McGill University

THE FATHER'S ROLE IN A CHILD GUIDANCE CLINIC

A Study of Twenty Cases Where the Father Was Seen and Which Were Active at the Mental Hygiene Institute in 1950

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by

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PREFACE

I wish to express my thanks to the staff of the Mental Hygiene Institute for their interest and help in gathering the information for this study. I am indebted to Miss Barbara Judkins, of the McGill School of Social Work, who suggested the subject to me.

I would like to express my appreciation to Miss Eva R. Younge, Director of Research of the School of Social Work, for her painstaking help in the initial and final stages of the preparation of the manuscript. To Dr. John J. O. Moore, Director of the School of Social Work, and to Mrs. Lucille Irvine, my thesis advisor, go my sincerest thanks for their interest and constructive criticism during the writing of the manuscript.

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Chapter One

INTRODUCTION

The parents play different roles in relation to the child. It is important for the child to experience a relationship with a parent of each sex if his psychosexual development is to be normal. The lack of a healthy relationship with a father figure for the little boy may result in a development of homosexual tendencies because of the lack of opportunity for male identification. For the little girl, the lack of a father figure is most serious at the age when she should normally be experiencing the Oedipal conflict. The lack of an opportunity to experience and resolve the Oedipal conflict may colour the little girls' relationship with men for the rest of her life.

Thus, the role of the father in the child's early life is an extremely important one. However, to-day the father spends less time with his children than he used to. With the increasing urbanization of family life, the father is forced to spend the major part of the day away from home earning a living, leaving the responsibility for managing the home and the children to the mother. This is especially true in North America[1], as pointed out by Dr. Gerald Pearson: "there is a

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[1]This refers to Canada and the U.S.A. There are exceptions of course; these generalizations serve to point out trends rather than to state universal facts.

tendency in American culture for the mother to take over more and more of the child's management, even of those parts which are obviously the father's prerogative. This tendency is undermining the father's position in the home to the detriment of the psychological development of the child."[1]

Caseworkers have played into this pattern in the past by focusing their treatment on the mother, regarding her as the one whose responsibility it was to deal with all the problems within the family. At the present time, however, there is an attempt to reinterpret the role of the father. In marriage counselling agencies and in some family service agencies, notably those of the Jewish Board of Guardians in New York, the father is required by the agency to participate in the treatment. With the increasing emphasis on working with the father in mind, the idea for this study was formulated.

The writer became interested in this problem while doing second year field work at the Mental Hygiene Institute.[2] Before undertaking the study, the writer had the impression that the fathers of the children who were being treated at the M.H.I. were not very much interested in the child's experience at the clinic, and that they preferred to leave the responsibility for seeing the child through the treatment experience

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[1]Gerald H.J. Pearson, Emotional Disorders of Children - A Case Book of Child Psychiatry (New York, 1949), p.303

[2]Referred to as M.H.I. in subsequent references

to the mother. The fact that the father's working hours coincided with the clinic's office hours was a real obstacle, but the writer's impression was that it was also a good excuse for the father to hide his unwillingness to be drawn into an area which the American culture pattern decrees to be "for women only."

The ideal North American father is strong and virile. His problems are those which lie in the highly competitive new world economy where the weak must fall by the wayside. By comparison, the mother's task is an easy one. She is spared the obvious and direct competition which the father meets on the job every day; yet it affects her in more subtle ways. She must keep up with the Jones' in economic and social status; her home must be as nice as theirs; her children must be as bright, well-behaved, and attractive as theirs. The ideal American mother is a warm, virtuous person who is not nearly as aggressive and forceful as her spouse. Her influence in the home is conceived as one of inspiring strength and confidence in her husband and children.[1] The father may administer the discipline to the children and take an interest in their achievements, but a more active role would mean a loss of masculine status and a betrayal of weakness.

This picture of the ideal roles which parents are supposed to play in our culture has been given by Margaret Mead.

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[1]cf.Margaret Mead, Male and Female (New York,1949)

However, human beings cannot be categorized so easily and, as this study will show, if one takes more than a superficial glance at any group of people living in present day North America many variations in the roles which they do actually play can be found. The caseworker, interested in each individual per se, is more apt to look for the factors which prevent parents from playing the ideal role decreed for them by their culture.

This failure to approximate the ideal parent can be more clearly seen in a child guidance clinic. The parents who bring their children to such a clinic have been confronted with a problem with which they cannot deal and which is serious enough to warrant professional assistance. The existence of this problem and their own inability to do anything about it emphasizes to the parents that they have failed. Since the treatment in a child guidance clinic also focuses on the parent's failure to fulfill this role in his relationship with his child, it is an excellent setting within which to investigate the factors which prevent parents from playing the ideal role.

In scanning the studies done in child guidance clinics, it was noted that most of them were concerned with the mother's relationship to the child. The writer found that there was comparatively little written about the father's relationship to the child, and his role in the treatment situation. It was felt that further investigation would be desirable and the possibilities for a study of this kind began to be formulated.

The M.H.I.has had difficulty in arranging contacts with

the father. The agency did not have evening office hours and therefore it was difficult to arrange appointment times. However, despite this, some fathers did come to the M.H.I., frequently taking time off work to do so.

Looking at the current caseload of the M.H.I.[1], it was found that of the 1,088 cases seen in 1950 there were only 32 cases where the father was seen in that year. Taking into account the fact that about half the cases constitute routine mental health examinations which the M.H.I. does for other welfare agencies, with the referring agency having the contact with the parents of the child, the percentage of fathers seen in the remaining cases is still very small. Why then, were some fathers able to come to the clinic whereas the great majority could not? Were the fathers unwilling to come or was the clinic reluctant to include them? Did the fathers who participated in the treatment do so on their own initiative or at the M.H.I.'s insistence? In view of the fact that there is an attempt at present on the part of caseworkers to bring the father more intimately into the family picture,[2] further investigation of the above questions seem pertinent at this time.

The problem has been approached from the casework point of view. In a child guidance clinic the parents are usually

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[1]Mental Hygiene Institute Annual Meeting, Report of Mental Hygiene Activities, 1950 (Montreal, May 4, 1951)

[2]Dr. H. Gomberg, Director of the Family Service Division, Jewish Board of Guardians, pointed this out in his address in Montreal, Dec. 1950

treated by the caseworker, and the focus of treatment is the parent-child relationship[1]. The parent's attitudes and behaviour towards the child are worked through and the worker helps the parent understand the motivation of his behaviour in order to help him change it. Since he is only one part of the parent-child relationship, there must be close co-operation between the caseworker and the psychiatrist who in the meantime is treating the child, the other partner in the relationship. At the M.H.I. the psychiatrist and the caseworker work in close co-operation and the psychiatrist frequently sees the parent at various intervals during the course of treatment with the child. However he does not treat the parent; his contacts complement those of the worker. This is also true when the father is the parent who comes to the clinic. The psychiatrist may see the father, but it is the worker who treats him, except in rare cases where the father needs psychiatric help more than the child does. In order to have a fuller understanding of the father's role at the clinic[2], this study will include his contacts with the psychiatrist as well as those he has with the caseworker.

The following are the questions with which the writer approached the study:

How was the father brought into the treatment

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[1]See J. Franklin Robinson, "Current Trends in Child Guidance Clinics," Mental Hygiene, Vol.XXXIV no.I (Jan. 1950) pp.106-116

[2]This refers specifically to the M.H.I. throughout the study

situation? How did he respond to the suggestion that he come to the M.H.I.? What was the father's attitude to the child's difficulties? What services were offered by the M.H.I.? How did he respond to the service offered? Did services to the father effect any change to the child's behaviour or in the father-patient relationship? Would a more intensive contact with the father have been desirable? If so, why was it not given?

The research was divided into two parts. The first deals with what actually took place at the clinic and this information was obtained from the records, for the most part. The second part is based mostly on the workers' opinions. It deals with the effect of the services on the father as well as on the child and his problem. The desirability of a more intensive service to these fathers and the various problems which this entails are also discussed in this section.

The writer is attempting to present a picture of the experience of one child guidance clinic in working with fathers. It is hoped that a description of the experience of one agency in this relatively new field will be of value to other agencies offering casework service to the father.

As has been previously mentioned, the cases under

discussion have all been taken from the M.H.I. in Montreal. The data for the study were obtained from the case records and from interviews with the workers on the cases. The evaluation or opinions stated in this study concerning the services at the M.H.I. have been made by staff members. In accordance with the premise stated by David Morrison[1] that "only those who know" are qualified to assess or give an opinion, and that people who do know are professionally trained personnel, it was decided that the professionally trained caseworkers would be best qualified to give an opinion. Therefore, all evaluations of the services given at the M.H.I. came from the workers on the cases. Their opinions were obtained from the records and from personal interviews with the writer.

The necessity for personal interviews with the workers, and the fact that two of the three caseworkers at the M.H.I. had been on the staff a short time, limited the choice of the sample to the two years immediately preceding the study. The current year 1950 was chosen as the sample period because these records were easily available. The study is limited to those cases where the child was under treatment in 1950 and in which the father was seen at the clinic. The interviews with the father may have occurred before 1950, but if the case was still under treatment in that year it was included in the study.

The first problem in compiling the records was to find

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[1]David Morrison, "Scientific Methods for use in the Investigation of Flight Crew Requirements," Flight Safety Foundation (Woods'Hole,Mass., Nov.1948) p.vii

out in which of the cases, active in 1950, the fathers had been interviewed at the clinic at some time. Since all the cases at the M.H.I. are seen in Social Service, unless the case is being carried concurrently by another casework agency, the workers were asked to prepare a list of their own cases in which they had seen the father.

In order to check that all possible cases were included, the secretary of the M.H.I. was contacted and the appointment book was checked for all appointments made with fathers in 1950. A total of 32 cases was found and these comprised the original sample.

After more detailed study it was found that in cases where the father was only seen once it was usually in order that the psychiatrist could get an impression of him, and not in an effort to draw him into the treatment. After due consideration it was decided to omit those cases in which there had been only one interview with the father. These were more in the nature of consultation visits and the father could really not be said to have played a role in the treatment. The revised sample on which this study is based, therefore, consists of 20 cases which were active at the M.H.I. in 1950, and in which the father was interviewed at least twice by either the social worker or the psychiatrist.

There were several cases which were considered "open" by the clinic, yet there had been no interview with members of the family in 1950; the contacts had been carried on by telephone. These cases were not included.

Since the sample group is such a small one, none of the findings can be considered statistically valid. The writer feels that the method most suitable to a study of this kind is to state a factor or situation common to a certain number of cases and then illustrate it by excerpts from a typical case. This descriptive method of presentation is used to give the reader a picture of the dynamics operating in the various cases. It also shows some of the difficulties the workers have to contend with in attempting to give casework service to the father.

There is one general limitation of this study related to the fact that the records, from which the information has been extracted, were not written with a view to supplying data for research purposes. They do not always contain the material which was sought. Wherever possible an attempt has been made to supplement the material by discussions with the workers on the cases. In these instances the worker's memory had to be relied upon, and although it did help to fill some gaps in the records, it may not always be as reliable as the written information obtained from the records. All the information from the records and from the workers was recorded on document schedules[1] and the cases were analyzed from them according to the questions previously stated on pages 6 and 7.

In order to insure psychiatric service to those who are unable to pay for private treatment, the M.H.I. charges a nominal fee which is graded according to the family's income.

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[1]See Appendix pp. 102-103

There is a maximum income of $70. per week for a family of five persons, beyond which families are not eligible for M.H.I. services. If the family income is lower than the minimum for which a fee is charged, the family is still eligible for the service at no fee. Thus, the families composing the sample came from the middle and lower socio-economic group. This is the section of the community served by the M.H.I.

The group of child clients was predominantly male. There were 17 boys and only 3 girls in the sample group. Half the children were referred either because of retarded development or because of difficulty in school achievement and behaviour. The other half of the sample group was referred either because of personality disturbances shown in exaggerated fears, poor interpersonal relationships, and nervous habits, or because they were behaviour problems at home and in the community.

Seventeen of the 20 children were referred by outside individuals or agencies. In only three cases, all boys, were the children referred by their parents. The referral sources for the 17 children were as follows; eight were referred by the Protestant School Attendance Department or one of its personnel, six by a hospital or upon the suggestion of a physician, and three by the Family Welfare Association. The referral sources for the three remaining children were as follows; two were referred by their mothers and one was referred by the father. Thus, most of the patients were referred by sources outside their own family.

The writer believes that in order to view the father's role in a child guidance clinic in some perspective, it is necessary to understand the father's role in the family to-day and the function and setting of a child guidance clinic. These two points will, therefore, be discussed in some detail before an analysis of the case material is made. In order to familiarize the reader with some of the problems which various types of agencies have encountered in working with fathers, the experience of caseworkers in these agencies will also be cited here.

The question of the father's coming to the M.H.I. and the factors which influenced him to come will then be discussed and a description given of the type of service the father received at the M.H.I. and his response to it. The last factor is extremely important in planning the possibility of greater participation by the father in the agency's treatment plan. The final aspect of the study will be a discussion of the effect of services to the father on the child's behaviour and on the father-patient relationship. This subject will be carried a step further, to a discussion of the feasibility of more intensive service to the father and the obstacles to carrying it out. The conclusion of the study will give a summary of the findings and it will point to trends or conclusions which might be drawn as a result of the findings.

Chapter Two

THE CLINIC SETTING AND THE FATHER'S ROLE IN IT

This study takes place within the setting of a child guidance clinic. It is important to understand the structure and function of such a clinic before going into detail about the service it offers, i.e., we must clarify what the clinic is set up to do before launching into a discussion of what it does and/or what it should do. Another problem of a general rather than a specific nature which must be discussed here, is the changing status of women and its effect on the role which the father plays in the family. This will help the reader to view the study in proper perspective. The writer feels too, that more specific mention should be made of the experience which various agencies have had in working with fathers. This will form a basis for comparison, and will present some of the thinking prevalent in the profession on the subject of including the father in treatment.

"The child guidance clinic is an attempt to marshall the resources of community on behalf of children who are in distress because of unsatisfied inner needs, or who are seriously at outs with their environment[1]." Its service is

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[1]George S. Stevenson and Geddes Smith, Child Guidance Clinics: a quarter century of development (New York,1934), p. 1

rendered through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist and a social worker. Although diagnosis and treatment of the child is one of the functions of the child guidance clinic, it also attempts to educate citizens and other agencies in the community regarding the unmet needs of many children. In this way it attempts to prevent behaviour and personality disorders. It was because of this attempt at prevention that parents were drawn into the clinic picture, and the necessity for working with them as well as with the distressed child was realized.

"In early clinical efforts the child was seen as the victim of conditions and not as a participant in them. The early chief aims of the clinics were, adequate and correct diagnosis, and manipulation of the environment in terms of the needs of the child[1]." There is common agreement to-day that basic to clinic practice is the recognition that both child and parent have played a part in the creation of the problem and that they should both share in resolving it. This mutual responsibility of parent and child is discussed by Franklin Robinson in his article on Current Trends in Child Guidance Clinics. He states that, the child-parent constellation is regarded as a unit in which the personality difficulty of each individual contributes proportionately to the rela-

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[1] Robinson, op.cit. Vol.XXXIV, No. I, p. 109

tionship difficulty out of which symptomatic behaviour arises[1]. Thus the idea grew that parents were also considered to need treatment, rather than mere advice in resolving difficulties with their children.

Since it had been the practice for the caseworker to see the parent while the psychiatrist saw the child, this change in the approach to the parent meant that the caseworker's function became redefined. She had to work in close co-operation with the psychiatrist throughout the treatment process. There was more interdependency between them and the approach to the problems of behaviour gradually became the collaborative approach of the clinic team as we know it to-day. "The work with the parent revolves around his relationship to the child and it approaches the parent's basic personality organization[2]." Instead of concentrating on the child's needs exclusively and offering the parent advice on how best to fill them, the child guidance clinics began to consider the personality difficulties of the parent which had contributed to the problem.

Charlotte Towle pointed out the wisdom of such an approach as early as 1930; "....where the children are objects of dissatisfaction, treatment which concentrates on pointing out the child's needs and how the parent can fill them,

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[1]Robinson, op.cit. Vol.XXXIV, No. I, p. 110

[2]Ibid. p. 112

increases the irritation[1]."

It is worthy of note that the term "parent" and not "mother" has been used above. Theoretically the importance of both parents in the emotional life of the child is understood by social workers, educators, physicians etc. However the practice has been to deal almost exclusively with the mother as the responsible parent. This is a practice which is not peculiar to child counselling agencies or child guidance clinics. Mildred Osborne[2] points out the same practice of excluding the father in an agency administering Aid to Dependent Children. The agency policies and procedures are built around the assumption that the mother is the head of the household. The Aid to Dependent Children grant is made payable to her, despite the fact that the father may still be in the home; only in rare instances is the grant made payable to the father.

This state of affairs contradicts the attitude, traditional to western civilization, that the father is head of the household. This latter patriarchal attitude, prevalent in Europe since medieval times, cast the woman into a role of complete subordination to the husband. Legally she had no personal rights; she always had to be under the guardianship of a male whose responsibility it was to discharge her debts

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[1]Charlotte Towle, "The Social Worker." Orthopsychiatry, Prospect and Retrospect, 1928-1948, pp. 586-597

[2]Mildred Osborne, "Are Fathers Forgotten?" The Family, (Jan.1942) pp. 295-303

and to educate and support her and her children. Neither did she have any rights of personal property; it became lodged in the husband upon her marriage. For almost 200 years women held the above position even in American domestic law[1], which was evolved from European origins.

> When the 19th century dawned upon the new republic of America, the family was a closely-knit institution - the unit of society as it had been since the beginning of civilization. Both law and public opinion supported the patriarchal family in which the husband and father was the only "person" recognized by law, and all rights over property and the persons of wife and children were lodged in him[2].

Despite the apparent solidity of the patriarchal family in America, the development of a new industrial order coupled with the spread of democratic ideas and the extension of the western frontier where the woman had to be much more self-reliant and consequently on a more nearly equal footing with the man, contributed to the breakdown of this pattern. The growth of the Women's Rights movement in the second half of the 19th century was stimulated to a large extent by these new democratic ideas. The change in public opinion with regard to the rights of women can be illustrated by the changes which were made in the domestic laws of the states; these accorded married women the right to own and manage property by gift or bequest. After the Civil War the higher education of women became more

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[1]See Nathan Miller, "The European Heritage of the American Family," The Annals of the American Academy of Political and Social Science, Vol. 160, (March '32) pp. 1-6

[2]Willystine Goodsell, The American Family in the Nineteenth Century," The Annals of the American Academy of Social Science, Vol. 160, (March, 1932) p. 13

and more common, serving to assist them in attaining greater freedom. At the same time, the husband was spending less time at home with his family, having followed productive activity out of the home into the factory. Thus the education of the children was left entirely to the mother and the school, since the father did not have the leisure to devote to it.

As the woman has gained freedom, her husband's activities have become more restricted. Whereas the responsibility for wife and children as well as earning a living, going to university and voting for his government, had previously been the man's exclusive rights and responsibilities, all of these functions are now being shared with women. Although the man's activities are more restricted they are more exacting: where the criteria for success are money and power, where each man is free to enter the competitive race, the task of earning a livlihood consumes all one's energy. Thus the children and their upbringing assume secondary importance as demands on the father's time; the rewards in terms of social prestige that come with success in the economic sphere are considered of greater concern to him than community recognition for "raising a fine family." Since the father's energies have of necessity been so occupied in the economic sphere, the mother has become the responsible parent. The raising of the children has been delegated to a great extent to outside institutions such as nurseries, schools, youth groups. This situation is not a static one but an inevitable result of the social changes of the last century and a half.

As Margaret Mead says, "we are passing through a period of discrepancies in sex roles which are so conspicuous that efforts to disguise the price that both sexes pay are increasingly unsuccessful[1]."

Thus we see that at the present time the notion does prevail to a great extent, at least in our large urban areas, that the mother is the head of the family in all but the economic sphere. Precisely because this situation is not a static one, one can already see the elements of change in this definition of the father's role in the American family. Home and School Associations have already started to invite fathers as well as mothers to their meetings; the Protestant Foster Home Centre in Montreal has changed its Foster-Mothers' Parties to Foster Parents' Parties and the Children's and Youth Services agencies of the Jewish Board of Guardians in New York, where child counselling is done, sees the father as well as the mother in every case as a matter of routine[2].

Psychiatrists and caseworkers have tended to fall in with the cultural pattern of large American cities which designated the children as the mother's concern, rather than to adhere to psychoanalytic theory which emphasized the important role played by both parents in the child's life. However,

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[1]Mead, op. cit. p. 300

[2]See Saul Hofstein, "Interrelated Processes in Parent-Child Counselling" J.S.S.C. Vol. XXVI No. 2 (Dec.1949), pp. 286-299

there seems to be a growing awareness in child guidance and child counselling centers, of the necessity of working with fathers as well and the importance of redefining the father's role to include a greater share of the responsibility of child-rearing. When this was first suggested in the early 1930s by people like Charlotte Towle[1] it met with almost no response in the various clinics. Public opinion still thought of the children as "mother's department." Meanwhile one finds an increasing number of articles written in the nineteen forties (1940s) concerning the father and the necessity for including him in the casework process.

Anna Freud's work in residential nurseries during World War II helped further to focus on the father's role in the child's emotional development. In a setting such as the residential nursery, some of the mother's functions are taken over by mother-substitutes. But there is no one to take over the functions of the father and this remains a serious gap in the nursery programme. Miss Freud describes the importance of the father-child relationship and at the same time she clarifies the father's role in relation to his children in the modern family.

> The infant's emotional relationship to its father begins later in life than to its mother, but certainly from the second year onward it is an integral part of its emotional life, and a necessary ingredient in the complex forces which work toward the formation of its character and personality....the earliest emotions directed towards the father are bound up with feelings of admiration for his superior strength and power. The father in his turn becomes the giver of material advantages and is gradually recognized as power behind the mother, round whom normal family life is

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[1]Towle, op.cit. pp 586 - 597

> centered. It is the father's role even more than the mother's to impersonate for the growing infant the restrictive demands inherent in every civilized society[1].

In America, World War II also proved to be a powerful stimulus in focusing the attention of workers on the role that the father plays in the home. The increasing incidence of children raised while the father was at the front brought into sharp relief his unique influence and the need for it in every family. Jane M. Johnson[2] of the Hartley Salmon Clinic in Connecticut has attempted to analyze the relation of the father's absence from the home to a child's maladjusted behaviour. This study was undertaken "because there seemed to be an increasing number of children without fathers referred during the war years[3]." It was found that there seemed to be more girls than boys with conduct disorders; the boys' deep resentment was expressed in a passive type of behaviour rather than in overt aggression. It is interesting that Miss Johnson found that boys whose fathers were out of the home because of divorce or separation, had the same types of reactive behaviour as the boys living with rejecting fathers. It seems probable then, that

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[1] Anna Freud and Dorthy Burlingham, Infants Without Families (New York '44) p. 103

[2] Jane Meredith Johnson, "The Absent Father" Smith College Studies in Social Work, Vol. XVIII, No.2 (Dec.1947) p. 128

[3] Ibid.

the increasing incidence of divorce in the United States has also contributed to this renewal of interest in the role of the father. An additional stimulus to this interest in the father's role in the family was also provided by World War II, when so many children had to be raised without fathers in the home.

During the forties most social agencies and child guidance clinics were unaware of the need for any set policy with respect to fathers. It very often happened that the agency's interest was drawn to them by sheer accident. A typical example of this is described by Mildred Burgum of the Jewish Board of Guardians[1]. She found that even though the clinic did not have a contact with the father, the work that was done with mother and child had a telling effect on him. She found that in cases where there was a profound antagonism between mother and child, where the child is beyond the mother's control and the father has taken on the role of the child's protector, the father gets worse as the mother gets better. In cases like these the mothers are usually aggressive women, according to Miss Burgum, who dominate the family: they are greatly conflicted about their femininity which they associate with submission. They either overtly or secretly strive for masculine roles. The fathers are dependent, immature, inadequate. They are rarely good providers and they usually allow employers to

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[1]Mildred Burgum, "The Father Gets Worse; A Child Guidance Problem" American Journal of Orthopsychiatry, Vol.XII (July,1942) pp. 474-485

take advantage of them. The father's predominant dependent needs place him in the relationship of a sibling to his own child; he and the child both strive for dependent gratifications from the mother. In these cases, where the mother-child relationship is extremely poor, the father is in the position of the favoured sibling. But his hostility to the child is not great so long as he feels sure of the mother's love. An improved mother-child relationship disturbs the father because the child then becomes the favoured sibling. In the course of treatment the mother elaborates her dissatisfactions with the father and turns against him the aggressions formerly channelized in her relationship with the child. The greater security which the child gains in its relationship with the mother or worker stimulates his dissatisfactions with the father and it makes him aware of how inadequate is his father's protection. The father thus loses the role of the good parent with resulting discord in the home. This example illustrates the truth of Charlotte Towle's statement[1] that treatment cannot be given to any member of the family without affecting the group.

Because they have frequently encountered situations similar to that described by Mildred Burgum, the agencies of the Jewish Board of Guardians and the Jewish Family Service of New York feel that there must be some resolution of the adult problems in the family before the parents can help the child in the treatment situation or in life. In these agencies, therefore,

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[1]Towle, op.cit. p. 596

the treatment does not start with the child and later include the parents. Rather, it starts with the parents and when they are ready to deal with their relationship to the child, he is included in the treatment process.

> In the development of the child, the nature of the marital relationship of the parents is of enormous importance. It will make all the difference to the child's sense of security whether.....the marital relationship is used for mutual feeding of neurotic needs which, calm though the surface may seem for a long time, always carry the potential danger of an explosion of the conflicted feelings lingering in the unconscious. Participation in contact will mean for the parents an examination of their feelings and attitudes as parents and, more often than not, it also will involve an examination of their relationship as husband and wife[1].

These agencies actually offer a marital counselling service as a prelude to the parent-child counselling service. A more detailed discussion of their treatment process will be included at a later point in this chapter.

At about this time, late 1930's and early 1940's, psychiatrists began to postulate about the 'type' of father who brought his children to a child guidance clinic[2]. One psychiatrist said he believed that it is the passive, submissive man carrying out the mother role in his general behaviour who brings his child to clinic; another thought that the assured, dominant, masculine, well-integrated man is the kind of person who tries

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[1]Elsa Lichter, "Participation in Treatment by both Parents," Diagnosis and Process in Family Counselling, New York, 1951 p. 69

[2]Lillian Beron, "Fathers as Clients of a Child Guidance Clinic" Smith College Studies, Vol. XIV No. 4 (June,1944) pp. 351-366

to find help for his child; another thought that paternalistic fathers compose the majority of applicants.

In Lillian Beron's study of Fathers as Clients of a Child Guidance Clinic she found that it was the passive, submissive man struggling against his passivity who predominated. She found that the use the fathers made of the clinic varied with their personal adjustment. All the well-adjusted fathers came of their own accord, showed decisiveness, and were able to participate in treatment and use the clinic constructively. All of them assumed responsibility when their wives appeared unable to do so. The fairly well-adjusted group wanted their wives seen and punished, or else they looked to the clinic to give them support in the marital struggle. The poorly adjusted fathers blamed their wives or an outside authority in excess, and had no interest in using the clinic other than as a place where they could turn their children over to be the agency's responsibility.

There has been insufficient research on the subject to allow for the classification of a 'type' of father who brings his child to a child guidance clinic. However, concerning the problem of the use which the fathers made of the clinic, it seems highly probable that Miss Beron's statements have some validity. It appears logical that a well adjusted person should be able to accept the clinic's services without feeling threatened and that his greater ego strength should enable him to make constructive use of the help. The clinic's service in dealing with such fathers does not aim at changes in their personalities or in their established patterns of life. It offers a service which

is more in the nature of counselling rather than therapy. This type of service seems to be suited to a child guidance clinic setting, since the clinic is child-centered and therefore its resources for therapy with parents are limited. From the few studies which have been done on the effect of service to parents in child guidance clinics, it would appear that the clinic is more successful with those parents who can use a counselling type of service, than with those who require therapy. This means that parents who are so seriously disturbed that they cannot accept this type of service, can probably not be helped to ameliorate the parent-child relationship. In some instances the clinic may attempt to offer a therapeutic service when counselling fails, but experience points to the fact that this is rarely successful.

It is important for an agency to be aware of the areas of service in which it is most successful. This is especially true in contacts with fathers. They very often have to take time off work to keep their appointments and unless they feel, after every interview, that they are being helped they will not consider it worth while to return. They haven't the time for experimentation. Therefore if the clinic wants to bring them into the treatment situation it must have a definite purpose in doing so, as well as a definite service to offer.

The parent-child counselling centers of the Jewish Board of Guardians have evolved a definite policy with regard to the role which the father should play in treatment. Its inclusion of the father is not done haphazardly, nor does it depend on the father to take the initiative in demanding to be included: its

service makes definite provision for a point in the treatment process at which the father is asked by the clinic to come in. Saul Hofstein[1] has described the interrelated processes in working with the child and his parents and it is of interest to mention them here briefly. This illustrates a method of integrating the father to form a valuable part of the treatment process.

The application period is the beginning phase of treatment; it is during this time, which may consist of 4 or 5 interviews, that the father is seen. The purpose of this is to discover his role in the difficulty, or perhaps to offer him help if he wants it. During this period there is an air of tentativeness for all the participants, since they are free to decide whether or not they want to embark on the treatment process until the end of the application period.

> There is a tendency in this phase for the mother to maintain control of the father's contacts which she has initiated. She is threatened by the worker getting into a close relationship with her husband; only as she finds reassurance in her own experience at the clinic where the continuing focus is, that the area of concern with her husband will be the same as with her. As the father, through his own interview and what the mother has been bringing him from hers, can develop confidence in the counselling process, he can free his wife and child to involve themselves and begin to face what is his part in the problem[2].

Mr. Hofstein points out that it is essential for the worker to give the father a sense of carrying real responsibility for the decision as to whether he and his family will continue at the clinic. This includes him as a responsible part of the

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[1]Hofstein, op.cit. pp. 286-299

[2]Hofstein, op.cit. Vol. XXIV p. 292

treatment process from the start and implies that he too has contributed to the difficulty which the clinic wishes to help him solve. There is a joint interview at the end of the application period in which all three members participate. The decision to go on is made here and the experiences of the various family members are momentarily brought together.

> The middle period is of fairly intense concentration by mother, father and child, with each concerned with his own contribution to the relationship problem. While there is concentration on the individual aspects at the office, the processes all come together at home where the family works together on using their new understanding and freer use of themselves in changing the total situation. During this period the content often includes a consideration by the parents of their own earlier relationship with their parents. The father moves more slowly during this period but tends to accelerate during the middle of it. After the father has been through this phase, he feels that he can trust the agency and is more willing to let the mother and child carry the major part of the agency experience. There is another joint interview ending this middle period[1].

From this account one can see that the major part of the treatment is focused on the mother and child. However, the father is brought in for a shorter intense period in order that the clinic may help him with his share in the difficulty and help him change as his wife and child change during treatment. The fact that the father has not as much free time during the day as the mother has, also makes this agency's solution a practical one, since it requires less frequent interviews with him than with the mother. The workers at this agency feel that the child attaches considerable significance to the fact that

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[1] Ibid. p. 294

the father, as well as the mother, is participating.

From the experience, or lack of experience of clinic personnel in working with fathers, one can see that there seems to be a need for a definite policy on the clinic's part with regard to the father. The changes that occur at home in parent-child relationships during treatment sometimes hinder the work done at the clinic. The fact that the father-child and the father-mother relationships can deteriorate as a result of treatment[1] show the necessity for including both parents in attempting to ameliorate the difficulty. Once the father has been included the indications from the clinic experience have been that those, who are well adjusted persons themselves, are able to use the clinic's help constructively; they constitute a real helping power in the work being done with the child[2]. For the less well adjusted father, the clinic's work does not meet with as much success as in the former case. It is therefore of less obvious value in its effect on the child.

The impression one gets from the experience of the various clinics is that better results are achieved with the father when the worker's goals are superficial. If the aim is to ensure the father's co-operation and to help him see his part in the difficulty, there seems to be reasonable hope for success,

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[1]Burgum op. cit. p. 480

[2]Beron op. cit. p. 366

according to the experience of the Jewish Board of Guardians in its counselling centers. However, if the aim is to change his personality and pattern of life, there seems to be little hope of success from the type of treatment which can be given the parent in an agency set up to deal with parent-child relationships[1]. Another factor which impressed the writer was the haphazard attitude which is characteristic of many of the agencies covered in the literature, with respect to the fathers of their patients. Contacts with him are usually left to his own initiative; in relatively few clinics is there any set policy regarding the clinic's role in relation to the father. This situation appears to be due, not so much to a lack of agency time, as to a cultural lag in the sense that clinic practice has not yet developed to the stage at which clinic theory has arrived. The above impressions have resulted from the writer's examination of research monographs and articles written by others. Let us now turn to some of the problems with which this particular study is concerned. Perhaps a closer scrutiny of actual case material will help us to a clearer understanding of the reasons for the difficulties in working with the father.

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[1]Frances Miller and Laura Richards, "Parental Behaviour as an Index to the Probable Outcome of Treatment" Vol. IV No. 2, Smith College Studies in Social Work (Dec.1933) pp. 139-150

Chapter Three

FACTORS MOTIVATING THE FATHER TO COME TO CLINIC

It has been shown[1] that the cases in which the fathers were seen at the M.H.I. in Montreal constitute a very small fraction of the total number of cases seen at this clinic. There is no set policy regarding contacts with fathers: practice varies according to the individual case. It is therefore of interest to know why the fathers in the sample group did come to the clinic. Were they asked to come by the M.H.I. personnel? Did they come on their own initiative and why, or did they come at their wives' insistence? What causal factors can be isolated in these cases which might account for the fact that the father became involved in treatment? This chapter will attempt to describe the various types of situations which bring the father to clinic.

In studying the sample group of 20 cases it was found that there were two types of factors which seemed to account for the father's attendance at the M.H.I. These were the dynamic and/or situational factors operating in each case. For the purposes of this study, situational factors are defined as those factors which are independent of emotional forces composing the father's personality and contributing to his relation-

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[1]Supra, p. 5

ship with the mother and patient. For example, a situational factor is recognized where both parents are working and the father can more easily take time off work than the mother can and he, therefore, is the parent who brings the child to the clinic. Other examples are cases where the mother is in the hospital and the father brings the child to the M.H.I., or where the father is asked by the clinic to come in because the mother is too dull to understand the psychiatrist's recommendations. Dynamic factors, on the other hand, are defined as those forces in the emotional life of the individual which motivate his behaviour. Examples of this are unfulfilled dependency needs, fear of authority, feelings of inadequacy.

In the 20 sample cases, 13 fathers were seen at the clinic due to dynamic factors and seven came as a result of situational factors. It was found that there were no dynamic factors peculiar to the group of fathers who came, on what appeared to be their own initiative, as compared with those who were asked to come by the agency personnel.

If the clinic takes the initiative in asking the father to come in, it must have some definite purpose for doing so. The writer was interested in knowing whether the mother's insistence that the father be seen at the M.H.I. too, had influenced the clinic in asking him to come in. In connection with this possibility it has been noted that Mary Richards[1] suggests as a

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[1]Mary E. Richards, "When to Include the Father in Child Guidance." Smith College Studies, Vol. XIX No. 2 (February,1949) pp. 79-95

result of her study, that one should be wary of including the father when the mother is insisting upon it. The mother's motive may be punitive and hostile; she may be testing that worker and the clinic. Therefore it is important to understand the mother's motive, as well as the effect it might have on her, to include the father in treatment. Similarly, if the father comes to the clinic without being asked, it seems important to understand his motivation in coming so that he can be helped to make the best use of the clinic's resources.

In order to get a clearer picture of what motivated the clinic to ask some fathers to come and what motivated some fathers to come spontaneously, it is necessary to study the sample group more closely. The cases will be divided into two groups. Group I will consist of those cases where the fathers were considered to have come because of dynamic factors. Group II will consist of those who were considered to have come because of situational factors. The following table illustrates the main dynamic factors which brought 13 fathers to the M.H.I.

TABLE I

Dynamic Factors Which Brought 13 Fathers to the Mental Hygiene Institute

Main Reason Why Father Came To The Clinic	Number
TOTAL	13
Father contributed to child's difficulties[a]	6
Came as a support to the mother	3
Lack of co-operation from the mother[a]	2
Father angry at referral to M.H.I.	2

a) In these cases the father was asked to come by the agency personnel

We willfirst consider the eight cases where the father was asked to come by the M.H.I. personnel. In the early clinic contacts the father had not been seen at the clinic and the impressions of him were formulated, in all but one case, from what the mother or the child patient said about him during the interviews. In the one case where this was not so, the case-worker had met the father previously at the Juvenile Court and was able to observe at first hand his extremely punitive attitude to the patient. From what the clinic learned of the situations, it seemed advisable to see the father and to assess the marital situation as well as the clinic's relationship to both parents.

In none of these cases had the mother asked to have the father seen at the clinic. In seven of the eight cases the contact with him was initiated through the mother and in most of them she was willing to have the worker see him. Thus the mother's attitude usually was a favourable one[1], and she herself played a part in arranging the contact.

There were two cases, however, where the mother had some difficulty in accepting the father's coming to the M.H.I. In both families the mother appeared to be the more dominant marital partner. She seemed to be afraid that the clinic might take over her supportive role in her relationship with the father. It is interesting to note here the findings of Nancy

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[1] cf. Richards, op.cit. Vol. XIX pp. 79-95

Staver's study[1] concerning the help which a child guidance clinic can render to mother-dominant families. She found that, although the child can usually be helped to some extent, the parents in mother-dominated families are not likely to benefit from treatment. The two cases mentioned above seem to substantiate these findings since the patients were helped, but the marital relationship did not change greatly. The two situations will be quoted briefly here.

In one case[2] the psychodynamic factors in the father's personality which contributed to the child's problem are illustrated. The worker's impression of the father from the mother's description of him, was that of a passive, withdrawn person who seemed to be afraid to go out and meet people. The mother stated that he had never wanted the patient and had been very resentful when he learned of her pregnancy. The father himself came from a deprived home and was harshly brought up. He had little formal education and had been taught mostly by his own father. He was very close to his own mother and to his brother and had very little social life outside his contacts with his family. The problems for which the patient had been referred, such as his refusal to go to school and his fear of crowds, were very similar to the father's pattern of withdraw-

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[1]Nancy Staver, "The Use of a Child Guidance Clinic by Mother-Dominant Families," Smith College Studies in Social Work, Vol. XIV No. 4 (June,1944) pp. 367-388

[2]This case was one of the 6 cases, cited in table one, where the father was asked to come to the clinic because he contributed to the child's difficulties

ing from social contacts. From the mother's report it seemed that the father was overprotecting the child and hindering him from overcoming his fear. The psychiatrist felt this might be due to unconscious rejection, and hence the father should be seen. The mother, who was the more dominant marital partner, had been trying to 'build the father up' and she derived satisfaction from his dependency on her. In playing the dominant role she seemed to convince herself of her own adequacy. She felt that if the M.H.I. worker entered into a relationship with her husband, her own role would be threatened. Consequently she had difficulty in accepting the suggestion that the father should contact the clinic.

In another case[1] we can see a similar pattern. Here again the mother was the more dominant marital partner who also had difficulty accepting the father's coming to the M.H.I. From her description, the worker's impression of the father was that he was a very quiet person and definitely the more passive marital partner. Thefather was not close to the patient and spent little time with him. The patient's symptoms were similar to those in the case described above. He was extremely dependent, and he showed retarded speech for which there was no organic basis. The mother implied that the patient had completely rejected his father and was entirely dependent on her. Therapy was aimed at helping the child to achieve a greater

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[1]This case was also one of the 6 cases in table one where the father was asked to come because he contributed to the patient's difficulties

measure of independence. During treatment it became increasingly evident that the mother was just as resistant to emotional separation as the child was, if not more so. Since she did not seem able to co-operate with the clinic, it was decided that the worker should see the father for the purpose of getting a more objective picture of him and his relationship to the child. At this point the mother became increasingly anxious and it was apparent that she felt threatened by the father's impending visit to the M.H.I. In order to help her with this, the worker suggested that she accompany the father to the clinic. She refused to do this. She handled her anxiety by getting her husband to tell her everything that went on at the clinic. Thus she asserted her authority over the father and she felt that she had 'won out' against the worker.

These situations indicate some of the complexities which may arise when the father is introduced into the treatment situation.

As was mentioned previously[1] not all of the clinic's initial contacts with the father were made through the mother. In one case in this group it was felt wiser to contact him directly by mail. Although the mother was willing to have him seen, she was afraid to ask him about it herself. In this particular instance the father was a very disturbed person with strong paranoid trends, who had already spent some time in a mental hospital. His behaviour was erratic and uncontrolled at

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[1]Supra p. 34

times, and it was feared that he might harm his wife if she suggested a visit to the M.H.I. The contact was therefore made by mail. The direct approach to the father proved very successful. He was able to identify with the authority of the clinic and was anxious to co-operate in helping the patient.

There were four remaining cases of group one[1] where the fathers were asked to come because it was felt that they contributed to the patient's difficulties. In each of these cases the clinic's message to the father was delivered to him by the mother: in none of these cases did she object to his coming.

Thus in the cases of group one where the father was brought into the treatment situation by the clinic, this course of action was taken when casework with the mother alone was not achieving the goal of helping the child. Where the father was felt to be the parent who bore a greater measure of responsibility for the problem, it was not possible to get at the core of the difficulty by casework which concentrated on the mother. Therefore the clinic felt it necessary to establish a contact with the father as well. Where there was a lack of co-operation in working with the mother, the clinic was forced to make a contact with the father as the only alternative in helping the mother overcome her resistance to treatment.

The remaining five cases in group one, which have not yet been mentioned, consist of those in which the fathers were

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[1]See table one item one

not sent for by the clinic. These included three fathers who accompanied their wives, and two who came because of their anger at the referral. They refused to recognize the existence of any problem and they came alone to the M.M.I. to deny the need for the clinic's service.

In connection with the three fathers who accompanied their wives to the M.M.I. for the initial interview there is no clear statement in the records as to the possible reason for this. There are indications, however, that two of the fathers did not come on their own initiative but upon the insistence of their wives who desired some moral support. Both of these fathers were described in the records as being extremely passive and dependent individuals. The third father in this group was rather aggressive. There is no information in the record to suggest a reason for his presence. It is interesting to note that his relationship to the boy was a poor one, whereas the mother, who was the more passive marital partner, got along well with the boy. Also, he was the parent who referred the boy and who took the initiative in making further appointments. This pattern was reversed in the two other cases, where the father was the more passive parent and the mother was the one seeking help.

The following case illustrates this latter instance. The father came to the first interview with the mother. He was a thin, rather meek looking man. He took a much less active part in the interview than did the mother, and maintained an apologetic air throughout. He said he did not think that the boy's problems were serious enough to warrant psychiatric

treatment. He implied that it was solely his wife's idea to have their child come to the M.H.I. The mother immediately contradicted him, saying that he was not with the boy all day long and did not know what she had to go through.

The mother had been a patient at the Allan Memorial Institute[1] and she was still taking insulin treatments in the day clinic. The father seemed more concerned about the mother and her illness than about the patient. The worker had the impression that he felt guilty about the mother's illness, as though he had caused it. His attitude to the mother was submissive and apologetic. It was apparent that the mother knew of his disapproval of her decision to refer the patient to the M.H.I., yet she brought him with her to the initial interview.

The two remaining cases are those where the father came to the clinic because of his anger at the referral. There is a great similarity between the personalities of these men as well as between the problem situations which they brought to the clinic. Both had feelings of inadequacy, yet they played the more aggressive roles in the family while their wives were passive and dependent. They seemed to need to adopt an aggressive role to deny their unfulfilled dependency needs. In each case the child who was brought to the clinic was a mental defective; he had been referred by the Protestant School Attendance Department[2] because he was slow in learning. The fathers felt

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[1]Psychiatric section of the Royal Victoria Hospital

[2]Henceforth referred to as P.S.A.D.

personally threatened by the referral. Their coming to the clinic was an act of aggression against the authority of the P.S.A.D. and also that of the M.H.I. The following case illustrates this.

The father was the more forceful of the two parents and although the first appointment at the M.H.I. was made with the mother, the father kept it instead. At the first interview he kept insisting that there was nothing wrong with the patient and that the school was wrong in referring him. Following the father's visit to the clinic, an appointment was made with the mother, but the father again came instead of her. At this interview the father's defensive attitude gave way somewhat. He spoke with a great deal of warmth of the boy. He told the worker how he had insisted, a few years previously, that the patient have a serious eye operation so that he might not feel inferior in the future because his eyes were crossed. It became apparent that the father had great feelings of inferiority and that he identified with the boy. Because of this, the father felt the referral to be a criticism of himself and a proof of the doubts which he had about his own adequacy. His apparent anger at the referral was an attempt to "shout down" the anxiety which it had aroused in him.

The above instances illustrate how psychodynamic factors can influence the father's inclusion in the treatment process. The cases in group II are different in that there were outside situational factors which led to the father's participation. These are illustrated in the following table.

TABLE II

Situational Factors Which Brought Seven Fathers to the Mental Hygiene Institute

Reason For Coming	Number
TOTAL	7
Mother not available	4
Mother too dull to be worked with[a]	2
Patient becomes involved with the law	1

a) The father was asked by the clinic to come in

Since the M.H.I. serves the lower income groups[1] it very often happens that both parents are working; this means that the mother has undertaken duties in addition to her primary ones of home-making. However when one of the parents must attend the child guidance clinic in families where both parents work, it is usually the mother who will sacrifice her wage earning hours to fulfill her duties to the children. Sometimes however, this is not feasible and the father finds that he can more easily take time off work than the mother. Sometimes, too, the mother is out of the home or is ill and unable to attend the clinic. When situations like these were found in the sample group, they were categorized as those in which the father came because the mother was not available. There may have been dynamic factors contributing to bring the father to the M.H.I. But where the writer felt that the prime reason for his coming was due to the mother's inability to attend, the cases were included in group II. There were four such situations and in

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[1]Supra, p. 11

all of them the mother was seen as well, but the clinic had more contact with the father.

An example of this exists in one case, where both parents were working during the day, but the father found it easier than the mother did to take time off work because he was a taxi driver and had no specific working hours. The patient was referred to the P.S.A.D.[1] because of his irregular school attendance and because he was a behaviour problem in school. He fought frequently and tended to take out his feelings on children smaller than himself. The father impressed the worker as an aggressive person who seemed to resist authority. He described himself as a more effective disciplinarian than the mother. His attitude to the patient was almost sadistic and it became apparent that he was jealous of the mother's relationship to the child. The father knew that his wife did not love him; her extreme devotion to the boy placed the father in the role of the rejected sibling, which he had known so well as a child. This caused his great hostility to his son, and he beat the boy mercilessly at every opportunity.

In this case it may be seen that the father appeared to be contributing to the patient's difficulties. Yet this did not seem to be the reason that it was he, and not the mother, who brought the patient to the clinic. He found it easier to take time off work and therefore he came in. This pattern repeated itself throughout the clinic's contact with the case. There were twice as many interviews with the father as with the

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[1]Supra, p. 40

mother, despite the worker's impression that the mother would be able to use casework service to better advantage than the father. This illustrates a very important tendency in casework with the parents at the M.H.I. namely, that the parent who is more easily available is the one on whom casework service is usually focused despite the fact that more might be accomplished by seeing the "less easily available parent" at regular infrequent intervals.

In group II there were two cases where the clinic asked the father to come in. Again as in group I this was done because the clinic could not work with the mother. The difficulty was that the mothers were too dull to understand the psychiatrist's recommendations. Since the problem in both patients was one of mental deficiency and the mothers did not seem to be able to grasp the fact that the patients were different from other children, it was necessary to see the father and discuss the clinic findings with him. It was not clear from the records whether the father was asked by the mother to come, or whether he was contacted directly. However, it did not appear that either mother objected to his coming to the clinic.

Thus here again as in group I when the clinic did not find it possible to work successfully with one parent it took the initiative in contacting the other parent.

Although women have more independence before the law to-day, legal responsibility for the children still rests with the father where the Civil Code is used, as it is in the Province of Quebec. A situation which involves the family with the law would therefore tend to involve the father more easily

than does a permissive, therapeutic situation. In one case[1] it was the coercive force of the Juvenile Court which caused the father to seek the help of the M.H.I. The boy was a teen ager who had been seen at the clinic alone. The father-son relationship was extremely poor but the father showed no interest in participating when the boy was being seen at clinic. One day the boy ran away from home. The boy was then involved with the law and the police were out looking for him. It was this c risis situation which brought the father to the M.H.I. for the first time.

Dynamic factors in the father-son relationship certainly contributed to the father's motivation to come to the clinic. However, the fact remains that he did not come until a crisis situation occurred. He was afraid that the boy would be penalized by the law for his action. Subsequent developments showed that the father had good grounds for his fear since the police chief was advocating placement in an institution for deliquents. This fear that his son would be sent away and that he had failed as a father were the two main considerations which influenced him to come to the clinic. The very fact that the law was going to decide about his son's future seemed definite proof of his inadequacy. It is interesting that at that point he did not appeal to the law or its enforcers, but to the agency which had been working with the boy. At that point he seemed to want

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[1]Supra, p. 42; Table II item 3

direction in dealing with his son; the crisis made it impossible for him to ignore his role in the difficulty, as he had been wont to do.

Thus in most of the cases in group II the most important reason for the father's coming to the clinic was the negative one of the mother's inability to bring the child herself. It cannot be denied that in some instances there seemed to be dynamic factors which influenced the father to come as well. For instance in the case described on page 43 it is obvious that the father's action in bringing the child contained punitive and hostile elements both to the agency and the patient. However, since the patient had been referred by the school attendance department it would ordinarily have been the mother who would have brought him. This would have happened here too despite the father's attitude, had the mother not been unable to leave her job during the day. In the other cases, too, the father came because the situation demanded his presence; where the mothers were of low intelligence the clinic required it; and where the patient was involved with the law the police precipitated it by threats of having the boy institutionalized.

We have examined the sample group of 20 cases in order to learn what brought the fathers to the clinic initially. It was found that there were dynamic and situational factors responsible for this and that the cases could be grouped according to which factors played a more prominent part in causing the father to be included. The various dynamic reasons comprising group I were mentioned and examples were given of typical

situations. The only situation which existed in group I only, was that in which the father accompanied the mother to the clinic as a sort of moral support to her. This was not found in any of the cases in group II i.e. there were no situations where the father accompanied the mother; he came instead of her. It has been previously stated[1] that there were both dynamic and situational factors influencing the father to come to the clinic; dynamic factors have been defined as those forces in the emotional life of the individual which motivate his behaviour. Situational factors are those which are independent of the emotional forces composing the father's personality and contributing to his relationship with the mother and child. It has been noted in this chapter that there were dynamic factors both in groups I and II which might have been significant in motivating the father to come to the M.H.I. In group II the dynamic reasons seemed to be secondary to the situational ones, in influencing the father's participation.

It is noteworthy that the clinic had very few contacts with the father, and in no case was there a comprehensive treatment plan made to work with him. When he was seen, it was either to explain the psychiatrist's recommendations, to enable the clinic to have a more objective picture of him than was possible when the worker relied on reports from the other members of the family, or to help him accept the referral to the M.H.I.

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[1]Supra, p. 31

Chapter Four

TYPES OF SERVICE GIVEN THE FATHERS AND THEIR RESPONSES TO THEM

In order to simplify the task of describing the type of service offered to the father, the categories of service defined by Florence Hollis[1] have been used. These are psychological support, clarification, environmental modification and insight development. Psychological support is a combination of various techniques used by the worker to "reinforce the client's ego strengths through guidance, and to release tension through reassurance[2]." The worker also encourages attitudes that will enable the client to function more realistically and more comfortably. The emphasis, then, is not on helping the client develop understanding; to achieve that, clarification and insight development are used. The emphasis here is on reinforcing the client's ego.

Clarification, on the other hand, has a high intellectual component. "The dominant note in clarification is understanding; understanding by the client of himself, his environment and/or people with whom he is associated[3]." The

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[1]Florence Hollis, "The Techniques of Casework," Principles and Techniques in Social Casework, Edited by Cora Kasius (New York,1950)

[2]Ibid, p. 116

[3]Ibid, p. 118

emphasis is on the fuller understanding of conscious material rather than of unconscious, repressed material.

Environmental modification is the term used to denote "those steps taken by the worker to change the environment in the client's favour by the worker's direct action[1]." Examples of this are: the placement of a child in an institution for mental defectives, securing a homemaker for a man whose wife is in a hospital, and so on.

Insight development is a deeper level of clarification: it is more emotionally tinged than is clarification. It involves a reliving of past emotions in a therapeutic atmosphere where the client is made aware of the irrationalities of his behaviour.

The types of service given to the fathers in the sample group of twenty cases was primarily a combination of psychological support and clarification. There were 16 cases out of 20 in which this service was given. The four remaining cases were given psychological support and environmental manipulation. It is noteworthy that psychological support was given in every case and that insight development was not given at all.

Florence Hollis says[2] that frequently, if sufficient psychological support is given, the individual can handle his own environment without direct intervention by the caseworker. The caseworker's aim is to allow the client to help himself as

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[1]Ibid, p. 413

[2]Ibid, p. 420

much as he can. Since the child guidance clinic does not attempt to treat the parent's emotional problems per se, the extent of the caseworker's intervention in the client's emotional life will be less than if the parent himself is the focus of treatment. It is understandable and psychological support, which intrudes relatively little in the client's emotional life, should be the type of service which is given the parent most frequently in a setting such as the child guidance clinic.

Another area which will be dealt with in this chapter is the father's response to the service which the clinic offerred him. This was found to vary widely. The evaluation of the response to the service has been done by the writer. Three types of response were recognized. The criteria used to distinguish them are as follows:

VERY WELL: Those fathers who accepted the clinic's services and suggestions and were able to change their behaviour and attitude towards the child and to his problem.

FAIR: Those fathers who accepted the clinic's services and suggestions but were unable to change their behaviour and attitude towards the child to any noticeable extent. Cases where the father's attitude to the child improved but the marital situation grew worse, were also included in this category.

POOR: There are three criteria here.

1) Those who were unable to accept the clinic's services.

2) Those who accepted the services but were unable to change their attitudes and behaviour to the child in any way.

3) Those who accepted the services and whose attitudes and behaviour to the child became worse.

The following table shows the types of service offerred the father and his response to it.

TABLE III

Fathers' Response to Service Given at M.H.I.

TYPE OF SERVICE GIVEN	TYPE OF RESPONSE				TOTAL
	Very Well	Fair	Poor	Unknown	
Environmental Modification Combined With Support[a]	2	2	-	-	4
Clarification Combined With Support	1	7	7	1	16
TOTAL	3	9	7	1	20

a) Support refers to psychological support

In order to understand why some fathers were able to respond more positively to casework service than others, it is necessary to know a little more about their relationship to the patient. Let us examine the four cases where the service given was psychological support and environmental modification.

In the cases where the fathers responded very well, their attitudes to the patient were accepting ones and they seemed genuinely concerned about the problem in terms of the patient's welfare. In all these four cases the patients were mentally retarded and some form of institutionalization or home training had to be arranged. The two fathers who responded very well seemed to have a better understanding and acceptance of the

patient's difficulties than the mother. In one case the father impressed the worker as being a well-adjusted person, with a capacity for dealing with the family's problems adequately. In the other case, the father impressed the worker as being immature and unable to face his responsibilities very well. He was essentially a dependent person who responded well to help from others, but who was unable to deal with a situation if too many problems arose at the same time. In keeping with his usual behaviour pattern, he responded very well to the help given him by the worker since some of his environmental pressures upon the family had been relieved by the worker's help. He was able to carry on once the situation became less complicated.

Thus the factor common to both cases where the father responded very well to the service given, was the father's positive attitude to the patient and his problem.

In the two cases where the fathers' response to the service was only fair, their attitude to the patient seemed to be one of rejection, in the opinion of the worker on the case. Both fathers blamed others for the patient's difficulties; one father blamed the mother's family for babying the patient and the other father blamed the mother for the child's condition, claiming that 'she babied the boy.' Both fathers seemed to have a great many emotional difficulties themselves and could not be regarded as well adjusted individuals. One father drank heavily; he had been the only boy in his family and had been over-protected by his parents. As a result he was unable to carry any responsibility and 'escaped into drink.' The other father

was suffering from some kind of 'nervous trouble' on which he never elaborated. He had a strong need to keep busy; his behaviour pattern was one of escaping into work whenever he was troubled or upset, and that occurred often.

Both fathers were willing to come to the clinic and be included in the planning for the patient. They were both asked to come by the worker because the mothers were too dull to understand the doctor's recommendations and to participate in planning for the patient.

It was often found that there was a difference between the father's behaviour at the M.H.I., and the unfavourable reports which the mother had given of his behaviour at home and his relationship to the patient. Frequently these fathers would be most co-operative when they were seen at the clinic. The following case is an example of this.

The mother claimed that the father preferred the older child to the younger, who happened to be the patient. She said he was very demanding of the patient and beat him frequently because he felt it was a good disciplinary measure. She said that he accused her of spoiling the boy and thought that the child should be in school and not at home. He drank heavily and had frequent mood swings.

As a contrast to the above report the worker's description of his behaviour at the M.H.I. was as follows:

The father was quite willing to come to the M.H.I. He saw the patient's main difficulty as 'nervousness' which became noticeable three years previously. He spoke quite readily about

the difficulties in the home and he gave the worker the impression of being a warm person with a fair amount of awareness of the patient's condition. He accepted the worker's explanation that the patient was retarded and he co-operated in planning for the possibility of institutional placement. At the close of the contact with him, the worker's impression was that he was well-intentioned but rather immature and unable to provide any real emotional support for his wife and child at that point.

This discrepancy between the mother's reports of the father's behaviour at home and his behaviour at the clinic illustrates the necessity for a clinic contact with the father. A personal contact is essential if the clinic is to get a true picture of the father's personality and if his co-operation in the treatment is to be enlisted. The mother's reports cannot be relied upon. She may be reporting what she feels to be the truth, but this is highly subjective. The clinic needs to have a more objective picture of him. The father's resistance to the treatment may also be influenced by how the mother interprets it to him. Thus, even if the contact with the father is not a prolonged or intensive one, it would seem advisable for him to be seen by clinic personnel.

In comparing the fathers who responded very well with those whose response was only fair, one similar and one dissimilar factor can be seen. The factor common to both is the father's willingness to co-operate with the clinic: the difference between them is in their attitude to the patient. The attitude of those fathers who responded very well was one of acceptance

whereas the fathers who responded fairly well had a rejecting attitude to the patient.

The fact that the two fathers who rejected the patients were still able and willing to co-operate with the clinic makes one question their motives. It has been shown that both fathers were dependent and immature people; they were unable to lean on their wives for emotional support since their wives were dull and dependent themselves. The fathers' co-operation with the clinic might indicate their need of the clinic as a source of help for themselves. The caseworker had taken the initiative in offering them help; perhaps they were willing to accept the help and to co-operate with the worker because of their great need to satisfy some of their dependency needs.

These suggestions are not being offered as conclusive answers to the problem of why these fathers, who obviously had a poor relationship with the patient, were able to respond fairly well to the service given by the clinic. They are merely comments which indicate the need for further study of this problem.

The 16 cases where the fathers were given psychological support and clarification will be examined now. As has been mentioned previously, there was one father who responded very well, seven fathers who responded fairly well, seven who responded poorly, and one case where there was no indication of response.

The following is a description of the case where the father responded very well to the service given. The record describes him as a dependent person who had been forced to assume

the dominant role in the family. His personal and marital adjustment was shaky, but he was able to hold a job and to give a superficial impression of stability. His pattern was one of escaping into work and as a result his family saw very little of him. He described his wife as a weak, ineffectual sort of person; their incompatibility had become more evident through the years and it had reached the point where they no longer had sex relations. It seems surprising that a person with so many obvious difficulties should be able to respond so well to case-work services. Why should he have responded so well to psychological support and clarification when so many other fathers who were offered the same service could benefit little from it?

A caseworker's point of view is that the answer lies in the man's personality. Perhaps he had some strengths which could be worked with in the short period of time that he had contact with the clinic. The worker on the case felt that he had more stability than the mother. After his first interview at the clinic, where the worker had initiated the contact, the father asked for further appointments himself. His behaviour during the interviews was interesting. He was quite uncommunicative at first, just as he was in his relationship with the various members of his family. He could not discuss his problems: he seemed to be afraid to admit that they existed. As the interviews progressed he allowed himself to be somewhat dependent in his relationship with the worker, and he became less rigid and defensive during the interviews. He was able to carry over this relaxed attitude in his relationship with his son, and the

father-son relationship improved.

Apparently the father's relationship with the worker gave him the opportunity to lean on someone, which he seemed to need. It must be noted that although the father's attitude to the patient improved, his personality difficulties were very deep-seated and needed much more intensive therapy before any real change could take place. Since the evaluation for the success of the service was based on the movement in the father-patient relationship, this father was considered to have responded very well. He had been able to gain enough relief and support in his relationship with the worker to change his attitude to his son.

The seven fathers who had responded fairly well to the service given were those who had been able to accept the service offered, but who were unable to change their attitudes and behaviour to the child to any noticeable extent.

When one examined the personalities of these fathers there appeared to be a noticeable instability in their personal adjustment and in their marital relationship. However, they were still able to play their roles as breadwinner and head of the family without too many obvious signs of strain.

The attitudes of these fathers to the patient's problem does not differ markedly from those of the fathers who responded poorly to theservice given: the prevailing attitudes to the patients were punitive, and they blamed someone else for the problems for which the child was referred. There was one attitude in this group which was non-existent in the fathers who responded

poorly: this was the attitude of three fathers who felt that the problem was not serious enough to be referred to the M.H.I.

In only two of the seven cases could the father-patient relationship be said to be a very poor one at the time of referral. These two fathers definitely rejected the patient. In three other cases the father-patient relationship did not seem to involve tensions. In one of these families the main problem was in the father's relationship to the mother; his relationship to the patient was not as disturbed as was his relationship to the mother. Of the two remaining cases, one patient was a girl to whom the father was very attached and the other was a mentally retarded child with whom the father identified and toward whom he was very protective.

None of the fathers in this group refused to come to the M.H.I. Five fathers came willingly when asked by the clinic to come, and two came spontaneously, i.e. without having been asked to come by the clinic or by the mother. From the information available in the records, there did not seem to be any resistance connected with their coming to the clinic.

It has been found necessary to include some discussion of the father's personality where it is thought to be relevant in understanding the reason for his response to the service. A closer study of the personalities of the fathers who comprised this group revealed that in five cases the father played the more passive role in the marriage in relation to his wife[1], and

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[1]See Miller and Richards, Op. Cit. Vol. IV pp. 139-150

in two cases he seemed to be struggling against his passivity. In these last two cases the fathers appeared, superficially, to be rather forceful individuals. However, the workers felt that they were essentially very passive personalities who were attempting to deny their passivity and were overcompensating by exhibiting aggressive behaviour.

In the five cases where the father played a passive role in the marriage, he was not always the more disturbed partner. There were two cases in this group where the father was thought to have greater emotional stability than the mother. These two showed improvement in their attitude to the patients after their contact at the M.H.I., but this improvement was not consistent and therefore they were considered to have responded only fairly well. The contacts with these fathers were few; none of them was seen more than three times. It is possible therefore, that the improvement would have been more lasting if the service to him had been more extensive.

In the two cases where the fathers' aggressive behaviour was felt to be an overcompensation for his essentially passive personality, this feeling was expressed by both the worker and the psychiatrist on the cases. One father was of an ethnic group in which the culture pattern dictates that the father's role in the family shall be highly authoritarian. Yet this father was apprehensive of authority and he apparently needed to prove that he was able to play this role by behaving extremely punitively towards his children and by restricting his wife's activities. He drank excessively. In casework contact he was

able to admit that he was unhappy. It is interesting that he accepted casework service only after an authoritarian approach to him was used. The Family Welfare Association threatened to get the Juvenile Court to place the child because of the extremely poor care she was getting at home. The father then consented to accept casework service and attempt to ameliorate the situation with F.W.A. help.

The second of these two fathers was a rather dull man, in the psychiatrist's opinion. The patient was a borderline mental defective who had been referred by the school authorities. The father was furious with the school personnel for referring the boy, and he kept insisting that there was nothing wrong with him. The father's attitude when he first came to the M.H.I. was extremely belligerent. He had identified with the inadequate side of the child's personality and felt personally threatened by the referral. During the casework contact his belligerent attitude disappeared. He was able to express his disappointment in his wife's personality; he complained about her reserve and submissiveness which forced him to assume the more aggressive role in the family. He seemed to be continually struggling to maintain a protective attitude towards his wife and child, and the forceful role which he played did not come naturally or easily to him. However, it was a necessary overcompensation for his feelings of inadequacy. He was anxious to come to the M.H.I. when he first learned that his son had been referred there. His motive for this was interesting; he wanted to come to the clinic, not to help the boy, but to prove to himself and

the clinic that there was nothing wrong with the child. This was in keeping with his pattern of denying his inadequacy.

In six of the seven cases in this group, the crux of the problem in the parent-child relationship lay in the competition between one parent and the child for the love and attention of the parent of the opposite sex. This is a normal phenomenon in the life of a child, but it is not normal in the adult. In the emotionally healthy adult this Oedipal conflict is resolved during childhood. Where this has not been the case, the adult often seeks this love and approval from a marriage partner. His marital relationship is therefore a mere repitition of the relationship desired or actual, with the parent of the opposite sex. When this adult becomes a parent himself, his relationship to the child is essentially a hostile one, since they are both competing for the love of a parent figure. Edmund Bergler speaks of this in discussing neurotic marriages[1].

> The marriage of two people is, among other things, a protection against the unavoidable third party of childhood, the father for the boy and the mother for the girl. If now a third person is added in reality i.e. a son or daughter, the old conflict is mobilized.

In these cases, then, the parent's Oedipal conflict was not resolved and therefore his or her relationship with the patient was fraught with conflicts.

There was one case where this pattern of parent-patient rivalry was not evident early in the contact. In this case the

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[1]Edmund Bergler, Unhappy Marriage and Divorce, (New York,1946) p. 106

patient was a girl and it was the mother who was competing with her for the father's love. This case has been mentioned previously[1]; it was this father who was trying to live up to the authoritarian role which his culture dictated. He beat all his children mercilessly and he expected them to obey his slightest wish. Because his attitude to the children superficially seemed such a rejecting one, the worker could not at first discern the underlying attachment which the father had for the patient. This was brought out into the open in the process of treatment.

The father began to take more interest in the patient after he was seen at clinic the first time. He began spending more time with her and behaved almost as if he were courting her. He bought her a ring and accompanied her to all her M.H.I. appointments as well as to all her dancing lessons. The patient's symptoms, extreme nervousness and hand-kissing, began to disappear. At this point the mother began to be jealous of the father's attentions to the child, and instead of her previous superficially protective attitude to the child she became openly hostile. She had frequent arguments with her husband about child-rearing and she finally demanded that the patient be placed.

Another case in this group illustrates a similar development which occurred during the treatment. In this case, however, the quality of the father-patient relationship did not change so radically as it had changed in the above mentioned case.

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[1]Supra, p. 59

Another difference in this case was that the patient was a boy. The patient had an extremely close attachment to his mother and he refused to have anything to do with the father, unless the mother was present. During treatment the child's relationship to his father improved; simultaneously, a noticeable increase in the child's independence was noted. He was no longer as emotionally and physically dependent on the mother as he had been at the commencement of treatment. While this change was occuring in the child, the mother was admitted to the hospital for an operation. The father stayed home to take care of the boy, thus cementing their relationship further. When the mother returned from the hospital, the patient began to turn against her and the mother felt that there was a contest of wills between them.

It is interesting to note that in six of the seven cases where the fathers' response was fair, they were not seen at the M.H.I. more than three times. In the seventh case of this group, the father brought the child to the interviews with the psychiatrist, but he himself did not receive casework service or psychiatric treatment at the M.H.I. Thus the father's role in this group of seven cases seems to be an adjunct to treatment with the mother and child. In none of these cases was there a plan at the M.H.I. to focus treatment on the father rather than on the mother. In only one case was the father asked by the clinic to come for another appointment after his initial interview at the clinic. In the six remaining cases the fathers themselves took the initiative in returning to the

M.H.I. The extent to which the fathers entered into the treatment situation was therefore a matter of their own initiative rather than a result of planning by the clinic.

Seven fathers in the group which was offerred psychological support and clarification responded poorly to the service given. There is one common factor among them which is worthy of mention. In the opinion of the psychiatrist or the worker on the case all seven men were fairly seriously disturbed and they had great personality problems. Two fathers had been in mental hospitals at one time, one father was referred to a mental hospital after being seen at the M.H.I., and one father had a markedly schizoid personality. The three remaining fathers had strong feelings of inadequacy; they worked long hours in an attempt to escape from their problems, and they spent little time with their wives and families.

All seven fathers rejected the patient. In three cases their attitude to the patient was extremely punitive, in one case it was overprotective, in one case the father was openly uninterested in the patient, in one case he continually depreciated the patient's achievements, and in one case the father remained aloof from the patient and had little contact with him. The attitude of most of the fathers to the patient's problem was a negative one in that they blamed others for the existence of the problem or they were uninterested in it. There were two fathers who blamed themselves for the problem yet they showed little capacity to ameliorate the situation without help.

The attitude of the fathers to coming to the M.H.I. was

on the other hand, a much more positive one than their attitude to the patient. They were willing to come and no matter what their reasons were, this was a positive step since it showed that they were prepared to accept some responsibility in the situation. Five fathers came to the clinic without being asked and one father came readily when he was asked. There was only one who was unwilling to come, but even he finally did attend.

As in the cases where the father's response to the service was only fair, the incidence of father-patient rivalry in these cases was also high. In six of the seven cases the father seemed to be rivalling the patient for the mother's love. In one case where the child was sent to camp for the summer, the relationship between the parents improved during the period that the child was out of the home. In another case the relationship between the father and a step-mother grew worse when the father's relationship with his son grew better.

In both cases, the father appeared in the relationship of a sibling to his own child, and a less favoured sibling at that. His unfulfilled dependency needs caused him to regard his wife as a mother-figure and to strive for dependent gratifications from her and this involved him in rivalry with his own child.

The following case illustrates the father-son rivalry which existed in most of these cases; it is fairly typical of this group of cases in that the father is rather disturbed and his response to psychological support and clarification given by the M.H.I., was poor.

The father came to the clinic because the patient's real mother was dead. The father was a submissive man who forced himself to face his responsibilities as a way of denying his inadequacy. The father told the psychiatrist that he had never been able to establish a close relationship with his son and he regretted it. From this contact and from subsequent interviews with the step-mother it became apparent that there had been marital difficulty between the patient's real parents. Apparently the father had been rivalling the patient in his relationship to the mother. The mother's attitude seemed to be one of preference for the patient; she kept him close to her and allowed him to sleep in her bedroom since the father worked at night. After the mother's death the father remarried. The step-mother told the worker that she got along better with the patient than his father did, yet the patient enjoyed seeing her at odds with the father. He often said that he would separate them.

In this part of the record we can see repitition in the second marriage of the father-patient rivalry which existed in the first marriage. The father apparently felt very guilty about his underlying hostility to the boy: he opposed the clinic's suggestion to place the boy in a boys' institution in Montreal. This action was subsequently taken in spite of the father's reluctance, because the patient had started a fire in the basement of the apartment house where the family was living. After the boy was placed, the father turned to alcohol. He became more and more disturbed and was eventually admitted to

the Psychiatric Division of the Queen Mary Veterans' Hospital. The father was seen at the M.H.I. some time after his period of hospitalization; he expressed resentment over the 'loss' of his own child due to the placement, when the step-mother had her child in the home with her. The caseworker offered him a return appointment after this interview, but he sent a message through the step-mother that he did not want to discuss the marital problems because it upset him too much.

In this case the father was unable to use casework service because he was too disturbed. This father is quite typical of the fathers who responded poorly in that it was his own personality problems which prevented him from benefitting from the service given. The father's relationship to the patient was poor as a result of his own personality maladjustment. As Frederick Allen says[1], 'Parents' uncertainties and emotional entanglements, focused and intensified around the child, throw out of balance the necessary functions of mother and father roles. We see in clinical practice the confusion that ensues when the father, uncertain of his ability to attain masculine status, exaggerates or denies the functions of the father role.'

With respect to the phenomenon of father-patient rivalry which was evident in these cases, Edmund Bergler[2] feels that this occurs where the parent has not resolved his own Oedipal conflict. This leads to the selection of a mate who

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[1]Frederick Allen, Psychotherapy with Children, (New York, '42), pp. 35-37

[2]Bergler, Op. Cit.

will satisfy his neurotic needs. The marital unions in the seven cases under discussion do have some of the symptoms of the neurotic marriage that Mr. Bergler speaks of it.

It has been mentioned previously[1] that the common factors in these seven cases where the fathers responded poorly were their personal and marital maladjustment. In five of the seven cases we have definite indication that the father's functioning at work was impaired. There is no mention of this in the two other cases. This would lead to the impression that these men had inter-personal as well as intra-personal problems which were severe enough to hamper their functioning at work as well as in their relationship to their wives.

With such a negative picture of the personalities of these fathers it is understandable that their response to treatment was such a poor one. In a study[2] which attempted to find out whether parental behaviour could be used as a guide to the probable outcome of the child's treatment, the following conclusions were drawn: 'Results suggest that when parental behaviour indicates an involved emotional relationship (excessive love or hate) with the child, prognosis is poor for therapy of the type usually given in a child guidance clinic.' Although the topic under discussion is the father's response to the service and not the response of the child, the above results are borne out in the seven cases of this group with respect to the prognosis

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[1] Supra, p. 57

[2] Miller and Richards, Op. Cit. p. 50

of treatment for the father.

There is one more case in the sample group where the service given was psychological support and clarification. There was no indication, however, whether the service to the father had any effect on his relationship with his son. His attitude to the patient's problem seemed to be one of great concern on the surface; this was accompanied by a great deal of eagerness to be seen at the clinic. His personality falls into the same pattern as those of fathers whose personal and marital adjustment was poor. Despite the father's apparent concern about the boy's problem, the worker's impression was that the father was really interested in help for himself. This might account for his frequent telephone calls to the worker early in the contact, and his willingness to come for interviews. The father did not seem able to work on the problem in his relationship to the patient. Since the worker felt that the father wanted a service which a child guidance clinic could not give i.e. therapy to an adult, the clinic decided to focus treatment on the mother. The father's role was limited to helping the clinic get a fuller picture of the patient's family life.

This chapter has attempted to describe the types of services the fathers in the sample group were given, and their response to them. The four types of casework service discussed by Florence Hollis in her book "Women in Marital Conflict," were used as tools for the analysis. It was found that no one type of service was given the fathers at the M.H.I., but rather a combination of two types e.g. psychological support was

coupled with environmental manipulation. The father's response varied from 'poor' to 'very good' except in one case where it was unknown. Most of the fathers responded either fairly well or poorly to the service offered. There were only three cases in which the response was considered 'very good.'

In considering the clinic's plan for working with the father, it was found that in most cases the clinic did not plan to continue casework service to the father after the initial contact was made. It was only where the mother was unavailable or where the father indicated specifically that he wished to continue the contact, that the father's visits extended beyond the initial interview. Thus the father's role was really an adjunct to the treatment of the mother and child. In no case was the possibility of focusing treatment on the father rather than on the mother considered. Even in those cases where the father was not co-operating with the clinic, the father's role was mainly to supply the clinic with more information. As one worker expressed it, "The purpose of seeing the father is usually to help us get a clearer picture of the child's environment, and to supplement the information which the mother gave."

Many problems which are brought to a child guidance clinic have in them elements of discord between the parents. Thus very often the parents' relationship to one another is the main difficulty and this should be treated as well. Violet Shapiro[1] comments that as the parents become more positively

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[1]Violet R. Shapiro, "Factors Determining the Focus of Treatment" Diagnosis and Process in Family Counseling. (New York), pp. 81-98

related to each other and to their roles as parents, they can turn to the problem of their child and feel free to take help with it. Miss Shapiro feels that once the parents' own relationship has become more stable, the child can be brought into the helping experience at a point where the parents could be more related to the child's needs than to their own. This type of treatment involves a type of planning on the agency's part, where both parents are drawn into the treatment.

Chapter Five

EFFECTS OF SERVICE TO THE FATHER AND REASONS FOR ITS LIMITED USE

After having discussed in chapter two, the theoretical reasons for the advisibility of including the father in treatment, it is of interest to see how useful this is in actual practice. Two aspects of this enquiry are dealt with in the present chapter. The first deals with the effect of service to the father in changing the patient's behaviour, and in changing the relationship between the father and patient. The second aspect considers the various reasons why a more intensive service was not given. In one group of cases there were obstacles beyond the clinic's control which prevented it from offering service: in another group of cases the clinic was doubtful if more intensive service would be beneficial. In a third group the clinic did not think it desirable to offer further service, and in another instance further casework was left to the referring agency.

The information concerning the above two areas of discussion was obtained from the records. In most cases both the mother and the child were seen again after the contact with the father was terminated, so that the psychiatrist was able to observe any change in the child's behaviour at first hand. The caseworker almost invariably received a report from the mother

about the father's relationship to the child. In some cases the worker had a contact with the school or another casework agency, where additional information was obtained concerning the child's behaviour and/or the father-patient relationship. It is difficult, however, to evaluate how much improvement is due directly to the work with the father. Some improvement may be due to other factors such as environmental changes which relieve some of the pressures on the parents or on the child.

Since the treatment of the father was aimed at ameliorating the father-patient relationship it seemed reasonable to suppose that any improvement in the father-patient relationship which occurred during, or shortly after, the clinic's contact with the father was due in a large measure to the service given him at this time. For the purposes of this study the criteria for evaluating the results of the service will be based on whether the change occurred within a short time of the clinic's contact with the father.

Of the 20 cases in the sample group, there were 17 cases where the service to the father brought no improvement in the patient's behaviour. There were three cases in the sample group where the patient's behaviour did improve. In these latter cases where there were positive results after the father was seen at the clinic; the kind of service he was given was clarification and support. He was considered to have responded fairly well. It is interesting that in two of the three cases there was very little contact with the mother.

In one case, the patient had been treated very harshly

by her father who "believed in beating all his children" in order to command respect. The patient's disturbance manifested itself in symptoms of facial twitches and hand kissing. After the patient was seen twice by the psychiatrist the latter suggested that the father be asked to come in. The father was very co-operative at the first interview. It was the doctor's opinion that he was apprehensive of symbols of authority such as the M.H.I., the psychiatrist, and the caseworker. This probably contributed to his efforts to co-operate with the clinic. From the time of his first interview at the clinic, the father made obvious efforts to behave according to how he thought the clinic wanted him to behave towards his family. In his interviews with the psychiatrist, he reported that he was taking an interest in the children and he was trying to help out more at home. The patient also began to speak more frequently and more warmly of her father, while he was being seen at the clinic, and her symptoms began to disappear.

The Family Welfare Association had a contact with the family at this time and it too, reported a consistent improvement in the father-patient relationship. The father gave the patient a ring which he had made himself, as a sign of appreciation for her improved behaviour. He began to bring her to her appointments with the psychiatrist, instead of allowing the mother to do this, as had previously been the practice; when he went to visit relatives in the States he took the patient along on the trip.

Here we see that, although the father's immediate

co-operation with the M.H.I. was probably due to his fear of the clinic, nevertheless his relationship with the patient improved considerably. The improvement appeared to be a consistent one during the two years in which the M.H.I. had a contact with the case.

In the second case, the improvement in the patient's behaviour and in the father-patient relationship was equally dramatic; however it was not consistent and it soon deteriorated as dramatically as it had improved. In this case[1] the father was very disturbed, and he had strong paranoid trends; his immediate co-operation with the clinic, after he was seen there only once, was due mainly to his attempt to identify with the authority of the clinic. The father spent a great deal of time with the patient and had long talks with him. The patient did improve at first but the father was not a stable personality and his previous, sadistic behaviour to the patient changed to over affectional, oversolicitiousness towards him which was very disturbing to the boy. The father not only had long talks with his son, he frequently embraced him and insisted that the boy sleep with him. The worker learned of this development from the mother. At that point the clinic contacted the father once more in an attempt to give him further clarification. At this interview the father became very hostile; he immediately projected all the blame onto the mother. His attitude to the boy changed and once more he became very punitive. He refused

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[1]Supra, p. 64

to see his own role in the situation and absolved himself of all responsibility for the boy. The patient soon began to show more severe symptoms than previously, and the father made frequent attempts to have the boy moved out of the home.

In this case it was very difficult to work with the father because he was unable to co-operate as soon as he felt that the clinic was criticising him in any way. It can be easily seen how his attitude to the patient affected the boy and contributed to his difficulties.

In the third case the patient was extremely attached to the mother and refused to have anything to do with the father. The father, in turn, did not pay much attention to the boy and left his care to the mother.

During treatment the patient showed signs of breaking away from his mother but she showed great resistance to separation. Since it was difficult to work with her it was decided that the worker would see the father to give him some clarification about the problem and his own role in it. The father was willing to come to the M.H.I. and appeared to be very co-operative. After his first interview at the clinic, the mother reported that the father was spending much more time with the patient but that his interest was not consistent. Soon after the father had to stay home and care for the patient because the mother was in hospital. He accompanied the boy to the M.H.I. and was seen several times more by the worker, who gave him further clarification and support. The father, and later the mother, reported that the boy's relationship to him was much

improved since the beginning of therapy. It is interesting to note that when another psychiatrist continued with the case next fall, he remarked that the patient appeared to be more fond of the father than of the mother.

In the 17 remaining cases the service to the father did not seem to contribute to any change in the patient's behaviour in the father-patient relationship, according to the information available in the records. There were some cases in this group in which the patient's difficulty was simply mental retardation without any problem in parent-child relationships. There were other cases in the sample group where the home atmosphere was so detrimental to the development of the child's personality that he had to be placed. It was only then that the child's behaviour indicated an improvement. There was one case in which a combination of temporary placement and treatment at the M.H.I. seemed to help the child. It did not bring about any change in the father-child relationship, however. There were several cases in the sample group where there was no improvement either in the child nor in the father-child relationship, despite the efforts of the clinic. Although some cases in this group showed improvement, it was clearly not a result of the service given the father. Therefore they were included in the second group of cases.

It has been mentioned previously that the mother was the parent on whom casework service was focused even though it was frequently obvious that she could not benefit from it. It seems logical to suppose that in these cases the fathers might

have been more intensively drawn into the treatment situation instead of the mothers, since they already had some contact with the clinic. Why was this not attempted by the clinic? What was the worker's opinion about this matter? These questions were posed to the workers personally since the answers were not to be found in the records. In twelve cases they felt it would have been desirable to offer a more intensive service, in four cases they were doubtful whether he could have used it or whether he needed it, in three cases they felt it was not advisable and in one case the casework was left to the referring agency.

The above figures show that the workers were aware of the need for a more intensive service to the father. Therefore there must be other obstacles which prevented them from offering it. The most obvious obstacle, mentioned at the beginning of the study, is the fact that the father is usually at work during the day, when the Institute has office hours. Since the M.H.I. clientele comes from the middle and lower socio-economic group, the father usually cannot afford to take time off from work to come in for interviews. This makes it necessary to have most of the contacts with the father during his lunch hour, or in late afternoon. Very few fathers work close enough to the M.H.I. office to enable them to keep a lunch hour appointment. As a result it is necessary to keep the contact with the father down to a minimum; he is usually asked to come only when it is felt absolutely essential for him to be seen.

It should be explained here that a contact with a

client may be a superficial one even though it is on a long-term basis. The kind of material that is dealt with in interviews and not the frequency of contacts determines whether the contact is on an intensive level. Where the client is seen frequently but the content of the interviews is on a superficial level, the contact will be termed an extensive rather than an intensive one, for the purposes of this study.

Although the purpose of this chapter is not to find out why the contacts with the father are not more extensive but rather why they are not on a more intensive level, the fact that the father cannot come more frequently has a bearing on the problem. Since casework on an intensive level helps the parent gain emotional insight into the family relationships and his own motivations[1], it is necessary that a strong worker-client relationship must be established before this can be done. There must be good rapport between the worker and the client; each must know the other well enough to feel free in discussing subjects which are highly emotionally tinged. These developments take time and regular contacts must be maintained with the father so that a strong worker-client relationship can be developed. Thus, an intensive contact is usually an extensive one as well. The difficulty in arranging an appointment time is a real obstacle, then, to an intensive contact with the father.

The second main reason for not continuing the contact

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[1] Eva B. Bronner, "Can Parents' Attitudes Towards Their Children be Modified by Child Guidance Treatment." Smith College Studies in Social Work, Vol. VII No. I, (Sept. 1936), pp. 1-16

with the father in the sample group of cases, was a lack of agency personnel to work with both parents. Since the mother was more easily available, she was the parent the clinic worked with in most cases. This obstacle has its roots in the clinic setting; and not in the parents' ability or desire to attend the clinic.

The third reason why the clinic did not continue its contact with the fathers has its roots in the clients themselves. Some fathers felt too threatened to be able to accept the service and therefore they withdrew before a more intensive contact could be established. There were seven cases in the first group where the clinic limited the contact, and five cases in the second group, where the fathers limited the contact.

Thus there were 12 cases where the workers thought a more intensive contact would have been desirable, yet this service was not given. These cases fell into two groups, according to the reasons for discontinuing the contact.

Upon closer examination of the seven cases in this group, it was found that there were really two reasons why the clinic limited its contact with the father. One reason was because the mother was receiving casework service, and the caseworker lacked the time to work with both parents concurrently; the other reason was that the workers felt that the fathers would not be able to benefit from a service on an intensive level focused on the relationship between himself and the child.

Since the child guidance clinic is geared to ameliorating parent-child relationships, the function of the worker is

to help the parent gain insight into the reasons for the problems in his relationship with the patient. This cannot be done, of course, without concentrating to some extent on the father's own personality, but the main focus of the worker's efforts would have been the father-child relationship. A parent who seeks the help of a children's clinic, by his choice selects to work on his parental relation to the child rather than on his own adult problems. Many parents who need help with their children do present neurotic problems in themselves. But the child guidance clinic must focus on the parent-child relationship and not get swept into the broader areas of the adult problem....in order to keep the function of the clinic in proper perspective.

In the five cases of this group where the mother was receiving intensive casework service, the workers had to take into account what effect an intensive contact with the father would have had on her.

A case which is a good example of a situation where the worker's contact with the father had a very bad effect on the mother and caused a rift in her relationship with the worker will be discussed here. This case was quoted previously when the changed quality of interpersonal relationships within the family as a result of treatment, was discussed. It has been pointed out that in this particular case the patient's extreme

dependence on his mother and rejection of his father was changed during the treatment process. The child became more independent and his relationship with his father became better. The mother was not prepared for this, since she had been the favourite parent, and she began to criticize the father and his attempts at establishing a better relationship with the boy. When the worker suggested that the father come in for an appointment, the mother had some difficulty in accepting this, and it was obvious that she would have liked to be present at the interview. Her attitude to the worker after the worker's interview with the father was one of competition. She vied with the worker for the father's attention, and tried to be included in everything he did. She even had the father report the contents of his interviews at the clinic to her. When she was able to get the father to tell her what he had discussed with the worker, she appeared to feel that she had "won out" against the worker.

Because of the mother's feeling of rejection and her hostility to the worker and clinic at that point, it was felt unwise to continue with a more intensive contact with the father. The worker felt that this would have alienated the mother completely, and a good opportunity to work through her feelings of rejection would have been lost.

Mary Richards[1] suggests that the decision to attempt to include the father in treatment, in cases where it is thought

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[1]Richards, Op. Cit., pp. 79-95

that both parents are in need of help, should be based chiefly on one consideration - what his coming will mean to the mother. Her study shows that if hostile or competitive elements are foremost in the mother's attitude to her spouse's coming to the clinic, it is probable that his coming will have an unfavourable effect on the treatment process.

The case quoted above, illustrates Miss Richards' findings. The worker found it difficult to continue casework service to the mother after the father had come to the clinic. Her son's growing separation from her was a threatening experience, and she needed the steady support of her relationship with the worker at that time. The father's intrusion into the relationship made it a threatening experience instead of a relaxed, therapeutic one.

In three of the five cases of group I where the mother was being worked with intensively, the caseworkers gave definite indication that the reason for not continuing their contact with the father was because of the damaging effect on the mother. In the two other cases, this reason is not so clearly stated, but it seems to have been a factor guiding the worker's decision not to pursue the contact. There were other contributing factors as well. The father's lack of insight into the patient's problem, and the absence of any motivation on his part to go into the reasons for his dislike of the patient, made the worker feel that there would be little value in prolonging the contact. It must be remembered that the M.H.I. is a community clinic which does not refuse any client who is within the

income group it serves. Therefore the workers must budget their time according to which clients can make the best use of the service they offer. If a client cannot be helped to accept the clinic's service within a relatively short period of time, i.e. one or two interviews, the worker usually evaluates the situation to try to decide whether further attempts should be made to work with him.

Although the time factor is a very important one, it has been pointed out above that there were other factors which caused the workers to decide against giving the fathers a more intensive service. The father's lack of insight, the effect on the mother if the father were included, the preponderance of the father's own neurotic problems, the difficulty in arranging appointments with him during the day, all having a bearing on the type of contact the father has with the clinic. The reason that these cases were grouped together was because of one thing they had in common. That was the fact that in these cases the workers made the decision as to whether a further contact with the father should be attempted. This decision had to be weighed in terms of the worker's time budget; because of this common basis for decision to all these cases, the writer felt that they could be grouped together.

The lack of the agency's time to work intensively with both parents in every case is a real obstacle, and it does not seem to be peculiar to the M.H.I. Charlotte Towle discusses this problem in one of her articles[1]. She suggests that although

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[1]Towle, Op. Cit.

it is more difficult to reach the father, it might be preferable to focus treatment on him rather than to continue unsuccessful attempts to work with a resistant mother. "It would probably be better to hold with assurance what our interpretive techniques reveal, even though it means travelling more slowly with fewer contacts. A little treatment along the line of least resistance might be more effective than intensive treatment applied as a counter-attack[1]."

There were five cases in the group where the fathers limited their contact with the clinic, and in all five cases the workers felt that the reason for the father's withdrawal was that he felt too threatened, after his first two or three contacts at the clinic, to accept further service.

In two cases the fathers told their wives that they did not want to return to the clinic: one father said it upset him too much and the other father adopted a very hostile attitude to the clinic and said 'that he knew more psychiatry than a psychiatrist.' In the third case the father took an extra job in the evenings. This was in keeping with his usual pattern of escaping into work when things became too difficult for him. As a result of this he was unable to keep further appointments with the worker. In the fourth case the father lived out of town and there was reality basis for the difficulty in arranging an appointment time. However, this father had been able to overcome this difficulty on two occasions, when he had his first

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[1] Ibid

two contacts with the clinic. Because of this it was felt that there were other factors operating as well, which prevented him from continuing the contact. This case will be dealt with more fully at a later point in the chapter when these 'other factors' can be discussed in greater detail.

In the fifth case of group II the father was paranoid and needed intensive psychotherapy. The role of the M.W.I. would have been to prepare him for referral to an adult psychiatric clinic or a mental hospital. After his initial contact at the clinic this father refused to return for further appointments. He insisted that there was nothing he could to about the patient's problem since it was his wife's fault.

Since the reason for not continuing the contact in the cases of group II was due to the client's withdrawal from it, and not to the clinic's inability to offer a more intensive service, the writer felt it would be of value to discuss these cases individually in order to try and find out why these fathers were blocked in accepting the clinic's service. Perhaps a more thorough discussion of these cases might help social workers in their attempts to understand and overcome a client's inability to accept help in the cases which present themselves in the various types of social agencies.

Some points of similarity were evident in the two cases in which the fathers told their wives that they did not want to return to the M.W.I. Both fathers were playing the more passive role in the marital relationship and both had managed to achieve a precarious personal and marital adjustment.

The interviews seemed to reactivate too many of the anxieties which the fathers had been attempting to repress. These anxieties were aroused before a strong worker-client relationship could be established with the father. As a result he could not regard the clinic as a source of strength, but as a threatening authority which might disturb his peace of mind.

Fern Lowry[1] has stated that "The worker-client relationship must be a free and comfortable one if the client's energies are to be rallied to the best of his ability." The difficulty, especially in short-term contacts, is in deciding how much time can be spent in establishing rapport with the client without going into areas which are painful to him.

In the two cases mentioned above, the clients apparently did not feel "free and comfortable," and therefore they were unable to accept the service offered.

In one of the cases the father was a weak, dependent person with a rather schizoid personality structure. Since the clinic felt that he was contributing to the patient's problems, an attempt was made to bolster his weak ego by drawing him into the clinic's planning for the patient and by putting some of the responsibility for the planning on his shoulders. The father continued his contact with the M.H.I. until the interviews began to revolve more directly around his relationship with the patient. He became very defensive in discussing

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[1]Fern Lowry, "Current Concepts in Social Case-Work Practice," The Social Service Review, Vol. XII, #3 (Sept.1938) p. 365

his relationship to the child and denied having any resentment towards him except for the first few days of his wife's pregnancy. After the interview in which his underlying hostility to the patient was discussed the father refused to return to the clinic; he told his wife that he knew more about psychiatry than any psychiatrist and he broke off relations with the M.H.I.

In the third case the clinic felt that the father was essentially a very dependent person. The worker's attempts at casework with the father seemed to be going very well, when suddenly he accepted an extra evening job and was no longer able to keep appointments at the clinic. Since the father had begun to develop a more permissive attitude towards the patient and his relationship to the worker had been a good one, the fact that he broke off the contact abruptly did not seem to indicate that he was disturbed by his interviews in any way. A closer examination of the sequence of interviews with the father revealed that the contact had at first revolved around helping with the patient's rehabilitation from Shawbridge and from Bordeaux Jail. As this problem began to diminish in importance in the father's mind, the subject matter of the interviews began to change. The father began to discuss his feelings about the other members of the family. In his last interview with the worker, prior to his accepting the evening job, he spoke of how he had always worked long hours to provide for his family, and he felt he had not been as close to his wife and children as he should have been. He expressed the feeling that his family was growing away from him and he had failed in

his role of father. This had apparently aroused a great deal of anxiety; the fact that he no longer continued his contact with the worker after that interview might very well mean that he found the subject matter of the interviews too threatening. It was easier for him to fall back into his old pattern of escaping into work, at that point. There is no statement in the record about the worker's opinion on the matter, but the sequence of events and the father's reaction to them made the writer feel that it was no accident that he accepted an extra evening job when he did.

The fourth case in this group was the one in which the father lived out of town and found it difficult to come into Montreal for appointments. This was apparently not the real reason why he discontinued the contact with the clinic, because he had been able to keep the first two appointments made with the worker. The father's personality in this case was similar to the one in the case just described. He was overcome with feelings of inadequacy and he, too, worked long hours as an escape from his problems. He showed very little insight in his contact with the worker. During his two interviews at clinic, to which he came without being asked, he discussed his poor relationship with his son and his feelings of failure in life. In this case, too, after the interview in which the father discussed his feeling of failure in life, he did not return to the clinic. Here the worker's impression was clearly stated; he felt that the father was afraid that his peace of mind would be disturbed at the M.H.I. It is interesting to

note that the father had disapproved of the patient's coming to the M.H.I. because "they might only raise questions about his mentality in his mind, which would be disturbing to him." This might very well have been a projection of his own fear of finding out more about himself. Since the father had taken the initiative previously in seeking help and since the worker felt that further interviews would not be of too much value because he was too disturbed, the clinic made no further attempts to prolong the contact.

In the remaining case of group II, the father was a very disturbed person. He had been in St. Anne's Mental Infirmary and he still had strong paranoid tendencies. For example, he thought that people talked about him in the bus when he came home from work. He was anxious to come to the M.H.I. at first. He was eager to co-operate with the psychiatrist and seemed to want to identify with his authority. He even attempted amateur psychotherapy with the patient after his first interview at the M.H.I. In keeping with his usual pattern of blaming others for his own defects, his attitude to the patient's problem was that it was completely the mother's fault. He co-operated with the clinic as long as he thought its staff felt that he was not responsible for the boy's difficulties. As soon as his relationship to the boy was discussed in interviews, and an attempt was made to focus on his role in the situation, he disclaimed all responsibility for the patient. He insisted that the problem had been caused by the mother and that she should deal with it. He refused to come to the M.H.I. after this and all subsequent

contacts the clinic had with him were by telephone.

After examining the personality of the father in the cases of group II, the point of similarity which emerges is that he was easily threatened by closer investigation into his relationship with the patient and into his own emotional difficulties. As soon as this was attempted by the clinic the father withdrew from treatment. The clinic did not actively attempt to draw him back into the treatment situation since "attempting to give a patient insight has therapeutic value only for a patient who is capable of tolerating such insight[1]." The workers did not feel that the father was ready, nor that he had the capacity for insight into his emotional conflicts. His withdrawal from the treatment situation was necessary defense against anxiety with which he was not ready to copy. "If the patient's bond to the therapist proves unable to stand the strain.....the patient may find devices to protect himself, and if such devices fail he may run away from treatment[2]."

There was a group of four cases which the workers were doubtful about, as regards a more intensive contact. In three of the four cases the question was whether the father would be able to use more intensive casework service; in the fourth case the question was whether he needed it. In the first three cases the father had little insight and the worker felt

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[1]Franz Alexander and Thomas M. French, Psychoanalytic Therapy, Principles and Application, (New York,1946) p. 128

[2]Ibid, p. 138

that they were essentially dependent, immature people. In interviews with the workers the writer learned that it was mainly because of the father's anxiety and their inability to relate easily to the worker, that the workers were uncertain about whether they would be able to use a more intensive case-work service. In the fourth case the father seemed to be adequate and the worker doubted whether he needed a more intensive approach. In his case the environmental stresses were so great that it was necessary to alleviate them first. When this was done he showed a good capacity to deal with his other difficulties in a realistic manner. Because of this the clinic did not offer any intensive service. He was seen frequently, but the service was focused on manipulating the environment.

There were three remaining cases where the workers did not think a more intensive service necessary. The reasons for this were not the same in all three cases. In one case the father was too disturbed to benefit from the M.H.I.'s services and he was referred to an adult psychiatric clinic. In the second case, the father was helped to gain a better understanding of his son's difficulties. The other area of difficulty for him was in his marital relationship. The worker felt that after working through his difficulties in the relationship with the patient, he was able to deal with the marital problems himself. In the third case the father was helped to accept the fact that the patient was mentally retarded. The contact was terminated after this because the worker did not think his other difficulties were serious enough to warrant continued service.

The last case in the sample group was one where the clinic felt that the father needed intensive casework. Since another casework agency was active on the case the intensive service which the father needed was left to the referring agency.

After studying the cases it was found that there were only two where there was a definite improvement in the father-patient relationship and in the patient's behaviour, as a result of the clinic's work with the father. In two cases the clinic's contact with the father also had some effect on the father-patient relationship although the results were not as consistent nor as definite as in the first two cases. In the remaining 16 cases the service to the father did not seem to have any effect on his relationship with the patient.

There were various factors which accounted for the lack of intensive casework service to the fathers. These could be grouped under two main reasons. 1) The worker lacked the time to work intensively on each case due to the pressure of the caseload in a community clinic which cannot refuse any cases in the income group it serves. 2) The fathers themselves refused further service.

It is not desirable to have the same worker treating both parents since this very often places the worker in the role of judge and elicits hostile and competitive feelings between the parents. It has been shown in this chapter that very often a parent will refuse service under those conditions. However, there is insufficient casework staff at the M.H.I. to have different workers assigned to each parent. This factor

is really a combination of the two main reasons stated above and has therefore been mentioned separately.

On the whole, the workers felt that the father should have been given a more intensive type of service in the sample group of cases. The results of the services given to him indicate that where he is not worked with intensively, the service will have little effect in changing the father-patient relationship and/or the patient's behaviour. Since it is important for the worker to budget her time, it might be preferable for the caseworker to see both parents routinely and then decide with which one the clinic should try to work. This could help save the worker's time in the long run, and it would seem to be the best way of enlisting the parents' co-operation in order to help those children the M.H.I. undertakes to give therapy.

Chapter Six

SUMMARY AND CONCLUSIONS

This study has shown that the fathers play a very small role in treatment at the M.H.I. They are seen only in a small proportion of the cases and in none of these are they given intensive casework service. In view of this fact it does not seem surprising that there were found to be no great changes, in most cases of the sample group, in the patient's behaviour or in the father-patient relationship as a result of the clinic's work with the father. There were only two cases where there was a definite improvement in this area.

Because there were so few positive results of the clinic's contact with the father, the workers were asked[1] whether they thought a more intensive service would have been desirable in their own cases. In most cases the workers felt that the father should have been given a more intensive service. In 12 cases the workers thought it would have been desirable and in four cases they were doubtful whether the father needed it or could have used it constructively. In one case the more intensive casework, which the father needed, was left to the referring agency. There were only three cases in which the workers were

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[1]Personal Interview

quite certain that such a service would not have been desirable.

Thus the failure to offer a more intensive casework service to the father was not due to the fact that the workers were unaware of the need for it. It was due in a large measure to a limitation of the clinic facilities i.e. a lack of agency personnel to work with both parents. If casework service is offered to both the father and the mother it means that more time has to be spent on each case. Since the M.H.I. is a community clinic and cannot be selective in its caseload, this limitation is a serious one.

The second major reason for not giving a more intensive service was the inability of some clients to accept it. In this latter group the fathers felt too threatened to be able to accept the service, and they withdrew before a more intensive contact could be established. Thus one of these limitations originates in the clinic facilities and the other limitation lies with the client.

The father's role in treatment at the M.H.I. is very limited, then. He is essentially an onlooker; he may be called upon to give information about the child, or he may demand an appointment to protest the referral. But he does not move beyond these stages. The clinic may offer him support and a little clarification about the patient's problem when he comes to give the necessary additional information about the child. It may help him accept his child's referral but it does not include him in its program of 'casework with the parent' which is the

social worker's task in a child guidance clinic.

There were two main types of service given to the father. The first was a combination of psychological support and environmental manipulation, and the second was psychological support and clarification. In no cases was the more intensive 'insight therapy' offered. The fathers' response to the service ranged from poor to very good, and most of the fathers were in the group which responded poorly or only fairly well. There were only three fathers whose response was considered very good.

It must also be noted that the service offered was definitely on a short-term basis. Even in the one case where there were more than three interviews with the father, the contact was on a superficial level. The reason for this lies in the clinic's purpose in seeing the fathers. It did not contact them for the purpose of drawing them into the treatment situation, but in order to get additional information about the child's home life. As a result, the kind of contact the clinic had with him was different than it would have had, if he had been seen with a view of making him a participant in the treatment process.

It was found that where the clinic took the initiative in asking the fathers to come in, the usual method of arranging an appointment with him was through the mother. In only one case do the records show clearly that he was contacted directly by the clinic. In this case the relationship between the parents was so bad that it was felt preferable for the clinic to contact the father directly. In all cases the mother seemed willing to

have the father seen at the clinic, but after he had been seen it was sometimes found that this was a threatening experience for her. This suggests that more thought should be given to the clinic's invitation to the father to come in for an interview.

It is interesting that one half of the total number of fathers in the sample group came to the [illegible].I. without being asked by the clinic to come. When the father's attitude about being brought into the treatment situation was explored, it was found that he was willing to be included. The reasons for this were not always bound up with his desire to help the child; they were very often bound up with his role in the family and his relationship with his wife. The father's relationship to his wife also played a very important role in determining what kind of relationship he would have with the patient. In 12 of the 14 cases where the father responded poorly or only fairly well to psychological support and clarification, there was evidence in the record that one parent was competing with the patient for the love of the other parent.

On the whole it was found that those fathers who responded very well to the service offered had an accepting attitude to the patient. The fathers whose response was either fair or poor were found to have primarily a punitive and rejecting attitude to the patient.

The importance of the relationship between the parents in its effect on their relationship to the child suggests the need for further study in this area. It would be valuable to

know whether it would be helpful for a child guidance clinic to offer a more thorough counselling service to the parents. This would mean a different approach to child guidance. At the present time the child guidance clinic is admittedly child-centered and the main focus of treatment is on the child. It is he who is seen by the psychiatrist. There seems to be a trend in some family counselling agencies towards what they call the family centered treatment. Here both parents and child are seen by caseworkers. The treatment is begun with the parents and it usually deals with their relationship to each other. When this is worked through satisfactorily the child is brought into the treatment situation. This type of approach is still in the experimental stage and needs further investigation. It is mentioned here because it is based on a premise which is supported by evidence in this study. That is, that the parents' relationship to each other has a great effect on their relationship to the child. This study has dealt only with the clinic's contact with the father and it was found that where this problem has not been worked through in the clinic's contact with him, there was no improvement either in his relationship to the child or in the child's behaviour.

The trend towards family-centered treatment indicates the possibility of a re-evaluation of the approach and the philosophy of the child guidance clinic. The aim of the clinic would remain unchanged but the question of whether a child's behaviour problem is symptomatic of disturbed parent-child relationships or whether it is a difficulty which has its roots

in the child himself and hence can be treated most effectively by focusing treatment on him, would have to be resolved.

If the child guidance clinic is to continue to operate according to the psychoanalytic concepts which emphasize the importance of both parents in the personality development of the child, it would seem logical that both parents should be included in a treatment process which tries to help the child to a healthier emotional adjustment.

A P P E N D I X

DOCUMENT SCHEDULES

Documentary Schedule I.

PATIENT

NAME.....SEX... AGE IN 1950..... WORKER.....

PROBLEM: The one originally stated upon referral as well as ones diagnosed by the psychiatrist.

M.H.I. CONTACT: Brief description of the patient's contacts at the clinic and an account of what the clinic knew about his behaviour at home and in the community during this period.

PARENTS

MOTHER: Brief account of the clinic's contacts with her throughout the patient's treatment. This reveals her attitude to the patient, the father, and possibly to her own parents. The worker's diagnostic impressions will be included.

FATHER: Why did he appear at the clinic?

FIRST INTERVIEW: A summary of what went on between the father and the psychiatrist of the worker, and their impression of him.

SECOND INTERVIEW: A summary of each interview at the M.H.I. and an account of the clinic's impression of the father. The interviews usually include a picture of the father's relationship to the patient before, and during treatment.

Documentary Schedule II.

1. Father's attitude to coming to the M.H.I.....
2. Father's attitude to the child's difficulties.....
3. Services given by the M.H.I.....
4. How did the father respond?.....
5. Was a more intensive contact desirable.....
6. Why not given.....

7. Did service to the father effect any change in the patient's behaviour or in the father-patient relationship.....

Documentary Schedule III.

1. Description, in narrative form, of the personalities of the mother, father, and patient and their inter-relationship..[redacted]..[redacted].....

2. A summary of the clinic's impression about the dynamics contributing to the behaviour of each of the above-mentioned family members. This card is to give an overall picture of the personalities involved in each case.....

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