All these suggestions would be interesting material for further research into the populations served by a child guidance clinic, and their different motivations, attitudes and expectations. The investigator feels that the points raised in the above discussion have an important relevance to the administration of child guidance clinics in general. Concepts such as the Maternal Reaction Type, may be useful to the clinic worker, who has to deal with a variety of mothers of different cultural backgrounds, religious persuasions, socio-economic groups, family adjustment patterns, and deep-seated personal motivations. And if the Maternal Reaction Type can one day be detected via the Preparation of the Child for the Clinic, this may short-circuit much of the probing that takes place in the initial exploratory stages of the clinic's efforts to help the mother and her child. Clinic waiting-lists are notoriously long, as the clinics themselves are usually underfinanced, and thus inadequately housed and staffed. There is often much wastage of time and effort on the part of both worker and client, in collecting detailed information about certain prescribed topics, that turns out to be irrelevant to the central problem.

A mother's failure to co-operate with the clinic after much of this probing has taken place, means further wastage. This could be eliminated if her tendency to do so could be predicted at the outset. Moreover, once her attitudes to the child guidance clinic became evident through discussion, the clinic worker might be able to direct more effort towards understanding and even helping her to modify these attitudes. Thereby the worker might indirectly achieve a modification of the attitudes that were pathogenic of her child's disturbance. The mother might find such an approach by the clinic worker more comfortable than one in which all the questions asked are about her child. She might feel that due attention is being paid by a sympathetic listener, to her needs as well as her child's, and thus she might be able to give a more honest and realistic picture of the problem. The Preparation of the Child for the Clinic would be a useful clue to her attitudes towards the Clinic, and thus a good starting point for the clinic worker.

It is even feasible that one or two sessions with the mother alone, conducted along the lines suggested above, might be sufficient to eradicate the child's problem entirely. The amount of relief and reassurance that a mother derives from being able to express all her ambivalent feelings about psychological treatment for her child, could itself enable her to relax and

interact more easily with him. The latter might respond to her new-found ease of mind, share it with her, and cease to behave in ways that were becoming a source of tension to both of them. Thus the whole problem of long waiting-lists until the child receives psychotherapy, would be alleviated.

The situation depicted in the preceding paragraphs is indeed an ideal of all child psychotherapy, and would probably be much more difficult to attain in practice. However, one should still strive towards this goal, and the present study represents an attempt in this direction. The investigator hopes that it will be repeated and perfected, and that its central issues be clarified by more thorough exploration of the association between the many intervening variables that have been discussed above. If the relationship between the Preparation of the Child for the Clinic, and the Maternal Reaction Type could be precisely defined, its implications might be very important for all those who are concerned with the psychological problems of children.

Chapter XII

Conclusions

In the present study, the investigator failed to verify her hypothesis. In the last chapter, some of the possible reasons for this failure were discussed, and a few suggestions were made for further research. Nevertheless, the hypothesis seems still to be worth investigating, even if it has to be altered in its formulation, to make it more amenable to better methodological procedures.

What have successfully been demonstrated are perhaps facts that have already been verified and elaborated upon in numerous other studies. They have been discussed particularly in the very recent literature on child psychiatry, i.e. since this piece of research was started. They may already be truisms, let they are important, and bear repetition and emphasis.

It has been shown that mothers differ in their ability to prepare a child for his first interview at a guidance clinic, where he is a potential candidate for treatment of his disturbed behaviour. How wide these differences are; whether they can be categorised with any consistency or intrinsic validity; and what the personality dynamics behind them are; -- these are all questions which have not been answered here, but whose significance has merely been speculated upon. The emphasis has been that the preparation of the child for treatment is one instance of a mother-child interaction. Just like any other sample of behaviour involving mother and child, it has been shown that this one is highly variable. It is handled and resolved in different ways by different mother-child pairs.

It has also been evident that mothers refer their problem children (or are themselves referred, with their children) to a clinic for many different reasons. They also arrive at a clinic with a variety of expectations from it. The latter are sometimes totally divorced from the ostensible reasons for which they first came there. The clinic therefore, signifies different things to each of them, according to their differing expectations of a child guidance service. In many of the mothers of our sample the prospect of psychological treatment for their children provoked considerable anxiety, whereas others were

excessively eager for it to begin.

Moreover, there was often a paradoxical maternal response to the prospect of treatment for the child: After seeking the Clinic's services with some urgency, and apparently co-operating with the worker at the first (Intake) interview, many mothers failed to return for the second interview; or as the beginning of treatment proper became imminent. In other words, much ambivalence seemed to be associated with her handing over of the child to a professional agency for help. Among the mothers who failed to return for the second interview, this ambivalence was clear. Among those who did return, it was also apparent. But it was expressed to a lesser extent, through more subtle communications, and in a variety of forms. One of these seemed to be the actual explanation given to the child of the Clinic, its function, and relevance to his specific needs.

Thus the investigator still clings to the postulate that the preparation of the child for psychological treatment is an important index of something in the mother-child relationship. It is as yet, not clear what this is. It does appear to have some association with maternal ambivalence towards the child's treatment. The latter may itself reflect a more general ambivalence towards the child per se.

Summary

A study was conducted at the Johannesburg Child Guidance Clinic, over a period of nine months, on a sample of near consecutive mothers and their children. They had either been referred, or were self-referred there for help. The mothers' reasons for coming were varied. But in each case there was some disturbance in the child's behaviour, which the mother or both parents, could not handle alone. They had therefore addressed themselves to the Clinic for advice, and for possible treatment of the child, who had become a 'problem'.

The investigator was particularly interested in what the child had been told about the Clinic, before he was brought there. Though the literature revealed a dearth of material on this question, it seemed that a variety of explanations might be given to him, varying in their degree of honesty, fullness, and comprehensibility to the child concerned. It was postulated that the particular type of explanation given, was symptomatic of the mother's own personality needs, and of her general approach to, and interaction with the child. All these factors might have had some responsibility in the genesis of the child's disturbance. Thus a relationship was expected to exist between this disturbance, and the kind of explanation given to the child about the Clinic.

The difficulties of psychiatric diagnosis in childhood (e.g. the overlap of symptoms; the variety of meanings attached to each symptom; the unformed personality of the child; and his inaccessibility to psychological investigation, except via his parents) prevented a formulation of the hypothesis in terms of a relationship between a specific disturbance of the child, and a particular explanation given to him. Moreover, the mother-child interaction was considered to be a more focal point of interest than the child's disturbance per se. Thus, a hypothetical relationship was formulated between the mother's reaction to her child's disturbed behaviour, and the type of preparation he was given for the Clinic.

Four categories of 'Maternal Reaction Type' were originally envisaged. Mothers were thought to be 'angered', 'frightened', 'ashamed', or 'concerned', in response to their child's behaviour. These categories were assumed to lie

on a continuum of felt responsibility for the production of the child's disturbance, and of a diminishing need to project the cause thereof, onto the child himself, other agents, and various external circumstances. Three categories of 'Preparation for the Clinic' were delineated, viz. 'full', 'partial' and 'poor'. They also lay along a continuum of truthfulness, comprehensiveness and respect for the child's ability to understand what was told to him.

The investigator aimed to assess the mother with respect to her 'Maternal Reaction Type' at the first (Intake) interview she had at the Clinic. Six to eight weeks later, when she brought the child to the Clinic for the first time, for a psychological investigation, she was to be seen again by the investigator, for a more detailed (History) interview. At the start of this interview, the mother was to be asked what she had told her child about the Clinic (if anything at all) before she brought him there.

Unfortunately, the number of mothers (whose children ranged between five and fifteen years of age) was drastically reduced from 44 in the original sample, to 33 in the final sample. This was mainly due to the failure of many mothers to return with their children for the second interview, and to the necessary exclusion of some subjects for various reasons that could not have been anticipated before the second interview. The result was that the hypothesised relationship between the two variables as it stood, could not have been tested statistically, because of an inadequate number of cases.

The investigator therefore decided to collapse the categories within each variable. The 'angry' and 'frightened' maternal reaction types were condensed into a 'Non-Involved' maternal reaction type; the 'ashamed' and 'concerned' into an 'Involved' one. The differences between the two were still on the basis of the mother's use of projection, and her acceptance or denial of responsibility for her child's disturbed behaviour. The 'Preparation for the Clinic' variable was re-classified into two categories, viz. 'Realistic' and 'Non-Realistic'. The 'partial' preparations of the child were re-assessed as either 'Realistic' or 'Non-Realistic', while all the 'full' preparations were re-classified as 'Realistic', and the 'poor' as 'Non-Realistic'.

A new hypothesis was formulated, predicting an association between the 'Involved' maternal reaction type, and the 'Realistic' type of Preparation for

the Clinic.

The investigator failed to find a relationship between the two variables that reached any level of statistical significance. Several other tests were performed to exclude the effect of intervening variables, such as the referral agent, the sex of the child, and the non-return of the mother to the Clinic for the second interview. A projective instrument was administered to the child, as an adjunct to the investigation, but it had no bearing on the main hypothesis. Psychologists' assessments of the child, psychiatrists' diagnostic interviews with the mother and child, as well as clinical casework meetings, were used as guides to the reliability of the investigator's own ratings. Relevant case material was included.

Some important methodological flaws were pointed out in the discussion of the findings, most of which were connected with the decision to collapse the original categories into fewer, but broader and less meaningful ones. Some alternative hypotheses were formulated on possible dynamic relationships between the main variables, and a number of suggestions were put forward for further research.

The investigator's overall conclusion was that research into the whole question of how a child is prepared for psychological treatment, is still worth pursuing, via other hypothetical constructs, which may be more amenable to operational definition and more compatible with standards of methodological rigour.

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Appendix A : Examples of the Intake Interview

D.F. : Male, seven years

(Mother : Non-Involved)

Mother is a very talkative woman, who would not answer questions directly if they seemed to provoke anxiety, but tended to describe elaborately situations that were not strictly relevant. She was dressed in slacks, and her whole approach to the interview was rather casual. She afterwards mentioned that she had been to the Clinic before, about two years previously, but couldn't remember why she had come. It had been about the same child, and eventually she recalled that at that time there was "an outside interference", viz. paternal grandfather (PGF). The latter wasn't working at the time, but living with them. He used to spoil D, and frustrate all mother's and father's efforts to discipline him. She did not return to the Clinic, but sought private help from a psychiatrist, as she had been advised to do. This had helped to some extent, mainly because she and father were both advised to form a "united front" in their handling of D, and to approach PGF directly, and tell him not to interfere. But mother resented somewhat the psychiatrist's attitude that the problem resided with them, rather than with D himself, whom he never even saw. She was prepared to admit that her handling of D might have been wrong, but then she added that she handles all her children the same way, and there is nothing wrong with the other two. She had returned now, because she felt that the Clinic would deal with D more specifically. She seemed intent in her rambling account of D's behaviour, on presenting as black a picture of him as she could, usually when a question had been asked that related to her own feelings. She seemed to have felt very threatened by the implication that she was responsible for his behaviour, and determined to convince the Clinic that he really was a bad, unmanageable child.

D is utterly disobedient at home. They have tried various methods of punishing him, but nothing has worked satisfactorily. He will never admit that he is wrong, and continues to misbehave in spite of hidings, deprivations and threats. He is unwilling to share anything with his two brothers, who are much kinder, amiable, and better companions to each other than he. He resents their touching any of his things, and sometimes becomes very aggressive towards them. Last week he held a bread knife to his baby brother's throat, and mother is terrified of how far he will go. In spite of this, mother denied that D was at all jealous of his brothers, or that he was an aggressive child. He gets on very

well with his friends, does excellent work at school, and is perfectly good when he is alone with mother or father. This makes mother think that he is quite adjusted, apart from his inability to be disciplined at home. She suddenly remembered that he has never yet spent the entire night in his own bed, but always comes to hers in the middle of the night. He is very afraid of the dark, and they have to sit with him for hours until he goes to sleep. She tended to deny that this was a problem either, as many people she's discussed it with have said it was fairly common.

Mother was willing to have D's name put on the waiting list, but was not really receptive to any discussion of her own feelings, or of the possibility of having these explored at the Clinic. She said she agreed that she would have to become involved, but gave the impression that she would strongly resist this when the time came. What she seemed to want was direct advice on how to discipline D, a freedom from responsibility for his problems, and support for her notion that there was little hope of ever changing him into a good child, however hard she tried.

C.D. : Male, seven years

(Mother : Involved)

Mother is a very young and attractive woman, who is also exceedingly well-groomed. She spoke intelligently, and in a friendly and fairly relaxed manner. Towards the end of the interview however, she expressed feelings of great apprehension about coming to the Clinic, having expected to meet an elderly, unmarried and childless woman, who would sit back and tell her what a poor mother she had been. She confessed to having taken a tranquilliser before coming, and had actually been put onto a course of these by her doctor only yesterday. She despises having to resort to pills for relief from her unbearable state of tension, aggravated at the moment by the presence of paternal grandfather (PGF) in their home. He is on a visit from overseas, and mother resents him terribly, feeling that he is making the whole situation more difficult. After the interview, which she seemed to prolong, she expressed relief in having been able to talk to someone

other than a relative, and an eager desire to come back again as soon as possible.

She was referred to the Clinic by C's school principal at the end of last year. C had been behaving strangely at school in various situations. He kicked the tyres of passing motor cars in the street; he couldn't pass other children in the corridor without hitting them; and he expressed a fear that some workmen at the school were going to throw him into a hole they were digging. The principal couldn't find out whether these workmen had actually threatened him in this way, or whether this was entirely C's fantasy. It has not only been these three incidents which have caused mother concern about C. She actually approached the principal herself some months ago, because she was finding C so difficult. He is very defiant of her attempts to discipline him, and will only respond if she shouts at or hits him, or if father intervenes. He does naughty things which she can't understand, and then attempts to conceal all evidence of his misbehaviour. For example, last July, just prior to their going on holiday, he set the garage on fire, burning even his own prized toys. He then adamantly denied that he had been playing with matches. The very next day, when mother slipped out of the house for two minutes, he took his sister's new skirt, which mother had just made, and her teddy, of which she was very fond, and tried to burn them. He succeeded in blackening the teddy, then tried to wash it, and finally hid it away. He seems to be very jealous of his sister, especially when mother buys or makes her clothes. He is often rude to mother's friends or visitors, and refuses to apologise, preferring to forego some pleasure instead. Mother finds his behaviour anger-provoking, exasperating, embarrassing, and incomprehensible. His teachers also complain about his being a disruptive element in the classroom, and mother refuses to attend Parents' Day, for fear of being told all over again how impossible he was. Only his Afrikaans teacher, a male, has commented favourably on his progress. Mother thinks that this is because the Afrikaans lesson only lasts ten minutes, and that C can't sustain his concentration for much longer. He seems to be a most intelligent child, but he becomes bored very easily.

Mother blames herself for many of C's misdemeanours. When he was conceived she developed a heart complaint, and became very exhausted during her pregnancy. This was aggravated during her second pregnancy, and after his sister's birth, she had to have an operation. Her two separations from C at this time, and her subsequent inability to re-establish a relationship with him,

make her feel very responsible. People have told her that he should have grown out of the effects thereof by now, and that his behaviour is typically boyish, and will also pass. But mother still worries, and often wonders what she has done to deserve such a difficult child. She feels that some kind of retribution is involved, and this upsets her terribly, since she is not sure where she has gone wrong. They came to settle in South Africa two years ago, on account of mother's health, and have been very happy here. Mother herself has felt very well. She thinks that C's adjustment to school and friends here was not all that easy. She expressed some anxiety about whether he would now have to go to a special school. C's name was put down on the waiting list.

C.M. : Female, twelve years

(Mother : Non-Involved)

Mother is a rather tense woman, with a slight speech defect. She came to the Clinic on the advice of a friend, who suggested that she might be helped there over her difficulties with C. The idea seemed quite foreign to her, and although she thought C was very unhappy at the moment, she remarked that she was not really a 'problem' child.

Mother has been widowed for five years now, and plans to remarry fairly soon. Her fiancé, whom she has known for about sixteen months, is a wonderful and kind person, completely accepting of her children, and very good to them. C however, has reacted to mother's intended re-marriage with marked hostility, jealousy, and resentment. She is never openly rude to her future step-father, but complains to mother after he has gone, that he has no right to correct her, or to tell her what is good for her. Mother finds that generally C has changed from an adorable little girl into an impossible and rebellious one.

Mother admitted to a very special attachment to C above her other two daughters. C was born shortly after mother had lost a six-week-old son, and to her C always represented the two children in one. Both she and father doted on her, and were particularly encouraging and proud of her dancing talents. Mother

became very engrossed in C's ballet after father died (from a sudden heart attack), and she has always been attentive to her achievements in this field. C has now accused mother of losing interest in her dancing, which mother says is partially true, as she has less time. There have been several outbursts recently, when C behaved so badly that mother lost her temper, and said things she didn't really mean. She told C that she was still young, and didn't intend spending the rest of her life as a widow; that whomever else she chose to marry would never be as fond of C as her present fiancé was; that C too would one day marry, without considering her mother as an obstacle; and that she'd send C to boarding school if she didn't behave. Mother felt terribly distressed about this. She can't understand why C is apparently so unhappy at the moment, and why she cannot realise that she herself will benefit from mother's re-marriage. Things will be easier for all of them, and far from losing her mother's love, C will be gaining someone else's too. She is also very afraid that the marriage won't work if C's antagonism persists. This she doesn't know how to handle.

Mother's own feelings about the loss of her husband and her baby son were discussed, as well as her inability to talk to any of her children about their father. She was also asked about C's adolescent development. It emerged that mother was reluctant to face the fact that C was indeed growing up. It seemed that C's conflict about adolescence, her grief at the loss of her own father, and her resentment of mother's planned re-marriage, might all have been interlinked, and perhaps accounted for her current behaviour. Mother was advised to try and acknowledge these feelings in C, and to help her verbalise them if she needed to. Mother seemed fairly responsive to these suggestions, although she said it would probably be very difficult to carry them out in practice.

The possibility of private treatment was discussed, and mother said she would consider this if the problem became more acute in the next few weeks. Meanwhile C's name was put on the waiting list.

J.D.S. : Male, twelve years

(Mother : Non-Involved)

Mother is a frank and intelligent woman, who is also most accessible. She was referred to the Clinic by her own psychiatrist, from whom she has received a good deal of help in the last few years, over her difficult relationship with her mother (MGM). The strain of this situation as well as her apparent inability

to handle J, have made her feel utterly desperate and inadequate.

J has always been a rather difficult child, showing signs of excessive aggression even at nursery school. She has considered seeking help for him for a long while, but his teachers and various other people have always reassured her that there was nothing seriously wrong with him, and that all children behaved in the same way. Father particularly, has tended to dismiss her worries about him as being exaggerated, and even now he is not entirely in favour of her coming to the Clinic. This has made mother feel even more lonely and anxious about her reactions to J's behaviour. He tends to be rude to her, father, his siblings and the servants, especially when he comes home from school. He upsets the whole family atmosphere, and the other children seem to be following the pattern he has established. His behaviour at school is apparently quite different. He is timid and reserved, and even self-conscious. In the barmitzvah class, his teacher has described him as the "one angel amidst a crowd of hooligans". The school principal has also expressed a fondness for him, and suggested to mother that she stop worrying about him. Only if he were doing things that were underhand, should she have any cause for concern. Mother admitted that at times she has worried that he would become dishonest. Her present fear is that he should grow up to be uncouth and ill-mannered.

The family circumstances in recent years have not helped mother in her attempts to discipline J. Father is frequently away for five days at a stretch on business, and mother is unable to control all four children on her own. Her father (MGF) died three years ago, which upset her greatly. Furthermore, MGM became quite helpless and depressed afterwards, and mother began to flounder completely in her handling of MGM. MGM and father don't get along either. There have also been financial difficulties, and J and his brother and sister are all being moved from a private school to a government one next year. J is not upset about this, as he doesn't like the compulsory Hebrew studies at his present school. J is due to have his barmitzvah in February, and mother is terribly anxious about how he will cope, as he is so self-conscious.

Mother has mentioned the Clinic to J on occasions, having been encouraged to do so by her psychiatrist. She regrets however, that she talked about it in rather threatening terms, when he began to misbehave at various times. He replied that she didn't need to go and see anybody about him, as he was quite

capable of behaving properly if he wanted to. Recently she told him that the Clinic was a place where people went when they couldn't get along with eachother, as she and he seemed not to, and needed help for this reason. She was very eager to have J's name put on the waiting list, in spite of father's opposition to this move. She expressed a desire to see her own, rather than any other psychiatrist, as the former happened to be on the Clinic staff.

M.T. : Female, six-and-a-half years

(Mother : Involved)

Mother is a young, attractive and intelligent person, with a lively sense of humour. She came to the Clinic on her own initiative, because she is "at her wits' end" in trying to handle M properly. She feels sure that she is doing something wrong, or else that she hasn't understood something in M that an outsider may recognise more easily.

She mentioned at the beginning that M was a fat child. She also kept reminding one of M's size, by calling her "large", and talking of her dress measurements. Mother herself is slim, but she said she had also been very fat until she was 13 years old. She knows how miserable fat children can be, and is very upset by M's tendency to put on weight. She has often tried to put her on diet, on the advice of a doctor, as well of M's teacher. Sometimes she puts the whole family on diet, to make it easier for M. M will adhere to the regime for a day or two, but soon starts eating in secret. In spite of having been teased by the other children, and excluded from sports teams, M just won't lose weight.

M also has school difficulties. She started school last year when she was five, and managed fairly well during the whole of Grade I. Now she is virtually always at the bottom of Grade II, and failing badly. Mother knows that M is not very bright, but she is sure that she is at least of average ability. M's teacher has also said this. She has thought of keeping M back in Grade I another year, but because of her size, she would be unhappy amongst the younger