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

Brown, J H

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within, out of feelings of her own unworthiness. Her fears about her internal badness cannot be dispelled by externalisation or projection, and she indeed shuns the use of these defences. Instead she says of her child, "I have failed him."

This continuum is also thus characterised by the relative use among the four groups of mothers, of projection as a defence against anxiety. The four types of maternal reaction may be similarly derived from Melanie Klein's theoretical analysis of the Paranoid-Schizoid and Depressive positions of Infancy, with the diminishing use of projective defence mechanisms, as the transition from the former to the latter position is successfully negotiated (Ibid.)

It is important to note that the categories postulated above are distinguishable by virtue of the mother's conscious recognition of an internal feeling state. Hence the operational definitions of this study are expressed in terms of cognitions and attitudes, rather than in terms of underlying feelings and emotions, which are less amenable to exploration in the interview situation. It should also be clear that the emphasis is more strongly upon the mother's fantasies of the nature and origin of her child's disturbance, than upon its actual manifestations and probable etiology.

Chapter VI

The Interview as a Research Instrument

In the last chapter it was decided that the child's disturbance was to be investigated through its impact on the mother, by assessing her conscious reactions to it. The investigator aimed to do this by interviewing the mother herself, on her arrival at the clinic for help.

The procedure at the Child Guidance Clinic, where this research was conducted, has been described in Chapter I. The Intake interview, in which the mother merely outlines the child's problems to a skilled worker, provides an excellent opportunity for assessing the mother's feelings about these problems. It was therefore at this first meeting with the mother, that the investigator planned to get some idea about her reactions to her child's disturbance, in terms of the four categories tentatively proposed in the last chapter.

Before the interview is used as a research technique, some of its drawbacks should be considered. Many writers have pointed out the latter, and have chosen the rating scale, observational methods and longitudinal studies as preferable means of investigating attitudes and behaviour. The present investigator has chosen the interview for convenience, and for its suitability to the exploration of psychodynamic factors, which was a primary interest of the present study, and which the other techniques often tend not to pick up.

The study by Sears, Maccoby and Levin (1957, q.v. Chapter III) was based on recorded interviews of 279 mothers of five year-olds, who reported in detail their feelings about certain prescribed areas in their child-rearing practices, over the preceding five years. The authors were aware of the many defects of the interview situation, which also relied heavily on retrospective reports by the interviewees. They took many precautions, including those of the specific manner of wording each of their questions. They pointed out that mothers often responded in the way they felt a good mother ought to think and behave, and thus they tended to give superficial and stereotyped answers, in order to put themselves in a good light. Thereby, they not only sought to impress the interviewer, but also to reassure themselves. Sears et al. (Ibid. p. 200 ff.) found that several 'probes' were useful in obtaining more reliable

information from their mothers. Some examples of these follow:

" 'Do you ever find the time to play with X just for your own pleasure?'

instead of

'Do you ever play with X?';

'In what ways do you get on eachother's nerves?'

instead of

'Do you ever get on eachother's nerves?'

'How much attention does X seem to want from you?'

instead of

'Is X an attention-seeking child?' "

One can also make a wide range of answers appear socially acceptable, by framing one's questions in this way:

" 'Some people feel a child ought to ... and others feel.... What do you feel?' "

One may juxtapose two stereotypes or values thus:

" 'Do you keep track of exactly where X is, and what he is doing most of the time, or can you let him watch out for himself quite a bit?' "

The above, as well as many other examples given by the authors, are useful to the prospective interviewer. When skillfully used, such probes may effectively enhance the value of the interview as a research instrument, in the investigation of past and current attitudes.

Nevertheless, all the problems of the interview method are not thereby circumvented. Yarrow (1963) cited stereotyped questions and a mother's ego-involved responses to these as only one of the hazards of the interview method.

Yarrow felt that in structuring the questions, the interviewer often overlooked many other important dimensions of a situation. A mother cannot be expected to give reliable and accurate information on anything affecting her as personally, or involving her as intimately, as her child's behaviour does. Socio-economic status, education and familiarity with cultural prescriptions and tabus (e.g. Dr. Spock), must inevitably influence a mother's reports, as would her own personality needs, values, defences, class identifications and mores. A mother often requires a frame of reference of other mothers and their children, when interview questions demand ratings on relative scales. She may not possess this, or else there may be great variation from mother to mother in the frame of reference chosen. Finally, Yarrow claimed that low correlations were too often interpreted as positive evidence for the interviewer's particular hypothesis, and over-hasty assumptions of cause-effect relations tended to be made.

The research worker himself may be a source of unreliability in reporting the data obtained from a mother in an interview. In his recall thereof, he might easily select aspects that are relevant to his research hypothesis, his own experience, or his unconscious personality needs, while ignoring others. This difficulty could be overcome to some extent by having the interview tape-recorded. A verbatim report would thus be available for analysis by other raters. But even then, the whole structure of the interview still depends on the interviewer, who may elicit certain responses in the interviewee, and not others.

The introduction of a tape-recorder to the interview also has distinct disadvantages. Roberts and Renzaglia (1965) studied the effects upon a counselling situation of using a tape-recorder with the knowledge of both counsellor and client. Clients made more favourable self-references when they knew they were being recorded, and contrariwise, more unfavourable ones when not. Counsellors were likely to be less client-centred when they knew they were being recorded than when they did not know.

In using the interview as a research tool, the investigator has been cautioned by all the considerations enumerated above. They are helpful guides to the structuring and management of the interview situation, and important reminders that its findings must always be interpreted with extreme care.

Chapter VII

Specific Predictions - Version One

Already mentioned so far in this study have been the general aims, the broad theoretical expectations, and the investigator's own orientation in the question of parent-child relationships. Below follows a more specific clarification of the research predictions.

The primary assumptions and expectations could be restated thus: Mothers of problem children differ in the kind of preparation they give their children for their first encounter with a child guidance clinic. There is a continuum of such preparation, ranging from a full and honest explanation of the nature of the clinic, and why its services are required, to a false and distorted representation of its function. (The latter helps the mother to deny defensively the child's problem, and to protect her own self-esteem.) The position of a particular clinic mother along this continuum, is dependent upon certain factors in her own personality make-up, and upon the nature of the mother-child relationship. These factors (i.e. those which lead her to use one or another preparation technique) may also have played a part in the genesis of the child's disturbance, for which he has now been referred to the clinic. Hence, there should be a relationship between the nature of the child's disturbance, and the type of preparation his mother gives him before bringing him to the clinic.

Following Kerr's study (1945, q.v. Chapter II) it was decided to use three categories of maternal preparation of the child for the clinic. These were 'full', 'partial', and 'poor' explanations of the nature and function of the child guidance clinic, and the purposes for which a particular child was to be brought there.

As explained in Chapter V, the second variable, viz. the child's disturbance, was to be classified in terms of the impact it had on the mother. Four categories were envisaged here: The 'angry' mother, the 'frightened' mother, the 'ashamed' mother, and the 'concerned' mother, each occupying a position along a continuum of her own feelings of involvement in, and responsibility for her child's problems.

The predicted associations between the two variables, defined in the above manner, would be as follows:

A) The mother who consciously recognises her full or partial responsibility for her child's disturbance, will be best able to accept the clinic's services. She will not be unduly threatened by the prospect of a treatment programme in which she herself may be implicated, but instead she will be able to accept her responsibility in this regard as well. She will therefore be the best equipped to prepare her child honestly, realistically, and democratically, for his first encounter with the clinic. Hence 'full' preparation of the child for the clinic is most likely to be given by the 'concerned' mother.

B) The mother who feels some responsibility for her child's disturbance, but still needs to attach most of the blame for it onto him, will be more hesitant about using the clinic's services for herself and for her child. She will feel some shame in having to seek child guidance at all, and she will have to rationalise her decision to do so, by giving her child only a partial preparation for his first encounter with the clinic. (She may, for example, explain the clinic to him in terms that imply that he is to be treated there, rather than that it might help them jointly.) Hence 'partial' preparation of the child for the clinic is most likely to be given by the 'ashamed' mother.

C) The mother whose tendency it is to deny responsibility for her child's disturbance, will be the most severely threatened by the idea of child guidance. She will resist being implicated in the treatment programme of the clinic, if she accepts its services for her child at all. She will continue to deny her responsibility for his problem and its treatment, by making no mention of the clinic to him before his first encounter with it, or by describing it to him in terms which conceal its true purpose and potential function for both of them. Hence 'poor' preparation of the child for the clinic is most likely to be given by 'frightened' and 'angry' mothers.

Chapter VII (CONTINUED)

Specific Predictions - Version Two

In the course of investigating the hypotheses that were formulated in Version One of this chapter, it became evident that the tentatively constructed categories were too manifold: To find a sample large enough to satisfy the criteria of statistical analysis, it would have taken far longer than the nine months the investigator had in order to collect the data. There was thus no alternative but to collapse the categories of both variables, viz. the Maternal Reaction Type, and the Preparation of the Child for the Clinic, and to re-formulate the research predictions slightly differently.

The number of Maternal Reaction Type categories was reduced from four to two broader ones. The essential difference between the two new categories of maternal reaction to the child's problem behaviour, is the extent to which the defence of projection is used against anxiety. A mother in the first category would be so anxiety-provoked by her child's behaviour that she would defend herself against it by externalising its source. In this way she would regard it as alien to herself, involving her only insofar as it caused her anger or fear. On the other hand, the second category of mother would be deeply involved in her child's disturbance, on a conscious level. She would feel vulnerable on account of his behaviour, but not only because it might be directed against her, to anger or to frighten her, but because she would see herself as partially, or even fully responsible for it. Her feelings would be rather those of shame, guilt and concern for her unhappy child. These two new categories of maternal reactions to the child's behaviour are called the 'Non-Involved' and the 'Involved' types respectively. It should be borne in mind that there may be degrees of 'involvement' in each category, but that there is a cutting point at which 'Involvement' prevails over 'Non-Involvement'. What has been done operationally, is that the 'angry' and 'frightened' maternal reaction types have been condensed into a 'Non-Involved' maternal reaction type, and the 'ashamed' and 'concerned' into an 'Involved' one.

The number of categories in the second variable, the Preparation of the Child for the Clinic, has also been condensed from three (viz. 'full', 'partial' and 'poor') into two. The first category is called the 'Non-Realistic' preparation.

Included in it are all those explanations of the clinic where its essential purpose has been concealed from the child, or where it has not been mentioned to him at all. Whenever a child has been given no reason for coming to the clinic, or a false one, this preparation is also termed 'Non-Realistic'. The second category is called the 'Realistic' preparation, though it may comprise varying degrees of truthfulness, however, and comprehensiveness of the description of the clinic given to the child, and of the reasons for his coming there. He would at least have been told something about the clinic's purpose, and its relevance to his difficulties.

The predicted association between the two variables, now re-defined, would be as follows:

> The mother who consciously recognises a responsibility for her child's problem behaviour, will be more easily able to use the clinic's services than the mother who does not, and who instead alienates herself from her child's problem behaviour. She will be less threatened than the other mother, by the prospect of a treatment programme in which she herself may be implicated, and more able to accept her responsibility in this regard as well. She will therefore be better equipped to prepare her child honestly, realistically, and democratically for his first visit to the clinic, than her counterpart, who is more likely to make no mention of it to him, or else to describe it in terms which conceal its true purpose and potential function for both of them. Hence, 'Realistic' preparation of the child for the clinic is more likely to be given by the 'Involved' maternal reaction type than by the 'Non-Involved' maternal reaction type; and conversely, 'Non-Realistic' preparation of the child for the clinic is more likely to be given by the 'Non-Involved' maternal reaction type than by the 'Involved' maternal reaction type.

Chapter VIII

The Sample

For a period of about nine months, 44 mothers were investigated, of whom 33 were left in the final sample, as the remainder did not return after the first (intake) interview. The 44 mothers were selected from the entire population of mothers attending Intake interviews at the Clinic[1] during the period of the present investigation, on the following basis: Of the six or seven interviews conducted at the Clinic per week, two or three were allotted to the investigator. Two or three alternative appointments were offered over the telephone to the prospective client, by the Clinic's secretary, or by one of its social workers. If the time selected by the client coincided with any of the times at which the investigator was scheduled to conduct the interview, that client became a potential subject for the present study.[2]

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1. Henceforth, when this word is capitalised, it refers to the Johannesburg Child Guidance Clinic, where this research was carried out.

2. The fact that the present study was being conducted was not disclosed to the new client, but many mothers were surprised at the youth of the investigator, and automatically assumed that she was a student. It may also be relevant to note that the nine months over which this study was conducted, coincided with the investigator's first pregnancy. Whatever uncontrolled variables operated on this account between the researcher and the client, would thus have had a greater effect towards the end of that period, than at the beginning.

However, the investigator was not allotted cases if the mother could not speak any English, and if the child did not fall into the age range of five to 15 years. The investigator herself excluded a mother from the sample if the child was an obvious case of organic brain damage or mental defect. These details were usually only possible to discover during or after the Intake interview, and not over the telephone. Hence many more than 44 Intake interviews had to be conducted before a suitable sample was collected.

Very often the client did not keep the appointment offered to her. If she herself did not phone to explain why, the Clinic usually contacted her, and offered her another appointment. If the latter again coincided with one of the investigator's scheduled times, the mother became a subject, i.e. she was not excluded for having missed the interview the first time.

The Clinic is the only non-private institution of its kind in Johannesburg, and caters for White families only. The fees charged are nominal, and parents are requested to pay what they think they can afford. The Clinic itself is a registered welfare organisation, and exists on subsidies and on funds collected from the public. It is fed by a widely spread and diverse population of varying income levels, educational standards, language groups, occupations, religious affiliations and nationalities.

The average age of the 44 mothers in the original sample of the present study was 37 years. That of the 33 mothers in the final sample was 35 years. The average number of children of the mothers in both the original and final samples was three. The child most frequently brought to the Clinic for help was a first child. The next most frequent was a second child, and the third most frequent an only child. This applied in both the original and final samples. The average age of the children (whose mothers were only selected as subjects if their children fell into the age range of five to 15 years), was 9.3 years in the original sample, and 9.7 years in the final sample. The average IQ of those children (all in the final sample) who were tested by the psychologist (only 27) was 107.6 on the old South African Individual Scale. In the original sample, 32 of the children were boys and 12 were girls; in the final sample, 23 were boys and ten were girls.

The mothers in the original sample all lived in Johannesburg, except ten, who lived in towns within a thirty mile radius of Johannesburg. Of those ten, seven returned for the second interview, in spite of the distances they had to travel to and from the Clinic.

Nine of the mothers in the original sample were not South African by birth, but were fairly recent immigrants from the United Kingdom, Zambia, Germany and South America. They had all lived in South Africa for five years or less. Of these nine immigrants, only two did not return for the second interview, both of whom were from English-speaking countries. All the mothers in the sample could speak English, but this was not necessarily the language they had spoken at home themselves, or the language they now used to communicate with their children. In the original sample eight mothers spoke Afrikaans, and six of these remained in the final sample. One mother who remained in the final sample, was of Italian origin, had married a Pole, and came from South America, where the family's home language had become Spanish. The investigator communicated with her in French, whenever the mother's English was not adequate.

The mothers were of many different religious affiliations, and had often married men of other faiths. (There was however, no intermarriage between Jews and gentiles). Of the 44 mothers in the original sample, ten were Jewish, seven Anglican, six Methodist, six Roman Catholic, five Presbyterian, two atheist, and eight others (Dutch Reformed, Lutheran etc.). Of the 33 mothers in the final sample, eight were Jewish, five Anglican, five Methodist, three Roman Catholic, three Presbyterian, two atheist and seven others.

In the final sample, 25 mothers were married, three were widowed, four were divorced or separated, and one was divorced and remarried. Of those who did not return for the second interview, nine were married, one was widowed and remarried, and another was divorced and remarried.

The most frequent occupation of the mothers in both the original and final samples, was that of housewife (23 and 15 respectively). Most of the working mothers in both samples worked part-time only, and were secretaries (eight and seven respectively), sales-ladies (four in the final sample), book-keepers (two in the final sample), or hairdressers (two in the original and one in the final sample). In addition, there was a teacher, an unqualified librarian,

a medical technologist, a photographer, and a beautician. All of these except the last remained in the final sample.

The socio-economic class of the mothers was arbitrarily divided into three categories, viz. upper-middle, middle, and lower-middle. They were all White, and therefore not from the lowest class of the South African population. Moreover, mothers from the highest class would have been able to afford private treatment, and would therefore have been excluded from the present study after the first interview (see Chapter IX). The classes were determined by the present investigator according to the area in which the mothers lived, their husbands' occupations (where applicable), and the fees they were prepared to pay the Clinic. In the original sample, 12 mothers were rated upper- middle class, 19 middle class, and 10 lower-middle class. In the final sample, the figures were eight, 15 and ten, respectively.

The mothers were referred to the Clinic by a variety of agents. In the original sample, 15 mothers were self-referred (by the mother herself , or by both parents jointly); nine by a school teacher or principal; 11 by doctors, clinics or a welfare organisation; eight by friends or relatives; and one by the child, who asked to be taken for psychological help. In the final sample, these figures were 12, six, seven, and one, respectively.

The above description shows that the sample of mothers upon which the present study was conducted was drawn from many different sections of the population, and was far from homogeneous. Neither could it be called a representative sample of the whole population, by virtue of the fact that it comprised a group of mothers who had addressed themselves, or had been referred to a child guidance clinic for help in the management of their 'problem' children. Furthermore, the investigator herself excluded many mothers who did not meet certain prescribed criteria, from the final sample. A control group of matched subjects, or of randomly selected subjects, would not have been feasible in the circumstances of the present study, whose aim was to investigate the behaviour of mothers who came to the notice of a clinic, and not of others. Therefore, whatever results emerge, they will have to be interpreted with due regard to the specific nature of the sample used, and the limitations imposed thereby.

Chapter IX

Research Design and Method of Investigation

Once the categories of the two main variables were collapsed in the manner described in the last chapter, it became possible to present the elemental design of the study very simply. It takes the form of a two-by-two contingency table, represented below:

Sample Table

Maternal Reaction and Preparation of the Child for the Clinic

Maternal Reaction Type	Preparation for the Clinic	
	Realistic	Non-Realistic
Involved		
Non-Involved		

The plan of research whereby the data for the above table were to be collected, can be divided into the following stages:

I. The Telephone Interview
(when the mother or referral agent first contacts the Clinic)

An appointment is made by the Clinic secretary or a social worker with the new mother client. The latter becomes a subject of the present study if certain criteria are met (See Chapter VIII).

II. The Intake Interview
(within a week of the Telephone Interview)

The investigator meets the new mother client, who broadly outlines the child's problem. The investigator gathers certain identificatory details for the Clinic's information, and selects the mother as a subject if she meets a set of prescribed criteria (see Chapter VIII; also infra). The mother's 'Maternal Reaction Type' is categorised at this point.

III. A) The History Interview
(six to eight weeks after the Intake Interview)

The investigator sees the mother-client for a second time and asks what 'Preparation for the Clinic' has been given to the child, if any. The second variable is categorised at this point. A detailed account of the child's history, his problem, its onset, and the family set-up, is given by the mother, which is recorded for the Clinic's information.

B) The Psychological Investigation of the Child
(contemporaneous with the History Interview)

The child is seen by a psychologist, and where possible, is given an IQ test, and a projective instrument devised by the investigator. The child is also asked what he or she knows about the Clinic, and the reasons for his or her coming there. Doubtful cases of 'Preparation of the Child for the Clinic' are now categorised, with the help of new information derived at this stage.

IV. The Case Discussion
(about four weeks after the History Interview)

The investigator meets the entire staff of the Clinic to discuss each case, and her own assessments of it, in the light of subsequent information derived from the psychologist's interviews with the child, and the psychiatrist's interviews with both mother and child.

Doubtful cases of 'Maternal Reaction Type' are now categorised, with the help of new information provided by the Clinic team.

Prior to an elaboration of the method of collecting the data to fit the above table, an important theoretical consideration must be discussed. This arises from the very decision to collapse the categories, and alter the research hypothesis, however slightly, after the data had already been collected.

That bias might have crept in to make the investigator reconstruct the Maternal Reaction categories according to what was already known about the Preparation-for-the-Clinic behaviour of each type, is not an impossible contention. The explanation of the Clinic given to the child (as reported by the mother at the second interview) was available in 33 of the original 44 cases, before it was decided to condense the categories. However, as explained in Version Two of Chapter VII, the 'concerned' and 'ashamed' categories were condensed into one broader category, viz. the 'Involved' ones; and the 'frightened' and 'angry' categories into another broader, 'Non-Involved' one. Since the investigator was not changing the original assessment of the Maternal Reaction Type, but only classifying it more broadly, the possibility of bias entering in at this stage was greatly reduced.[1]

The condensation of the three 'Preparation-for-the-Clinic' categories into two, was not as simple. All the 'full' Preparations of the Child for the Clinic were included in the 'Realistic' category, as were some of the 'partial' preparations. All the 'poor' Preparations of the Child for the Clinic were included in the 'Realistic' category, as were the remaining 'partial' ones. Assessments of the former 'partial' category, therefore had to be done afresh. This was not a very sound methodological procedure, as the investigator may have had some idea of the direction and degree of association between the two

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1. It cannot be argued that bias was entirely eliminated from the rest of the investigation. In the detailed account of the research design and experimental method that follows, the issue of the reliability of the investigator's judgements is discussed.

variables, from the 'full' and 'poor' preparations that had already been re-classified. However, it was done on a logical basis, whereby those 'partial' preparations that gave the child some idea of the nature and function of the Clinic, albeit an oblique one, were re-classified as 'Realistic' preparations. Those that represented the Clinic "in terms which were inadequate, or which the child was not fully able to understand" (Kerr, 1946; q.v. Chapter II) were re-classified as 'Non-Realistic'.

In the investigation of the two main variables, and in the search for a relationship between them, methodological considerations have sometimes had to be sacrificed for those of availability of subjects, and procedural form, at the Clinic to which they had addressed themselves for help.[2]

At the Intake interview, the mother was given an opportunity to state the child's problem and the reasons she desired help, or had been referred to the Clinic for help in its management. Nothing was discussed in great detail, but an outline of the Clinic's function, aims, services, procedures, and fee-structure were given to the mother, as well as a sympathetic hearing to her complaints, anxieties, queries, and sometimes great distress. Several questions may have been asked her, wherever possible in the manner suggested by Sears et al. (1957, q.v. Chapters III and VI). These were used to aid the investigator in her understanding of the problem, and to enable her to make an assessment of the mother as 'Involved' or 'Non-Involved', in her conscious reation to her child's disturbance. The most useful probe was:

> " It isn't easy for a mother to talk of her feelings about her own child. But can you perhaps tell me the kind of feelings you have every time your child behaves in this particular way (the symptom appears, he does .... etc.)? What are your immediate reactions, your spontaneous emotions, your momentary impulses? How are you affected by his/her behaviour? "

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2. This has been outlined in Chapter I.

The form of this interview was largely determined by conventional Clinic procedure, and several details in which the investigator was not primarily interested for this study, had to be collected and recorded. The entire interview lasted from twenty to thirty minutes, depending on the personality of the mother, her specific needs, and the nature of her complaints. The investigator's main aim was to establish as good a rapport with the mother as possible; to be able to assess her in as unbiased a way as she could; and to give her as much confidence in the investigator and the Clinic, as the mother herself was ready to have.

At the end of each Intake interview, it was explained to the mother that in order to try and help her and her child, she would have to be seen (as would perhaps other relevant members of the family) for a fuller account of the child's history. This would include details of his development since birth; of the onset and course of his disturbance; of the family constellation; and of the family backgrounds of both parents. She was also told that the child would be seen at the same time, but separately, by a clinical psychologist, for an exploratory interview and a psychometric assessment of his potential ability. At a later stage, she and the child would both be seen again, jointly or separately, by one of the psychiatrists on the staff, for a diagnostic interview. On the basis of all these investigations a decision would be made by all the caseworkers concerned, as to what would be the best form of treatment. (The latter was explained briefly, or in more detail, if the mother queried the word.) The investigator apologised to the mother for the long waiting list at the Clinic, and promised to contact her for a second appointment, six to eight weeks later. If she could afford, and wanted private treatment (but first needed the go-ahead from the Clinic to make it a palatable idea to herself or to her husband), she was referred to outside psychiatrists or psychologists, and the case ceased to be a Clinic one. She was however, given the assurance that she could always return to the Clinic if she wanted to. She was also reassured on the confidential nature of all interviews held at the Clinic, with the proviso that the staff worked as a team, and that inter-worker discussion of the cases would therefore be inevitable. True confidences given to a particular worker at any time, would however, be treated as such.

No mention was made at this interview of what the mother should tell her child about the Clinic. This was left entirely up to her. If she spontaneously asked how to explain the Clinic to her child, it was suggested that she try and

be as truthful as possible in this regard. The reasons given for this advice were that at some stage the child would himself discover the true nature of the Clinic, whether she tried to conceal it from him (protectively?) or not. The child's confidence in the Clinic was as important as her own, if the treatment was to have any chance of success. Creating suspicion and mistrust in him would only impede progress. Before being as directive as this however, the investigator always attempted to explore the mother's own feelings about handling this situation (i.e. of explaining the Clinic) with her child. Never were any interpretations made to her. Rather did the investigator try to be as reassuring and as sympathetic as possible.

No tape-recorder was used (see. Roberts and Renzaglia, 1965; q.v. Chapter VI), but each interview was written up immediately afterwards. Examples of the Intake interview, with the investigator's assessment of the Maternal Reaction Type in brackets, are to be found in Appendix A.

When the second interview was carried out, six to eight weeks afterwards, each mother had come to the Clinic together with her child. The investigator's main purpose here was to establish what the mother had told her child about the Clinic, before bringing him there that day. (He was to have his first contact with it by way of an IQ test by a clinical psychologist, and an assessment of his personality functioning.) The Clinic's main purpose in this interview with the mother was to obtain a full history from her, covering the areas already outlined above. The investigator therefore was obliged to do both, since the ostensible reason for seeing the mother again, was to investigate the problem with a view to its handling and treatment by the Clinic.

The investigator began the interview with an introductory patter, reminding the mother of what she had said at the Intake interview, and that this was her opportunity to give a fuller picture of the problem, for which there had not been time before. It was mentioned that her child was concurrently being seen by the psychologist, and casually she was asked how she had explained the Clinic to him, if at all, before they came. The investigator tried to obtain a clear picture of the mother's feelings about the preparation of her child for the Clinic, and of how she actually handled the situation. No interpretations or comments were made that might have seemed approving or disapproving of the mother's attitudes or behaviour. Then, in an atmosphere as reassuring as the

investigator could create, the mother was encouraged to give a full history. (The investigator was guided by a conventional type of format used at most child guidance clinics, but did not always follow any particular order in gathering the information required. Instead the mother was allowed to relate her account in the manner and order she chose, probed where necessary for facts that she had ommitted.) The interview was again written up by the investigator immediately afterwards. All the details of the History interview were not relevant to the present study, and have therefore not been included here. But a full list of the explanations of the Clinic given by the mother to the child, is to be found in Appendix B. (They have been divided into 'Realistic' and 'Non-Realistic' categories.)

The interview between the psychologist and the child was used as an adjunct to the investigations, but no predictions were made from or about it, to test the main hypothesis. The child's IQ as tested by the psychologist, was used as a means of checking the homogeneity of the sample.

The investigator also devised a simple projective instrument of her own, which the psychologist administered to each child who was capable of responding to it, in the course of the interview with him. This was done in the following way:

A set of five hand-drawn pictures was presented to the child (see Appendix C). The first one depicted a boy or girl (depending on the child's own sex) standing at the closed entrance of the Child Guidance Clinic. The other four showed the face of a woman, each with a different expression, and below was printed the emotion she was supposed to be feeling. The woman was 'angry', 'frightened', 'ashamed' or 'concerned'. Presenting the first picture, the psychologist said to the child:

" Here is a boy (girl) who has been brought to the Child Guidance Clinic."

Pointing to the remaining four pictures, the psychologist continued,

" Here are four pictures of

1) a mother whose child makes her angry and cross with him/her;

2) a mother whose child makes her feel frightened or scared of him/her;

3) a mother whose child makes her feel ashamed of him/her;

4) a mother whose child makes her feel concerned about what is making him/her unhappy, and do the things he/she does.

Which mother do you think belongs to the boy/girl who has been brought to the Clinic?

What did he/she do to make her feel angry/frightened/ashamed/concerned? "

In addition, each child was asked if he knew the reason he had come to the Clinic. A record of these responses was kept by the psychologist, as were notes of any other of the child's remarks or behaviour that were relevant to the present investigation.

This instrument was not scored quantitatively, and it had no bearing on the main hypothesis. Nevertheless, the responses were of clinical interest, and all those that were available, have therefore been included in Appendix D. (In brackets are the ratings made at the Intake interview of the Maternal Reaction Type, and of the mother's explanation to the child, as she reported it at the History interview. See Appendix B for the mothers' actual explanations to their respective children.)

Neither the design of the present study, nor the specific needs of the client and requirements of the Clinic, permitted a reliability check on the investigations by a separate worker, conducting a certain percentage of the interviews. Personality factors of the investigator herself; her understanding of the research project as a whole; her motivation in conducting this study; and her interaction with the mother-subjects;-all these would have been impossible to control if other interviewers had been used. The importance of these factors is not denied, and indeed their influence is recognised as necessary and inevitable. Without them no rapport would have been achieved between the investigator and client, and no material of clinical worth could have been obtained. It may therefore be said that the investigator has sacrificed some reliability for the sake of validity in this study. That is, if validity can be thought of as the truthfulness of the information given by the mother, as she herself perceived it, however distorted a perception it was of things as they really were.

Nevertheless, as some sort of check on the investigator's own perception of the mother and the mother-child relationship, as the mother communicated it, the investigator referred to and used the clinical psychologists' reports of their interviews with the child, as well as the psychiatrists' diagnostic conclusions after their meetings with both mother and child. Discussions with each of these workers took place at regular Clinic staff meetings, once a week, after all the preliminary investigations into each case had been completed. Sometimes the mother and/or child were seen more than once by a Clinic staff worker, as a precursor to therapy proper, and then follow-up interview material was also available. The predictions were never modified on the basis of this information, but the latter was used as an index of the clarity of the categories and hypothetical constructs.

It should be mentioned that the Maternal Reaction Type was not always easy to classify in terms of the categories that had been decided upon. Difficulty was experienced occasionally with the first categorisation of the Maternal Reaction Type, and there were four mothers in the original sample, which the investigator was hesitant to classify. In each of these cases, it was doubtful whether an apparently 'angry' Maternal Reaction actually concealed a great deal of 'concern' for the child, as a separate, feeling, and vulnerable individual, for whose hurt the mother felt largely responsible. After case discussions with the Clinic team, the investigator was eventually persuaded that in each of these cases, the mother was indeed 'concerned', and that her 'angry' exterior was not a fully integrated part of her real personality and interaction with her child. These four mothers were thus first categorised as 'concerned', and then re-classified as 'Involved', when the four Maternal Reaction Type categories were condensed into two. Three of them remained in the final sample. Thus the percentage of doubtful Maternal Reaction Types was the same in both the original and the final samples (4/44 and 3/33 respectively, or 9.09%).

The number of doubtful cases with respect to the second variable, viz. the Preparation of the Child for the Clinic, was two out of a total of 33 (i.e. 6%). Both these were classified as 'partial' preparations, in the first categorisation. When the three categories of this variable were collapsed into two, the investigator was not certain to what extent the preparation given to these two children was of a kind that they could understand, and reconcile with their own difficulties. Thus, when they had to be re-classified as 'Realistic' or

'Non-Realistic', the investigator was hard put to it to decide. The information given by both these children to the psychologist, persuaded the investigator that the children had in fact understood something of the Clinic's function. Thus the two doubtful preparations were both termed 'Realistic'. (The actual preparations referred to are those initialled RM and JD, in Appendix B. The two childrens' responses to the psychologist's questions bear the same initials in Appendix D.)

Chapter X

Results (Part One)

The specific prediction, (H_1) as stated in Chapter VII, Version Two, was that

> " Realistic preparation of the child for the Clinic is more likely to be given by Involved maternal reaction types than by Non-Involved maternal reaction types; and conversely, Non-Realistic preparation of the child for the Clinic is more likely to be given by the Non-Involved maternal reaction types than by Involved maternal reaction types. "

According to the null hypothesis (H_0) no difference would be expected between the two groups of Involved and Non-Involved maternal reaction types in the proportion of Realistic preparations of the child for the Clinic.

Because the direction of the expected difference between the two groups has been specified in H_1, a one-tailed test was called for. The one chosen was the χ^2 test for two independent samples, with the incorporated Yates's correction for continuity (Siegel, 1956; p.107). The significance level was fixed at $\alpha = .05$, and the number of cases in the final sample was 33 (N). This included all the mothers of the original 44, who returned for the History interview.

A two-by-two contingency table was constructed, with df = 1. The region of rejection of H_0 consists of all $\chi^2 \geq 2.71$ (Ibid, p.249).

The findings are presented in Table 1 below:

Table 1.

Maternal Reaction Type and Preparation of the Child for the Clinic

Maternal Reaction Type	Preparation for the Clinic		
	Realistic	Non-Realistic	
Involved	11	5	16
Non-Involved	8	9	17
	19	14	33

The value of χ^2 for these data is .821.
The probability of occurrence under H_1 for $\chi^2 \geq .821$, with df = 1, is
$p < \frac{1}{2}(0.5) = p < .25$.
Because this p is greater than $\alpha = .05$, H_o must be accepted, and H_1 rejected.

The conclusion is that there is no difference between the two groups of Involved and Non-Involved maternal reaction types, in the proportion of Realistic preparations of the child for the Clinic.

Chapter X

Subsidiary Results (Part Two)

A number of subsidiary statistical tests were performed, to check the possible effect of various intervening variables upon the predicted association between the two main variables. All the hypotheses tested below were strictly post hoc, and were not conceived at the start of the present study, as having any direct bearing on the main hypothesis. Instead, they arose in the investigator's mind out of the very failure to confirm the main hypothesis, as possible reasons for this, and as likely leads for future investigations.

Firstly, the investigator was only able to test the central hypothesis on those mothers who returned to the Clinic for the second interview (i.e. 39 mothers), and not on the original sample of 44 mothers. She therefore attempted to investigate whether the final sample was biased by the presence of returning mothers, who would more likely be of the Involved maternal reaction type, than would non-returning mothers.

The reasons given by many of the non-returning mothers for not keeping their appointments (in those cases when they telephoned to cancel), made it appear that often their failure to return was connected with difficulties in explaining the Clinic to the child. Several of these mothers openly expressed a fear of suggesting to the child that something was wrong with him, by telling him that he was to come to the Clinic. They therefore decided to break off contact with it. It was impossible to analyse the differences between the two groups of returning and non-returning mothers with respect to the Preparation they gave their children for the Clinic, as this information was usually not available for the non-returning mothers. But what was analysable were the differences between the two groups with respect to the Maternal Reaction Type.

Using all the 44 cases of the original sample (N=44), and a one-tailed χ^2 test for two independent samples, with df=1, and a significance level of α = .05, the following hypothesis (H_1) was tested:

" There should be a greater likelihood of non-return among the Non-Involved maternal reaction types than among the Involved maternal reaction

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