1953

A Study of the Behavior Patterns of the Physically Handicapped Child as Related to the Maternal Attitude

Helen E. Frazier
Loyola University Chicago

Recommended Citation
https://ecommons.luc.edu/luc_theses/1014
A STUDY OF THE BEHAVIOR PATTERNS OF THE PHYSICALLY HANDICAPPED CHILD AS RELATED TO THE MATERNAL ATTITUDE

by

Helen E. Frazier

A Thesis Submitted to the Faculty of the Graduate School of Loyola University in Partial Fulfillment of the Requirements for the Degree of Master of Social Work

February

1953
LIFE

Helen F. Frazier was born in Washington, Pennsylvania January 26, 1909.

She was graduated from Washington High School in Wash-
ington, Pennsylvania in February, 1929 and entered Provident
Hospital Training School in September, 1929. From 1933 to 1948
she worked in the clinic at Provident Hospital. In 1943 she
studied one year at the University of Toronto School of Public
Health Nursing. She was graduated from Northwestern University
June, 1946 with the degree of Bachelor of Philosophy. She began
her graduate study at Loyola University in September, 1948.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the purpose of the thesis--Scope of the study--Limitations of the study--Procedure--Summary.</td>
<td>1</td>
</tr>
<tr>
<td>II. THE STUDY GROUP</td>
<td>11</td>
</tr>
<tr>
<td>Consideration of objective data--Age, sex, and race of children--Source of referral--Age at onset of handicap--Age at time of referral--Behavior problems prompting referral--Summary.</td>
<td>11</td>
</tr>
<tr>
<td>III. THE PROBLEMS OF THE CHILDREN WHICH THE PARENTS VERBALIZED AS THE ONES CAUSING THE ANXIETY</td>
<td>22</td>
</tr>
<tr>
<td>What does the parent see as the cause of the problem?--In what environment does the problem occur most frequently?--Summary.</td>
<td>22</td>
</tr>
<tr>
<td>IV. ANALYSIS OF FINDINGS REGARDING THE MATERNAL ATTITUDE</td>
<td>33</td>
</tr>
<tr>
<td>Developmental history--Maternal attitude regarding feeding--Toilet training--Maternal attitude towards discipline--Maternal reaction to child's problems--Summary.</td>
<td>33</td>
</tr>
<tr>
<td>V. SUMMARY AND CONCLUSIONS</td>
<td>48</td>
</tr>
<tr>
<td>Conclusions based on the results of the findings.</td>
<td>48</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>51</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>55</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. AGE, SEX, AND RACE OF CHILDREN AT THE TIME OF REFERRAL</td>
<td>12</td>
</tr>
<tr>
<td>II. SOURCE OF REFERRAL</td>
<td>14</td>
</tr>
<tr>
<td>III. AGE AT ONSET OF HANDICAP</td>
<td>15</td>
</tr>
<tr>
<td>IV. AGE AT TIME OF REFERRAL</td>
<td>16</td>
</tr>
<tr>
<td>V. BEHAVIOR PROBLEMS PROMPTING REFERRAL</td>
<td>20</td>
</tr>
<tr>
<td>VI. DEVELOPMENTAL HISTORY</td>
<td>35</td>
</tr>
<tr>
<td>VII. MATERNAL ATTITUDE REGARDING FEEDING</td>
<td>39</td>
</tr>
<tr>
<td>VIII. TOILET TRAINING</td>
<td>41</td>
</tr>
<tr>
<td>IX. MATERNAL ATTITUDE TOWARD DISCIPLINE</td>
<td>42</td>
</tr>
<tr>
<td>X. MATERNAL REACTION TO CHILD'S PROBLEM</td>
<td>44</td>
</tr>
<tr>
<td>XI. MATERNAL REACTION IN HELPING CHILD CONFORM TO HIS ENVIRONMENT</td>
<td>46</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

This study is an analysis of a selected group of cases of physically handicapped children known to the Institute for Juvenile Research from January, 1949 to January, 1951.

Since all the children were presenting behavior problems serious enough to come to the attention of a child guidance clinic, this study was undertaken in an attempt to ascertain to what extent the behavior patterns of the physically handicapped children are affected by the maternal attitudes. Its specific objectives are to determine what the behavior patterns of this group of children are and to what degree the handicap affects the mother's attitude toward the child. It is hoped the study will point out the significance of the following factors. Does the onset of the injury affect the maternal attitude? Is the attitude of the mother directed at the child or the handicap? Does the child reared with siblings present a different behavior pattern than an only child? Does the type and location of the handicap affect the child's behavior pattern and the mother's attitude?

The Institute for Juvenile Research where the data was
collected for this study is a State Child Guidance Clinic whose primary function is to help children to make a more adequate personal adjustment in their family and social groups. For the most part, the children seen at the clinic are considered normal in that they are not mentally ill but the type of behavior problem which they are presenting would be considered a deviation from the behavior patterns of a normal child and they are causing someone concern. The work of the clinic is accomplished through the combined efforts of the three professional disciplines: Psychology, Psychiatry and Social Service. Physical examinations are not done if the child has had a recent examination and a report of the examination can be secured from the medical agency or the physician.

While the study is concerned specifically with the paternal attitude toward the handicapped child, the writer would like to point out that both the mother and father are seen at the clinic. However, the mother is seen more frequently since she is the one who usually brings the child to the clinic. At the time of the initial contact with the patient, the social history is secured from the mother by the social worker. The child is examined by the psychologist. At a later date, both mother and father and the child are seen by the psychiatrist. The information secured by the three examiners is written up and becomes part of the case record. In addition to the written record, the information secured by the three examiners is further checked on
individual diagnostic cards by each examiner.

The case records for this study were selected from the total number of cases of physically handicapped children seen at the Institute for Juvenile Research from January, 1949 to January, 1951.

The study was limited to children who fell into the normal intelligence group. At the Institute the normal intelligence quotient range is considered to be numerically speaking from 80 to 119 and includes the categories of dull average (80-89); average (90-109); and high average (109-119). While the focus in this study is not on the intelligence of this group it was felt that limitation in this area was essential. A too wide range may be misleading, in that it might be a factor in determining the kind of behavior problems the child was presenting and the type of adjustment he could make in his environment.

The study was further limited to three specific classifications of handicaps and three categories of maternal attitudes.

The physical handicaps selected for study included the residual handicaps from disease, handicaps from injuries and congenital handicaps. These classifications were chosen from the social history card under the category Health in the "Develop-

---

1 At the Institute for Juvenile Research the diagnostic card is used for the purpose of classifying social psychological and psychiatric data. Each examiner uses a special card to code the information.
mental History of the Patient." In selecting these particular classifications of handicaps, certain questions stand out. In the group "Residual Handicaps from Disease" the handicap may or may not be obvious and it poses the question as to whether this factor affects the mother's attitude. With the "Handicaps from Injuries" the age of the child and the type of injury together with the degree of incapacitation would make one wonder if the mother's attitude might be altered. In the group "Congenital Handicaps," the question arises as to whether the mother might be more accepting or rejecting of the child. In this group it would seem that the ordinal position and the number of siblings might be significant factors in the child's relationship with his mother.

The maternal attitudes selected for consideration were those checked on the social history and under the category entitled "Maternal Attitudes in Helping a Child to Conform to His Environment." The study is based on the hypothesis that the classifications of the maternal attitudes are valid on a diagnostic level and no attempt is being made to prove them otherwise.

For purposes of this study, the writer defines a mother with a rigid attitude as one who assumes an inflexible, dominating tendency in specific areas of the child's early development, training and in his social contacts. This evidence is seen in the psychiatric and social histories in which mothers adhered to
definite feeding schedule, early and abrupt introducing and early and rigid toilet training. One mother stated, "I am sure I made John grow up too fast. I expected too much of him." Another mother said, "If Mary refuses to eat three meals a day, I threaten her with a strap." Further evidence of rigidity is seen in the area of toilet training which in many cases was begun early, and when soiling occurred it was handled by threats or physical punishment. In other cases, mothers inhibited their children from playing with their friends and limited them from engaging in other activities outside the home.

The writer's conception of permissive is a mother who consistently yields to the wishes or actions of her child. She is the type of mother who will submit to the demands of her child and finds it difficult to place limits. In general, this mother is not too concerned about abnormal behavior in her child. This attitude is seen in several statements of mothers in the case records. One mother remarked, "Ralph's crying is so emotional that I cannot help giving into him, although I know that it is wrong." Another mother said, I always dress Silly, because he refuses to dress himself." One mother was afraid to displease her son because he would go into a rage.

The writer interprets a mother with an adequate attitude as one who has good emotional control, flexible in meeting the needs of her child and capable of giving the child warmth and understanding.
Based on the limitations, there were thirty-seven cases selected for study from a total of eighty-six physically handicapped children known to the Institute for Juvenile Research over a two year period. Of the thirty-seven cases, there were fifteen with congenital handicaps with six showing rigid mothers, seven with permissive mothers, and two with adequate mothers. Handicaps from injury showed a total of twelve cases with five showing rigid mothers, seven with permissive mothers, and none with adequate mothers. There were a total of ten residual handicaps with seven whose mothers displayed a rigid attitude, two who had permissive mothers, and one whose mother seemed to be adequate. From the thirty-seven cases, there was a total of eighteen mothers with rigid attitudes, sixteen mothers with permissive attitudes and three mothers with adequate attitudes.

Originally the plan was to do a comparative study, but it was felt that any comparison based on such a limited number of cases would not be valid. The focus was then changed to consider in a general sense the consistency of the mother's attitude in certain areas of the child's development and training in relation to the handicap and the type of behavior patterns presented.

A schedule was prepared for the collection of data. The schedule was divided into eight parts. The first five parts

2 See schedule in the Appendix.
deal with identifying information regarding age, race, and sex of the children, the home situation, source of referral, financial situation, and the developmental history of the child. This data was collected from the social history card which had been checked by the examiner after the interview with the mother.

Part six presents the behavior problems prompting referrals which the parents checked on the application forms as the ones causing the anxiety. Part seven, "Maternal Reaction to the Child's Problem," is the classifications checked on the psychiatric card by the examiner who interviewed the mother. This was selected as a method of determining the mother's attitude toward the child rather than the handicap. Part eight which contains the statements the mother verbalized as the ones causing the anxiety during the interview with the social worker was considered as a means of determining where the mother placed the problem, on the handicap or the child.

Over a period of years there has been a change in thinking regarding the needs of children in general and the needs of the handicapped child in particular. Today it is recognized that all children have common needs and that the physically handicapped child has all the needs of normal children plus special needs which the handicap imposes on him.

Prior to 1918 emphasis was placed on the curative aspect of the care for the physically handicapped child. Advances in the development of human behavior and psychiatry have shown a
slow recognition on the part of all people directly concerned with the care of children that the needs of the handicapped child extend beyond curative to rehabilitation and social adjustment of the individual. As a result of this increased knowledge regarding human behavior, community thinking has changed regarding the basis for behavior problems in children. Today, much importance is placed on the child's early life experiences, especially in terms of his relationships with his parents and siblings in the specific culture in which he was reared. Such things as the degree of dependency on his mother and the methods of parental management will affect his responses to his illness.

A study made by social workers at the Detroit Orthopedic Clinic showed that problems presented by the handicapped child frequently bring to surface many deep-seated feelings of the parents which previously had been suppressed and perhaps unsuspected. Since the mother's feelings seem to have a tremendous influence on the behavior patterns of children, it does seem that her attitude in relation to the handicapped child who is presenting behavior problems would warrant investigation.

With a change in community thinking and the organization of child guidance clinics it is felt that the maternal attitude is a significant factor in influencing the development of a

---

child's personality and his personal adjustment in social relationships. The specific application of this to the behavior problems of the handicapped child would seem to merit exploration on the basis that the family constitutes the area of most intense feelings. It does seem then that the presence of a handicapped child in the family and the problems which he is presenting must to a certain degree be affected by his relationship with his mother.

David M. Levy has pointed out

the most potent of all influences on social behavior is derived from the primary social experience with the mother. The child's outlook on life, his attitude toward people and his entire psychic well-being is presumed to be altered by the maternal attitude.4

In summary, thirty-seven physically handicapped children seen at the Institute for Juvenile Research over a two-year period were selected for the basis of this study. All the children in the group were presenting behavior problems and had a handicap that fell into one of the three classifications selected for study.

Of the total number of cases selected for study, fifteen children had congenital handicaps, twelve were classified as handicapped from injury, and ten had residual handicaps from disease. Eighteen of the children had mothers who displayed a

rigid attitude, sixteen children's mothers were classified as permissive and three children had mothers with adequate attitudes.
CHAPTER II

THE STUDY GROUP

The purpose of this chapter is to consider the facts in the child's environment which would seem to have bearing on his interpersonal relationships. Since the family and its setting has a tremendous influence on the growth and development of the child it would seem that the objective data would give a better over-all picture of the study group and point out some of the contributing factors responsible for the child's behavior problems.

The tables presented were organized from material secured from the parents by the three examiners during the diagnostic process at the clinic.

The purpose of the diagnostic process in child guidance is to obtain a comprehensive picture of the situation, the person, and the person reacting to his situation, including those earlier experiences which have contributed so much to shaping his character.¹

Table I shows that there were more boys than girls referred to the clinic during the study period. Of the twenty-seven boys the concentration was between the ages of seven and

nine years, while in the group of eleven girls the concentration
was between the ages of thirteen and fifteen. Of the total num-
ber of cases, thirty-two were white, four were negroes, and one
was an Indian child.

TABLE I.
AGE, SEX, AND RACE OF CHILDREN AT
THE TIME OF REFERRAL.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>1</td>
</tr>
<tr>
<td>4-6</td>
<td>10</td>
</tr>
<tr>
<td>7-9</td>
<td>14</td>
</tr>
<tr>
<td>10-12</td>
<td>5</td>
</tr>
<tr>
<td>13-15</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>26</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>32</td>
</tr>
<tr>
<td>Negro</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
</tr>
</tbody>
</table>

While it is recognized that no definite conclusions
can be drawn from such a limited number of cases, the writer
would like to point out that six times as many white parents were seen at the clinic than other racial groups. In collecting the data, the addresses of the clients were not checked so that proximity to the clinic facilities may be a significant factor in that the parents living in the city of Chicago may be more aware of available resources.

Table II shows that of the total number of handicaps, fifteen were congenital, twelve were handicaps from injury and ten were residual handicaps from disease. Of the fifteen congenital handicaps, eight were referred by the parents and four were referred by the medical agencies. The social agencies referred the largest number of handicaps from injury and the medical agencies referred the greater number of handicaps from residual diseases. These figures would seem to point out that since the parents referred equally as many children as the medical agencies, that apparently the child's problems caused them enough anxiety that they voluntarily sought help. The fact that the medical agencies referred as many children as the parents would seem to indicate that it was felt that the children's problems stemmed from causes in addition to the handicap.

Table III shows that the age of the onset of the handicaps, other than the congenital handicaps occurred between the ages of two and six years. This is a period in the child's life when the mother's attitude is the most significant factor in determining the child's development and reactions in that the
child as yet has not attempted to establish meaningful relationships outside the family.

**TABLE II**

**SOURCE OF REFERRAL**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Handicaps</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Medical&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Social Agency&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>15</strong></td>
<td><strong>12</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

<sup>a</sup> The social agencies making the referrals were Aid to Dependent Children, Red Cross, Juvenile Court, State Division of Child Welfare Region III.

<sup>b</sup> The medical agencies making referrals included Illinois Research, St. Luke's Hospital, the Eye and Ear Infirmary and doctors in private practice.
TABLE III

AGE AT ONSET OF HANDICAP

<table>
<thead>
<tr>
<th>Age</th>
<th>Handicaps</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
<td>Injury</td>
<td>Residual</td>
</tr>
<tr>
<td>Under one year</td>
<td>15</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Table IV showing the age at the time of referral indicates that the majority of the children came to the attention of the clinic between the ages of five and nine. The data points out that while the majority of children received their handicaps early in life, help was not secured for them until after they reached school age. In view of this observation, it should be pointed out that the school did not make the majority of the referrals. It also seems that the conclusion could be made that these children probably were presenting problems before they entered school and because of their broadened social relationships, the parents became more concerned about the
differences in their child's behavior.

<table>
<thead>
<tr>
<th>Age</th>
<th>Handicaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Information dealing with the family setting shows that in the majority of the families both of the natural parents were in the homes, and in the largest number of families there were no other children. In the families where there were other siblings the handicapped child was the youngest child. An only child in a family is at a disadvantage in that often the parents
seek to meet all their needs in this child. When this child has a handicap, especially in the congenital group, the parents have a tendency to have considerable guilt feelings which may make them reluctant to have other children.

English and Pearson have stated that an only child experiences an undiluted reaction to parental attitudes—he can not project his feelings about his parents onto sibling substitutes.2

The position of the youngest child presents a different picture. Even though parental attitudes may have been diluted, the fact that he is different and must compete with the other siblings who in many instances are normal may account for many of his behavior problems.

According to Gordon Hamilton,

the secure child who has been successfully solving the problem of sharing the parent has little difficulty in solving the problem of sibling rivalry. Fundamentally, sibling rivalry is serious only when the child already has a parental problem.3

It would seem then, that in families where there were other siblings, the basic problem was still between the parent and child and that the other siblings might be a contributing factor in the child's problem rather than the primary factor.

---

2 O. Spurgeon English and Gerald M. J. Pearson, Common Neuroses of Children and Adults, New York, 1950, 44.

Information on the financial status revealed that all but five of the families were economically independent. While information on the occupations of the parents was not recorded on all the records it is interesting to note that of the twenty-eight cases where the occupation of the parent was recorded there were several salesmen, an accountant, a lawyer, one superintendent of a garage, several postal clerks, two electricians, a motorman, an insurance agent. From an overall picture of the occupations it does seem that the conclusion could be made that most of the families were above the marginal income group. Another observation that could be made would be that economic status in this particular study did not seem to be a factor in relation to the handicapped child not receiving adequate medical attention.

The five families receiving assistance were the families where the mother was the only natural parent in the home and they were receiving Aid to Dependent Children. In two of the families the mother was handicapped by being hard of hearing.

All the children in the study who were of school age were attending public schools. This would seem to indicate that none of the children were so seriously handicapped that they required the services of the special schools. It would also point out that all the children were able to participate in the life

4 Special in this study means any school established to give services to only children with handicaps.
of physically normal people by making some modification of their activities and slight adaptations of environment.

Table V, showing the Behavior Problems Prompting Referral is presented in three parts: The Socially Unacceptable Acts, Defects in Learning, and Somatic Dysfunction. These are the problems which the parents checked on the application forms as the ones causing them concern. For purposes of presentation the problems were classified into the three categories mentioned above. In the Socially Unacceptable Acts, temper and disobedience stand out. Both of these acts are of an aggressive nature and are characteristic of children who have not been able to deal adequately with their frustrations.

Edna Stern has stated in her book on The Handicapped Child that

the handicapped child will not express his unhappy sense of dependence in words. He is more likely to take it out in being a little tyrant or in irritability or in having tantrums or living too much within himself.\(^5\)

In Defects in Learning, nervousness and restlessness rank first with excitability second and failure to adjust third. It does seem that this behavior is representative of children who are frustrated and who are attempting to meet their dependency needs in this type of behavior.

In the Somatic Dysfunction group enuresis and feeding

---

problems seem to stand out. While studies have been made regarding the relationship between enuresis and feeding difficulties, no definite conclusions were made. However, it has been pointed out that the two problems represent different periods in the child's period of growth and development and the methods of handling may have been different.

**TABLE V**

**BEHAVIOR PROBLEMS PROMPTING REFERRAL**

<table>
<thead>
<tr>
<th></th>
<th>Handicaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
</tr>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
<td></td>
</tr>
<tr>
<td>1 - Temper</td>
<td>5</td>
</tr>
<tr>
<td>2 - Stealing</td>
<td></td>
</tr>
<tr>
<td>3 - Truancy</td>
<td></td>
</tr>
<tr>
<td>4 - Sex misbehavior</td>
<td>3</td>
</tr>
<tr>
<td>5 - Disobedience</td>
<td>6</td>
</tr>
<tr>
<td><strong>Defects in Learning</strong></td>
<td></td>
</tr>
<tr>
<td>1 - Falls to adjust</td>
<td>5</td>
</tr>
<tr>
<td>2 - Withdrawn</td>
<td></td>
</tr>
<tr>
<td>3 - Excitable</td>
<td></td>
</tr>
<tr>
<td>4 - Depressed</td>
<td></td>
</tr>
<tr>
<td>5 - Nervous, restless</td>
<td>10</td>
</tr>
<tr>
<td>6 - Shy</td>
<td>1</td>
</tr>
<tr>
<td>7 - Fearful</td>
<td></td>
</tr>
<tr>
<td>8 - Submissive</td>
<td>6</td>
</tr>
<tr>
<td><strong>Somatlc Dysfunction</strong></td>
<td></td>
</tr>
<tr>
<td>1 - Enuresis</td>
<td>1</td>
</tr>
<tr>
<td>2 - Speech defect (Stuttering)</td>
<td>2</td>
</tr>
<tr>
<td>3 - Speech Defect (Other)</td>
<td>3</td>
</tr>
<tr>
<td>4 - Tics</td>
<td></td>
</tr>
<tr>
<td>5 - Allergic condition</td>
<td>1</td>
</tr>
<tr>
<td>6 - Glandular symptoms</td>
<td></td>
</tr>
<tr>
<td>7 - Neurological (spastic convulsions)</td>
<td>8</td>
</tr>
<tr>
<td>8 - Feeding problems</td>
<td></td>
</tr>
<tr>
<td>9 - Other</td>
<td></td>
</tr>
</tbody>
</table>
In summary, the thirty-seven cases selected for study showed that more boys were referred to the clinic than girls and that there were six times as many white children seen than other racial groups. The concentration in ages among the boys was between seven and nine years, and among the girls was thirteen and fifteen years. Although the majority of the children received their handicaps early in life, they did not come to the attention of the clinic until after they had entered school.

None of the children were handicapped to the extent that the services of specialized schools for the handicapped child were required. In the majority of the families both natural parents were in the home and in all the families the natural mother was in the home. All but five of the families were economically independent and their occupations represented a group a little above the marginal income group.

The parents and the medical agencies were responsible for the greatest number of referrals. Of the behavior problems prompting referral, nervousness, restlessness, excitability, and failure to adjust stand out in the defects in learning; temper and disobedience occur most frequently in the group of socially unacceptable acts and enuresis and feeding problems seem to be most prevalent in the somatic dysfunction classification.
CHAPTER III

THE PROBLEMS OF THE CHILDREN WHICH THE PARENTS VERBALIZED AS THE ONES CAUSING THE ANXIETY

The purpose of this chapter is to consider the factors which seemed to cause the parents the most concern about the child's behavior. These statements are the problems of the children which the mother verbalized as the ones causing the concern during the interview with the social worker. Did they see the child's behavior as resulting from the handicap or apart from the handicap? Where did the problem occur—in the home, school, or community?

Of the total thirty-seven statements, twenty-seven showed that the parents focused the behavior problem on the child and did not mention the handicap. Of the ten who mentioned the behavior as resulting from the handicap, it is interesting to point out that in only one case the handicap detracted from the child's appearance. Of the nine remaining handicaps, two were hard of hearing, one had poor muscle coordination and asthma, another had "spells," two parents felt their children were retarded, another parent stated that her child used his asthma to
get his way. One mother said her child had always been in poor health and required a lot of attention, and another parent placed an injury received in early childhood as the basis for the child's behavior problem.

The following statements are recorded to show that the mother seems more concerned about the child's behavior than his handicap and is seeking help with the child in relation to his behavior at home.

(1) Patient has nervous habits. He twitches his nose and sniffs. He breaks one habit and gets into another.

(2) Mother is afraid of patient, he goes into a rage when displeased with her. If she so much as touches his bicycle he becomes enraged and attacks her verbally with the most obscene and vulgar language applying all sorts of names to her. Mother feels patient needs a nice boarding school.

(3) Patient has a very angry disposition and temper. She has always been mean and difficult. She is lazy and will not look after her personal appearance. She steals and smokes and will lie without batting an eye.

(4) Patient bites his nails and even his toe nails continuously. He fights with his brother and sister. He is made mad easily and is stubborn and always thinks he is right. He uses vile language against himself and mother. He feels nobody loves him.

(5) Patient sucks her thumb. She is a poor eater and
and wets her clothes.

(6) Patient has many fears (thunder, lightening, dogs, and noises). He refuses to dress himself, leave the house alone or become self-reliant in any way. He has a good memory but easily distracted. He is cantankerous and has silly behavior.

(7) Patient is under a nervous strain.

I feel that if I don't find out what is causing this I will go insane. He needs my attention all the time. If I am cooking he will turn the gas off. He breaks anything he puts his hand on. I don't want to place him anywhere, but I need help immediately. If it is necessary, I will place him.

(8) Patient seems to take delight in acting like a much younger child in a kind of "show offy" way or to gain attention. He has extreme difficulty in getting along with other children and is obviously disliked. Patient is a very nervous child.

(9) Patient daydreams and cannot sleep. He is shy and nervous.

(10) Patient is hard to manage and difficult to get him to do anything.

(11) Patient has a violent temper. He has no fears and will set fire in the basement.

(12) Patient's present problem is that she just doesn't obey anyone. She steals, is selfish, has temper outbursts, acts smart and is not accepted by the group.

(13) Patient is very nervous, gets excited, runs
around the room and talks fast.

(14) Patient is nervous and he will not return home in time for dinner. He does sleep walking and usually comes to mother’s bed mumbling and she sends him back to his own bed. His movements are clumsy and uncoordinated.

(15) Patient is destructive to himself, is interested in light switches and starting motors such as trucks. He is hostile to his siblings, will take their possessions and attacks them. He has to be watched constantly.

(16) Patient is shy in public in contrast to his demanding and getting much attention at home. He is afraid of the dark and afraid to be alone. Patient cries a lot and then two blue veins stand out under his eyes and he is left exhausted. "His crying is so emotional I cannot help giving into him although I know this is wrong."

(17) Patient is restless and nervous. "I suspect that he has been masturbating when he is at home, but I am not sure of this."

The behavior problems which seemed to stand out in the mother’s statements were defects in learning, such as nervousness and restlessness. Among the socially unacceptable acts, temper and disobedience were mentioned most consistently. All the problems mentioned seemed to occur primarily in relation to the mother. However, in all these statements the mother was the informant. The reader will recall that in the preceding chapter
evidence was presented which showed that while most of the children received their handicaps early in life they did not come to the attention of the clinic until they reached school age. Since the type of behavior problems seen is characteristic of such younger children, the conclusion could be reached that these handicapped children had not experienced a sense of security in their earlier periods of development and the problems presented are a carry-over resulting from not having their needs met adequately on a younger level in their primary relationships. Now that the child is expected to step into a wider environment his previous frustration becomes increased. While normal children have difficulty in forming relationships during the latency period, the handicapped child experiences greater difficulty because of the limitations the handicap imposes on him.

The roots of insecurity that result in inadequate social adjustment lie in the prelatency experiences of the child. The child who is insecure in his primary relationships with the parents does not with facility become secure in a group situation. No socialization can be expected until the child has received sufficient gratification in the parental relationships. As the child gains the needed security he will often seek broader contacts.1

The statements further reveal that most of the children showed an exaggerated form of dependency. One mother complained that her child acted like a younger child. Another child refused to dress himself and required most of the mother's attention, and

1 Irene M. Josselyn, Psychosocial Development of Children, Family Service Association of America, New York, 1948, 85.
Dependency is a part of all illnesses. However, family attitudes as well as those of the child will influence his attitude toward being dependent. In many illnesses and especially handicapping conditions, the individual may be required to alter his whole life pattern which is a traumatic experience. When they find that this normal way of life must be given up, the change requires a reduction of this energy in ways socially acceptable and satisfying to the ego needs. The reactions vary. How an individual handles the situation in which he finds himself depends upon the interaction of his biological endowment with the influence of his past training and environment.  

If a child has not had the experience of satisfactory outlets for his energy one could conclude that he would have even greater difficulty meeting his needs.

The following statements of parents indicate that while they focus on the child's behavior their concern is mostly regarding the child's adjustment away from home.

(1) Patient was and is now a behavior problem in that he is disobedient, mischievous, and exceedingly noisy and very difficult to discipline both in school and at home. His constant fighting, kicking and talking make for a poor if any adjustment in school.

(2) Patient does not play well with other children because she is so easily irritated. She does not adapt herself to the wishes and rights of the other children. She is impulsive.

hits and bites the youngsters when they displease her. She tires easily of any game.

(3) The school said patient is acting up. He is all right at home and like all children he just wants his way. The teacher states he will not play with the other children. He is incapable of being controlled.

(4) Father is concerned about patient's nervousness and slowness in school.

(5) Patient truants from school. He is nervous and jumpy during the day.

(6) Patient does not obey in school and truants frequently. He has done a considerable amount of stealing mostly of a petty nature. He does not get along with children, particularly at school.

(7) Patient is withdrawing from friends, has become sullen and sarcastic and makes no effort to make a social adjustment, rather denying a need for one.

(8) Patient wouldn't go back to school because the teacher was cross to him. He vomits and shakes every time another would get him to go to school. He runs away from school.

(9) Patient goes into care and takes things. He plays sexually with boys smaller than himself. He gets bad marks in school and misbehaves so severely that the teachers cannot handle him.

(10) Patient is not interested in school and she
The statements in which the mothers were concerned about the child's behavior in the classroom indicate that the concern seemed to be in relation to the child's social adjustment rather than academic achievement. In many of the statements the behavior problem was a carry over from the home situation. Truancy from school and stealing were mentioned by several mothers.

One of the common misdemeanors of childhood which brings the child to the attention of adults is stealing which may occur for various reasons. Delinquent behavior, from a structural point of view, presupposes a weak, absent, or distorted superego. Deviation in sound superego development in the child is frequently seen in the child's need for punishment, or where the parents are delinquent and where no taboo against stealing exists and the child incorporates the standards of the parents. Stealing may also be an expression of hostility toward the parent or society in general.

Truancy, like stealing, is another example of asocial behavior. This is seen in situations where the child finds the environment too threatening whether at school or home.

Truancy may be related to current situations or may be a symptom of emotional disturbances having their origin in the past. Truancy with some children occurs when the child feels unloved and wishes to create guilt in the parents for the way they treat him.

One might conclude that truancy in any form is an escape from an intolerable situation.

The following statements indicate that the mother places

---

4 Ibid.
the handicap as the basis for the child's behavior which is causing concern in the home.

(1) Patient's problem is that he just does not hear well enough to understand. Patient is nervous and mother does not have time to teach him.

(2) Patient has poor coordination. He also has asthma which is brought on when excited. Patient is not able to use either hand excessively although he tends to be ambidextrous.

(3) Patient has asthma which he uses to get his way. Patient is jealous of brother and throws things at him. Mother cannot teach patient. He keeps to himself and is withdrawn from her.

(4) In February patient began having "spells" during which her face would become flushed. One week later patient had a fit and lost consciousness.

(5) Patient has a stomach ache and three hours later she starts to vomit and then alternates with vomiting and losing stools. Patient also has worms connected with diarrhea and vomiting. Patient has been sickly and a problem all her life.

(6) Patient doesn't mind but that is because she doesn't hear. Patient is a nervous child, even before her deafness, apparently because everything has to go exactly her way.

(7) Since patient had a fall at fourteen months of age, he has had temper tantrums, hanging his head and hollering. He cries as though he were in physical pain. "He seems to
be miserable."

(8) Patient's hair began falling out, and gradually lost all of it. Patient is overly sensitive, takes things seriously, gets extremely nervous and jumpy when things do not go her way.

(9) Patient is not capable of learning because he is retarded.

(10) Patient forgets at times and he "becomes blue."
"I wonder if he is normal."

The statements of the mothers who indicated that the handicap was the cause of the behavior problem reveal that the mothers were mostly concerned with the child's inability to conform to his environment. One mother pointed out that the behavior existed before the handicap and that the child used the handicap to get his way. Several of the mothers seemed defensive and overprotective toward the child indicating that if it were not for the handicap, the child would not have a problem. Another placed the behavior problem at the time the injury occurred.

In summary all the statements of the mothers seem to indicate that their children were insecure in their primary relations and because of their frustration were presenting behavior problems in an attempt to conform to their environment.
Twenty-seven of the mothers' statements concerned the child's behavior in the home and primarily in relation to the mother
rather than the father and other siblings. The fact that the
mother was the informant might have some significance in the
statements.

With the ten mothers who placed the problem on the
handicap, only one of the children had an obvious handicap, so
that in this study the type of handicap and its appearance did
not seem to be a significant factor.

With the mothers who were concerned about the child's
behavior in school, they seemed more concerned about the child's
relationship with other children rather than his academic achieve-
ment. Information also indicated that in the majority of cases
the child exhibited a similar pattern in the classroom as was
shown at home.

With the group of mothers who blamed the handicap as
causing the problem, evidence shows that the mothers were de-
fensive and overprotective of the child.
CHAPTER IV

ANALYSIS OF FINDINGS REGARDING
THE MATERNAL ATTITUDES

The purpose of this chapter is to present information which would tend to reveal the mother's attitude during specific periods in the child's development. Since early life experiences in the primary relationships play such an important role in the child's personality development, it does seem that the maternal attitude during this period would need exploration as a means of determining the basis for the child's reactions.

Physical illness or discomfort either alone or more often in a variety of combinations with additional factors such as originally unstable personalities and undesirable parental attitudes may tend to establish exaggerated or add to already existing difficulties in children of varying intelligence or forms of emotional response.

In exploring the maternal attitude three periods of the child's development were selected for consideration. Each period represents a different phase in the child's development and also represents periods in which the relationship with the mother may be altered. However, all the periods are during a

1 Leo Kanner and Sanders E. Lockman, "The Contribution of Physical Illness to the Development of Behavior Disorders in Children," Mental Hygiene, XVII, October, 1933, 605-617.
time in the primary relationships when the mother has more contact with the child and assumes the major responsibility for his care and protection. The data was selected from the Social History card as checked by the examiner.

In presenting the developmental history, information on the delivery was felt essential, because the type of experience the mother had at this time might contribute to her attitude toward the child later. The writer is aware that many factors, such as early life experiences, attitude toward marriage and pregnancy no doubt have great influence on the mother’s attitude. The delivery period was selected as a starting point because in many cases it represented the time that the mother was first aware that she had a handicapped child.

Table VI giving information concerning the delivery shows that there were sixteen normal deliveries and fifteen difficult deliveries. Of the fifteen difficult deliveries, the greatest number were in the congenital and residual handicaps. There were two cases of injury to the patient and three with injury to the mother. However, the table shows that there were seven premature births which might affect the mother’s attitude towards the child and account for some of the child’s later behavior patterns. Premature children require extra care and attention and this factor alone requires closer contact with the mother than is normally required in the case of a normal child.
When maternal attachment is increased or intensified through whatever agency, in the first year of life, there naturally follows a lessened ability to yield to a growing independence of the child. When maternal attachment is intensified by illness during the first year of life, maternal release is hindered and the attitude of the child fixed by the one-year-old relationship.²

This factor would seem to operate in the cases of the congenitally handicapped children born prematurely. However, the table shows that the largest number of premature deliveries occurred in the handicap from injury group of children. It seems valid to conclude that the excessive contact of the mother during the first year of the child's life might tend to hold this mother-infant relationship over to the later periods in the child's growth. This would tend to make the child more dependent and less able to compete with children of his age group, which might account for the injuries in this group of children.

TABLE VI
DEVELOPMENTAL HISTORY

<table>
<thead>
<tr>
<th>Delivery</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>8</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Premature</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Difficult</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Injury to patient</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Injury to mother</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

² David M. Levy, Maternal Overprotection, New York,
Table VII gives information regarding the mother's attitude towards feeding. It is during this period in the child's development that he is completely dependent upon the mother to meet all his needs. The material presented shows the feeding method, information on the weaning period and the time of weaning. An explanation of the feeding method is given so that the data on the table might not be misleading. Most authorities in the field of infant care feel that it is most important that children be breast fed when possible. However, there are various reasons why mothers might not breast feed their children. Excluding health reasons, the mother's attitude toward the child is one of the most significant factors in the method of feeding and the length of time the child is fed.

The length of time a mother allows or keeps her child at the bottle presents a problem that differs from breast feeding time. A nursing mother is much more "tied down" than a mother who feeds artificially. Further, it is easier to make up a twenty-four hour milk formula as a nearly exclusive diet than to add or substitute vegetables, fruit, and cereal mixtures. Indeed it has been shown that prolonged bottle feeding may be a sign of neglect, an easy way out of certain feeding responsibilities.  

So that in considering the maternal attitude and its influence on the length of time a child is fed and the method employed, such facts as social, economic, and physical all play an important role in determining a mother's attitude. It is beyond the scope of this study to attempt to consider all the factors in-

3 Ibid., 58.
fluencing maternal attitudes in relation to length of feeding and method. The data as classified by the examiner is presented as checked on the social history cards by the social worker.

In feeding method the table shows that twelve children were breast fed less than three months, while thirty-one of the children were bottle fed. In order that the figures might not be misleading, the twelve children who were breast fed less than three months may be included in the thirty-one children classified as bottle fed. A broad generalization might be made from the method of feeding by pointing out that the majority of the children were fed entirely by bottle and of these, twelve were bottle fed after three months of breast feeding.

In a recent study done by M. Levy, he concluded that the most significant factor in the study of the time phase of lactation is the mother's attitude to the infant. The studies showed that over-protection tends to prolong while rejection tends to shorten the period.  

Twenty-three of the mothers indicated that weaning was easy. If this is compared with the time of weaning the table shows that twenty-three mothers felt that weaning was easy while nineteen babies were weaned after nine months. While definite conclusion can not be made on the basis of the figures presented, it does seem that the figures show that there might be a rela-

4 Ibid., 59.
tionship between easy weaning and prolonged feeding. Since pro-
longed feeding is one of the first forms of infantilization it
does seem that most of the children were being kept overly de-
pendent.

Inasmuch as the early nursing period is of such great
significance in the establishment of a sense of security
for the child it is not surprising that the weaning period
may be extremely disturbing if the child is not ready to
relinquish this oral gratification. This situation is the
same whether the weaning is from the breast or the bottle.
If the external circumstances or a rigid schedule results
in abrupt or too early weaning the child may react poorly
to the change. A type of gratification has been removed
before the child is ready to go without it.5

However, it does seem that when weaning is prolonged as this
study indicates, it can also establish a dependency relationship
that will affect the child’s adjustment in later life. It does
seen that extremes in either direction in terms of long and short
feeding periods will cause insecurity in the child.

Data concerning walking and talking show that twenty-
four of the children in the study group were walking by eighteen
months. This evidence would seem to indicate that the handicaps
did not prevent the child from progressing in this area at the
same rate as normal children. Also in the majority of cases
there were no problems with speech. However, in the children who
did present speech problems, the children spoke no sentence be-

5 Irene M. Josselyn, *Psychosocial Development of
Children*, Family Service Association of America, New York, 1948, 49.
fore three years of age. The reader will recall that the relationship between the mother and child is different than during the first year of life. Meaning represents a separation from the mother and re-establishing the relationship on a different basis. If the child did not receive adequate gratification in having his dependency needs met on the oral level, the conclusion might be made that he will have difficulty in other areas of development. However, this does not seem to be the picture in the area of walking.

TABLE VII
MATERNAL ATTITUDE REGARDING FEEDING

<table>
<thead>
<tr>
<th>Feeding Method</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Breast fed</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>(less than 3 mo.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 - Breast fed</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>(3 mo. or more)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - Breast fed with suppl. bottle</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>4 - Bottle fed</td>
<td>14</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>5 - Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Meaning

<table>
<thead>
<tr>
<th>Meaning</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Easy</td>
<td>8</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2 - Difficult</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3 - Unknown</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Time of Meaning

<table>
<thead>
<tr>
<th>Time of Meaning</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - By 6 months</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2 - After 6 months</td>
<td>8</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>3 - Unknown</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
In relation to talking twenty-five of the children had no difficulty while nine of the children spoke no sentence before three years of age. Of the nine children with speech difficulties, five showed partial deafness, two were spastic, one had paralysis of muscles and one had a skull fracture and another a hairy and cleft palate.

It does seem in the group of children who had speech retardation the handicap was the significant factor. In the three children where speech stopped after having been established emotional problems seemed to be the significant factor.

Table VIII presents data regarding toilet training. This is a period in which the child is no longer completely dependent upon others and is conscious of himself as a separate person. Evidence shows that in fourteen cases training was begun before nine months while in fifteen of the cases it was not accomplished before three years or more. Eleven of the mothers showed a relaxed attitude toward toilet training while twenty-three mothers' attitudes were classified as either rigid, punitive, or lax.

This is a period of confusion for both mother and child. The parent is now making demands which require self-control on the part of the child. The child soon realizes he can control the parents' attitude by conforming or defiance. It does seem that the attitude of the mother during this period in the child's development will greatly influence his behavior in later
years of development.

TABLE VIII

TOILET TRAINING

<table>
<thead>
<tr>
<th>Time of Training</th>
<th>Handicap</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
<td>Injury</td>
<td>Residual</td>
</tr>
<tr>
<td>1 - Before 9 months</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2 - Accomplished by 1 year</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3 - Accomplished between 1 and 3 years</td>
<td>4</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>4 - Accomplished when 3 years or more</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5 - Incomplete at time of history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maternal Attitude

<table>
<thead>
<tr>
<th></th>
<th>1 - Relaxed</th>
<th>2 - Rigid</th>
<th>3 - Punitive</th>
<th>4 - Lax</th>
<th>5 - Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table IX which presents information regarding the maternal attitude toward discipline shows that all but two of the mothers had problems in this area. In the congenital group all the mothers' attitudes were classified as either inconsistent, permissive, or rigid. The same classifications are seen in the groups of handicaps from injury and handicaps from residual
diseases. With ten of the children discipline was administered by only one parent so that in the majority of the cases both parents participated in disciplining the children. One would expect to find considerable inconsistency where two parents were involved. Evidence in the records such as: Father accuses mother of being inconsistent in handling and disciplining children. Mother interferes with father disciplining children. Mother tries not to punish patient but talk to him, whereas father flies off the handle. Mother cannot control her temper and "blows up at times."

TABLE IX
MATERNAL ATTITUDE TOWARDS DISCIPLINE

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Handicap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
</tr>
<tr>
<td>1 - No problem</td>
<td>7</td>
</tr>
<tr>
<td>2 - Inconsistent</td>
<td>5</td>
</tr>
<tr>
<td>3 - Permissive</td>
<td>3</td>
</tr>
<tr>
<td>4 - Rigid</td>
<td></td>
</tr>
<tr>
<td>5 - Administered by</td>
<td>3</td>
</tr>
<tr>
<td>1 parent</td>
<td></td>
</tr>
<tr>
<td>6 - Unknown</td>
<td></td>
</tr>
</tbody>
</table>

The child who fails to develop control of his behavior is a confused and unhappy child. If he is not helped to find a satisfactory balance between control and satisfaction his behavior becomes random and unpredictable. Wise discipline offers the child guidance toward optimum gratification with minimal expenditure of emotional energy in
However, when parents show that they are incapable of emotional control the child reacts in the same manner.

Table X shows that twenty-two of the mothers' attitudes were classified as protective or defensive. These classifications were checked by the psychiatrist at the time of the psychiatric interview. Evidence in the records shows that some mothers were ashamed of the patient, and others limited social activities. One mother projected the blame for the patient's behavior on to the teacher.

Infantile parents particularly have difficulty with the handicapped child. Because of their immaturity they cannot help identifying with the helpless child and cannot permit themselves to help him to develop and mature. With the masochistic mothers the crippled child acts as just punishment to satisfy their unconscious guilt. Mothers who show compulsiveness disturb the handicapped child by not permitting free play and relaxed movement.7

With the seven mothers whose attitude or reaction was classified as annoyed, these mothers were concerned with the amount of time the handicapped child required. While all children are to a certain extent a drain upon the mother's emotions the handicapped child makes more demands. Mothers sometimes resent them because they feel the other children are being neglected. Besides emotional demands, the handicapped child is an

---

6 Ibid., 89.

intellectual challenge to the mother inasmuch as she must learn new ideas in handling the child.

Evidence shows that with the four mothers whose reactions were classified as indifferent one of the mothers treated the child like a normal child inasmuch as she expected him to do what the other children did. Another mother denied that the child was a problem, did not appear interested in giving information and felt if her child did have a problem he would soon grow out of it.

The twelve mothers whose reactions were classified as concerned, seem to focus on the mannerisms of the child. Most of them were concerned about nervous habits such as extreme restlessness, twitching of the facial muscles and distractability. One mother remarked that her child broke one habit only to learn another.

TABLE X

MATERNAL REACTION TO CHILD'S PROBLEM

<table>
<thead>
<tr>
<th>Handicap</th>
<th>Congenital</th>
<th>Injury</th>
<th>Residual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overanxious</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Concerned</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Accepting</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Annoyed</td>
<td>10</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Protective and Defensive</td>
<td>10</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Indifferent</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Perplexed</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undetermined</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
With the mothers whose reactions were classified as over-anxious there was a tendency to make demands on the child that he could not meet and to expect accomplishment beyond his capacity.

Table XI shows that eighteen mothers were classified as rigid in helping a child conform to his environment. Data show that this type of mother was inflexible in handling the child and at times used punitive measures. There was a tendency to insist that the child conform to her demands and when the child rebelled, it was handled by beatings and restrictions beyond those normally applied.

The sixteen permissive mothers had a tendency to be submissive and readily give in to the unreasonable demands of the child. They seemed unable to exert any type of control over the child.

With the three mothers who were classified as having adequate attitudes, even though their children were presenting behavior problems, two of the mothers stated that they were aware they were handling the child wrong and all of them included themselves in the problem. Of the three mothers with adequate attitudes, the two mothers who had children with congenital handicaps had been referred to the clinic by a medical agency where they were receiving help. The one mother whose child had a handicap resulting from disease recognized the child was using the handicap to control her and she voluntarily brought
the child to the clinic for help in this area. All the mothers with adequate attitudes seemed to recognize self-involvement in the child's problem.

**TABLE XI**

MATERNAL REACTION IN HELPING CHILD CONFORM TO HIS ENVIRONMENT

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Handicap</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Congenital</td>
<td>Injury</td>
<td>Residual</td>
<td></td>
</tr>
<tr>
<td>Rigid</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Permissive</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Adequate</td>
<td>2</td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

In summary it does seem that the maternal attitude is the most significant factor in determining the kind of relationship a mother will have with her child, whether he is handicapped or normal. The evidence presented showed that the mother-infant relationship formed the basis for the child's later relationships with his family, school, and community.

Information also showed that while it is agreed that the maternal attitude is significant in the normal development of the child, in some areas the attitude seemed to have more influence than in others.

There was a tendency for the mother to prolong the dependent relationship with the child but in the area of walking
and talking most of the children developed normally. One might conclude then that the maternal attitude may be altered in various stages of the child's development and growth. This does not in any way minimize the importance of the infant-mother relationship but merely points out that the mother's attitude may alter from time to time.
CHAPTER V

SUMMARY AND CONCLUSIONS

This study represented an analysis of thirty-seven cases of physically handicapped children known to the Institute for Juvenile Research from January, 1949 to January, 1951. All the children included in the study were classified as having either a congenital handicap, a residual handicap resulting from a disease or a handicap received from an injury. The specific focus of the study was on the behavior patterns this group of children presented as related to the maternal attitude. Only children who were classified in the normal intelligence range were selected.

The data presented showed that more boys than girls were referred to the clinic. While most of the children received their handicap early in life, they did not come to the attention of the clinic until they reached school age. Mothers were responsible for the greatest number of referrals with medical agencies second for the next highest number of referrals.

The problems the children presented as checked by the parents were analyzed. Among the "socially unacceptable" acts temper and disobedience stood out. In "defects in learning,"
nervousness, restlessness, excitability, and failure to adjust were checked most frequently, and in "somatic dysfunction" enuresis and feeding problems occurred most often.

The statements of the mothers were analyzed in an effort to determine if the problem was placed on the child or the handicap. The majority of mothers placed the problem in behavior on the child and indicated it was in relation to the mother and in the home rather than the school or larger community.

The mother's attitude was studied in relation to selected periods in the child's development and growth. Evidence shows that there was a tendency for the mothers to be over-indulgent as indicated by prolonged feeding. Over-protective or defensive attitude was detected in most of the mothers. In relation to helping the child conform to his environment the mothers' attitudes were largely classified into two groups, the rigid or permissive.

On the basis of the data presented the following conclusions seem justified:

(1) Since the majority of the children were an only child, parents are reluctant to have other children when the first child is handicapped.

(2) Although most of the children received their handicap early in life, the parents did not become too concerned about the child's behavior until they came in contact with other children.
(3) The basis for the child's behavior seemed to stem from difficulties in the primary relationships. The handicap may have intensified the already existing difficulty.

(4) There was no evidence in this study to show that the type and location of the handicap was an important factor in determining the maternal attitude.

(5) In the families where there were other siblings, the problem still seemed to be in relationship with the mother.

(6) The behavior patterns the children presented seemed to be those of children who were emotionally insecure and who were attempting to handle their frustrations in socially unacceptable ways.
<table>
<thead>
<tr>
<th>Case Number</th>
<th>Date Examination</th>
</tr>
</thead>
</table>

**I. Age at first examination**

**II. Sex and Race (one)**

- 1. White-Male
- 2. White-Female
- 3. Negro-Male
- 4. Negro-Female
- 5. Other (specify)

**III. Home Situation and Siblings (one)**

- 5. Ordinal Position (continued)
  - 5. Only boy with sister
  - 6. Only girl with brother

**5. Ordinal Position**

- 1. Oldest
- 2. Youngest
- 3. Middle with brothers and sisters
- 4. Middle with siblings same sex

**III. Home Situation and Siblings (cont.)**

- 2. Independent

**7. Religion**

- 1. Protestant
- 2. Catholic
- 3. Jewish
- 4. Other (specify)

**8. Grade Placement**

- 00. Not in school
- Insert grade (01 through 12)

**IV. Responsibility for Application**

- 1. Court
- 2. Social Agency
- 3. Parent
- 4. School
- 5. Medical
- 6. Other (specify)
V-Developmental History of Patient

1 - Normal
2 - Premature
3 - Difficult
4 - Injury to patient
5 - Injury to mother

Post-Natal

Feeding (one or two)
1 - Breast fed less than 3 months
2 - Breast fed 3 months or more
3 - Breast fed with supp. bottle
4 - Bottle fed
5 - Unknown

Weaning (one)
1 - Easy
2 - Difficult
3 - Unknown

Time of Weaning (one)
1 - By nine months
2 - After nine months
3 - Unknown

V-Developmental History (continued)

Walking (one)
1 - By eighteen months
2 - After eighteen months
3 - Unknown

Speech (one or more)
1 - No difficulties
2 - No sentence before 3 years
3 - Speech stopped after es tablisment
4 - Difficulties such as stammering early speech

Toilet Training
1 - Begun before 9 months
2 - Accomplished by one year
3 - between 1 and 3 years
4 - when 3 years or more
5 - Incomplete—time of history
6 - Unknown

Mother’s Attitude Toward Toilet Training
1 - Relaxed
2 - Rigid
3 - Punitive
4 - Lax
5 - Unknown
V-Developmental History (continued)

Mother's Attitude Toward Discipline
1 - No problem 2 - Inconsistent
3 - Permissive 4 - Rigid
5 - Administration mainly by 1 parent
6 - Unknown

Health
1 - Congenital handicaps
2 - Residual handicaps from disease
3 - Handicaps from injuries
4 - Age at onset

VI-Behavior Problems Prompting Referral

Socially Unacceptable Acts (none, 1)
1 - Temper 2 - Stealing (solitary)
3 - Stealing (group) 4 - Truancy (home)
5 - Truancy (school) 6 - Sex misbehavior
7 - Disobedience 8 - Other (specify)

VI-(Continued)

Defects in Learning (none, 1 or more)
1 - Fails to adjust 2 - Withdrown
3 - Excitable 4 - Depressed
5 - Nervous, Restless
6 - Shy
7 - Chronically anxious or fearful
8 - Reluctance or fear of school
9 - Overly conforming, submissive
10 - Other (specify)

Somatic Dismuction (none, one or more)
1 - Enuresis 2 - Speech defect (stuttering)
3 - Speech defect (other)
4 - Tics
5 - Allergic condition
6 - Glandular symptoms
7 - Neurological (convulsions, spastics)
8 - Feeding problems
9 - Other (specify)
VI-Behavior Problems Prompting Referral (Continued)

Giving Help in Conforming to Environment

1 - Rigid, inflexible, punitive
2 - Permissive, indulgent
3 - Ambivalent, inconsistent
4 - Satisfactory, adequate
5 - Unknown

VII-Maternal Reaction to Child's Problem (one or more)

1 - Over anxious  2 - Concerned
3 - Accepting  4 - Annoyed
5 - Protective or defensive
6 - Indifferent, detached
7 - Perplexed
8 - Other (specify) __________
9 - Undetermined or unknown

VIII-Problems Arousing Anxiety in Parents

1 - The problems of the children
   which the parents verbalized as
   the ones causing the anxiety
BIBLIOGRAPHY

A. BOOKS


B. ARTICLES


