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Factors in maternal explanations of the guidance clinic to the child requiring psychological treatment.

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2015-01-12
http://hdl.handle.net/10539/16462

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types."

According to the null hypothesis (H_o), no significant difference would be expected between the two groups of Involved and Non-Involved maternal reaction types, in the proportion of mothers who returned for the second interview.

The findings are presented in Table 2 below:

Table 2.

Maternal Reaction Type and Failure to Return to the Clinic for the Second Interview

Maternal Reaction Type	Second Interview		
	Returned	Non-Returned	
Involved	15	5	20
Non-Involved	17	7	24
	32	12	44

The value of X^2 for these data is .2465.
The probability of occurrence under H_o for $X^2 \geq .2465$, with df=1, is $p < \frac{1}{2}(0.7) = p < .35$.
Because this p is greater than $\alpha = .05$, H_o must be accepted, and H_1 rejected.

The conclusion is that there is no significant difference between the two groups of Involved and Non-Involved maternal reaction types in the proportion of mothers who returned for the second interview.

* * *

Another intervening variable was the referral agent. A variety of persons were responsible for referring the mothers and their children to the Clinic, ranging from the mother herself, through the father, both parents, a friend or relative, a school teacher or principal, a doctor, specialist or remedial clinic, a welfare organisation or the law, to the child who asked to come himself (see Chapter VIII). The question arises as to who then actually prepares the child for the Clinic, by explaining it to him. If a child has been referred authoritatively, the explanation may simply (and realistically) be that he <u>has</u> to come. Are mothers giving the explanations to their children that they have been told to give, rather than those they would spontaneously have given themselves? Does the Clinic represent different things to different agents, who then refer mothers and children there for ostensibly different reasons, in terms of their own perceptions of its function?

To test the effect of the referral agent upon the type of preparation a mother gave her child for the Clinic, the investigator would ideally have liked to break down the former variable into the different categories enumerated above. However, in view of the small sample, these have instead had to be collapsed into two broad categories, viz. mothers who were self-referred and those who were referred by other agents. The hypothesis under test (H_1) stated:

> " If any difference occurred between the two groups of referred mothers, self-referred mothers would more likely be Involved maternal reaction types than otherwise referred mothers. Hence they would also be more likely than the otherwise-referred mothers to give Realistic

preparations to their children for the Clinic. Conversely, otherwise-referred mothers would more likely than self-referred mothers be Non-Involved maternal reaction types, and hence give Non-Realistic preparations to their children for the Clinic."

According to the null hypothesis (H_o), no significant difference would be expected between the two groups of self-referred and otherwise-referred mothers, in the proportion of Realistic preparations of the child for the Clinic. Again, a one-tailed X^2 test for two independent samples was chosen, with df = 1, and α = .05. N = 33.

The findings are presented in Table 3 below:

Table 3.

Referral Agent and Preparation of the Child for the Clinic

Referral Agent	Preparation for the Clinic		
	Realistic	Non-Realistic	
Mother (Self)	6	6	12
Other	13	8	21
	19	14	33

The value of χ^2 for these data is 1.039.
The probability of occurrence under H_0 for $\chi^2 \geq 1.039$, with df = 1, is $p(\frac{1}{2}(0.5) = p < .25$.
Because this p is greater than $\alpha = .05$, H_0 must be accepted, and H_1 rejected.

The conclusion is that there is no significant difference between the two groups of self-referred and otherwise-referred mothers, in the proportion of Realistic preparations of the child for the Clinic.

* * *

A substantial body of research suggests that differences in parental behaviour towards a child cannot be evaluated without reference to the sex of the particular child. Schaefer and Bayley (1963, q.v. Chapter III) made this point in their Berkeley Growth Study. It has also been suggested, for example, that there is a tendency for each parent to be relatively more affectionate and lenient with a child of the opposite sex, and more reserved and strict with one of his own (Brim, 1958). Bronfenbrenner (1961) remarked that this differentiation of parental attitudes should be examined further within different socio-economic levels, to which it must also have a reference.

In the original sample of 44 mothers, the sex distribution of their children was 32 boys to 12 girls, and in the final sample of 33, the distribution was 23 to ten respectively. It therefore seems likely that both the Maternal Reaction Type, and the kind of Preparation the Child received for the Clinic, may have been dependent upon the relative predominance of boys in the sample. It is not certain in either case in which direction the bias is likely to have operated. Therefore the investigator has decided to use two two-tailed tests, to examine the effect of the child's sex upon the two main variables.

In the first test, with the total original sample (N = 44), the research hypothesis (H_1) stated:

> " There should be a difference in the proportion of Involved maternal reaction types between those mothers who have brought male and those who have brought female children. to the Clinic. "

According to the null hypothesis (H_0), no difference would be expected between the mothers of boys and the mothers of girls, in the proportion of Involved maternal reaction types. $\alpha = .05$.

The findings are presented in Table 4 below:

Table 40

Sex of Child and Maternal Reaction Type

Sex of Child	Maternal Reaction Type		
	Involved	Non-Involved	
Male	15	17	32
Female	5	7	12
	20	24	44

The value of X^2 for these data is .174.
The probability of occurrence under H_o for $X^2 \geq .174$, with df = 1, is $p < 0.7\%$
Because this p is greater than $\alpha = .05$, H_o must be accepted, and H_1 rejected.

The conclusion is that there is no significant difference in the proportion of Involved maternal reaction types between those mothers who bring male children to the Clinic, and those who bring female children.

The second test aimed to investigate the effect of the child's sex upon the type of Preparation given to him for the Clinic. Here, N = 33, as the investigator could not use the mothers who did not return for the second interview, since no information was available on the type of preparation used. The research hypothesis (H_1) stated:

> " There should be a significant difference in the proportion of Realistic preparations of the child for the Clinic, between mothers of male and mothers of female children. "

According to the null hypothesis (H_o), no such difference would be expected.
$\alpha = .05$.

The findings are presented in Table 5 below:

Table 5.

Sex of Child and Preparation for the Clinic

Sex of Child	Preparation for the Clinic		
	Realistic	Non-Realistic	
Male	13	10	23
Female	5	5	10
	18	15	33

The value of χ^2 for these data is .182.
The probability of occurrence under H_0 for $\chi^2 \geq .182$, with df = 1, is $p < 0.7$. Because this p is greater than α = .05, H_0 must be accepted and H_1 rejected.

The conclusion is that there is no significant difference in the proportion of Realistic preparations of the child for the Clinic between mothers of male and mothers of female children.

* * *

The investigator would also have liked to test the effects of the mother's age, marital status, number of children, religion, nationality, occupation, socio-economic class and educational status, as well as those of the child's IQ, age and birth order, upon the type of preparation given the child before he is brought to the Clinic. However, with the final sample of 33 mothers, there were not enough cases to handle statistically, without collapsing the number of categories within each of these possible influences into broader categories of little meaning and usefulness. The same applied to an attempt to associate the child's symptomatic behaviour (i.e. the ostensible reason for which he was referred to the Clinic for treatment) and the Maternal Reaction Type (i.e. more probably the actual reason, according to the theoretical expectations of this study). The former was so manifold, and there was so much overlap of symptoms, that the investigator's earlier contentions about the difficulties of psychiatric classification in childhood (see Chapter V) were fully borne out by her own experience.

Chapter XI

Discussion of Results and Suggestions for Further Research

The failure to verify the specific predictions of this study necessitates a further consideration of the methodological procedures, as well as of the basic assumptions and theoretical reasoning behind them. If there were flaws in any of these areas, they might explain the poor association found between the main research variables, and also caution against similar pitfalls in any further research into the same themes.

Methodological errors are perhaps the easiest to detect, and to avoid repeating. The investigator has already discussed the various techniques of conducting research into human populations, such as the questionnaire, the interview, the rating scale, and the objective test, etc. (see Chapters III and VI). The dangers inherent in the one chosen here, viz. the interview, was recognised before the present study was started. Nevertheless, an important error was still made in the use of this particular technique, by regarding it as the operational definition of the hypothetical construct, i.e. the Maternal Reaction Type. The latter was only an abstract definition, which was accepted on a rational basis as being clear and relevant to the kinds of behaviour to be investigated. It became the focal idea of this study, and the investigator fitted it into broadly defined theories of personality development, in order to arrive at specific predictions about the sample used. But because the construct had so many manifestations, a whole series of procedures should have been designed to test its validity, rather than a single technique, such as the Intake interview, have been expected to encompass it. A variety of projective, observational, contemporary, reconstructive, individual and interactional measures might have been used, to test a number of predictions about maternal and child behaviour in different situations. The more frequently these predictions were verified, the more confidence one could have had in the unifying construct of 'Maternal Reaction Type', as an adequate conceptualisation of many diverse behaviours. In the process of evaluating the experimental results of such a study, the investigator might also have been able to define the construct itself more objectively, and use the unexpected results for its enrichment.

The above description of a desirable research procedure is derived from Garner and Wenar (1959), who admitted that it was indeed rarely attained. Even then, the hazards of such a multi-technique approach are also manifold, and tend to include some of the imperfections of the present study's single-technique procedure.

Garner and Wenar pointed out that the shrinkage of the original theoretical construct to make it amenable to actual experimental procedures, always results in a loss of breadth of the original idea. This is exactly what has occurred here, where the classification of a mother-child interactional process, was first condensed into a four-fold categorisation of maternal reaction to the child's behaviour, and then more drastically into a two-fold one.

Also, when negative results are obtained, Garner and Wenar warned that it is difficult to say whether they are due to a particular faulty technique, or whether the hypothesised relationship between the two variables is altogether non-existent. In the present study, though a single-technique one, unreliability could have been a feature of both the Intake interview, and the mother's verbal report of how the child was prepared for the Clinic.

The authors also stressed that statistical evaluation of results is always subject to some arbitrariness and oversimplification, as well as to a bias in the expectancy of the investigator. Valuable information may be sacrificed for the sake of purity of design, and thus some of the leads for further research are lost. The investigator's choice of the χ^2 test for two independent samples, was determined by the design of the study, and by the relatively small number of subjects available to her. Since there was no clear alternative test that could have been used, one could not compute its power efficiency, nor the degree to which it might have been wasteful of information.

The fact that the investigator was forced to collapse the original categories of 'angry', 'frightened', 'ashamed', and 'concerned' maternal reactions towards the child's behaviour, into the 'Involved' and 'Non-Involved' categories, is perhaps the most unfortunate defect in the whole research procedure. Although the original categories may not have been pure or even intrinsically valid hypothetical constructs, they were more meaningful and interesting, expressing greater psychological subtlety, than the somewhat rigid concepts of 'involvement'

and 'non-involvement'. It was difficult to foresee that the collection of an adequate number of subjects to test the original predictions would take as long as it would have done, had the categorisation been left as it was. This was mainly due to the wastage of cases seen and not used, because of various criteria that could not be applied before the first meeting with the mother at the Intake interview, e.g. natural parenthood, absence of organic pathology etc. (see Chapter VIII); or because of information about adoption, illegitimacy, organic pathology and other relevant matters that was only revealed at the History-taking interview, six to eight weeks afterwards. Then too, 11 of the 44 cases failed to keep the History appointment, and could not be used to test the hypothesis.

The investigator's contact with the 44 mothers who comprised the original sample, and especially with those who remained in the final sample, made her aware of the difficulties in using the 'Involved/Non-Involved' dichotomy as a categorisation of their maternal reactions towards their children's behaviour. Although the defence mechanism of projection, (the underlying principle on which the two categories of Maternal Reaction Type were supposed to differ) was fairly easy to detect, there was often a tendency for the mother to fluctuate in her use of this mechanism from one period in time to the next. The second interview with 33 of the mothers, six to eight weeks later, gave the investigator more insight into the transitoriness of the use of this defence by some of them. Maternal attitudes are probably in a great state of flux anyway, at the time the child is referred to the Clinic for treatment. The mother is more confused in her emotions, thoughts and behaviour towards her child, by the new presence in her relationship with him of the referral agent, if she has not come of her own accord. And if she has, why has she been precipitated into doing so now, and not when the problem started, as it usually did, some while previously? Hallowitz and Cutter (1959) have pointed out that the telephone interview with the mother, when she makes the first appointment to come to the clinic, is also very relevant in its effect upon her attitude when she arrives there. It is therefore feasible that a mother several threatened by the referral agent, the telephone interview, or either of the subsequent personal interviews with the investigator, would use projection to a greater degree than if not, and so give a different impression of her attitudes towards her child.

A very recent study by Badcock (1967) also emphasised the importance of time in maternal attitudes. His study, which bears definite similarities to the present one, aimed to investigate whether a mother's attribution of responsibility to herself a) as the cause of her child's problems; b) for obtaining help for it; and c) for involving herself in its treatment; was associated with her attitudes towards his placement in psychiatric treatment. Using a sample of 52 mothers, the author classified them on the Rotter-scale as being Internally- or Externally-Oriented for control of behaviour. He found that the 30 Internally Oriented mothers were indeed more likely than the 12 Externally Oriented ones, to take responsibility in obtaining help for their children's problems, and for involving themselves in treatment. They tended to be more desirous of 'shared involvement' with their husbands, with regard to the child's problem, but this association only approached significance. They also tended to belong to the upper social class more frequently than their counterparts. But there was no significant relationship between their Rotter scale scores (and other objective measures of their orientation in the control of behaviour) and their perception of themselves as the cause of their child's problem. Badock's main conclusion was that "felt responsibility is conceptually different for present and future behaviour than for past events". His mothers viewed responsibility prospectively, rather than retrospectively.

What has been realised through interviewing the present group of mothers is that the investigator has tended to pick up ephemeral emotions rather than enduring attitudes. The former, as has been pointed out above, were often the result of circumstances surrounding the child's referral to the Clinic, and the mother's arrival there. They were also intricately bound up in the transference relationship with the investigator, at the first Intake interview. Since she was not conducting therapy with the client, the investigator could not handle this transference, and make it more accessible to the mother's awareness. Had she attempted to do so, she may have made an entirely different assessment of the Maternal Reaction Type, and even had some effect in modifying it. The more enduring attitudes, which are by far the more significant in the genesis of the child's disturbed behaviour, are more difficult to observe, and to understand, especially in one interview. A longitudinal study, using the multi-technique approach advocated by Garner and Wenar (q.v. supra) might do this, and even then, not without difficulty.

Rae Grant and Kantor (1961) emphasised the multitude of external influences that act upon the mother to affect her relationship with her child. Momentary social conditions, such as marital difficulties, natural changes in maternal attitudes over time, and varying requirements of children over time, all influence the mother-child relationship at any given period. The authors insisted upon the need for measures of inconsistency of attitudes, and for generally more careful research into them. A study by Retner (1963) showed low correlation co-efficients between reports on factual information given by mothers about their children at two-and-a-half year intervals. The author did not comment on attitude changes, but if memory distortions occur to the extent that he found they did, changing attitudes over time were probably important reasons for their occurrence.

Part of the reason for the investigator's inability to observe the more lasting maternal attitudes affecting her interaction with her child, is that they often stemmed from the mother's own deep-seated, unconscious motives. The greater the mother's own disturbance (and it is likely that there was a considerable degree of disturbance among a group of mothers whose children were brought to a Clinic for psychological problems), the less accessible would these unconscious feelings, thoughts, and wishes be to her own awareness and rational understanding. The more outward manifestations of the mother's troubled psyche might be easy to observe. But it would be extremely unlikely that the internal mechanisms be understood from one interview, especially within the limits of time, procedure and role imposed on the investigator in that interview.

Some authors who have explored the deep unconscious motivation of mothers in their relationship with their children, have delineated certain themes which might be very relevant to the present study, but which could not be investigated here. Moriarty (1961) for example, in a detailed case study of four very disturbed mothers, showed how all of them had developed a phobic system relative to their respective children, and entrusted the care of the latter to a grandmother or else avoided pregnancy altogether. This behaviour was shown in each case to be a defence against extreme anxiety about their own mothering ability, which made them afraid to be alone with their children. They felt openly hostile towards them, or just hopelessly inadequate to cater for their needs. They all seemed to regress in varying degrees, to a child-like relationship with their own mothers or mothers-in-law, and had associated hostile feelings towards both

or towards themselves. In each case there had been a loss of a younger sibling when the patient was still a young child, and some correlation seemed to exist between the degree of pathology, and the age of the patient at time of the sibling's death.

Such a dynamic interpretation is what was beyond the scope of the present study, which tended however unintentionally, to focus upon symptomatology instead. A mother such as Moriarty has described, may have such deeply entrenched defences that her attitude towards her child might appear to be one of not caring. Her anger with herself and her aggression towards her child may be so effectively displaced onto a mother-figure, that she might seem to feel no responsibility, guilt, or concern at all. In this schema, she might easily be categorised as 'Non-Involved', whereas a dynamic interpretation of her attitudes might just as easily persuade one that she was very much 'Involved'.

Shields (1964, q.v. Chapter V) also described a mother-child interaction that would be hard to classify as simply 'Involved' or 'Non-Involved'. His 'Too Good Mother' cannot relinquish what has elsewhere been described as 'primary maternal preoccupation' (Winnicott, 1956) after the child has passed through infancy, and vary it according to the child's developmental needs through growth. In this interaction,

> " ... the child must remain an infant and she ... the wholly good, accommodating mother ... cannot accept her child as a differentiating and developing organism. The nursing couple becomes an establishment, a permanent state, subtly preserving an all-pervading mutual identification which actually amounts to infusion. The mother sees herself as the only supplier of infinite satisfactions, and is herself unable to tolerate the notion that her child can bear dissatisfaction, frustration, or hate.
>
> The major consequence, for the child, of this type of situation is that 'separateness' is not achieved. Both objective and subjective experiences of reality become confused, and the delineation of personality becomes an overriding problem. 'Me-ness' and 'mother-ness', and even 'otherness' are never wholly separated out. "

Such a mother would probably be categorised unhesitatingly in the present schema as 'Involved'. But is she not using projection (and also introjection and then re-introjection) to an excessive degree, in order to maintain her 'delusion' of fusion with her child?

Another example of a long-term interactional situation between mother and child that would be difficult to detect in one interview with the mother alone, was described by Szasz (1969). He portrayed a particular kind of communication process between mother and child, wherein the mother 'over-responds' to the child's needs because of her own inability to tolerate his being in any distress. The child's distress creates a high level of tension in her, because she interprets it as a sign of her own badness. Because of her lowered self-esteem, she then feels she must make her child happy, in order to have some reassurance of her goodness. One instance of this kind of maternal behaviour is the situation in which the mother feels she had fulfilled her duty, and need not be guilty or anxious, as long as the child has 'fun'. Both parents may be involved in this interaction, and the child too may also come to dread his [illegible] suffering and unhappiness. The differentiation of boundaries between parents are usually obscured in order that this kind of communication might be used habitually. (The response of trying to alleviate the pain or suffering of another is ostensibly helpful, but it is not always rational, and sometimes is experienced by the sufferer as indeed harmful.)

Here again, an apparently 'Involved' maternal reaction of responding immediately to a child's cry for help, may obscure a covertly 'Non-Involved' one, in which all feelings of badness have been projected onto the distressed child. The mother then dreads his capacity to return them to her.

The investigator has mentioned the transference situation that was an inevitable feature of the interview (and indeed an indispensable one) between herself and the mother. She was always aware of her own potential influence upon the mother's attitude towards the Clinic, and to the whole question of treatment for herself (i.e. the mother) and her child. However, because she did not want to handle the mother's transference feelings directly, and thus bias her results, she was in a rather helpless position. She had some insight into what the mother's feelings might have been, but could not use this to help the mother understand herself, via the here-and-now situation of the Intake interview. A probable outcome of this was that she [illegible]ed to 'store' this insight, and use it in a judgemental way, to make a private [illegible]ment of the mother's attitudes towards her, as a prediction of the mother's likelihood of co-operating with the Clinic. Thus she was perhaps prematurely trying to assess the mother's attitudes towards psychological treatment, and even attempting to forecast the

kind of preparation she was going to give her child for such treatment, as a short-cut to categorising her Maternal Reaction Type. In other words, the rating of the mother's attitudes towards her child was possibly influenced in part at least, by the investigator's unconscious rating of the mother's attitudes towards her, as representing the Clinic. This would be a grave methodological error, and all efforts were made to guard against it. In all honesty though, it would be impossible to say that it was never committed, however unwittingly or infrequently. The only way the investigator could have checked if a bias of this nature did indeed distort her findings, would have been to have a certain percentage of all the Intake interviews conducted by another person, who would have made his own assessments of the Maternal Reaction Type in each case. The difficulties of doing this have been discussed earlier (see Chapter IX). Furthermore, the transference between the client and this other interviewer, would also have been an uncontrolled factor, and so on for countless other interviewers. These are the difficulties of clinical research in general, and they have by no means been overcome in the present study.

All the above criticisms have dealt mainly with the weaknesses in the predictor variable, viz, the Maternal Reaction Type. There were also defects in the dependent variable, the hypothetical construct of the 'Preparation for the Clinic'. These were also largely the result of collapsing the three original categories into two, which was necessary for the same reasons as the categories were collapsed in the Maternal Reaction Type variable. The methodological risks of this step have already been mentioned in Chapter IX. Kerr's division (1946; q.v. Chapter II) of her explanation of treatment variable into three categories, seemed quite acceptable. However, psychodynamics were often obscured in her categorisation, and were even more so in the present one. To give an example, a distorted explanation of the Clinic in order to "make the child happy", and to "alleviate his distress" (see Szasz, supra), would fulfil an entirely different maternal need from an explanation that was distorted in order to threaten the child whom he misbehaved. Yet both explanations of the Clinic would be categorised as 'Non-Realistic' in the present schema.

The investigator may also be criticised for not controlling this variable sufficiently. She relied entirely on the mother's report for information on how the Clinic was explained to the child. The transference situation in the History-taking interview, as well as the carry-over of maternal attitudes from the Intake

interview, might both have affected this report, as might have a whole group of other factors bound up with the mother's personality, or related external circumstances.

In addition, it turned out not always to be the mother who actually handled the preparation of her child for the Clinic. This was not anticipated. Sometimes when an authoritative referral was made, the referring agent told the child about the Clinic (e.g. a school principal). The father, both parents together, a sibling, or the child himself, sometimes initiated the explanation before the mother confronted the child personally and privately. However, this is not regarded as an error, but rather as an important aspect of the mother's handling of the preparation task. Why did she allow the child to hear about the Clinic from someone else before she explained it to him; why did she need the father to help her do it, or else to do it for her; why did she not correct the child's misunderstanding of the Clinic, if she felt it had been misrepresented to him by another person? The subsidiary results show that there was no relationship between the referral agent (i.e. the mother herself or another person) and the type of Preparation the Child received for the Clinic (see Table 3, Chapter XI).[1] Nevertheless, the investigator could not answer the questions posed above, nor use any relevant information about them, within the narrow framework of the 'Realistic/Non-Realistic' dichotomy.

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1. A recent follow-up study by Richardson and Cohen (1968) of a sample of child psychiatry drop-outs, found that in many cases the parents of the referred child had not had the nature of the clinic's services adequately explained to them. Furthermore, referral agents themselves were not always adequately acquainted with these, and wanted more of a 'crisis' instead of a waiting-list service.

The unconscious aspects of maternal communication with the child have been stressed by Cohen, Charney and Lembke (1961), Sperling (1950; 1951), Despert (1948; 1949) and Kern (1946), all of whose observations have been discussed in detail in Chapters II and III. It should be emphasised here that what the mother actually communicated to her child in preparing him for the Clinic, was probably not only beyond the investigator's notice and understanding from the mother's report, but also beyond the mother's own conscious grasp. As Cohen et al. (1961) said, "the same unconscious maternal forces that have been operative in the development of the child's disturbance, are operative in the mother's expectations from treatment." Consequently they must also be operative in the way she describes or omits to describe treatment to her child. Sperling (1951) contended that in the "telepathic communication" between mother and child, subtleties of voice and tone, in the use of words, facial expression, and the exact time at which such communication occurred, were vital in the extraordinarily sensitive understanding between the two. The mother herself was unaware of these nuances in her communication with the child. Thus it is not likely that she would have been aware of them when preparing him for the Clinic. And she would hardly have been able to report about them in her account of how she explained the Clinic to her child. The same difficulty would have been experienced by the investigator in trying to categorise the preparation described by Despert (1949) as "simultaneously concealing and expressing" the ambivalence felt by the parents about letting the child become involved in treatment. Here the parents' intention is also unconscious.

Thus, because the investigator set out to explore "cognitions and attitudes" rather than "underlying feelings" (see Chapter V, p63), she has had to ignore vital elements in both the predictor and dependent variables, which may indeed be associated in ways which are far too subtle for the scope of this study.

Most of the authors who have been quoted on the unconscious aspects of maternal attitudes towards the child and his treatment, have mentioned the ambivalence of these attitudes. The failure to confirm the predictions of the present study may highlight the very fact of this ambivalence, and give rise to an alternative dynamic formulation of the association between the two variables. It is possible that the Maternal Reaction Type expresses one part of an ambivalent mother-child interaction, and the maternal Preparation of the

Child for the Clinic the other. If, for example, a mother is constantly undermined, disappointed, hurt, frustrated, and angered by her child's behaviour, which she perceives as a threat from outside herself, she may expect and hope that the Clinic will help to alter it, and turn her child into a benign, supportive, comforting and indeed idealised object. Her fantasied idealisations of the Clinic may express themselves verbally in its portrayal to the child as a place of hope for both of them, to help them re-establish their 'good relationship'. The converse might also apply when a mother is trying to maintain her belief in the positive aspects of her child's behaviour, and regards the Clinic as a potential enemy and destroyer of her child and their relationship. She might represent it to him in these terms when preparing him for treatment, if the latter has been forced upon her. The investigator would not go so far as to classify the Maternal Reaction Types described above as 'Involved' and 'Non-Involved' respectively, nor the suggested possibilities of Preparation for the Clinic as 'Realistic' or 'Non-Realistic'. But she is arguing that the exact opposite association from that which she has consistently predicted between the two variables, might obtain, even if only in one specific case. This would most likely occur in a mother-child interaction that functions largely through the defence mechanism of 'splitting', described by Melanie Klein (1952). The studies by Burlingham (1935), Rinsley and Hall (1962), and Cohen, Charney and Lembke (1961), quoted in Chapters III and IV, all lend support to the above suggestion, which may prove a fruitful starting point for a new study.

Another suggestion for further research would be to test the hypothesis that the child's early understanding of, and attitude to treatment, and the clinic in particular, is associated with the form of his disturbance. Throughout the early chapters of this study, the emphasis has been upon the mother-child interaction as a unit, rather than upon each of its members as separately functioning entities. Along with Ackerman (1958), Korner (1965), and others (see Chapter III), the investigator followed the Interactional Theory of behaviour, and the 'Two-Way-Street' approach to its understanding. She tried to pursue this in the present study, by having the child perform the projective instrument described in Chapter VIII (see also Appendix C), and relating the results thereof to her main results. However, this did not turn out to be a particularly useful index of the child's role in the mother-child relationship. The interview method too, tended to focus more directly upon the mother, than upon the child about whom she complained. Much more was learned in fact about

the mother and her personality, than about the "ongoing mother-child interactional process" the investigator set out to explore. It may have been true that in many cases the child himself was not the sufferer, but rather his mother. Nevertheless, his own expectations from treatment, however he came to it, must be an interesting source of information about his whole personality. If they are, as Ackerman suggested (1958, q.v., Chapter III) "often a carry-over of [his] attitudes towards [his] parental figures", they may, when understood, provide a valuable clue to the genesis of his disturbance within a pattern of family interaction.

The whole question of family 'homeostasis' (Ferreira, 1963; q.v. Chapter IV) has really been overlooked through the investigator's concentration upon the mother-child unit as the object of the present study. This was partly intentional, as stated at the very beginning, but also an inevitable outcome of the research design. Nevertheless, the investigator's neglect of the father's role especially, became evident from the number of cases in the final sample, in which he a) referred the mother and child to the Clinic (one); b) accompanied them there (eight); and c) took an active role in preparing the child for the Clinic (four). Because attention was focussed upon the mother-child relationship, no attempt was made to control these 'father-child', 'father-mother', and 'father-mother-child' variables, nor to assess their importance. One is reminded here of Ackerman's truism (1954; q.v. Chapter IV) that "the person who accompanies a patient on his first visit to the psychiatrist's office, is significantly involved in the patient's illness." Another study might investigate the father specifically when he seems to play an important part in the initiation of the child's treatment. Other family variables, such as the mother's marital status, the child's birth order, the number of the children in the family, and the space between them, might also be worth investigating in terms of their effects upon maternal attitudes towards the child's treatment.

Further research might use interviews between the clinic worker and the mother and child jointly, in investigating some of the areas of their relationship that have been discussed throughout the present study. This would provide a better insight into their interaction, and into how they deal with specific situations together. Family interviews, with three or more members, at home or in the office, would give another dimension to the understanding of childrens'

disturbed behaviour, its origins and current dynamics. Perhaps then one would no longer have to try and answer the question posed by Levitt (1959; q.v. Chapter V), viz. "Who is perceiving realistically, mother or child?". Instead one might view things more flexibly as being multi-determined.

An important variable to be investigated further seems to be that of social class. Here it was not possible to assess statistically its effects upon the findings (see Subsidiary Results, Chapter X, Part Two) because of an inadequate number of cases belonging to each category. However, it seems likely that the image each social class has of the Clinic would vary considerably, as would their attitudes towards psychological illness. Mention was made of the study by Zuckerman et al. (1960; q.v. Chapter III) in which social class was found to be "a significant contributor to test scores on the Authoritarian-control scale of the PARI". Middle-class and highly educated mothers showed more permissive and democratic attitudes than working-class mothers. The authors felt that this was the result of their more frequent exposure to schooling, the communication media, and especially womens' magazines. This was the impression that was gained from interviewing the present group of mothers too. Moreover, the 'permissive age' of child-rearing has its own language for describing a child guidance clinic, as well as its own particular expectations from it. The more educated (and perhaps co-incidentally, the younger mothers) might colour the preparation of their children for treatment with some of these 'permissive' metaphors. Thus social class and maternal age should be investigated separately, in assessing the relationship between Maternal Reaction Type and the Preparation of the Child for the Clinic.

Cultural differences may also play an enormous role, and it should prove interesting to conduct a similar study to the present one, across several ethnic groups. In a society such as that in South Africa, and in Johannesburg in particular, where the immigrant population is large, the whole problem of social acclimatisation may be worth investigating. What factors are involved in the immigrant mother's ability to use a child guidance clinic in the management of a 'problem' child, and to persuade the child to come for treatment? She might be expected to feel particularly vulnerable in her new surroundings, and thus especially reluctant to 'hand over' her child to a specialist. On the other hand, her adaptational difficulties might be so overwhelming, that she would be very glad of the availability of a service such as the clinic.

and have distorted idealisations of and expectations from it. The reason the family decided to emigrate in the first place, may have been linked with the pathology of one or more of its members. If the expected solution to the family problem is not found through settling in a new environment, the members will seek it elsewhere. It is not surprising therefore, that immigrant mothers arrive at a child guidance centre in search of help for their disturbed offspring.[2]

Religious differences too, are probably important influences in the formation of parental attitudes towards the psychological treatment of their children. Further studies might explore their effects more specifically. An interesting point to investigate, would be the effect of mixed marriages upon the formation of parental attitudes towards the child's treatment and how the task of preparing him for it is thereby complicated.

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2. One immigrant mother in particular, in the present sample, brought her twelve year-old daughter to the Clinic, complaining that she was running away from home, sleeping in the veld, defying her parents' authority, choosing unsavoury friends, and being troublesome at school. It later emerged that the daughter was also refusing to speak Spanish, Italian or Polish (all three languages were used in the home), and overidentifying with the South African way of life. She was speaking English and Afrikaans fluently, playing sport which she had never before enjoyed, and gaining tremendous popularity among her schoolmates, by behaving in ways that were acceptable to them, but totally foreign to her own upbringing. Upon further probing by the investigator, it became apparent that there was a great deal of marital conflict in the home. This was one of the reasons the parents had decided to emigrate from South America, and start afresh in South Africa. The daughter, just about to enter adolescence, was currently disturbed by conflicts over identification with either parent. By identifying with her Italian mother, she might have incurred the wrath of her Polish father, and vice versa. These conflicts were especially pronounced while she was in the throes of re-aroused oedipal feelings. The parents' common Spanish nationality symbolised for her their marital discord, and so she had instead chosen to reject all three nationalities of her background, and become 'too South African.'

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Name of thesis Factors in maternal explanations of the guidance clinic to the child requiring psychological treatment. 1972

PUBLISHER:
University of the Witwatersrand, Johannesburg
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