separating from each other at the first interview, may be an expression of the mother's resentment of the prospective involvement of her child with an outsider (Roemle, 1965). A mother may respond 'paradoxically' to advice given her by a case-worker, on how to handle the problem child. Her conscious or unconscious aggression towards the therapist for his or her preoccupation with her child while overlooking her own problems, may lead her to blot out and forget any suggestions offered, to fail to understand them, or to distort them so completely as to make them absurd. Sometimes she may even do the exact opposite of what has been suggested (Bird, 1964).

Parents also differ in their expectations of psychiatric services (Colman, Short and Hirschberg, 1948). They may have a good understanding of the function of a therapist, clinic or residential treatment centre. But on the other hand, they may endow any of these with a variety of distorted concepts. One example is the 'magic wand' idea, when the parents hope for a miracle cure, to be achieved in some mystical way by an authority figure such as the therapist, who would have no need of their own participation in the process. Or they expect that the child and they themselves will be given a formula or prescription for changing the disturbed behaviour, and removing the distressing symptoms. Others may view treatment as a punitive measure which will force the child to change his habits. One way that parents can dissociate themselves from the treatment programme, is to believe that all the child's symptoms stem from a physical cause, which only medical procedures can cure. Parents may also cling to the belief that "there is something wrong with [the child's] mind", thus absolving themselves from all responsibility for him, and challenging the expert to change him.

These expectations of what treatment can or cannot achieve also lead parents to present the problem to the clinician in different ways: They may minimise the symptoms to protect their own self-esteem, or exaggerate them to make them seem so great that they themselves cannot be blamed for incompetent handling of their difficult offspring. Rarely will they see themselves as genuinely and intricately involved in the genesis of their child's disturbance, but occasionally they may express such attitudes, without really feeling them. They may need to expose and deprecate themselves in this way, so as to forestall any criticism that they anticipate from the therapist.

Korner (1961) studied in detail this need of parents to take the blame for their child's problem behaviour. She considered this at least in part, a result of the parent's increasing awareness of psychological literature. The latter has made many of them feel self-conscious and unsure, and convinced that they have erred and mishandled situations with their children. In certain character types a new syndrome has even appeared, which might reasonably be named "The Parent Takes the Blame"! Taking the blame fulfils a very special need in their entire personality dynamics, and numerous gains accrue from doing so. As Korner pointed out,

> "... By taking all the blame one can delude oneself into thinking that one is in complete control of all the factors in the situation.... This delusion is well hidden, and all that is conscious is the guilt about having mishandled situations. This point of view, in a sense, denies the separateness of the child, and eliminates his own pathology as an unmanageable threat."

There is also a "traditional optimism of our cultural heritage", which emphasises our ability to alter our basic condition, in spite of the inherent and anti-democratic biological differences. Taking the blame serves to "reduce the threat of being a passive and helpless victim of circumstances ... to concretise internal threats so as to make them more manageable." By naming the thing, spelling it out, and pinning down the apparent source of trouble, the parent guards against the vagueness, mystery and multiplicity of such threats. This mechanism may also give the parent an opportunity to "expiate the guilt under circumstances that are safe and at a time of his own choosing", as well as "compensation for feelings of inadequacy as a parent, through feeling proud about being at least 'insightful'".

An impressive study of parental resistance to the treatment of their children (in this case, adolescents resident in a psychiatric hospital) is that of Rinsley and Hall (1962). In an intensive investigation lasting two-and-a-half years, the authors traced certain behaviour patterns in the parents of their group of hospitalised adolescents. These parents showed feelings of failure, frustration, anger and guilt at having been unable to meet the child's needs, and thus been forced to seek help in the form of an inpatient facility. These feelings were frequently projected onto the caseworker involved in their problem, and resulted in strong resistances towards the incursions that they felt casework treatment would make into their own life adjustments.

They sometimes tried to defeat the entire structure of the casework with themselves, by using several recognisable metaphorical communications in their interactions with the worker. Through various messages and statements, the parents often seemed to express the following anxieties:

" I am afraid to trust you with my child because you will:

a) see that I am a failure as (i) a parent, or (ii) a sexual object, and therefore I am a breeder of monsters;

b) allow my child to express his 'badness' which in turn will express my 'badness';

c) punish me for my unacceptable wishes towards my child;

d) carry out my unacceptable wishes towards my child;

e) take my child away, and that would destroy me. "

These communications were for the most part unconscious, or preconscious, and were usually expressions of the parent's preoccupation with his or her self-concept, ego-ideal and genital-erotic conflicts. Parents tried to rationalise their guilt by ascribing their children's problems to childhood accidents, or to "justifiable neglect" on their own part, if they "had to go out and work", "had too many other children to care for", or were "so often sick". They made efforts to impress the caseworker with their business, professional, intellectual, or housewifely competence, in the hope that this would mitigate the harsh criticism they anticipated. Sometimes they were regressively identified with the child, whose 'badness' gave them an opportunity for gratifying their own aggressive and erotic impulses. This involvement was often concealed beneath an ostensible concern about hospital laxity, or the bad types their child would meet in hospital. The need to describe the hospital as a "training centre" (and thus deny that the child was 'sick' or 'bad'), also stemmed from a regressive identification with the child. Such a parent would have constantly been afraid of being uncovered and punished by the caseworker for his use of the child as an instrument of his own desires. The child may also have served as a sibling, or a sexual partner, to the guilt-ridden parent. The parent might have even projected his or her unacceptable impulses onto the caseworker, and feared him for this reason. This occurred especially with regard to their need to punish the child for his delinquent and unruly behaviour. The hospital became a threat incase it injured the child, or even killed him, thereby reflecting the parents' own inadmissable wishes. Separation-anxiety experienced upon handing their children over to the hospital, was common among psychotic and infantile-narcissistic parents.

Other fears about the family equilibrium were expressed via such metaphors as:

" 1) my child is my instrument of control over my spouse, and you want to take it away from me;

2) you will recognise how I compete with my child, and will terminate the competition;

3) you will cure my child and return him to me, and fail to realise that I have given him up, and don't want him back. "

Parents expressed their resistances in a variety of ways, which were aimed at sabotageing the treatment. They stayed away from casework for long periods, deflected the caseworker's attention from themselves and their unhealthy interaction with their child, precluded any significant degree of emotional involvement with the hospital, and transmitted a variety of messages to the child himself, in the course of his treatment. The latter were done via the following metaphors:

" You musn't trust the hospital: you musn't tell them about your disturbed relations with me because

a) they are just like me; they won't understand you any more than I have; hence you will only be frustrated again;

b) if you tell them how bad (sick) you are, they will hurt (damage or destroy) you;

c) if you tell them about us, you will destroy me;

d) I will retaliate and destroy you;

e) I will abandon you. "

While the attitudes uncovered and interpreted by the above authors may again have been those of a particular parent sample, viz. those whose children are so emotionally disturbed as to require inpatient treatment in a psychiatric residential centre, this is a valuable study for its more general implications. Its conclusions might apply to any parent of a child requiring treatment, perhaps to a lesser degree, if the treatment were of a less drastic kind. An important assumption of the whole study was that such attitudes as were detected, could often be entirely unconscious, and difficult for the unskilled caseworker to observe. They were carefully concealed from both the caseworker and sometimes

from the parents themselves, beneath a respectable rationality, and hardened core of intellectualisation.

A later study on parental attitudes towards the residential treatment of their emotionally disturbed children has more relevance to the present piece of research. Schunam, Coe and Raegrant (1964) attempted to find direct correlations between a parent's acceptance or rejection of such treatment, and the kind of relationship the parent had with the disturbed child. More specifically, the authors investigated three areas of this relationship, viz. parental acceptance-rejection of the child; parental approach-avoidance of the child (overprotective, alienating behaviour etc.); and parental guilt feelings about the child; along an intensity continuum. Their overall hypothesis was that parents who accepted residential treatment for their children were more likely to be rejecting and alienating of them, and to experience more intense guilt feelings about them, than parents who rejected residential treatment.[1] This expectation that parental attitudes towards the child's treatment reflect broader attitudes towards the child as a person, bears a similarity to the present study's contention that the mother's preparation of the child for treatment is a sample of her behaviour towards the child in general, and that the former may be a useful guide to the nature of the whole parent-child relationship.

The authors used two groups of parents, evenly distributed and matched for referral source, socio-economic class, and diagnostic category, age at referral and sex of the child. In one group the children had been admitted for residential psychiatric treatment, and in the other, they had been recommended for it, but their parents had rejected this recommendation. Data was collected by four raters, using social histories and pre-admission psychiatric and psychological interviews with parent and child. (The average reliability coefficient of these ratings was .95) When comparisons were made between the two groups with respect to the three parental attitude variables, several trends were found. There was a significant tendency ($p < .05$) for families accepting placement to be characterised by less accepting mothers. The converse was also true. Most mothers in both groups were however, qualified in their

1. The authors did not clarify their reasons for making such an hypothesis nor the dynamic processes thought to be involved.

acceptance or rejection of their children. There were twice as many mothers in the placement-rejection group who were completely accepting of their children, while a half of the placement-acceptance group mothers were alienating. Placement-rejecting mothers tended to be more consistent in their attitudes towards their children, and their expressed attitudes were more akin to their actual behaviour. Placement-accepting mothers were significantly more guilty about their children than placement-rejecting mothers, but neither group expressed much guilt at all. There was no similar trend among the fathers in either group, for any of these attitudes. Some interactional influence of the age and sex of the child was apparent, making maternal rejection of the child most likely when the child was male, and aged between nine and 12 years.

The results were interpreted as showing a definite association between parental attitudes towards the residential treatment of their children, and towards their children themselves. But no causal relationship was inferred. It is here where the present investigator differs slightly from Schuham et al. No direct causal relationship is implied in the reasoning and expectations of the present study. But it is contended that a common dynamic factor underlies both the parental attitudes and behaviour towards the child, and the parental attitudes towards his treatment. (In the present study, the latter are explored via the kind of preparation a parent gives his child for such treatment.)

Some evidence in favour of the above contention is provided by a number of studies conducted at the Smith College School of Social Work (1933; 1934; 1939; 1940; 1941; 1942; 1943; 1949). A sizeable body of post-graduate research was aimed at investigating the variables of child guidance treatment, with special emphasis on its outcome. Relationships were found to obtain between the latter and numerous antecedent factors. These included maternal behaviour towards the child; parental attitudes towards treatment of the child at a child guidance clinic; parental co-operation with the clinic; parental harmony in child-rearing attitudes; the type of problem manifested by the child; the source and manner of referral to the clinic; the child's own attitude to treatment; the degree of maternal anxiety (as indicative of a generally neurotic reaction pattern); and the mother's tendency to take the blame for the child's disturbance. Some contradictory findings were reported, and a caution was issued against using the above variables (especially the parents' initial attitudes towards coming to a child guidance clinic) as a short-cut prognosis of the therapy (Herkimer, 1939/40).

But in general, parents' unfavourable attitudes towards the clinic and the prospective treatment of their children, tended to make the latter poor therapeutic risks. Furthermore, these unfavourable parental attitudes were usually found among partners who were discordant in their child-rearing behaviour, and who had been referred to the clinic authoritatively, or against their own wishes. Their children had rather serious problems and difficulties of overall adjustment. The initial attitudes of the children who did not respond favourably to clinic treatment, tended to be evasive, apathetic or defiant, and these attitudes worked summatively in their effect, with parental attitudes of a desire for discipline and a reluctance to accept help (Baugham, 1941/2). Lack of parental co-operation with the clinic often ensued upon initially unfavourable parental attitudes towards treatment, and the outcome of the treatment was then also unsuccessful.

Two of Smith College studies yielded interesting dynamic interpretations of the unsuccessful outcome of therapy among children whose mothers were over-anxious and self-blaming. Karpe (1941/2) found that among a group of parents who discontinued the treatment of their children at a clinic, both conscious and unconscious resistances motivated them to do so. Conscious resistances were connected with the public's feeling about a clinic, changes in clinic staff, transport difficulties, unwillingness to accept IQ test results, and a misconception of the clinic's function. Unconscious resistances on the other hand, kept parents from accepting and utilising help for which they had asked voluntarily. The treatment situation aroused marked anxiety among the latter parents, especially among the mothers. They expressed it in various ways, as in the need to blame themselves for the child's condition. This was most frequently not a true insight, but rather a plea for reassurance and comfort. More evidence of anxiety lay in the mother's attempt to avoid talking about her own childhood problems with the caseworker, or by deliberately evading this. Sometimes parental anxiety was so marked and pervasive, that the whole behaviour pattern required treatment beyond the scope of the casework function.

The findings of the second of these studies, by Cohen (1943), suggested that "self-blame for a child's difficulties, as it is expressed by a mother in the early interviews, may be the way a very neurotic person approaches a child guidance clinic." In assuming this blame, the mother was always found to offer some kind of excuse for having created the child's problems, or to insist that other factors were also responsible. Some mothers even seemed to show defiance

in their presentation of these excuses; others made a plea for reassurance that they were not to blame. Unless acceptance of the blame was sincere, and accompanied by a mother's recognition that she herself needed help, it was an adverse prognostic sign for the outcome of the child's treatment.[2]

One view of how the parent-child interaction might be dynamically involved in, and productive of parental attitudes towards the child's treatment was provided by Veiga (1964). Veiga's frame of reference, like that of Jackson, Ferreira and others (q.v. Chapter III) was the idea of family equilibrium and pathology. In discussing the family's reaction to the hospitalisation of one child with a mental disorder, he observed that this often took the form of a pathological separation-anxiety. And this disturbed reaction suggested that

> "... the child with emotional problems plays a role intertwined with the family's psychopathology.... Some families have unconsciously endowed their sick child with a role analogous to the meaning that a symptom or symptoms would have to an individual....
> .....
> ...the child is removed we observe the same reactions in the family members as when say a compulsive neurotic is forced to renounce his compulsion.... "

Pathological anxiety might develop, and there might be shifts of objects, symptoms, and roles within the family. The siblings for example, might begin to manifest the symptoms of the missing brother or sister; the mother might go into a depression upon losing her child; the father might identify regressively with his son or daughter. These changes, which reflect the family's attitudes towards the sick child's prospective treatment, "may give valuable clues to the meaning of the child's illness for the family." Veiga added that the child's "choice of symptoms, and the etiological and adaptational implications thereof, can be investigated along these paths."

Ferreira's "family myth" concept (q.v. Chapter III) also comes into operation in determining parents' attitudes towards the treatment of their disturbed children. Ferreira (1963) wrote:

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[2] Both these studies anticipated Korner (1961, q.v. Chapter IV, p40) in her dynamic exploration of the parent's need to take the blame for the child's problems, and bear similarities to her interpretations of her findings.

" Often... psychiatric help is sought whenever some important family myth becomes inoperative, or at least seriously threatened by developing events; In fact the rush to the psychiatrist [at this point] may constitute a last ditch attempt to maintain the status quo, and re-establish a previously steady state. The family as a whole may then come to expect that the psychiatrist will help them to regain the formula of their relationship, the myth that until now everyone shared and maintained.

The theme of this myth is apparently related to the way in which the family expects help, psychiatric or otherwise .... "

Ferreira observed two general themes with some frequency. One was a 'happiness' theme, and the other an 'unhappiness' one. The former was aimed at maintaining the status quo by doing nothing, while the latter was aimed at promoting action to improve the suffering relationship. These two themes had differential effects on the family's motivation for psychotherapy. Impelled by the theme of 'happiness' the family might make a plea that the psychiatrist offer a reassurance that "all is well", and that the disturbed family relationships continue as in the past, with no major changes or cause for worry. The theme of 'unhappiness' however, might lead the family to ask the psychiatrist to do something active to or for the member regarded as the 'patient'. In this way the therapy itself might become an integral part of the "family myth".

Such an example of the intimately and dynamically related areas of the parent-child interaction and the parental attitudes towards treatment of their child, well illustrates the view that has been proposed throughout this chapter. The simple comment of Ackerman (1954) is an excellent summary thereof:

"... among psychiatrists it is a truism that the person who accompanies a patient on his first visit to the psychiatrist's office is significantly involved in the patient's illness."

The present investigator's specific concern is with the parent who accompanies the child to a therapist or child guidance clinic. Ackerman also included marriage partners and other pairs in his idea. He believed that the two parties involved might frequently be "bound in neurotic love and neurotic competition" with each other, and that the entire interpersonal relationship between them might be as pathological as are their individual personality structures.

Clausen and Yarrow (1955) conducted a longitudinal study of 33 families, from which the husband was hospitalised for mental illness. Their aim was to

examine the perceptions and reactions of the wife in this situation. The impact of the event upon the wife was viewed from both its psychological and socio-cultural aspects. The wife's initial defences against her husband's deviant behaviour; her attempts to have him treated; her fears of social ostracism; the new role she assumed in the family set-up; her communication of her distress to others; and her expectations from psychiatric services; -- these were all indicative of what meaning her husband's hospitalisation held for her. Another clue to what the wife felt about her husband's illness lay in the type of explanation she gave her children of it, and of his consequent disappearance from the household:

> " In interpreting the father's illness to younger children, almost all the mothers attempt to follow a course of concealment. The child is told either that the father is in a hospital (without further explanation) or that he is in the hospital suffering from a physical ailment (toothache, trouble with his leg, tummy ache, headache). Only one mother spoke frankly about the illness from the beginning, explaining it to her five-year old that her father 'had gone to the hospital because he was nervous and upset, and that they were giving him some treatment to make him feel better'. While the mothers 'protest' that theirs have been sufficient explanations, there is both insensitivity and uncertainty in their responses.... Mothers begin to look anxiously at the child in terms of his resemblance to the father... and to wonder what the 'negative effect' was of associating with the father before he was hospitalised, or of seeing him or 'bad cases' in hospital. "

Objectively speaking, a husband's commitment to a mental hospital is more distressing to a wife than is a child's engagement in therapy to a mother. In the former case the loss of financial support, of an emotional relationship, and of a sexual partner, are often severe threats of insecurity to the now solitary wife. The mental hospital carries with it morbid connotations that die hard. But the mother of the disturbed child may subjectively experience her child's need for treatment as if he were indeed insane and being 'put away'. Her emotional involvement with the child, her dependence upon him, and her guilts about him, may make her feel as lonely and as frightened as the wife of a hospitalised mental patient.

Kahn (1966) tried to show that the reactions of a spouse to a partner's psychotherapy were linked to underlying personality traits in the former. More specifically, if the spouse possessed authoritarian, conservative and traditional attitudes, greater discomfort was likely to be experienced over the partner's

involvement in psychotherapy, and over the consequent changes in the latter's personality. This hypothesis was confirmed when the social class factor was excluded. The implication of this is that within a particular socio-economic group, attitudes towards the therapy of a marriage partner are connected with the broader attitudes of the individual concerned. The present investigator suspects that Kahn's findings might also obtain for parent-child pairs, where the relationship between the two members would itself be dependent at least in part, upon the individual personalities and attitudes of each.

To conclude, there is a weighty body of evidence in favour of the position that a parent's attitudes towards the psychological treatment of a child is to some extent indicative of his or her attitudes towards, and relationships with the child concerned. One cannot always use the former as a prognostic index of the outcome of the child's treatment, because many other factors are also involved. But the timing of a parent's request for help; the manner of referral to the treatment centre; the attitudes towards the child's prospective therapist; the degree of co-operation with and involvement in the treatment programme; -- all these may be useful clues to the essential nature of the parent's personality, his relationship with the child, and the pathogenesis of the child's disturbance.

Chapter V.

The Diagnosis and Classification of Psychiatric Disturbances in Childhood

The general 'hypothesis' of the present study, as stated in Chapter I, implied that the disturbed child's problems are at least partially the result of maternal handling. In order to formulate this claim more specifically, and to investigate its validity, it is necessary to examine the entire question of what constitutes a disturbed child. How is such disturbance recognised; what are the varying intensities and types of disturbance in children, can the nosological entities of adult psychiatry be applied in the classification of childhood problems; is any classificatory schema appropriate, and sufficiently discriminating in the categorisation of childhood personality maladjustments?

Most of the answers to the above questions are regrettably vague and controversial. The whole problem of diagnosis in adult psychiatry is still fraught with ambiguity. Different diagnostic criteria are used by experts of different psychological persuasions, who have received different training, and have different therapeutic goals. In the sphere of child psychiatry, much less unity prevails, and this is so for numerous reasons. Children are less readily available for scientific research into their personality problems than are adults, who have already been committed to psychiatric institutions, or who have volunteered to participate in controlled studies. The child's personality is not yet formed, as is the adult's, and changes frequently occur in symptomatology, adjustment level, and problem severity, throughout the childhood years. Sexual roles, and the specific behaviour linked with each of these, are not yet clearly defined in childhood. Psychiatric personnel often have to reach the child via his parents, and many distortions thus occur in the worker's perception of how the child himself experiences his discomfort, if at all. Moreover, it is difficult for an adult to project himself completely into the child's world in order to understand it, and hence adultomorphic interpretations are likely to be made.

Emotionally disturbed children usually come to the attention of a psychiatrist because society (a parent, a teacher, or the law) has experienced dissatisfaction with their behaviour. Very rarely do they come for help of their own accord. This situation creates a tendency for psychiatry to categorise such

children in terms of the complaints made about them, rather than by them about their own internal conditions. Furthermore, there is not much uniformity in terminology among these various referring agents, when they express their reasons for bringing the child for help. Such vague terms as 'nervousness', 'inability to concentrate', 'backwardness', 'aggression', 'jealousy', and many others, frequently recur among the common complaints made by adults about children. In attempting to make a diagnosis of the referred child, the psychiatrist is hampered by the absence of a clearly defined norm of childhood behaviour or adjustment. He may find an overlapping of symptomatology among two or more children with apparently different personality problems. Alternatively, no common behaviour patterns may exist among children with identical situational and dynamic features in their backgrounds. The behaviour of an inordinately timid and submissive child may be motivated by the same anxieties as that of a defiant, rebellious and antisocial youngster. How is each one to be labelled -- according to his underlying fears, or his effect on society? A choice in either direction, for the sake of nosological brevity and precision, must result in a gross oversimplification of what is involved in the complicated workings of the child's psyche.

Some interesting statistics on what children come to the psychiatrist, psychologist or clinic for, were provided by the early workers in this field.

Murphy (1930) grouped an unselected sample of 360 cases (aged between two and 17 years) referred to a child guidance clinic over one year, into eight general classes, viz.

school retardation	24 percent
behaviour	19 percent
interest[1]	13 percent
mental status (IQ assessment etc.)	13 percent
general retardation	10 percent
educational guidance	7 percent
nervousness	4 percent
miscellaneous	10 percent

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[1] i.e. parents' curiosity about what psychology had to say about their children.

He found that there were more than twice as many boys as girls in the sample, and that boys were more frequently brought for behaviour problems and school retardation than girls, who were more often brought out of 'interest'. Age was about equally divided between the two sexes.

Despert (1949) provided some comparable figures from 250 consecutive cases of children admitted in private practice for consultation and treatment. Her sample showed a relative predominance of girls (101/250) as compared to the normal population of children in psychiatric outpatient departments. The age range was from one year 11 months, to 16 years four months. A classification of the sample according to problem follows:

	cases	boys	girls
psychoneurotic manifestations (e.g. anxiety, obsessive-compulsive syndromes, tics, neurotic habits, psychosomatic symptoms etc.)	162	88	74
behaviour disorders	26	20	6
learning disabilities and speech disorders	16	12	4
mental retardation (?) and emotional blocking	18	9	9
psychosis (15 schizophrenic)	21	13	8
infantile autism	7	7	0

The above schema was obviously a more sophisticated one than Murphy's, whose was devised nearly twenty years earlier. But Despert still found much overlap in symptomatology among the various categories, and admitted that the diagnostic criteria for children were not yet clearly defined. She also gave a breakdown of referring agents (other psychiatrists, psychoanalysts and clinical psychologists treating the child; pediatricians and general practitioners; parents' therapists; parents of former patients; teachers and school psychologists; and the parents themselves), and found variations in the age of the child at referral; in the time of referral after the onset of the problem; and in the type of problem referred among these groups of referring agents. This also suggested a lack of uniformity in the perception of various skilled and lay people, of what constituted an emotional problem in a given child.

A study by Levitt (1959) challenged the reliance placed by clinics on the information given by a mother, concerning her child's symptomatology. He showed that the mother's perception of her child's disturbance was often different from the child's own experience of it. Seventy-three children seen consecutively at a large community child guidance clinic, aged between eight and 13 years, were simultaneously given the same scale, except that the pronouns 'I', 'me', 'myself' etc. were replaced by 'my child', 'he', 'she', etc. The mothers said their children agreed on the average degree of psychopathology among the latter, but there was no correlation between their scores on the scale, nor any itme by item agreement between them. The author posed the unanswerable question, "Who is perceiving realistically, mother or child?", pointing out that psychiatric diagnosis in childhood was still not clearly understood.

Ackerman (1958, p.193) also emphasised this difference between the mother's perception of the child's problem, and the child's own feelings about it:

> " The child himself in private interviews with the clinician has special problems of his own, and presents these to the clinician in a special way. The child does not have the adult's conception of what constitutes appropriate or inappropriate behaviour, or of what emotional illness is, nor does he have any idea about receiving psychological help. He comes because he must .... "

Diagnostic criteria must consequently be inappropriate when applied to children (Ibid, p.199) :

> " The disadvantages of traditional systems are mainly the following: they tend to carry over into childhood those conceptual trends of structured individual psychopathology which are familiar from the sphere of adult psychiatry, but are less specifically suited to child behaviour. They tend to conceive the child too strongly as a separate individual, and do not provide sufficiently for the child's interaction with the family environment. They tend to carry over into childhood the concepts of difference between normal and abnormal which prevail in adult psychiatry, but again are less specifically appropriate to the phenomenology of child life. They relegate disturbances of character development and the broader problems of social adaptation to the sphere of normal experience, and tend therefore to dissociate artificially the study of sick-healthy behaviour. Finally, their orientation is largely descriptive rather than dynamic, and as a result, too great a stress is placed on manifest behaviour while insufficient consideration is given to motivation, unconscious conflict, and the developmental trends of personality .... "

Ackerman nevertheless used a classificatory schema of childhood disorders,

with the following categories (Ibid, pp. 200-6) :

" A. Functional Disorders

1. Primary Behaviour Disorders
   a) habit
   b) conduct
   c) neurotic traits
2. Psychoneurotic Reactions
3. Character Disorders
4. Psychosomatic Disorders
5. Psychotic Disorders

B. Disorders With Organic Base

1. Secondary Behaviour Disorders
2. Mental Retardation
3. Organic Syndromes "

This is a familiar form of classification in child psychiatry, and is used by many clinicians and research workers in the field. It has many of the same disadvantages Ackerman found in other classificatory systems, and there is often considerable overlap between the categories.

Peterson (1961) conducted a factor analysis of gathered judgements of problem behaviour during the kindergarten and elementary school years, with the purpose of detecting any changes in problem expression during this time. He recorded 427 referral problems at a child guidance clinic, analysed their frequencies, and then investigated 53 of the most common problems encountered. Teachers then rated 831 kindergarten and elementary school children on a 0-2 severity scale for each of the problems. Four separate analyses were made for children of kindergarten, grades I and II, III and IV, and V and VI ages. Two factors emerged with remarkable variance in all four analyses, viz. a) the tendency to express impulses against society; and b) a variety of elements suggesting low self-esteem, social withdrawal, and dysphoric mood. Peterson called the former a 'conduct problem', and the latter a 'personality problem'. He noted that boys displayed more severe conduct problems than girls at all ages. In the kindergarten and primary school years, boys also showed more severe personality problems than girls, but later girls displayed more personality problems than boys. The traits comprising each type were listed as follows:

Conduct Problems	Personality Problems
disobedience	inferiority feelings
disruptiveness	lack of self-confidence
boisterousness	social withdrawal
fighting	proneness to become flustered
attention-seeking	self-consciousness
restlessness	shyness
negativism	anxiety
impertinence	lethargy
destructiveness	inability to have fun
irritability	depression
temper tantrums	reticence
hyperactivity	hypersensitivity
profanity	drowsiness
jealousy	aloofness
unco-operativeness	preoccupation
distractibility	lack of interest in environment
irresponsibility	clumsiness
inattentiveness	daydreaming
laziness at school	tension
short attention span	suggestibility
dislike for school	crying
nervousness	preference for younger playmates
thumbsucking	hay fever
skin allergy	specific fears
	stuttering
	headaches
	nausea
	truancy from school
	stomach aches
	preference for older playmates
	masturbation

Peterson claimed to have isolated the two main factors of 'conduct' and 'personality' problems in a number of other studies, using different subjects, other variables, and new analytic procedures. Together with other workers, he has relied heavily on this distinction between the two broad categories of psychiatric disturbances in children, especially in the validation of scales such as the PARI (q.v. Chapter III).

But a close inspection of these lists gives rise to many questions: No dynamics or etiology are implied. There is a suggestion of overlap between the traits associated with the two types of problem, as in 'daydreaming' and 'inattentiveness'; 'lethargy' and 'laziness at school'. One has difficulty in understanding why 'nausea' should be classified as a personality problem, while 'skin allergy' as a conduct problem. Does this not vary from child to child? Why is 'nervousness' regarded as an expression of an antisocial impluse? Is not 'truancy from

school' more so? 'Jealousy' and 'irritability' seem just as likely to reflect low self-esteem as they express impulses of acting out and antisocial conduct. There are several other examples of such ambiguity.

With the above criticisms in mind, the investigator had found Peterson's schema to be of limited usefulness as a comprehensive classificatory system in child psychiatry. Subsequent literature on this subject does not provide any better system that is not also encumbered by the same difficulties as have been mentioned above. Since the present research project is particularly concerned with etiological and psychodynamic factors in the emotional disturbances of childhood, the investigator has been forced to look for another way of assessing the latter, in terms of the processes involved, rather than via their end results and outward manifestations.

In Chapter III, parent-child attitudes and their relationship to the development of the child's personality were discussed. Here it may be appropriate to cite several studies aimed more specifically at investigating the mother-child relationship from a dynamic point of view, and its relevance in the symptomatic manifestations of the disturbed child. These studies were mainly retrospective analyses of the particular mother-child behaviour patterns in the past, that may have given rise to various disturbances. Such studies have their hazards. Nevertheless they do illuminate some aspects of the complex mother-child interaction patterns in a number of situations. And these patterns are a focal point of the present investigation.

Abbe (1958), on the basis of earlier evidence that child adjustment and emotional security at home were related to parental overindulgence, severity, submissiveness, and dominance, studied two groups of disturbed children and non-disturbed children, and their respective mothers. She hypothesised that children diagnosed as emotionally disordered would more frequently than normal children have mothers who were restrictive, lax, or overindulgent in their attitudes towards them. Furthermore, that neurotic children would tend to have restrictive mothers, and 'primary behaviour-disordered' children, lax and overindulgent mothers. Her main hypothesis was upheld, but there was no evidence of a relationship between a particular kind of maternal attitude and a specific emotional disorder in the child. Abbe pointed out that her failure to detect the latter may have been due to the lack of clarity in current clinical diagnostic categories

of childrens' emotional disorders. Maternal attitudes were also changeable over time, too vaguely defined to permit accurate evaluation, relative to the specific areas of child behaviour, and subjectively experienced by children in a manner unrelated to reality. All these considerations warranted further study, and were necessary to bear in mind by any research worker who aimed to investigate mother-child relationships.

Some selected studies from 1926 onwards, were reviewed by Gildea, Glidewell and Kantor (1961). While admitting that the weight of the evidence for a relationship between maternal attitudes and child personality and adjustment was ambiguous, and that many other factors remained uncontrolled in the investigations reviewed, the authors did find some aspects of maternal and child behaviour than seemed to be significantly associated. Variables of control and autonomy in both parents and children were linked to the successful socialisation of the child, with extremes of either control or autonomy reflecting a lack of success. A mother's acceptance of her child, her confident spontaneity in accepting her maternal role without severe conflict between its protective and supportive functions, and its controlling, training, and socialising functions; her capacity to find 'real' satisfaction in expressive, warm, and affectionate relationships with dependent young children; and her consistent behaviour in all the above dimensions -- all these factors had some apparent effect on her child's adjustment.

Gildea, Glidewell and Kantor went on to test their own hypothesis that school behaviour problems were prevalent among children in the same degree as their mothers felt themselves not to be responsible and impotent to influence the outcome of these problems. The data (obtained from 830 mother-child pairs) confirmed their hypothesis:

> ".... The lowest disturbance rates were found among the children of sophisticated mothers (who see multi-causation, feel responsible and potent); the next lowest among children of anxious, over-responsible mothers (who feel responsible but impotent, and see themselves as the only influence on the outcome of the problem); the third lowest rates appeared in the children of the confident, do-it-yourself mothers (who feel responsible, potent, but see themselves as the only influence in the outcome of the problem). The highest disturbance rates were found among the children of the projecting, impotent, paranoid mothers (who deny responsibility and potency, and see one or more external influences on their children); the second highest rates among the children of responsible mothers who feel relatively cautious or reserved about the success of their efforts to deal with behaviour problems in their children; the third highest rates appeared among the children

of depressed mothers (who felt responsible but impotent to influence the outcome of their situations). "

It is not clear from the study why attitudes of responsibility and potency should vary and interact with each other in this way, in their effect on the child's school adjustment. (Social class also affected the mother's attitudes, with upper class mothers showing the most benign attitudes.) Although significant patterns of maternal attitude combinations have been shown to relate significantly to child adjustment at school, the extent, direction and specificity of influence between these two variables has not been clarified.

Loevinger and Sweet (1961) offered an interesting dynamic interpretation of how maternal child-rearing patterns, especially the exercise of controlling functions, reflected the mother's anxieties over her own instinctual impulses. The findings of Gildea et al (q.v. supra) and other writers, may perhaps hereby be elucidated :

" A mother's repression of her inner life is maintained by denial of evidence of her child's inner life. Her blindness to the child's capacity for inner control requires her to impose external controls; at the same time her blindness to his inner needs permits her to violate those needs in imposing controls.

.....

... the child with whom every mother is concerned... whose inner life is increasingly recognised... whose impulses can increasingly be entrusted to inner rather than outer controls — each of these is the child within herself. Her relation to the child within is at once a measure of her ego development and a source of her relation to her real children. "

A finding by Edel (1962) may lend support to the above contentions. In a random sample of 37 child cases entering treatment in a New York psychiatric clinic, Edel found that the child's behaviour problem was similar to the covert personality trait of the mother ($p < .05$). The 'security operations' used by mother and child were not necessarily the same, but it was difficult to differentiate the child's security operation from his problem per se.

Some mothers never succeed in separating themselves emotionally from a particular child, or in allowing the latter to become a differentiating and developing personality himself. They cling to the primary maternal role of nursing the helpless infant, and of being totally preoccupied in this activity, until long after the child's infancy has passed. The result of such maternal behaviour, is that the nursing couple becomes a permanent establishment, wherein

the two personalities are infused and mutually identified. The mother perceives herself as the omnipotent supplier of all the child's needs, and cannot entertain the idea that the child can bear any dissatisfaction, frustration, or hate. The child in turn, never achieves his own separate identity, and thus remains confused in his notions of 'me-ness', 'motherness' and even 'otherness' (Shields, 1964). Such a situation may potentiate him towards psychotic behaviour in later years.

Dyk and Witkin (1965) conducted an intensive investigation into the maternal tendency to foster or interfere with the process of differentiation in her child, and the consequent effects on the child's personality. Regarding 'differentiation' in the child as the ability to experience the world in an "articulated way"; to have a "differentiated self, an articulated body concept and a sense of separate identity"; and to use "structured and specialised defences", they hypothesised that this process would be fostered by a mother who gave the child an opportunity to separate himself from her, and who contributed effectively towards his "formulation of internalised controls and frames of reference". They conducted a home interview study among mothers of two groups of ten year-old boys (comprising a total sample of 48 pairs). They evaluated the mother-child interaction in certain specific areas, and the child's degree of differentiation by means of various tests, e.g. figure-ground and field-dependence tests, intelligence tests, the Rorschach inkblot test, the Thematic Apperception Test, real life situation rating tests, and human figure drawing tests. Correlations between the home interview ratings of the mother-child interaction (as fostering or interfering with differentiation) and the various measures of differentiation in the child, were highly significant in the expected direction. Correlations also obtained between what the mothers communicated in their interviews, and how the child portrayed the parents in his T.A.T. stories, thus lending further support to the above findings. The degree of differentiation in the mother herself, was hypothesised as being a determinant of her tendency to foster or interfere with the differentiation process in her child. Thus, less differentiated children were expected to have less differentiated mothers. This expectation was also supported by the correlational analyses, but not at a clear level of significance.

The authors interpreted their results as having demonstrated an association between a facet of maternal behaviour and certain aspects of the child's

personality. They did not however, claim to have demonstrated a relationship between such maternal behaviour and the presence or absence of pathology in the child. (The latter was found in different forms, in children of both types of mother investigated.) Moreover, they stressed that no cause-effect relationship had been elucidated by their study. Instead,

> " Mothers may have made their children the way we found them; or the mother's behaviour, as we observed it, is itself an adjustment to the kind of child she brought back with her from the hospital; or the interaction observed is a product of the behaviour of each participant in relation to the other, and the interaction served as a continuous modifier of the behaviour of each in the course of their lives together. "

The 'interactional' approach is one that is helpful both in assessment and treatment. By regarding the relationship between parent and child as a 'two-way-street', one need not assess the child in isolation, as having a particular disturbance, problem, and personality structure. Instead, one assesses the whole relationship, comprising the interactional needs, stresses, behaviour patterns, roles, frustrations and gratifications that exist between the two or more people involved.

In the present study, the concern is with the mother and her child as the two primary characters, with the other figures playing comparatively lesser parts in the whole dramatic development. Using the above approach as a frame of reference, the investigator has decided to assess the child's disturbance via the mother-child interaction.

Some circularity may be apparent in this argument. It has repeatedly been suggested by the investigator that the child's disturbed behaviour is partially attributable to his experience of maternal handling, and hence the mother-child relationship as a whole. Now it seems that in order to test this postulate, the plan is to measure one of the variables, viz. the child's disturbance, using the other variable, viz. the mother-child relationship, as a yardstick. Clearly, this is not permissible by methodological principles. But "via the mother-child relationship" really implies something other than the child's experience of maternal handling in the past. More specifically, what is meant is <u>the impact that his current disturbance has on his mother, here and now</u>. How does she feel when her child behaves in a characteristic way;

when he manifests a particular symptom; or when his general personality pattern shows signs of disturbance, maladjustment and conflict? There are countless ways in which the mother may react, and a whole intrigue of emotions which she may experience in this situation. Overlap will again occur if an attempt is made to categorise mothers into several broad reaction types. But this overlap is likely to be less than that in the symptomatology of children diagnosed on a haphazardly adopted, vaguely defined, and often irrelevant psychiatric classificatory system. Moreover, in this way, psychodynamic factors can be taken into account and assessments can be made on the basis of direct contact, through interviews, with the subjects (the mothers themselves), rather than via other agents (as would be the case when a child patient is assessed through interviews with the parents). For these reasons the plan seems to be a feasible, and indeed a preferable technique in methodology.

The framework of the 'general hypothesis' would thus have to be changed from a postulated association between maternal handling and the maladjustment of the child, to one between maternal handling and maternal reactions to the maladjustment of the child.

No studies appear thus far, which indicate what the various categories of maternal reactions to their children's disturbances might be. However, the investigator has already reported upon the kind of emotions a mother may feel upon coming to the clinic with her disturbed child (q.v. Chapter IV). There appears to be great variation in the feelings of prospective clinic mothers, without even including those mothers who fail to seek psychiatric help, but who undoubtedly feel something about their children's behaviour problems.

Four tentative categories of maternal reactions to a child's problem behaviour were set up: The first group of mothers would be angered by their child's behaviour, and feel resentful on account of it. The second group would be frightened, and feel helpless in the fact of it. The third group would be ashamed, and feel exposed by it. The fourth group would be genuinely concerned about it, and feel a need to help the child over his difficulties, at whatever personal cost.

Also implied in the above categorisation is a continuum of the mother's degree of conscious awareness and acceptance of her own role and responsibility in her relationship with her child, and in the genesis of his disturbance.

At the lower end of this continuum would be the mother who denied all responsibility for her child's disturbance, projecting all the blame for it onto him or onto others. She feels no conscious apprehension for her own security, but instead regards his behaviour as something entirely external to herself, and in which she plays no part. She is only affected insofar as his behaviour makes her 'angry' with him. She says of her child "He is bad", or of his father, teacher, siblings, and peers, "They have made him bad".

The 'frightened' mother also projects her anxieties onto her child, but consequently perceives him as a threat to her own security. She differs from the 'angry' mother because she does feel some conscious apprehension about her child's disturbance, which seems to her as if it is directed primarily against her. She is therefore undermined by it, and afraid of it. She is thus more aware of her involvement in the mother-child relationship than is the 'angry' mother, but she cannot really accept her responsibility in it. Her statement about her child is, "He may be a danger to me or to others." In this way she projects onto her child, not only her own dangerous impulses towards him, but also those she harbours against others.

The 'ashamed' mother accepts some responsibility for the child's disturbance, and is conscious of the fact that she is implicitly indicted by his problem behaviour. She feels exposed and inadequate because of his failure to conform to expected norms. But she cannot relinquish her tendency to externalise her feelings of inadequacy, to project these onto her child, and to cling to the belief that "He is the reason for my feelings of failure.

The 'concerned' mother feels the greatest degree of personal involvement in her child's disturbance. She could be described in psychoanalytic terms as someone who has reached the 'Depressive Position' of early infancy (Klein, 1952). Such a mother experiences conscious awareness of her own responsibility in the genesis and perpetuation of her child's problems. She feels blameworthy, and truly guilty for what she may have done (or omitted to do), and still needs to do, to bring his maladjusted behaviour patterns about. Her anxieties arise from