the attitudes of the mothers toward treatment rendered inconclusive results in terms of significant differences between mothers of children under five years of age and mothers of children over five years of age.
VI  SUMMARY AND CONCLUSIONS

This study has attempted to discover influential factors in the emotional adjustments of mothers affecting their acceptance of help with the problems of their preschool children. The writer has sought to answer the following questions:

1. Is it a different type of mother who refers her child at the period of onset of symptoms, and what is the nature of the differences?

2. Is there a relationship between the time of the referral and the mother's attitude toward the child? If so, what is the nature of this relationship?

3. What are the attitudes of mothers toward child guidance help for their preschool children?

For the purpose of comparison, two groups of mothers were established. The first group was composed of mothers of thirteen children under five years of age, who referred their children during a two year time period, and who accepted treatment. A comparative group, formed on the basis of matching children individually in terms of specific criteria, was composed of thirteen mothers who had allowed their children's problems to go unaided until the children were over five years of age.

Qualitative conclusions were sought from the study of both groups of mothers, and were then compared in an attempt to discover significant differences.

In order to answer the question of whether it is a dif-
different type of mother who refers her child at the period of onset of symptoms, factors in the emotional adjustments of the two groups of mothers were studied. These factors included their early emotional experiences, their relationships to their parents, their predominant personality needs, their manifest feelings, and the nature of their marital adjustments.

The most significant differences between the two groups of mothers to emerge, were found to be in their early emotional experiences, their personality needs, and their manifest feelings.

Seven of the mothers in Group I (mothers of children under five years of age) were found to have had an early emotional experience of rejection, six of the seven having suffered the trauma of parental death. In contrast, the predominant early emotional experience of the mothers in Group II was one of strict training, rigid controls, and emotional inhibition. Eight of the mothers in this group (mothers of children over five years of age) had this experience.

Keeping the predominant experiences of the two groups of mothers in mind, it is interesting to note that ten of the mothers in Group I had a predominant personality need for dependency and affection, and nine of the group manifested feelings of inadequacy and inferiority. In contrast, seven of the mothers in Group II evidenced a predominant need for perfection and nine manifested feelings of domination.
It would appear that the personality needs and manifest feelings of these mothers were conditioned by their early emotional experiences. The mothers in Group I who had experienced rejection appear to be emotionally crippled as noted by their feelings of inadequacy and inferiority. They are searching for dependency and affection. The mothers in Group II who had an experience of rigid, emotional training, appear to have incorporated their parents' standards as noted by their need for perfection. Having been dominated, these mothers must now dominate.

The mothers' attitudes toward their children were found to be significant, at least in terms of those mothers who referred their children before the age of five. Ten of these mothers were found to be unconsciously hostile toward their children with their behavior toward the child characterized by anxiety and over-indulgence. Only four of the mothers in Group II were placed in this attitude group.

The largest group of mothers in Group II, six in all, were found to be overtly hostile toward their children, but there was found to be no concentration of more than half the mothers of this group in any one of the three attitude groups.

In terms of the mothers' attitudes toward the child, a study was made of their identifications of the child in an attempt to further clarify their attitudes. The most significant finding of this study was that six of the mothers in Group II identified their children with hated objects. These
six were of a total of ten mothers whose identifications it was possible to determine. All six of these mothers were found to be overtly hostile. Although no specific inferences may be drawn, the pattern of tendency to emerge from the study of attitudes and identifications seemed to be that mothers who identified their children with hated objects were overtly hostile to the children, and mothers who identified their children with loved objects were unconsciously hostile to them.

It would seem, although the evidence is inconclusive, that a relationship does exist between the mothers' attitudes toward the child and the time of referral. On the basis of these limited findings, it would appear that one of the factors influential in mothers' acceptance of help with the problems of the child under five is the anxiety characteristic of the predominant attitudes of this group.

No significance was attached to the mothers' attitudes toward treatment during its initial phase as more than half the mothers of both groups either did not want to participate in treatment or were ambivalent toward it.

It is the conclusion of this study that mothers are influenced, in part, by factors in their own emotional adjustments and by their attitudes toward their children to accept help with the problems of their children. The nature of the factors in the emotional adjustments of the mothers, and the nature of their attitudes toward their children are seen as
influencing the time of their referral. The mothers of children under five years of age were seen to have had early emotional deprivation, feelings of inadequacy, and needs for dependency. Those mothers who waited months, even years, after the onset of their children's symptoms before seeking help were seen to have had an early emotional experience of over-restrictions resulting, in part, in a need for perfection and feelings of domination. The implication is that child guidance help is a sign of personal failure for these mothers, whereas for the other group of mothers, it is a gratification of a need for dependency.

Approved:

[Signature]
Richard K. Conant
Dean
BIBLIOGRAPHY

Books:


Periodicals:


COPY OF SCHEDULE

1. Name of Child  2. Sex  3. Position in Family
4. Age at Application or Referral _______ years _______ months
5. Problem(s) as Presented by Mother
6. Clinical Diagnosis and Statement of Personality Patterns
7. Duration of Problem and Time of Onset Including Picture of Developmental History
8. Family Information Including:
   Yearly Family Income
   Name, Age, Occupation and Residence of Father, Mother and Siblings.
9. Information about Mother:
   a. Description of Personality
   b. Her Early Emotional Experiences
   c. Current Relationship with Her Parents
   d. Personality Needs and Manifest Feelings
   e. Nature of Marital Adjustment
10. Mother's Attitude Toward Child as Revealed by Manifest Behavior in Relation to Child.
11. Mother's Feelings about Child and His Problem
12. Mother's Statement(s) Indicating Object With Whom She Identifies the Child and Nature of Her Relation to Object
14. Mother's Attitude Toward Treatment Including Attitude Toward Worker and Participation in Interviews.