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FACTORS IN MATERNAL EXPLANATIONS OF THE GUIDANCE CLINIC TO THE CHILD REQUIRING PSYCHOLOGICAL TREATMENT

by

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JOHANNESBURG

March 1972

Declaration by Candidate.

I hereby declare that

1. This thesis is my own work;
2. It has not been submitted to any other university.

J.H. BROWN.

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J.H. BROWN.

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Abstract of Thesis

A study was conducted at the Johannesburg Child Guidance Clinic on a group of mothers who had either been referred there, or who were self-referred, for advice on and possible treatment of their 'problem' children. The latter ranged in age from five to 15 years. The mothers were selected on a near consecutive basis, provided they met certain prescribed criteria of English language fluency, natural parenthood, and an absence of organic pathology in the child about whom they complained. The original sample consisted of 44 mothers, but because some of these did not return to the Clinic, the final number was reduced to 33.

The aim of the study was to test if there was any relationship between what the 'problem' child was told about the Clinic before being brought there, and the nature of his problem. It was postulated that the specific way in which the mother handled the situation of preparing her child for the Clinic, was an instance of her general way of handling other situations with him. His disturbance was probably, at least in part, a result of such handling in the past. Hence an association was predicted between his disturbance and the explanation he had been given of the Clinic. If such an association were found, it might serve as a useful short-cut to the conventional diagnostic procedure at most child guidance clinics.

The child's disturbance was assessed from the mother's reaction to it, rather than in terms of its specific symptomatology. Four categories of "Maternal Reaction Type" were originally envisaged, but they later had to be condensed into two, because of the contraction of numbers in the sample. Three categories of "Preparation of the Child for the Clinic" were initially conceived, but later these were also collapsed into two.

A X^2 test of significance for two independent samples was used to test the hypothesis. No correlation of any statistical significance was detected. The possibility of methodological flaws was examined, and a detailed discussion of the intervening variables that remained uncontrolled in the present study, led to the conclusion that the original postulate was still worthy of investigation.

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Chapter I

Statement of the Problem

The influence of the interactional process between a mother and her child upon the emotional well-being or maladjustment of the latter, has lately been the subject of much psychological theorising and investigation. Common features in the histories of diagnosed adult psychiatric patients have given rise to various speculations about the kind of mothering they experienced in early infancy and childhood. Concepts such as the 'schizophrenogenic mother', or of the asthmatic's mother 'sitting constantly upon his chest', suggest that the mother's role in the production of the patient's symptomatology is differential and specific.

But most of these concepts have been derived from retrospective studies, that have attempted to reconstruct the patient's past, and the role his mother played in it, in the light of his present illness. Emotionally disturbed children provide a valuable opportunity for investigating the ongoing interactional process between the mother and the child. By exploring the mother-child interaction in a current, specific situation, one may be able to understand more clearly what underlies the child's disturbed behaviour patterns in more generalised settings, in which he is also currently functioning.

The present study aims to do this.

The child guidance clinic offers an ideal setting in which such research could be conducted. Many parents may come there of their own accord, in seeking help for their 'problem children'. Or they may be referred there by a variety of agents. Since it is the mother, and not the father, in whom the present investigator is most interested, and who is usually seen by the professional worker at a clinic, attention will be focussed mainly upon her.

Procedure may vary at different child guidance centres, depending on the community the clinic serves, the staff-client ratio, the psychological orientation, background and training of the professional workers, and numerous other factors. But a common method of investigation and treatment of a referred 'problem' case is as follows:

The mother is seen initially at an 'Intake Interview' by a member of the professional team (usually a psychiatric social worker), for a brief discussion of the child's presenting problems. Some time later (this interval varies considerably among different clinics), the mother is again seen by the same or another professional worker, so that she may give a detailed account of the child's development since birth, the birth itself, her pregnancy, the marital situation, and her own and her husband's family histories. At the same time as this 'History Interview' is held, the child has his first encounter with the clinic, and is investigated psychometrically. The mother and child each have one further interview with one of the psychiatrists at the clinic, before a case discussion is held, and the treatment programme is embarked upon. (The latter may be delayed by a very long waiting list.)

A situation that arises very frequently in the course of these preliminary investigations, is the mother's conflict about what to tell the child of the clinic, before bringing him there. She may ask the professional worker directly what to say. She may deliberately deceive the child, and bring him there under false pretences. She may evade the difficulty of the situation by not telling him anything at all, and leave him to find out for himself why he has come, hoping that somebody there would explain the reasons to him. She may be able to tell him the truth without any embarrassment, and not find the task a difficult one at all.

Whether this question is a relevant one for a mother who seeks help for her problem child, must depend on many factors bound up with her own personality. Her own fears about what the clinic is going to do, about exposing herself by revealing many personal details to the professional worker, about the promises of confidentiality that are made, about the severity with which the problem will be regarded, and about her own failure in the mothering task, are perhaps sufficient reasons for her possible doubts and suspicions, on first coming to the clinic for help.

It is thus assumed that the resistance a mother anticipates in her child, when telling him that he is to come to the clinic for treatment, is at least partially, a projection of her own resistances and anxieties. An inability to handle this very situation of explaining to her child the nature and function of the clinic (either by distorting the truth or by evading it), would then

reflect to what extent she is impeded by her own anxieties in her entire relationship with him. This situation can itself be regarded as a microcosm of a wider interactional process, in which such impediments may frequently occur, and hence give rise to a pathological and pathogenic relationship between mother and child. The expectation, therefore, is that the mother who handles the situation in a particular way, does so because of her anxieties, and will probably have handled other situations involving her 'problem child' in a similar way. Furthermore, it is this precise method of handling such situations that might account at least in part, for the child's apparent disturbance. On the basis of this general 'hypothesis', a number of more specific predictions will be formulated about the expected nature of the disturbance in a child whose mother explains the clinic to him in a particular way. [1]

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1. The idea of using the parental preparation of the child for treatment as a primary research variable came to the investigator as a result of an actual incident that occurred at the child guidance clinic:

> A psychologist asked a child who had been brought to the clinic if he knew why he had come there. He said that he did not, but when he was returned to his mother in the waiting room and she asked him how he had got along, he replied that it had been fine. And showing his mother his hands, he told her, "They didn't even touch my warts!"

Chapter II

Parental Preparation of the Child for Psychological Treatment

The child guidance clinic as we know it today, must have been a familiar feature in psychologically aware countries for at least the last thirty years. As an agency to which parents may address themselves for advice on child-rearing methods and problems, and as a centre to which they may bring a child with emotional, behavioural, intellectual or social difficulties, for assessment and possible treatment, it has become a well-recognised institution in most sophisticated communities.

One would therefore expect that many a parent, who has used its services over this time, has had to cope with the task of describing and explaining the clinic to the child who is to be taken there for help. In certain places, the concept of a child guidance clinic may already be as familiar to young children as that of a hospital, a school, or a library. But this can only be a comparatively recent development, and children's fantasies about what the clinic actually does, are still bound to be varied and indeed confused. How to explain why only certain children need to be taken to a clinic, and not others; what sort of people run a clinic, if not doctors or teachers; why a child should have to go, if it is not he, but his parents, who feel ill-at-ease, and in need of help — these are only some of the difficulties confronting the parent who wants to persuade a child to come to a child guidance clinic.

Yet a survey of the literature on child guidance clinics since their early appearance, yields a dearth of material associated with this question. As varied and confused as the child's fantasies about the clinic are likely to be, so are the parents' own descriptions of it. The latter are themselves expressions of their own fantasies, doubts and expectations.

A parent might ask the Intake interviewer for direct advice on how best to prepare a child for treatment. Several writers have advocated particular optimal ways of doing this. Among them was Anna Freud (1946), a pioneer in the field of child psychotherapy. She emphasised the absence of motivation for therapy in the child patient, when compared to the adult (1946, pp. 5-6):

"..... The decision for analysis never comes from the child who is to be the patient, but always from the parents or other persons round it. The child is not asked for its consent. If the question were put to it, it could hardly pronounce an opinion or find an answer. The analyst is a stranger, analysis itself is something unknown.

.....

..... in many cases the child itself is not the sufferer, for it often does not perceive the trouble in itself at all; only the persons round it suffer from its symptoms or outbreaks of naughtiness...."

Martin Grotjahn (1938) had made this same point when he dismissed as impossible the use of orthodox analytic technique in the treatment of children:

" Even a very depressed child would never be able to call himself depressed. The child sees himself only as he is reflected in the mirror of his parents' opinion. It is beyond the capabilities of the child to realise that he may have faults and defects. In his happy narcissism and self-overestimation he sees himself as perfect, and is not bothered by the superego of grown-ups. If he learns that something in him is wrong, then he takes this as something that he has to accept from his parents or their images. Even bodily pain is seldom conceived of as within himself, but as coming from without..."

Perhaps it was the publication and translation of Anna Freud's early work with child patients, using the psychoanalytic technique, that gave the impetus for much interest in child psychotherapy in England and America during the 1940's. Numerous studies dealing with epidemiological factors, therapeutic techniques, and individual case histories, were published at this time, and several of these were concerned with the question of the preparation of the child for treatment.

Blanchard (1940) also discussed the therapist's difficulty in motivating a child to come for treatment, when it was the parents' initiative that brought him there. The child will accept the parents' initiative and decision for his treatment only when it is sure and firm, and thus "a child's best preparation for therapy is the parents' readiness to continue with it." But Blanchard saw that parents themselves were ambivalent about handing their child over to a therapist, and were thus not always capable of being "sure and firm" in their decisions. Their ambivalence is expressed and communicated to the child in the very explanation they give him of their decision to take him for treatment.

The explanation may take a variety of forms: It may be a fairly realistic one, in which the parent tells the child that they both need help, for their mutual relationship. Here the parent accepts part responsibility for the child's problem, and faces the situation frankly with him. But not all parents have this much insight into their own role in their children's difficulties. They may explain treatment in terms of the child's nervousness, disobedience, or badness. They may evade an explanation altogether, and leave the child to find out from the therapist why he has been brought for treatment at all. They may invent a false reason for bringing the child, either because they cannot bring themselves to talk about it to anyone else, or because they themselves cannot consciously accept the real reason. They may use treatment as an ultimatum to the child if he is not more obedient, sometimes threatening to leave him at the clinic, or to have him institutionalised, if he does not improve within a limited time of treatment. Or they may use a fictional explanation, with the intent of placating the child, and coaxing him into coming, by their deception.

The child himself may have his own fantasies about what treatment involves, which are also interesting in terms of his particular problem. But this investigator's chief concern with Blanchard's paper is that she was the first to discuss the way a child is informed of treatment as a variable, dependent on deep-seated personality needs in the parent, and not simply as a necessary preparatory first step to the child's therapy.

Kerr (1946) conducted the first formal investigation into the relevance of parent- and child-orientation towards treatment, in the child guidance process. Although in many clinics parents frequently mentioned the question of preparing the child for treatment, Kerr noticed that little had hitherto been published on the subject. An exception was a policy statement of the Philadelphia Child Guidance Clinic (Witmer, 1954), wherein this comment was made:

> "..... an effective part of the intake process is working with the parents on how they can discuss the clinic with their child. Clearly they cannot explain what will happen, but they can let the child know their concern and the reasons for it, and the fact that coming to the clinic is a step they are taking together to get help for conditions they are ready to do something about. The parent who can be direct and realistic in including the child in the concern that motivated this step, will have provided a sound basis for the child's first experience with the therapist."

Kerr's primary aim was to determine the truth of the last statement, viz. "to show whether the preparation a child receives from his parents before coming to the child guidance clinic affects his initial attitudes towards treatment, and in turn, his ability to form a treatment relationship with the therapist."

Her sample included 75 cases aged between four and 18 years, with behaviour or personality difficulties of emotional origin. They were selected from an 'active' child guidance record file, over a period of six months, on the basis of there being some statement in the records about the preparation of the child for treatment. Most referrals were made by the parents themselves, teachers, physicians or social agencies. At the intake interview, one or both parents were interviewed by a social worker before the child was seen. Among the issues discussed were the reasons for seeking help, the expectations from the clinic, background information about the child and his problem, and details of clinic procedure. The parents were also given an opportunity to decide whether they might be able to use the clinic's services. One of the initial difficulties for which the parents sometimes asked for help from the social worker, concerned the preparation of the child for treatment. The social worker discussed this fully with the parents if they wished, and tried at the same time to make an assessment of the child's and the parents' readiness to accept help. The preparation task might have been left to the parent in some instances, or else some suggestions may have been made by the social worker.

All these data about the initial interviews were recorded by the social worker, as well as other identifying facts concerning the patient, the referral agent and reasons for referral, the psychiatric diagnosis made at the clinic, assessments of the parents' attitudes towards each other, the child, the problem, the clinic, and towards treatment in general. Information about the parents' statement of how and when they prepared the child for treatment, as well as the actual preparation given, was also gleaned. Finally, an inquiry into how the child himself felt about the clinic, and a short follow-up examination of the initial phases of treatment were then made.

The results obtained "showed a definite relationship between the kind of preparation a child received before coming to the clinic, and his first reaction to treatment."

Three categories of preparation were extracted, viz.

"

good (32/75 cases), [where]

a) the emotional problem of the child was recognised with him at a level he could understand;

b) the purpose of the clinic and the possibility of the child and parent using it together were explained realistically; and

c) the child's attitudes and questions were discussed with him in advance, with an attempt to let the child himself take part in the decision to use the clinic.

partial (17/75 cases), [where]

a) the child receives some explanation of the clinic and/or a reason for coming, before the psychiatric interview;

b) child guidance was not represented falsely, although it may have been explained in terms which were inadequate or which the child was not fully able to understand.[1]

poor (26/75 cases), [where]

a) there was a complete absence of any explanation, or

b) a false or distorted explanation of the clinic and the reason for coming to it was given. "

Examples of the 'poor' explanations above were "somewhere to play"; "a doctor for a medical examination"; "going shopping and dropping in to see a lady on the way"; etc. Interestingly, Kerr observed that "in all these cases the parents' attitudes towards the child, his problem, and the clinic were ambivalent, or markedly negative and rejecting. These feelings may have been overtly expressed or inhibited and repressed, so that the parent himself was unaware of them, using defences of seeming indifference, rationalisation, displacement and projection."

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1. Kerr noted that the "chief distinction between 'good' and 'partial' preparations lay in the relative amount of emotion with which the parents discussed with their children the possibility of treatment. His anxiety about his own relationship to the child, his feelings of guilt about having to seek help when he recognised his own responsibility in the problem, his sense of personal failure toward the child, etc., makes adequate preparation extremely difficult for the parent."

Kerr's specific predictions that well-prepared children would express positive attitudes to treatment; partially prepared children ambivalent or indifferent attitudes; and poorly-prepared children indifferent or negative attitudes, were for the most part confirmed. The same variances held for the ease with which these respective groups of children were able to form a relationship with the therapist. Furthermore, a linear correlation was detected between the parents' attitudes to treatment, and their ability to prepare their children for it. The social worker's assistance in planning the preparation with the parents had a positive influence on the actual preparation given. But if the parents' anxiety was too great, and there was strong parental ambivalence about treatment, specific planning was of no avail, as intellectual guidance could not override emotional motivations.

This is indeed an interesting study, and a valuable contribution to the understanding of the motivation for treatment in parents and children, and its effect upon the treatment process itself. However, several questions remain unanswered in Kerr's study, although she has hinted at them as possible areas to be explored: What makes some parents able to give their children a good preparation for treatment, while others cannot? Is it precisely the parent who enjoys a better relationship with his child who can prepare him more fully for treatment? Would this child not then be a better therapeutic prospect anyway, having had the benefits of a healthier parent-child relationship in the past? And is the parent who is potentially capable of giving the child good preparation for treatment not the same parent who will discuss this with the social worker in advance, and be receptive to whatever suggestions that are made -- simply because he is a more stable and mature personality, with a consequently better adjusted child? These variables have not been controlled in Kerr's study, and it is probably inconceivable that any similar study would be able to control all of them satisfactorily and simultaneously. Nevertheless, one is led to ask the broader question of how the personality of the parent and that of the child with the consequent interactional patterns of behaviour between the two, affect the parents' preparation of the child for treatment. If one could detect any consistent relationship between these two variables, something might be learned about the parent-child dyad from the way the preparation task itself is handled. The latter might then become a useful aid in the diagnosis of family pathology.

Despert (1948; 1949), a well known child psychotherapist, also wrote several papers, giving practical advice on how to introduce a child to the therapeutic situation. She stressed that the therapist should help the parents in this task, rather than allow them to use the damaging threats and falsifications which they often tended to do. The latter approach would definitely jeopardise further contact between therapist and child. Despert recognised that parental attitudes underlying such unfavourable techniques of introducing the child to therapy, were probably very revealing of the habitual techniques these same parents used in handling their children. She thus took Kerr's hypothesis a stage further, and anticipated the present study's premise that these attitudes are basic expressions of the entire parent-child relationship: Parental management of the task of preparing a child for treatment may be viewed as a representative sample of parental handling of the child in general.

Despert (1948) also pointed out that a child's unwillingness to separate from the parent on arriving at the therapist's may be linked with the parent's own anxieties: "The child feels the more insecure about the strange set-up as his parent manifests more reluctance to leave him there." This raises the question of whether a parent's rationalisations about not describing the treatment situation truthfully to the child, for fear of upsetting him, do not reveal an ambivalence about letting him become involved in it. Hence many preparations given to the child may simultaneously conceal and express this ambivalence, which is actually the parent's intention.

Ackerman (1959) dealt at length with the question of the ambivalent motivation of parents. His stress throughout was upon the interdependence of family members, when the emotional illness of any one of them was in question. He believed that no individual patient could be prepared for (psychoanalytic) therapy in isolation, and without reference to the whole family group. This was so in the case of the child patient too (1958, p. 188) :

> ".... Unlike the adult, the child has not come voluntarily to the psychiatrist. He may or may not be abnormal or emotionally ill. At the outset only one thing is certain: he has somehow violated the norms of his personal community. Surely there is something wrong, but what is wrong may be within the child, or outside the child, or both, in varying combinations. Therefore the evaluation procedures used in child diagnosis are of particular importance."

The kind or preparation a parent gives a child for treatment must also reflect areas of family psychopathology, if (as Ackerman held) the child's 'illness' is itself a symptomatic expression of these (Ibid, pp. 191-2) :

> "..... The parents of disturbed children are conflicted people. They are concerned for the welfare of the child and yet they are ambivalent and guilty. At times their feelings of guilt are covered with a solicitousness that does not ring true. Their actions toward the child will reflect divided emotions. The conflict of parents reveals itself in inappropriate behaviour in the initial interviews. The parents may be coercive. They may force the child to submit to the interview in a way that is traumatic. They may frighten the child or in some way communicate to ... [him] a menacing image of the clinician. Sometimes they offer false reassurances to the child, which only intensify his fears. To cover their hostile feelings, parents may engage in various manipulations. They may wheedle or coax the child, or engage in deceptive tricks in an effort to win his co-operation. They banter with ...[him] or offer subtle forms of soothing or even direct bribes .... Such ... [are the] machinations of hostile and guilty parents .....
> .....
> ... they may be doubtful of the clinician ... guarded about revealing themselves, and yet paradoxically ... very willing to push the child into an exposed position ..... "

Ackerman found it no wonder that a child frequently entered the therapy situation totally bewildered by this new experience. Because he has no adult frame of reference as to what constitutes emotional illness, he cannot have any ideas about receiving psychological help. The investigator therefore feels that his initial attitude towards the clinician, influenced as it may be by the kind of preparation (if any) he has had for the interview, is probably a projection and carry-over of his attitudes towards the key figures in his own family. Furthermore, as Ackerman himself stated (Ibid, p. 271),

> ".... It is not uncommon for a child in therapy to protest, 'It is my parents who are upset, not me,' and implicitly be demanding that the therapist do something about his parents. This is certainly not without justification."

Perhaps Ackerman's most significant contention as far as the present study is concerned, was that "mental illness limited to a single member of a family group is a rarity." (Ibid, p. 91) More often there are multiple illnesses, in which all members are interlocked, and through which their roles

are reciprocally related. Some family members may achieve partial immunity from the illness through victimising one or several other members, or by keeping one or more of the other members sick. They thereby protect themselves from breakdown at the expense of another's overt symptomatology. This balance may survive within a specific framework of reciprocal family role relations. But as soon as it is circumstantially or otherwise upset, the whole family finds itself in a distressing conflict.

This phenomenon may indeed affect a parent's preparation of his child for treatment. If parents are ensuring their own immunity from breakdown, and maintaining a 'healthy' but precarious state of family equilibrium by regarding a single child as ill, and in need of help, their rationalisations and intellectualisations about the need for his treatment, are bound to be distorted. Hence the actual explanation given to him of the therapist, and of therapy itself, may reflect quite accurately their own needs and their relationship to him in terms of these needs.

The concept of therapy that explores and uses family interactional patterns has become a very popular one in recent years. In the field of child psychiatry, more and more writers are accepting Ackerman's argument that the total pattern of family interaction must be understood, before evaluating the child's disturbance, and planning his treatment. Although very little has been published during this time on the precise subject of parental preparation of the child for treatment, child guidance workers have become increasingly aware of the unconscious components of parental motivation, in seeking psychological help for their offspring. Furthermore, this has been linked with parental expectations of the child in general, and with the basic patterns of family interaction within which the child's disturbance first originated.

An important study in this sphere was that of Cohen, Charney and Lembke (1961), who investigated the covert strivings of parents who applied for the hospitalisation of their emotionally disturbed children. The cases studied by these authors were of course more severely disturbed then the average parent-child constellations seen at child guidance clinics. Here the parents were applying for the admission of their children to a childrens' psychiatric residential hospital, after a history of repeated attempts to have them treated in a variety of settings, all of which had broken down. Or the application for

admission had been forced on them by community pressures that they now acknowledge the seriousness of their child's disturbance. But their central hypothesis may also be relevant (to a lesser degree, perhaps) to the parent-clients of child guidance clinics:

> "... for the most part parents are not, and necessarily cannot be, aware of what it is they are actually seeking. In general, the more severe the child's disturbance, the more likely it is that the parents are unconsciously committed to a destructive exploitation of the child in the service of their own emotional economy. While the emergent severity of the child's disturbance impels them painfully to search for relief, they need to put on to the search for help very much the same expectations of the child that they have so disastrously lived out for some time. It is necessarily the same unconscious forces that have been operative in the development of the child's disturbance which the parents bring to their expectation of treatment .....
> .... the intake diagnostic procedure in childrens' psychiatric institutions should not be considered complete unless there has been a purposeful uncovering and exploration of the unconscious components of parental motivation."

The writers observed that the contradictory and ambivalent motives of these parents sometimes emerged only after therapy had begun, and then to block the treatment programme of the child. They aimed to identify several significant patterns of such distorted parental expectations of the hospital, and to show how these were characteristic of the family interactional process wherein the disturbed child was reared.

Five major areas of neurotic motivation in parents were delineated, after they had studied 175 referrals in a serial fashion, without any selection of cases. These categories were not considered to be exhaustive, nor mutually exclusive, but they helped to define the "major characteristic operations of parental resistance to treatment of the child." As such, they proved to be a valuable guide to the "further understanding of the unique complexity of each family."

The first group comprised those parents who had conflicts over unresolved dependency needs of their own. They looked to the hospital as a) a possible parent figure, who would take over the role of father and mother to the child, and all responsibility for him; b) an ally to them in their quest for gratifications from the child; c) a recreated image of their own lost and idealised

parent figures; d) a referee in a major family conflict; or e) a benevolent all-giving parent of whom they themselves felt deprived.

The second group had conflicts over the child's impulses, and how to desexualise, neutralise or control these. Frequently, the child was perceived by one parent as a rival for the spouse's love and attention. Or the parent's own guilt about casting the child in this role made him want the hospital to contain the mounting excitement of the seductive relationship. The child was otherwise the agent of the parent's own destructive impulses, which he had to deny because they represented hostility to the spouse or to the child himself. In this case, the parents appealed to the hospital "to cleanse the child of his impulse life without at the same time challenging the parental denial of their own impulses."

In the third group there was much overlap with the second. Parents of this group had conflicts over their destructive impulses toward the child. They may have been guilty enough about such impulses to seek help for the child, but fundamentally they regarded him as so badly damaged, as to be beyond help. In this way they obtained some absolution from their guilt, and exoneration in the form of specific reassurance that the child was indeed hopelessly defective. But at the same time their aim was to have their parental guilt undone, "without improving the lot of the unwanted or too frightened child."

Conflicts over the basic identity of the child comprised the fourth category, the most subtly involved attitude formations of parents. In this group the parent related to the child as if he was someone else; he was endowed with multiple identity, e.g. a grandparent or another sibling. This inevitably led to a great deal of hostility in the parent-child relationship, as there could not be a resolution in what was not its fundamental source. The child acted out these parental projections, and the hospital was asked to correct his disturbing symptoms without touching the parents' underlying motivations. An example of this would be the parent who claimed to have an ideal marital relationship, were it not for the child. Or another, the parent who was not yet emotionally separated from his or her own parent, and endowed the child with the latter's identity. Such a parent would claim: "He is the apple of his granny's eye; she stays alive for him. But he doesn't like her too much."

Finally, the fifth group had conflicts over impulses to their own parents or to society. These parents wished to "use the hospital as a cloak of respectability, but simultaneously to have the child's deviant behaviour supported .... They use the child as the agent of their own negative impulses and unconsciously stimulate and reinforce his symptoms."

The writers admitted that parents also had realistic and positive motivations to get to the roots of the child's disturbance, and made appropriate readjustments in the emotional balance of the family. But the above-mentioned neurotic manifestations must be observed early, to avoid subsequent staff disillusionment. They suggested that a clue to these underlying fantasies might be given in the parents' own questions about the hospital's services, or in discussion with the intake worker on how best to prepare the child for his examinations (own italics):

> ".... The most frequent distortion at this point is for the parents to conceal from the child the identity of the institution as a hospital, but in each case for widely varying reasons. In one instance, it was implied to the youngster that he was going to a school for retarded children, out of the need to deny the child's capacity for growth, which so threatened the parents' equilibrium. Another case saw the fear of defining the hospital as a reflection of long-standing denial of the child's problem, recognition of which might in turn have disclosed the parents' hostility to the boy."

Of all the studies so far cited, the one above most closely approaches the investigator's own theoretical expectations, and therefore it has been quoted from in detail. Like that of Cohen, Charney and Lembke, the proposal of the present study is that parental attitudes towards the treatment of the child are a carry-over of parental attitudes towards the child in general. These attitudes have been productive in, and are also themselves the result of, an interactional process within the family, which has endured for some time. The mere fact of their habitual repetition must have played a contributory role in the genesis of the child's disturbance, for which he is now to be brought for treatment. It is agreed that the parents themselves may in fact need treatment more urgently than the child, and that in many cases they are likely to sabotage the child's therapy for a variety of personal reasons. It is also agreed that parental motivation should be thoroughly explored before a child is involved in any treatment programme. Cohen, Charney and Lembke

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