

**A Study of the Effects of the Mother-Child Relationship
on the Socialization Process of Individuals (Children
and Adults) as seen in a Comparative Study of Normal and
Abnormal Families (Families with and without identified
Patients) based on the Systematic Method of Evaluating
Case History Data**

1972

by

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THESIS

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Degree of Master of Social Science in Social Work
(Psychiatric Social Work)**

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ERRATA

P.35, Line 25, Summary Sheets ought to read Summary Work Sheets

P.62, Line 1, Communications ought to read Communication

P.99, Line 3, findshimself ought to read finds himself

Appendix D, Exhibit 3, Summary Work Sheets ought to read
Summary Work Sheets as seen Collectively

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A.D.C.R.

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CHAPTER I

AN OVERVIEW OF THE AREA OF STUDY

A

DELIMITATION OF THE AREA OF STUDY

The mother-child relationship has been a field of interest of a variety of educational disciplines. The subject has been studied from many viewpoints.

Medicine for instance studies the biological tie between mother and child, Anthropology studies the mother as the culture-bearer in relation to the child, Sociology studies the mother in terms of role theory and as part of a sub-system (family) within a broader system (society) in which she helps to socialize the child in preparation for adequate role performance in later life. Theology, too, focuses on the mother's function and stresses her encouragement of spiritual growth in the child. It idealizes her role by setting expectations and taboos to guide her behaviour.

This present study is being carried out from the perspective of the profession of psychiatric social work. It has borrowed from the abovementioned disciplines, but has used Psychiatry,

Psychology, and Social Work as its chief base of knowledge.

Numerous studies exist that deal with the importance of the mother-child relationship on personality development and functioning of the individual as covered by these three disciplines. Psychiatric social work has borrowed heavily from such sources in order to aid in its understanding of human behaviour.

In order to understand the personality (being to a large extent a product of the mother-child relationship) we need to study its "evolution". Any attempt to help an individual scientifically and effectively has as a prerequisite a logical, coherent body of knowledge.

B

PURPOSE OF STUDY

The main purpose of the study under investigation is to determine the importance of the mother-child relationship in influencing the personality development of the individual.

To determine the importance of this area for personality formation it was considered necessary to view the individual together with all the other variables that may affect his development. Only after perspective was gained on all the processes and factors that make this development possible was it thought scientifically

valid to isolate the mother-child relationship and estimate its importance to the whole by testing it out against the other factors.

To facilitate this procedure, a large part of the study is concerned with reviewing the total personality functioning, instead of setting out with no more than an isolated study of the mother-child relationship.

The author is well aware that studies of the mother-child relationship are very numerous indeed. However, the present study claims a special feature — it not only investigates the quality and influence of mothering, but also measures these quantitatively. Quantifying data help to increase objectivity, lessen value judgments on the part of different individuals who work with the same material, and bring the study closer to the ideal of the exact sciences.

To the knowledge of the investigator, it is the first time that a quantitatively measured study has been carried out to ascertain the influence of the mother-child relationship on personality development.

C

SCOPE OF STUDY

In this work, the interaction of the individual and his

environment is reviewed from birth onwards, with special focus on the exchange between mother and child in the process of living, growing, developing, and learning.

In order to cover these areas, the family was examined with regard to the general emotional "climate" it offered during the individual's formative years. Relationships, within the family, and other variables which might affect family functioning (such as socio-economic and cultural factors) were also examined. It was felt necessary that these be taken into account when evaluating the strength of the mother-child relationship because it is well-known that such variables affect the final product of what the mother gives to the child emotionally and socially.

Another purpose of the study is to evaluate and compare the mother-child relationship in two separate but matched groups of subjects, here termed normal and abnormal cases, to see if any significant differences in the mothering experiences of these two groups could be identified, both qualitatively and quantitatively.

History taking is therefore focussed on the client who has come in for help (abnormal), and in this study he is sometimes referred to as the identified patient or client in order to distinguish him from the rest of his family members. The normal person who is matched with this client is for the sake of simplification also referred to as the identified patient or client for the same reason.

Material for this study was obtained through interviews by psychiatric social work students undergoing training in the Cape Town School of Social Work, by qualified psychiatric social workers, and by the investigator (also so qualified). Out of a total of 70 interviews, comprising the sample, 21 (18 normal cases and 3 abnormal cases) were carried out by the investigator.

The data were recorded and evaluated according to the Systematic Method of Evaluation (SME), which was developed by Mr. J.L. Stricklin, Senior Lecturer in the Cape Town School of Social Work, and Chairman of the PSW Course.

D

PROCEDURE OF COLLECTING AND RECORDING INFORMATION

- (i) Introduction: Information about the client and his milieu was obtained through verbal interviews. As has been mentioned above, the interviews were carried out by psychiatric social work students and by qualified psychiatric social workers. The interviewers were graduate students who had had previous experience in interviewing and also in using the SME. This factor encouraged uniformity and precision, not only as to the means of obtaining information but also on the type of information received.

(ii) The Interview: Most of the interviews between the abnormal clients and their families took place in the office of the agency in which the interviewer worked (either as employee or as student in field instruction).

In the case of normal clients, interviewers sometimes needed two interviews to obtain the relevant information. In most cases, however, a single interview, lasting one-and-a-half hours, was used to obtain a Psycho-Social History.

For both types of case (normal and abnormal) the interviewer encouraged the interviewee to discuss areas of importance outlined by the SME. In this way, the interviews were to an extent guided by her.

Interviews for the abnormal cases took a longer time in that the interviewees had a greater need to discuss their present problem per se. This ventilation of problems had to be allowed, as treatment was being carried out simultaneously by the worker.

In the normal cases, the interview had to be directed by the interviewer to a greater extent because of the lack of a presenting problem (the clients had not come for help) and because of limited time.

In the normal families in which a child was the identified patient the parents were interviewed. Where the identified patient was an adult, both he and his parents (if available) were interviewed.

In the abnormal families, both parents and identified patients were interviewed, irrespective of whether the case concerned a child or an adult, as the need for treatment made this necessary.

Why, the reader may ask, where the identified patient was an adult, were the parents interviewed as well? The reasons were as follows:-

It was considered more likely that they would be aware of the developmental history of the identified patient, such as birth weight and the age at which the patient was toilet trained.

Moreover, the interviewer could in the course of his interviewing directly assess the parents' attitude towards the client and towards child-rearing (a crucial area of the investigation).

Furthermore, it was likely that the parents would not only give more detailed information about the patient's behaviour, but might be more "objective" than the client himself.

The interviews generally covered all areas affecting development.

Questions such as the depth of an interview, the need to concentrate on particular areas of an individual's life cycle, and similar matters of judgement, were left to the discretion of the interviewers. In this particular respect the interviews can be regarded as unstructured.

Interviewers recorded brief notes during the interview. In some instances, a tape recorder was used to record information.

- (iii) Method of Recording: Information was obtained by recording the psycho-social history of individual cases for both normal and abnormal groups. This procedure is inherent in the SME and can be described as a specialized type of case history recording with emphasis on psycho-social background.

The psycho-social history per se (as will be seen in a later and more detailed description of it) records information concerning the client's family functioning (cultural, social, and emotional), birth history, developmental milestones, and his relationships with significant people in his environment.

- (iv) Reliability of Information Received: It can be said that information contained in the case histories can be considered reliable for the following reasons.

In the case of abnormal clients, material was obtained solely for the purpose of carrying out treatment. It was unlikely that clients and informants who had voluntarily come for help would grossly deceive the interviewer.

Clients and informants were aware that the more direct they were about problems the more precise the treatment goals became. In some cases, a balanced account of behaviour of self and others was not possible owing to the

subjectivity of the person involved in the interview. Such distortions as sometimes resulted from the client's anger, guilt, or denial, were however in themselves regarded as part of the pathology in which the person was enmeshed. In the majority of the cases the whole family was usually involved in the treatment of the identified patient, which made further validation of information received a simple task.

Furthermore, clients were made clearly aware of the confidentiality of the interview material.

It must be borne in mind, too, that the interviewers had had considerable training in obtaining information from a client without necessitating the raising of defences. They were skilled in building a trusting relationship in which the patient or client would feel free to expose himself to his listener.

The information received from the normal clients may also be regarded as highly reliable. Parents were motivated to discuss not only the normal development of their children but also the "abnormalities". This was achieved by reassuring them that normal people, too, had difficulties in their life-cycles and that these should not necessarily be viewed as pathological.

Most of the parents used the interview as a rewarding learning experience in which they raised problems encountered during child-rearing, asking the interviewer for

clarification.

Histories for both the normal and abnormal groups were fully recorded soon after the interviews to minimize errors and distortions.

- (v) Reliability of Interpretation of Data: The understanding and interpretation of the psycho-social histories by the investigator can be regarded as reliable because most of the interviewers were trained under the same instructor as the investigator. In this way, concepts used, and the deduction and evaluation of behaviour, held similar meanings for the interviewers and the researcher. The researcher was able to recheck information which did not seem clear by verbal contact with interviewers.

Since all 70 histories were evaluated, interpreted, and scored by the researcher, a consistent standard was applied throughout the processing of the data.

CHAPTER II

A REVIEW OF THE PLANNING, SELECTION AND SUITABILITY OF THE SAMPLE FOR RESEARCH STUDY

A

INTRODUCTION

Before planning and selecting the sample for the research study it was important carefully to examine the exact formulation of the title of the research, viz.:

"A study of the effects of the mother-child relationship on the socialization process of individuals (children and adults) as seen in a comparative study of normal and abnormal families (families with and without identified patients) based on the Systematic Method of Evaluating Case History Data".

A comparative study of normal and abnormal families obviously presupposes two groups of individuals. The first group is the experimental one (abnormal) and the second group is a control group (normal).

It was decided to consider an unhealthy mother-child relationship as one that reflected defective personality adjustment. A

mother-child relationship in which no defective personality adjustment was reflected was regarded as healthy. There obviously had to be some clearly definable criteria which would set these two groups apart.

B

FORMULATION OF DEFINITION FOR SELECTION OF UNIVERSES

After consideration of the advantages and disadvantages of various criteria, it was finally decided to define as abnormal all individuals who were receiving or had received help from recognized resources in the community. These resources were Welfare Agencies, private psychiatric consultation, and any other professional service either directly or indirectly paid for.

Individuals who seek outside help generally experience a higher level of stress which results from their poor adjustment with the environment. This stress motivates them to seek help in their problems. It was therefore concluded that all individuals who utilize a recognized helping resource in the community could legitimately be considered as people with poor personality functioning -- in other words, that the maladjustment manifested itself in sufficient severity of stress as to motivate the person to seek help.

Following from this decision, it could therefore be

additionally concluded that individuals who had not sought outside recognized help for personal problems had not undergone sufficient stress in adapting to their environment to motivate them to seek such help. This implied a healthier personality adjustment. If such persons did suffer stress, but had nevertheless not sought aid, this implied that they had had sufficient ego strength to deal with their own problems.

C

SOME PROBLEMS IN THE DEFINITIONS OF "NORMAL" AND "ABNORMAL"

The described criteria for defining normal and abnormal individuals might not have operated satisfactorily for a number of reasons. (However, the author's experience in the field, and her consultations with specialists in social work, provided strong corroborative evidence and indicated that the criteria were not invalid.)

For instance, the majority of the individuals who were considered normal might not have approached outside resources for help precisely because they had undergone such an extreme degree of stress. The severity of this stress could have resulted in gross personality disorganization. This state in itself could have become a barrier to seeking help — as disorganization either becomes a 'normal' way of life, or the person continues on a lower level of

functioning without even realizing that he has problems. In both these cases the person would not be motivated to seek help although he would require it.

In order to guard against the abovementioned loopholes it was decided that steps should be taken to recognize such problems at the outset by not accepting families in which gross pathology was evident for use as units of the control group. If this measure failed, and a case which really needed treatment was entered as normal, the pathology would nevertheless be picked up by the SME and would be reflected in the Diagnostic Percent Score. In this way, it would bring itself up for inspection.

When the investigations had been completed, the selection process was proved successful in 34 out of the 35 cases, in that only one normal case required treatment. In one other normal case treatment was questioned. The table below has been used to determine the treatment needs of cases of the sample.¹

TABLE 1
Diagnostic Percent Scores which determine
Likelihood for Treatment

Category	Treatment Needed 0 - 60%	Treatment questioned 61 - 70%	Treatment not Needed 71 - 100%	All
Normal	1	1	33	35
Abnormal	35	-	-	35
All	36	1	33	70

D

ASCERTAINING SIZE OF UNIVERSE
FOR NORMAL AND ABNORMAL CATEGORIES

When selecting the number of cases, it was important to have a universe as large as possible to maximize the significance of the results. But at the same time the universe had to be sufficiently limited that it could be handled by one investigator over a period of two years.

The sample size chosen for each category was 35, making a total of 70 cases for the entire universe. The value of a round figure for purposes of convenient statistical handling was also taken into consideration.

The units of the sample for the abnormal category were chosen from case histories prepared by Psychiatric Social Work students of the University of Cape Town. These case histories were drawn up in the course of the regular Field Instruction prescribed for these students at Agencies, under supervision. The rest were taken from trained psychiatric social workers and from the social work records of Agencies in the community. The chief focus of selection of case histories rested on the amount of detail of personality dynamics that was included in the detailed case record.

Most of the Psychiatric Social Work trainees, as also the qualified personnel in this field, worked at "White" agencies.

For this reason, the majority of the subjects of the histories are White persons.

After selection of the abnormal category had taken place, the next step was to find a normal control group of 35 cases to match each abnormal case. The main purpose of matching was to control such variables as differences in sex, age, socio-economic level, profession of father and mother, age and education of father, mother and client, ordinal position, race, and religious affiliation.

In choosing the normal sample, schools, crèches, church ministers, and nursery schools were asked to cooperate in finding families which had similar demographic 'structures' as the abnormal families.

Letters were sent out by the author from the University to potential families for the normal group, explaining the purpose of the research study and the requirements needed for it. Response forms were attached to these letters, and addressees were requested to state either a willingness or unwillingness to be interviewed.

After the replies were received, each prospective interviewee was contacted, and a meeting arranged in order to collect the relevant information.

Of the 35 normal clients, 18 were interviewed by the researcher.

E

PROBLEMS ENCOUNTERED IN MATCHING
THE NORMAL AND ABNORMAL CASES

There were many difficulties encountered in trying to match the normal and abnormal families because of the relatively large number of variables that had to be taken into account in the selection.

In some cases it was found that not all characteristics could be matched accurately, and for these cases it sufficed if the most important ones corresponded. Factors of matching which were given priority were sex, age, race, religious denomination, and standard of education of the identified client, that is the person who requires help.

F

RESULTS OBTAINED FROM THE MATCHING
OF THE NORMAL AND THE ABNORMAL GROUPS

TABLE 2

Normal and Abnormal Clients classified according to
Race and Sex

Category	White		Coloured		All Clients		All
	Male	Female	Male	Female	Male	Female	
Normal	22	9	4	0	26	9	35
Abnormal	22	9	4	0	26	9	35
Total	44	18	8	0	52	18	70

From Table 2, showing the comparative race and sex distribution, it can be seen that the two groups of normal and abnormal clients were perfectly matched in these respects. In both race groups there seems to be a higher proportion of males. A reason for this could be that males are given more opportunity to display overt behaviour patterns as there is less pressure on them to conform. Pressure of society on females to conform to normative patterns seems greater and, furthermore, females have much less planning to do with their leisure hours as they get absorbed into home-running or other domestic affairs which take up much of their attention and energy.

The unrepresentative racial distribution (31 Whites, 4 Non-Whites) is due to the fact that most of the case histories were taken at White Agencies. The distribution is thus an artefact of the research itself and does not reflect the nature of the socialization experience.

TABLE 3
Normal and Abnormal Clients classified according to
Age

Age Range (years)	Normal	Abnormal	All
0 - 2	1	-	1
3 - 5	5	7	12
6 - 11	12	11	23
12 - 15	8	6	14
16 - 20	4	5	9
21 +	5	6	11
All	35	35	70

Table 3 above shows the two groups of clients classified according to age.

The biggest concentration of clients is to be found in the age group 6 - 11. The median of the distribution also lies within this group.

At age 3 - 5 years, the young clients probably first

experienced separations from home. Resulting stress, owing to the adjustments which have to be made outside the home may account for maladaptation leading to symptoms.

The latter part of the 6 - 11 year period, and the actual 12 - 15 year period, mark the onset of puberty and adolescence. This is a difficult period in which childhood Oedipal conflicts are renewed. Such conflicts have to be dealt with by an already weakened ego which finds the stress engendered too much to cope with.

Matching the normal and abnormal clients, as the table shows, seems to have been fairly close. The biggest differences are to be found in the 3 - 5 year and the 12 - 15 year categories, where the difference between the population of normals and abnormals is as much as two. Slight discrepancies in age probably do not hold much significance as the general age ranges seem to correspond rather closely to the Freudian Developmental Stages (oral, anal, phallic, latent, and adolescent). These stages, although they do not have clearly-defined chronological boundaries, roughly correspond to periods of age shown in the table.

TABLE 4
Normal and Abnormal Clients classified according to
Ordinal Position

Ordinal Position	Normal	Abnormal	All
Eldest	15	17	32
Middle	7	4	11
Youngest	12	10	22
Only	1	3	4
Unknown	-	1	1
All	35	35	70

Table 4 indicates that eldest children predominate as identified patients, with the youngest following in importance.

Eldest children quite easily become identified patients because they are the first newcomers in their parents' married lives. If a neurotic set-up exists in the parents' marriage, these children are easy "targets" for neurotic development as they interact with their parents most; do not have siblings to absorb their time; and, being single, cause the parents to be most involved with their care which sometimes leads to unhealthy preoccupation with the child.

The same explanation holds for 'only' children.

Youngest children are quite often "babied" for longer than usual and on account of this have more interaction with their

parents.

It must be borne in mind that just being 'eldest', 'youngest', and 'only' does not predestine one for abnormal development but that, in most cases, given the other conditions of having neurotic parents, etc., it sets the likelihood for such development.

TABLE 5
Normal and Abnormal Clients classified according to
Educational Standard

Educational Category	Normal	Abnormal	All
Pre-school, Nursery	7	7	14
Other	-	1	1
Substandards	1	2	3
Standards I - III	9	5	14
Standards IV - VI	7	10	17
Standards VII - X	5	4	9
Matriculated	3	2	5
Attends University	1	1	2
Other Post-Matric. Specialization	1	-	1
University Graduate	1	2	3
Unknown	-	1	1
All	35	35	70

The Pre-school, Nursery, Other, and Standards I to VI levels appear to predominate among the abnormal patients. This clustering occurs mainly because 29 of the abnormal clients are still at

school and, thus, does not reflect their final educational attainment.

Matching has been fairly successful considering the fact that about five very important variables had to be taken into account.

One abnormal identified patient, under the educational category of 'Other' attends a School for the Deaf.

TABLE 6
Normal and Abnormal Clients classified according to
Religious Affiliation

Religious Category	Normal	Abnormal	All
Protestant	26	24	50
Jewish	8	7	15
Catholic	1	3	4
Unknown	-	1	1
All	35	35	70

As far as religious affiliation was concerned, normal and abnormal clients were fairly closely matched, the greatest difference being that the Protestant and Catholic categories differed by two in each case.

The Protestant group had the largest representation, which probably reflects the fact that Protestants preponderate in the general population of Cape Town. The Jewish group follows in

importance. There seems to be a significantly small representation of the Catholic group; only three clients were Catholic. Could this imply that Catholics turn rather to their own personal agencies of help, such as their Church — a religion in which the role of the priest as a therapeutic agent is emphasized more so than in other religions? In the researcher's opinion this is highly likely as it is helped by several factors which are common to the therapeutic relationship.

Some of these are that the priest is viewed as an extended representative of "divine power" and in most cases this immediately sets up positive transference (a condition which is essential in any treatment situation) for those who go to him for help; he is seen in the capacity of a counsellor, too, and can also relieve guilt through the confession system.

TABLE 7

Normal and Abnormal Clients classified according to
Socio-Economic Standard

Socio-Economic Category	Normal	Abnormal	All
Upper	13	12	25
Middle	18	15	33
Lower	4	7	11
Unknown	—	1	1
All	35	35	70

Another factor that the study attempted to control was the socio-economic level of families in the normal and abnormal category.

There was a difference in matching in three instances in the 'Middle' and 'Lower' categories.

In the abnormal category the greatest number of cases came from the 'Middle' category (15) with the 'Upper' following with 12 families.

The clustering in the 'Upper' and 'Middle' groups can be explained by the fact that most of the clients were drawn from the White population which is predominantly upper and middle class economically.

Despite the fact that the sample does not correctly represent real needs for therapeutic services of different socio-economic groups which seek help (especially the 'Lower' category), it does however point to the fact that personality problems exist for all socio-economic groups, irrespective of class.

TABLE 8
Normal and Abnormal Clients classified according to
Family Type

Family Type	Normal	Abnormal	All
Natural nuclear	31	22	53
One-parent mother	3	5	8
Stepmother	-	2	2
Stepfather	-	1	1
Living with siblings	-	1	1
Adoptive parents	1	-	1
Foster parents	-	2	2
Living alone	-	1	1
Illegitimate	-	1	1
All	35	35	70

In the abnormal category there are 13 "unnatural" and non-nuclear family types, as compared to four in the normal category. This, however, does not prove that families which are normal do not have unusual family circumstances; families of this type were deliberately avoided when selecting the normal sample group.

However, in evaluating only the abnormal sample group it can be concluded that just over one-third of the sample of 35 had disturbances in their environmental set-up which quite often immediately sets up a precedent for stress and difficulty in adjustment.

TABLE 9

Normal and Abnormal Clients classified according to
Age of Father and Age of Mother

Age Range	Normal		Abnormal		All	
	Father	Mother	Father	Mother	Father	Mother
25 - 29	1	5	-	7	1	12
30 - 34	10	7	9	5	19	12
35 - 39	3	5	6	6	9	11
40 - 44	5	6	3	5	8	11
45 - 49	5	4	5	6	10	10
50 - 54	5	3	5	1	10	4
55 - 59	2	3	1	2	3	5
60 and over	3	1	3	2	6	3
Unknown	1	1	3	1	4	2
Total	35	35	35	35	70	70

In assessing the matching of parents' age for the normal and abnormal groups it can be seen from the above table that the fit was fairly close.

TABLE 10

Normal and Abnormal Clients classified according to
Occupations of Father and Mother

Class of Occupation	Normal		Abnormal		All	
	Father	Mother	Father	Mother	Father	Mother
Professional	14	4	11	6	25	10
Semi-professional	14	3	11	-	25	3
Skilled	5	-	3	-	8	-
Semi-skilled	1	1	3	1	4	2
Unskilled	-	-	1	1	1	1
Self-employed	-	1	2	2	2	3
Housewife	-	26	-	25	-	51
Unknown	1	-	4	-	5	-
All	35	35	35	35	70	70

Both the normal and abnormal families seem to have parents who are uniformly distributed as far as occupation is concerned, with the highest number being clustered in the professional and semi-professional groups. Again (as for socio-economic level), the sample selection created this situation as clients who have families in the 'Upper' and 'Middle' groups in South Africa tend to be Whites who generally fall into the higher educational group for the population.

Looking at the occupation of the mothers of the abnormal clients, it seems as though the fact that a mother stays at home to care for her children does not offset the tendency towards faulty

adjustment patterns, as 25 of the mothers in this category are housewives.

The match for this category seems to have fitted fairly closely. In the cases which did not fit exactly, every possible attempt was made to get a match as close as possible. For example a professional might have been (as a last resort) matched with a semi-professional, but never with a semi-skilled as this would leave too wide a difference in the general social and cultural background.

G

EVALUATION OF MATCHING NORMAL AND ABNORMAL CLIENTS

In the final evaluation of matching, there seems to have been a very close correlation of the variables between normal and abnormal families.

Even if there were differences in variables, these were not of a major difference as a "twin" as close to the ideal (normal case) was chosen.

Certain factors, such as sex, age, religion, and socio-economic standard were given priority over others, and sometimes a more fitting normal match was sacrificed just to allow an important factor to be controlled. For example, if a normal matched an

abnormal case as far as sex, age, education, profession and age of parents, but did not match for race, then this case was not used as it was felt that race was a major factor which could not be overlooked.

An important conclusion that was reached at the end of the investigation is that the sampling method used to select the normal category was highly successful in that only in one case was treatment required by a 'chosen' normal family and in one other case was treatment questioned.

CHAPTER III

THE INSTRUMENT

1. INTRODUCTION

The instrument used for this study is named "A Systematic Method of Evaluating Case History Data", briefly known as the SME.

This instrument has been devised by Mr. J.L. Stricklin, Senior Lecturer in the University of Cape Town School of Social Work, and Chairman of its graduate PSW Course. The study underlying the development, refinement, reliability, and validity of the SME has been submitted to the University by Mr. Stricklin in the form of a thesis for the Degree of Ph.D. in Social Work.

It is of importance to mention that the SME consists of seven steps, of which only the first four are employed in the present research. The remaining three steps were considered irrelevant for the objectives of the study on which the present work reports.

The investigator became familiar with the SME in the post-graduate Psychiatric Social Work Course, during which time she received training regarding the application and use of the SME from its originator.

2. SCOPE OF THE INSTRUMENT

In setting out to ascertain the importance of the mother-child relationship on personality development, it was considered firstly necessary to evaluate the overall personality factors (both constellational and constitutional) of an individual. Thereafter, the mother-child relationship was to be isolated and compared with the other factors which make up personality development and functioning.

The SME, with its basic aim of evaluating personality maturation, ideally fits the needs of this research project. Furthermore, in addition to collecting this material within the framework of the Psycho-Social History, it organized this data "into psychodynamically determined areas".² One of these areas is explicitly titled the Mother/Client Relationship.

The SME may be considered an 'objective' instrument. It has been useful in the present research in that it reduced the subjectivity inherent in 'free' case history taking by providing a detailed guide on the content of interview material. The True/False questionnaire also helped to increase uniformity and objectivity in the assessment of case history data.

Lastly, the numerical evaluation inherent in the SME helped to make measurement and comparison a relatively simple procedure.

3. THE SME METHOD

The SME consists of seven steps, of which the following first four were utilized for this study:-

- I. Collect the Case History Data
- II. Complete the Summary Work Sheets
- III. Answer the appropriate Psycho-Social Index (PSI) True/False Questionnaire
- IV. Complete the PSI Face Sheet³.

STEP I: Collection of Case History Data

The Psycho-Social History, in addition to collecting information on the mother-child relationship, covers areas which affect this relationship (such as Current Family Functioning and Condition at Birth), and other areas which are in turn affected by the "product" of the mother-child relationship, i.e. the personality of the individual. Examples of the latter are an individual's adjustment and other general areas of his social functioning such as relationships with friends (Others/Client Relationship).

It must be stressed that, in the present study, the mother-child relationship and personality assessments were not viewed in the "vacuum" of the family set-up per se, but that wider cultural, social, and religious factors were also evaluated as it is a well-known fact that these are collectively brought to bear on the total Gestalt of the mother-child relationship.

History taking, or a collection of facts preceding a

given situation, has been a most valuable diagnostic tool in many disciplines, be it Medicine, Science, Psychiatry, or Psychology. Likewise, Social Work research too has also made use of data obtained from history taking.

The Psycho-Social History provides for the collection of relevant information from which the mother's interaction with her child (both on a conscious and an unconscious level) could be evaluated, together with her child's reaction to his upbringing.

Relevant information about the client from other sources was also included in the history. Some of the more common ones were medical reports, school records, IQ tests, and psychiatric evaluations.

This step of history taking was not used in evaluating all 70 cases of the sample as some of the interviewers who were 'professionally experienced' did not have to follow the set procedure. This is an accepted practice in certain instances (which is borne out by the author of the SME) in which persons experienced in using the PSH, or those with expertise in this field, can proceed to the second step without writing out a formal history.⁴ (A specimen of a Psycho-Social History Collection Guides is to be found in Appendix D).

STEP II: Use of Summary Work Sheets

The Psycho-Social Index (PSI) was designed to present graphically and concisely the information secured in the

detailed Psycho-Social History.

The value of this step lies in the fact that information can be succinctly recorded and read with greater speed instead of requiring the evaluator to read through a lengthy history.

According to the author of the SME:

The purpose of the Summary Work Sheets is to provide a framework in which the evaluator can begin to list, summarize, and note his important observations and conclusions from the totality of data in the case history. The importance of the framework is that it forces the evaluator to consider the multitudinous, detailed data from various points of view. The combination of the PSI categories, under which the examiner's impressions are noted, give assistance in understanding all of the etiological possibilities that explain the personality maturation and current functioning of a given individual.⁵

This summary of the PSII proved invaluable in assessing the True/False Questionnaire (Step III), as a holistic picture could be gleaned without the boredom that might have been involved in reading through a lengthy PSII. Information could be rechecked when answering the True/False Questionnaire without the need to delve through unnecessary detail.

For this sample, summarizing of the PSII data out of the Summary Sheets has been done by the interviewers themselves. (A copy of the PSI Summary Sheets is to be found in Appendix B).

STEP III: Answering the appropriate True/False Questionnaire

The third step of the SME consists of answering the appropriate True/False Questionnaire.

There are seven sets of questionnaires for clients of the following age groups:

- Group I Ages Birth Through 2-11/12 Years
- Group II Ages 3 Through 5-11/12 Years
- Group III Ages 6 Through 11-11/12 Years
- Group IVa Ages 12 Through 20-11/12 Years With Family
- Group IVb Ages 12 Through 20-11/12 Years Without Family
- Group Va Ages 21 Years and Older With Family
- Group Vb Ages 21 Years and Older Without Family⁶

There is a maximum of 250 questions in the questionnaire and it thereafter varies according to certain age groups.

Certain questions do not apply to all age groups, and have therefore been omitted. This procedure of excluding questions has been guided by the personality dynamic considerations of the particular age groups and present home circumstances (Family Functioning). An example of such dynamic considerations can be seen in the fact that questions pertaining to adult genital sexuality have been omitted in the questionnaires of the pre-adolescent age groups.

The category of Current Family Functioning distinguishes between whether the client is living with his family or without his family. The members of a client's family, (if he lives with them) normally affect his functioning through their close emotional ties with him, and this often influences his

behaviour. It is for this reason that their effect on him and on his environment has to be evaluated as well. A client who does not live with his family is likely to be less affected by his home environment as he experiences not only social distance but emotional distance as well.

The investigator is of the opinion that the answering of the True/False questionnaire has been a very objective and successful part of the research instrument, in that it has enabled her to evaluate areas which are seemingly irrelevant and which she might have otherwise overlooked, in certain cases. In this manner, the same areas were examined for all 70 cases in a standard way, thus increasing uniformity and objectivity.

The fact that the investigator had definitely to commit herself to a true or false answer quite often forced her to "think through" the cases in a more thorough manner than would have been likely had she used a more subjective type of evaluation. At times, it was difficult to commit herself to an answer. Later this problem eased after a discussion with the author of the SHE who advised that one had to choose an answer which "tipped the balance" in favour of either a true or a false answer. (Refer to Appendix D for a specimen of the True/False questionnaire).

STEP IV: Completing the Face Sheet

Completing the Face Sheet requires making numerical calculations to determine the level of functioning in each of the

areas outlined. Thereafter a graph can be plotted which shows a linear picture of the overall scores for each case.

In describing the method of using the Face Sheet, the author of the SNE says:

The total number of true answers in each of the categories and sub-categories are written as Raw Scores on the PSI Face Sheet. By selecting the appropriate scoring guide according to the chronological age of the client, it is now possible to look up the actual Raw Scores in each of the groupings and enter the appropriate Index and Sub-Index Scores on the Face Sheet. Now total the Index Scores and find the appropriate percentage PSI score. It should be noted that the guide for the three Per Cent Scores is the same regardless of the age of the client. This is possible because the necessary mathematical corrections have been made in working out the Index and Sub-Index Scores.

Using the seven Index Scores as reference points the examiner should now draw his graph. The peaks are indicative of the areas of difficulty experienced by the client. The higher the peaks (closer to zero) the more serious are these difficulties.⁷

The last paragraph of the quotation, regarding the graph forms, is clearly validated in the chapter headed Findings of the Study (Chapter V, Part 2).

In reviewing the sample of abnormal cases and comparing them with the normal group, a definite consistent difference in the graph constructions will be noticed, with the former

usually occupying the top end of the "graph square" and the normal cases the lower end. (A specimen of the Face Sheet is to be found in Appendix D).

4. EVALUATION OF THE SME

The SME has been used for various purposes. Some of these are teaching, agency use, and as a research instrument.^{8,9}

It is of importance to mention that when the present research was started the original version of the SME was utilized, but the author of the SME, busy with his own study, was revising the SME from time to time -- there were eight such revisions in all.

Simultaneously with the revisions in the instrument, changes were likewise incorporated in the evaluation of the case material undertaken in the present work.

It is the first time that the final version of the SME has been used for research purposes.

As a research instrument the SME has been valuable in that it balances objectivity (required for scientific work) and subjectivity (required for the abstract sensitivity inherent in social work) to a remarkable degree.

As far as the 'objective' aspect is concerned, the scoring system especially was most valuable in that it provided simple,

understandable criteria to show value differences in the quality of mothering between normal and abnormal cases. As a result, the significance of this can be understood, not only by persons in social work and related professions, but also by lay persons who do not have complex theoretical knowledge.

The scoring system greatly eased the problem of comparison and calculation of likenesses and differences.

The True/False questionnaire helped to ease evaluation of cases and held the criteria of factors taken into consideration constant for all 70 of the cases.

The Psycho-Social History Collection Guides (see Appendix D) helped to obtain interviews that were to a large extent 'standard' in the type of information received. At the beginning, difficulty was sometimes encountered in deciding whether a question could indeed be answered as true or false — was some position in between not desirable? With practice, however, the anxiety connected with this problem lessened after it was realized how few of the questions for each case really were in any doubt. The more experienced one becomes at using the SNE, the greater perspective and balance one obtains in overall evaluations.

CHAPTER IV

THEORETICAL BASE OF STUDY

A

INTRODUCTION

The subject of this thesis was chosen as a result of an extensive study of personality theories. All were found consistently to emphasize the importance of the influence of the mother-child relationship on personality development.

Various theorists have different methods of approaching and explaining personality development. In order to keep the explanation of this study in perspective, it became necessary to use a single theory as a frame of reference and thereafter to draw in the viewpoints of other theorists -- either to refute, reinforce, modify, or expand on the parent theory. The parent theory chosen was Freudian psychoanalytic theory.

There were three major reasons for this becoming the mainstream of the study. The first was that the investigator had, in the course of her training as a psychiatric social worker, been taught personality dynamics within this framework. Secondly, the SME uses the psychoanalytic explanation of behaviour as its base.

Thirdly, most of the other theories incorporated into this study (except the Behaviouristic theory) were developed by Neo-Freudians who used Freud's model as the parent-base and therefore have logical connexions with it.

Psychoanalytic terms and explanations have been made use of widely in this research project. It is therefore important to offer an introduction to the "language" of psychoanalytic thought by means of some definitions.

B

DEFINITIONS

I. PSYCHIC APPARATUS

This term was first used by Freud to explain a theoretical construct of the mind which he divided into the ID, EGO, and SUPER-EGO.

- (1) ID: The id forms the basis of the psychic apparatus, and is the energy storehouse of the mind. It forms the first link between the body and the mind and obtains its energy from physical sources which it converts into usable psychic energy.¹⁰

It is important to describe some of the associated mechanisms of the id, viz. the UNCONSCIOUS, DRIVES, and REPRESSION.

-
- (i) UNCONSCIOUS: The unconscious refers to memories, thoughts, feelings, and urges which cannot be consciously recalled (except through psychoanalytical treatment). The id per se remains unconscious because its contents are too threatening to the individual's psychic well-being.¹¹
- (ii) DRIVES: Psychic energy can be differentiated into sexual and aggressive components. The function of the sexual drive lies in helping the individual to become emotionally attached (cathexed) to an object in order to fulfil a need, while the aggressive drive "pushes" the individual to obtain the object he is cathected to.¹²
- (iii) REPRESSION: Drives exist in their natural form in the id as psychic energy and can lead an individual to be almost cannibalistic and animal-like in his behaviour. This mode of behaviour is so repulsive to civilized man that he keeps this "unconscious" part away from his "normal thinking self" through the mechanism of repression.

The mechanism of repression uses energy to suppress energy, thoughts, and feelings which are unsafe as far as the individual is concerned for his normal healthy functioning in society.

In order to aid it in its work, repression makes use of defence mechanisms.¹³

- (iv) DEFENCE MECHANISMS: Defence mechanisms help the individual to deal with some of the repressed energy by using it up in some other form than the original form.

Defence mechanisms are applied by the ego.¹⁴

- (2) EGO: The ego forms the second layer of the psychic structure and makes use of the id energy for its functioning.

The ego is the conscious acting self. In its functioning, the ego has to consider both the id (own needs) and environment (needs of others) in order to act in a safe manner. This often requires a compromise on both sides. In order to meet these conditions, the individual "refines" most of his id needs and then gives expression to them through the ego.¹⁵

- (3) SUPEREGO: The superego forms the conscience of an individual and is the third part of the psychic structure. The superego is partly conscious and partly unconscious, and acts as a prohibiter and punisher of its owner. In this way it governs what is acceptable behaviour and that which is unacceptable behaviour.¹⁶

II. PERSONALITY MATURATION

Maturation refers to the physical growth and unfolding of the biological potential an individual is born with.¹⁷

III. DEVELOPMENTAL STAGES

Developmental stages help in the unfolding of the psychic apparatus. These stages are referred to as oral, anal, phallic, latent, and adolescent. They occur in a set sequence and are partially dependent on biological maturation for their expression.

IV. FIXATION

This refers to a static level reached at a given developmental stage.

When this occurs, very little healthy psychic growth can occur and consequently the personality fails to reach maturity.

V. CATHEXIS

Cathexis means the directing of emotional energy onto an object to such a degree that a bond is created with it. This bond thereafter automatically draws energy from the individual without requiring much conscious effort as the cycle becomes self-perpetuating. Repetition of rewarding experiences with an object usually underlies the motive for an individual to become cathected to an object.¹⁸

C

THE MOTHER-CHILD RELATIONSHIPINTRODUCTION

In this chapter the mother-child relationship will be discussed under three broad divisions:-

- (i) The development of the mother-child relationship.
- (ii) The importance of the mother-child relationship on the personality maturational process.
- (iii) Viewpoints of various theorists on the importance of the mother-child relationship for overall personality development.

Ab initio, the writer would like to stress that the mother-child relationship is a process in which all three divisions above intertwine and overlap. For the purpose of clarity and explanation, however, it is necessary to divide and isolate certain aspects of this relationship in order to understand how its workings contribute to the growth and development of the individual's personality. Because of the overlapping, the author has however had to repeat certain information, either to clarify an associated fact, or to expand on another fact, or to look at a specific point from yet another angle in order to evaluate its contribution to the body of knowledge under study.

The importance of the study of the mother-child relationship is underlined in the following quotation:

In recent years psychoanalysis has approached the

problem of personality development in the light of environmental "stimulation", provided not only by maternal behavior but in terms of the inter-relations between mother and child. This emotional experience has thus become the core of analytic research.¹⁹

DEFINITION OF THE MOTHER-CHILD RELATIONSHIP

For the purpose of this study the mother is seen as a person upon whom the child is dependent for meeting his needs. According to Fenichel:

The first object of every individual is the mother. This statement is not to be taken literally, for there is no grounds for assuming that the physical act of birth in any way binds the child psychologically to the mother. That person who performs the first care of the child is to be considered the mother.²⁰

Usually the mother is, of course, the biological parent and is present from birth onwards. However, substitutes such as a nurse, adoptive parent, or even a father can fulfil this role, as long as they provide the conditions inherent in the mothering process.

The mothering process involves caretaking functions such as provision of food, comfort, and affection. It is this consistent provision of nurture and care that enables the child to become cathected to the mother. That is, it becomes familiar with and emotionally attached to her.

The mother, too, receives emotional satisfaction in caring for her child; this mutual reciprocation helps to establish a bond between the two which is perpetuated and strengthened by repeated experiences. It is in this two-way process of child needing and mother giving that the relationship between mother and child develops.²¹

THE INITIAL DEVELOPMENT OF THE MOTHER-CHILD RELATIONSHIP

At birth the infant is unaware of his environment and is unable to think, plan, or fulfil his own needs. These "personality functions" cannot be carried out partly because of his physical "incapacity" and partly because his psychic development (ego and superego) has not yet taken place. He is in fact in a general state of "non-differentiation" as far as mental development is concerned.²²

The child's senses of sight and sound are also underdeveloped. As a result he cannot utilize stimulus input. At this first objectless phase of life the child lives through feeling alone. This can be seen from the fact that he reacts to feelings within himself, some of these being hunger, pain, and discomfort. He accordingly relates to his environment in a narcissistic way by taking in whatever appeases his hunger, pain, or discomfort. At this stage he is unaware of the mother as the source of these satisfactions. In fact, the child is so oblivious of this source

that he "imagines" himself to be his own satisfier.²³

After the second month of life the mother's face, recognized as a consistent relief-bringing factor, helps the child to separate her from the "surrounding meaningless chaos" of his world. Her voice, touch, smell, and texture help the child to become more familiar with her.²⁴

Still later, improved vision helps the child recognize his mother even though it is only when he is in need of her. This can be observed in the fact that when the child is fed, dry, and comfortable he does not seek his mother's attention although she might be close by.

However, from the sixth month onwards, having been subject to repeated experiences with his mother, the child begins to recognize her irrespective of whether she is needed. In addition, he sees her as being able either to bring or withhold satisfaction. This initial realization of the mother being the guardian of his needs places her in a very special position as far as the hierarchy of the child's relationship preferences are concerned. It is in this way that she becomes the first person worth remembering. The infant soon begins to associate her with his hunger-milk syndrome and thus her image (almost as a reflex) comes to mind whenever he is hungry or in need. We say, therefore, that the mother becomes the first "ego object" of the child, who clings to her and distinguishes her from strangers. Ainsworth concluded this from his

observation of children of such age who began crying when faced with strangers.²⁵ Besides acting as a security against hunger, the presence of a mother figure also acts as security against the uncontrolled environment.

By developing a cathexis with the mother, the child enjoys being close to her, looks forward to her coming, and responds to her physically and emotionally by moulding eagerly in her embrace.²⁶

During this process of cathexis and ego object internalization, another important intra-psychic process simultaneously takes place in the child. The basic psychic drive differentiates into the libidinal (love, pleasure) drive and the aggressive (hostility, anger) drive, the separation and distribution of which depend on the child's relationship with his mother. If the child has experienced a predominantly satisfying secure relationship he will basically love his mother and the libidinal tie will be dominant in his cathexis with her. Intrapsychically, he internalizes the "good" mother and will consequently feel happy, secure, and content.

In most cases where the mother leaves the child in a severe state of discomfort before attending to his needs, tension and anger are generated. As a result, the mother is perceived as the "object" who frustrates, and so the child internalizes the "bad" mother. In this case, the aggressive drive predominates in the child's tie with his mother and the relationship becomes a hostile dependent one in that the child needs his mother on the one hand

and yet, on the other, she causes him much anger.²⁷

It is very unlikely that "pure types", as far as the above-mentioned drives are concerned, will be found. Instead, a certain degree of both types are found in all children as they inevitably undergo a measure of frustration and satisfaction in their relationship with their mothers.

In the final analysis, however, the good or bad representation of the mother depends on which type of mothering predominates. The long-term effect of this internalization process and its significance to personality formation will be discussed in the last section of this chapter.

The writer would like to add that, in the analysis of the case histories, it was sometimes found that the child became more attached to the father precisely because the father attended to his needs in a more satisfactory manner than the mother. The father's frequent presence, even though peripheral to the mother's, is recognizable to the child within the general family Gestalt. Affection ties with the father are influenced by his connexion with the child's total image with the mother; for instance, "I like mother", "Mother likes father", "I like father".

FACTORS WHICH HELP TO ESTABLISH AND MAINTAIN THE RELATIONSHIP BETWEEN MOTHER AND CHILD

From the moment of birth the child has needs which have to be

fulfilled through the mothering process. The activities that ensue from these needs help the mother to relate to the child at levels which are meaningful and important to him. Montagu outlines the following requirements:

The organism is born with certain basic needs which must be satisfied if it is to survive. These needs are: oxygen, food and liquids, bowel and bladder elimination, activity, rest, sleep, avoidance of pain and danger. It has been discovered that these basic needs must be satisfied in a dependency relationship such that the organism becomes increasingly aware of the fact that it is receiving its satisfactions whenever it requires them in a supportive manner; that it is being satisfied by persons who want to satisfy it, and who are — to put in the best way possible I know — all for it; that it is being satisfied by persons on whom it can rely in the increasing awareness that its expected satisfactions will be met and not thwarted, that is to say, not frustrated."²⁸

It seems important to explore further the two broad categories of needs, viz. physiological and psychological.

1. PHYSIOLOGICAL NEEDS

Freud regarded the nutritional need of the infant as the pivot for the mother-child relationship for three main reasons.

Firstly, feeding is the most important area of communication between mother and child. Secondly, this is the most urgent need which initially makes the child aware of his dependency on his mother. Thirdly, the psychological need

for the mother's affection and his attachment for her arises from the primary need for food.²⁹

The need for food requires elaboration in order to clarify its implications. Freud's actual views on this point (as cited by Bowlby) might help in this regard. He says the following:

... the basic danger confronting an infant is that his psychical apparatus might be thrown out of order by the presence of excessive stimulation arising from unsatisfied physiological need. This danger the infant is helpless to deal with alone. Mother, however, can put an end to that danger. Consequently the infant, knowing from 'experience that she satisfies all its needs without delay' . . . 'wants to perceive the presence of its mother'. The conclusion of this argument appears to be that the secondary drive that ties the infant to the mother is, by ensuring the mother's presence, that of preventing the psychical apparatus from becoming deranged 'by an accumulation of amounts of stimulation which requires to be disposed of' ...³⁰

The above quotation implies that the child enjoys being close to the mother primarily because she appeases his hunger and that her presence acts as assurance against starvation and discomfort.

The natural process of feeding requires the mother to position herself in relation to the child in such a manner that his head rests in the bow of her arm with his body close

to her breast. In this position the child feels warmth, softness, rhythm (heart-beat and breathing) which mingle simultaneously with the flow of the milk into his mouth. All these sensations are highly satisfying to the child. He soon builds up an attachment for the mother whom he wants to have around him all the time as she makes him feel secure. In this way the mother stimulates the secondary needs of the child and helps the relationship move from his physical need for her to a psychological need for her.

The manner in which the mother attends to the hunger needs of the child determines whether the child will introject a good need-fulfilling mother or a bad frustrating mother. This affects his perception of the world for the rest of his life as these pleasant or unpleasant memory traces of feelings experiences remain indelible in his psyche.³¹ A mother who is unhappy about some matter, such as severe financial need or an unhappy marriage, is likely to find difficulty in giving her whole self to the child during the feeding process.

2. PSYCHOLOGICAL NEEDS

The term "psychological needs of an individual" is a broad concept which covers aspects such as affection needs, contact needs, verbal and emotional stimulation and communication, and the formation of a body image. Each of these needs, will be discussed separately with focus on the part the mother-child relationship plays in its unfolding.

(a) Affection

During the first few weeks of life the child remains almost a passive recipient of his mother's nursing. With growing recognition of her he gradually seeks out interaction with her. This can be seen in that the child ceases being satisfied with just feeding and nappy changing. Instead of falling asleep or resting quietly as he has always done, he begins actively to compel his mother's attention by cooing and gurgling.

The mother in turn can respond to this call for affection with a smile, a look, by holding him close, and generally by giving him her full attention. Through these demonstrative patterns of behaviour she stimulates and encourages the child's ability to interact with the environment. Further, she gives him emotional feedback which reassures him of his importance in her existence.

In most of the cases dealt with in the abnormal category of the sample, there seemed to be a general lack of affection shown by the mothers although they were physically present. This was often the result of a personality problem of the mother, aggravated by some current difficulty such as an unhappy marriage.

This lack of affection can be seen as a form of maternal deprivation and has been designated as "family hospitalism".³² The term aptly describes cases in which the child's emotional needs remain unfulfilled or at best

only partly fulfilled even though the mother was present. Its theoretical assumption is supported by the findings of this study in that almost all of the abnormal cases had some of the stated characteristics of this type of family (lack of support for mother in her role, marital discord, etc.). Such characteristics affect the mother's capacity to be sensitive to the child as a whole and to his needs. She will tend to administer food and attention mechanically whenever she feels it to be necessary to the child, treating the child more as an extension of herself rather than as one who has needs distinctive from her own.

A further characteristic of the abnormal sample mothers was their mood patterns and effect. Most of them were either depressed, over anxious, withdrawn, or hostile. This in turn affected their child-rearing attitudes as they became harsh and punitive in the face of minor irritations. Discipline, too, was inconsistent and meted out more in accordance with the mothers' own mood than in the interest of the children.

Another way of looking at the reason for the child's becoming withdrawn is the fact that the initial attempts of the child to engage in pleasant behaviour were not responded to by the mother. They thus remained underdeveloped through lack of stimulation.

Other important factors that can affect the amount

of affection a mother gives to her child are her capacity to engage in close relationships of emotional interchange and in her ability to mother. Observations carried out by Spitz³³ on human beings, and experiments carried out by Harlow³⁴ on animals, point to the fact that a person is likely to give affection only to the extent that he has known it. Harlow's experiments will be discussed more fully later on. After observing institutionalized children who had received very little consistent mothering, Spitz came to the conclusion that these children were unable to form close relationships with people on account of lack of basic trust. Disappointment at being 'let down'; not having learned how to love through being loved, weighed heavily against their forming relationships.

Later, such mothers tend to repeat their own experiences in the socialization of their children. Mothers who are severely deprived have very little to offer their children emotionally. They tend to be insensitive to their children's unspoken needs for affection and find difficulty in coping with even their minimum demands for attention.

(b) Contact Comfort

During the process of nursing the child, the mother provides "contact" comfort through stroking, cuddling, and holding. Winnicott lays great emphasis on the holding process as he feels that this is an important way in

which the mother conveys her love to her infant.³⁵ The way in which the mother holds her baby can produce feelings of either security or insecurity. A factor which influences this aspect is the mother's emotional attitude towards the child. Examples can be seen in mothers who regard the demands of their infants as an emotional strain or who identify their child with someone else (either themselves, their husbands, or mothers) for whom they have negative feelings.

Thus, if the mother identifies her child with someone with whom she has experienced such unhappiness, these feelings might well interfere with her capacity to show the child any positive affection. In the case of children who have severe congenital problems such as skull or limb deformations, a mother experiences definite shock which she has first to overcome before she can develop a positive bond with the child.

Children have a certain degree of empathic communication with adults and although they may be physically held in the correct way they seem to be able to sense whether there is emotional acceptance as well. Good mothering depends on the ability of the mother to empathize with the child. It does not rest merely on an intellectual understanding of the child and his needs.

A cold, fear-ridden mother (sometimes on account of her guilt for the dislike of her child, which could be

either conscious or unconscious, or her dislike for close physical contact) might hold her baby in an insecure manner and convey these feelings to her child. This stands in sharp contrast to a warm mother who embraces the child physically and emotionally to such an extent that he feels swathed in love and security. However, it is important to show affection only to the extent that the child needs and wants it. In discussing this point, Bowlby is of the opinion that different children require different amounts of mothering and that mothers should take the cue for this from the child himself in almost the same way that she gauges his hunger satiation needs.³⁶ A mother should not be over-involved with her child throughout the day and should allow him to turn away from her whenever he feels a need to do this.

In the abnormal sample, case number A.28 shows a classic example of a mother who "over-mothered" her child to meet her own need to be mothered (through which she received vicarious satisfaction). This resulted in the child's being totally insufficient in self-help skills of eating as the mother kept it dependent upon herself. In addition, the child was not allowed to play with friends because the mother feared it would "catch germs". The child was bathed and clothed and "disinfected" more regularly than usual with the result that it developed compulsive hand-washing symptoms. In this case the

mother's need for self-esteem (being a good mother) and her insecurity and rigidity in hygiene training contributed largely to her child's symptoms.

Returning to the discussion on holding, Harlow's many experiments and observations on the mother-child relationship should be mentioned. He used the term "contact comfort" to describe the security the young feel in the soft warm physical closeness with mother. Contact between mother and child is important in that it serves as a pleasurable tactile sensory stimulus to the skin. The two-way implications of this experience for later life is that it is a deciding factor as to whether the child would enjoy being physically and emotionally close or distant in his relationships with people when he grows up.

In an experiment carried out by Harlow on monkeys, using models of monkeys as surrogate mothers, he compared the reactions to a cloth monkey and a wire monkey. He found that the young need and prefer soft warm contact with mother figures into whom they can 'sink'. He came to this conclusion after observing the fact that the young monkeys in his experiment spent more time with the cloth "mother" than with the wire one, and that whenever they were afraid they ran to the cloth "mother" for security.³⁷

He also carried out another experiment in which the

necessity for physical (tactile) and emotional warmth in the mother-child relationship was shown as an important area to ensure healthy life adjustment.

He observed two sets of monkeys, the first set with a "normal" mother-child relationship and the other set without mothers. When both sets became adults, he brought them together and made the following observations. The first set were socially warm; engaged in normal mating behaviour; were interested in the opposite sex; conceived easily and later made good mothers to their offspring. But the second set of monkeys were found to be apathetic. They led socially cold and isolated lives; were uninterested in the opposite sex, and showed little inclination for mating behaviour. The females had to be forced into mating and did not seem to enjoy the close physical contact that mating brings. When these females eventually managed to conceive and give birth, they made very poor mothers in that they failed to take even physical care of their young, treating them like objects and showing very little empathy and warmth.³⁸

Although in the human species the majority of even the deprived mothers do not behave in such a blatantly rejecting manner, thanks to some of our cultural expectations, there exist however degrees of coldness, distance, and aloofness depending on the amount of mothering they themselves had received as infants.

(c) Communications

Communication in the mother-child relationship encompasses the whole of verbal and non-verbal feedback signs and gestures which contribute toward mutual understanding.

In the first few months, before the infant is even aware of his unintentional communication, showing itself in crying, etc., the mother reacts to these external cues and in this way almost teaches the child communication. This is the stage of pre-verbal communication.

According to Harry Stack Sullivan, empathic communication exists between mother and child in which the child has an awareness of the emotional tone of maternal attitudes. This sensitivity to feelings leaves behind memory traces of either frustrating experiences with her or gratifying experiences.³⁹

Besides extra-verbal communication, the mother also plays a role in stimulating verbal development. In following the development of speech in the child it can be seen that between the ages of fifteen and eighteen months the acquisition of verbal gestures helps the child to contribute much more to his own care. Instead of mother relying on her own experiences or sensitivities to realize the child's needs, the child can tell whatever he feels or wants. Instead of his having to rely more on emotional forms of communication, in that he cried

when uncomfortable, had a tantrum when angry, or smiled benevolently when he needed warm interaction, developing speech helps the child to convey these verbally, with consequently less energy usage.

The mother helps speech development in that, in the course of her relating to the child, she responds to his coos and gurgles with words. The word sounds leave memory traces in the mind of the child and help towards the acquisition of language form.

(d) Body Image

"Body image refers to an individual's feelings and attitudes, both conscious and unconscious, towards his body and is probably a psychological construct which is mutually developed along with the maturation and growth of the individual's self concept or ego."⁴⁰ The formation of a body image, i.e. the infant's psychological realization of itself as a separate person, begins at the age of about four months.

Previously the child feels that his mother is part of himself and he is therefore self-sufficient as far as his needs are concerned. If the child has been well cared for, the new realization of mother as a separate person will not be a painful process as he has not experienced frustration in getting his needs met and therefore trusts mother's giving. In this case he would

experience his independence with security and confidence. But children who are not well cared for by their mothers before this individuation process feel disappointed and even more anxious when they perceive mother as a separate person. They have already experienced much pain in getting needs met, despite the fact that they "thought" they had control over need-satisfaction. Now perceiving this source of gratification as separate makes them even more hopeless, more dependent, cut off, and alone with no control over their environment.

Difficulties in the individuation process can also result when mothers over-mother children and treat them as babies for a longer period than usual or, from their own neurotic need, cling to them as though they are extensions of themselves. Smirnoff discusses this more fully when he says:

... the individuation process appears to be an essential development phase, which is far from being a mere maturational fact but a developmental process which depends mainly on the mother-child relationships: the child's experience is predominantly conditioned by the mother's emotional maturity and the gratification she finds in the mothering procedures. As long as the child represents merely a cherished possession — an illusory phallus, as is often the case in the mother's unconscious fantasies — and not as an individual human being whose gradual independence the

mother expects and further, individuation cannot take place in the normal manner.⁴¹

The mother-child individuation process is the first step to body image formation. Thereafter, the manner in which the mother handles the child in her daily care activities such as holding, looking, bathing, clothing, and feeding contribute to his feeling about his body per se.

The mother who spends time and conscious effort in handling her baby gently and with admiration for its form, growth, and autonomy, helps to create in her child feelings of pride, mastery, and self-love. But the mother who handles her baby roughly, cares for it mechanically, and shows uninterest in its growth and physical mastery, conveys those feelings of uninterest to the child who fails then to become sufficiently positively occupied with development of his body.

Furthermore, poor handling causes a child to associate his body with pain and discomfort. This helps further to alienate it from his thoughts as an object of pleasure and pride.

D

THE IMPORTANCE OF THE MOTHER-CHILD RELATIONSHIP
ON THE PERSONALITY MATURATIONAL PROCESS

In the first part of this chapter, the initial development of the child's relationship with his mother was outlined.

From discussion, it was concluded that the mother is the chief person on whom the child is dependent to get its needs met and, generally, it is for this reason she exerts the most influence over his development.

Following from that largely general and descriptive discussion, the importance of the mother-child duality can now also be reviewed from the angle of her influence in guiding his intra-psychic development during the psycho-sexual development periods.

The development phases (oral, anal, phallic, latent, and adolescent) as outlined by Freud will be used as the basic framework of reference in this section.

These development phases are dependent on the maturation process, which involves physical growth. The former is in fact dependent on the latter for its unfolding and expression, as will be shown later. This dependence is succinctly described by Smirnoff as follows:-

Development depends on many different factors, and specific areas of development — such as acquisition of motor skills, sensory perception, linguistic abilities

and emotional responses — follow their own pace owing to the gradual unfolding of maturational processes. Thus various manifestations and behaviour patterns cannot make their appearance until certain levels of psychological, neural, and sensory organization, as well as levels of cortical integration, are attained. Until the various systems have reached a certain level of maturation, all education remains ineffective. Maturation brings with it certain learning potential but the fulfilment of this potential depends largely on the motivation for learning provided by the environmental stimulation.⁴²

Thus the functional capacity of physical potential in an individual can only be released after biological maturity has been attained.

In speaking of environmental stimulation, Smirnoff means the (either conscious or unconscious) motivation and learning of how to direct one's innate potential into certain socially functional modes in order to make it meaningful for life adjustment. For example, the individual has the potential of emitting different sounds; however, order in the use of sounds through language development comes about only after the person has been taught how to use these for communication.

The triad, namely maturation of physical potential (a person without a larynx would be unable to speak), developmental task function, and environmental stimulation, can therefore be seen as an inter-dependent process in which all three synchronize to help the individual attain personality maturation and development.

Environmental stimulation plays an especially major role in governing this process as can be seen from the following:-

The developmental process is not entirely a matter of biological dispositions; it is also a learning process. Whether the child will or will not pass through the developmental stages safely depends primarily on the child's innate dispositions, and upon his interaction with the physical and social environment. Freud did not believe in rigidly set universal developmental phases. He suspected that the way children develop is varied, depending on cultural patterns. The growth of the human personality is largely determined by an individual's life experiences; these may or may not foster inherited potentialities, may encourage or prevent growth, may stimulate development or thwart it. One's mental health is only partly dependent upon one's constitution. In most cases the environment, the constellation, and not the constitution have the final say about personality development.⁴³

Before porceeding to a discussion of each of the developmental stages it would serve clarity to outline the broad principles which underlie all these phases.

During each of these phases tension-producing libidinal energy is felt in the developmental "task appropriate" area. For example, during the oral phase the mouth is the focus of this energy and on account of this is known as the chief erotogenic zone.

Stimulation of this area brings about pleasure for the individual as his libidinal (sexual) energy is chiefly discharged through

the activity associated with the zone under tension. The pleasurable sensations are sexual in nature, the term sexual being used to denote eroticism as opposed to "genital" pleasure. The child is compelled to pay attention to the area "under heat" for the following reasons.

The accumulation of libidinal energy in this specific area creates tension and discomfort. Conversely, the discharge of this tension brings pleasure to the individual. This tension-pleasure alternation can be consistently and clearly seen in most of the stages. Two of these are hunger-satiation of the oral stage and genital tension -- orgasm release in the adult. Cultural expectations also encourage the individual to master the function related to this specific stage. This can be seen in the expectations mothers have for their children with regard to achieving complete bowel control by a certain age.

Generally, once the child "resolves" a stage, the energy "passes over" to the next zone requiring development. This does not imply that the zone from which the energy has moved becomes barren and unpleasurable. Instead, it continues to serve the individual with its function together with offering some pleasure. Sometimes children find difficulty in progressing from one stage to the next. Reasons for this could be insufficient gratification; for example, the oral zone will continue demanding gratification despite the fact that the child is chronologically and maturationally ready to enter the next stage. Another reason for

"non-movement" could lie in the fact that the child receives too much gratification at the given stage and he thus finds difficulty in progressing from this area of pleasure. In all these instances the child becomes fixated or partly fixated at that level.⁴⁴

If too much frustration is encountered in any one of these stages, the individual spends most of his energy dealing with this former zone and thus finds difficulty in mastering the new task area. Furthermore, he will have very little energy to tackle the new stage as most of it is already "tied up" in the past stage.⁴⁵

Thus far, in looking at the mother-child relationship, the role of the child has been outlined with regard to how his "internal mechanisms" contribute to the development process.

Looking at the mother, it can be seen that she plays a very significant role indeed as an environmental influence. It is she who spends the most time with the child during his most impressionable years — the period up to age six years, which is the pre-school period during which the child is exposed to very few other influences. In this very significant period, the child passes through three of his five developmental stages, viz. the oral, anal, and phallic stages.

Since most theorists highlight the influence of the mother on the child during the developmental stages, it would be useful to examine her role in this process more closely.

The ways in which the mother helps the child to deal with the libidinal energy, and her attendant attitudes towards a specific task function, help to colour his views on the task function. Psychoanalytic theory considers the developmental tasks as being correlated to all later life experiences in that the way in which the child handles the frustration and satisfaction of the specific functional stages will set the pattern of his handling similar life situations in later years.

The mother not only helps to show the child the manner in which to express drives but she is also responsible for regulating how much pleasure he can receive through instinctual release, how much control he should exercise, and what degree of frustration he has to bear. In the healthy individual, however, childhood expressions and controls of developmental tasks become a rich collection for the ego, bringing pleasure as well as effectiveness in dealing with the environment.

In summarizing the entire process, it can be said that the amount of satisfaction a child receives, and the concomitant attitudes and feelings, become for each stage internalized in the psychic structure and in this way form prototypes for all other associated activities in later life. The mother in her socializing relationship with the child thus virtually "maps" out his entire life pattern.

The developmental phases, their attendant needs, and the

child's resolution and interaction with the mother will now be examined individually for each stage.

ORAL STAGE

During the oral phase, the mouth is the most sensitive zone. The mother is not initially seen as a separate person, but as part of the baby himself. Later on, when aged about three months, the baby begins to recognize his mother as apart from himself and she becomes a highly-valued person because she meets his needs. His extreme need for her makes him introject her so that her memory stands as a security and forthcoming satisfaction whenever he is hungry and in this way helps to lower his anxiety of being helpless.

The oral introjection leads to the primary identification. At the oral stage the infant takes things into his mouth, thus incorporating whatever he loves. Then he incorporates an object, he may believe that he himself is like the incorporated object.⁴⁶

The implications of this process are that the child identifies with a "good, need-fulfilling mother" if he is well cared for, or a "bad, frustrating mother" if he is not well cared for.

Furthermore, as the child cannot at this stage think logically, he does not view his mother as the cause of his bad feelings. Instead, he feels that since this badness arises within himself he himself is the cause of it. These unconscious attitudes about oneself are forerunners of good or poor self-esteem in later life, as memory traces of once being a frustrated "object" leave their

imprint on the psyche.⁴⁷

The importance of the influence of these feelings is that they set up and colour a person's entire way of looking at himself and the world as safe or unsafe, good or difficult, for the rest of his life.

Freud, in his book "An Outline of Psycho-Analysis", describes how oral needs and affection intertwine to make mother the most significant person in a child's life.

A child's first erotic object is the mother's breast that feeds him, and love in its beginnings attaches itself to the satisfaction of the need for food. To start with, the child certainly makes no distinction between the breast and his own body; when the breast has to be separated from his body and shifted to the "outside" because he so often finds it absent, it carries with it, now that it is an "object", part of the original narcissistic cathexis. This first object subsequently becomes completed into the whole person of the child's mother, who not only feeds him but also looks after him, and thus arouses in him many other physical sensations pleasant and unpleasant. By her care of the child's body she becomes his first seducer. In these two relations lies the root of a mother's importance, unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love-object and as the prototype of all later love relations -- for both sexes.⁴⁸

ANAL PHASE

The anal phase begins about the second year in a child's life. During this period the toilet training of the child becomes the

main focus of communication between mother and child.⁴⁹

An important point to note is that bowel control should not be expected of the child until the sphincter muscle has developed. This function is very definitely dependent on physical maturation. Mothers who expect physical control from their children before this maturation can engender extreme frustration in the children who are literally physically incapable of carrying out this task.⁵⁰

Generally speaking, around this period the mother conveys her expectancy to the child that it is time he became used to other ways of evacuating his up to now uncontrolled clearing of bowels and bladder. She often does this by putting the child onto a "pottie" at the expected time of evacuation. In order to encourage him to use this new method, she praises him after a successful act to reinforce such behaviour.

On the part of the child, accompanying the development of the sphincter muscle, the anal area becomes the chief erotogenic zone. On account of the instinctual pleasure derived from his having a full rectum and actual passing of faeces he consequently becomes preoccupied with associated anal activities.

If one observes a child of this age, it is not uncommon to find him spending a great deal of time around the "pottie", looking at the contents, and sometimes experimenting by smearing. The stool of the child is his very first product and own possession which comes from within himself; since it is something that

emanates from the mystery of his own inside, it stimulates his curiosity. Children, if not influenced by adult views, show no aversion to faeces and behave fondly towards them.

Mother's need to collect the faeces and her delight at receiving them in the appropriate manner make them even more valuable. It is the first time that the child is asked to give to mother something that he possesses and for which he has a freedom of choice to keep or to give.

The actual training of the child comes about through his need to please mother and maintain his approval, especially when he regulates his functions to proper times and circumstances. This sometimes means enduring a little discomfort through control until she can attend to him in the proper way.⁵¹

Usually, toilet training at the beginning needs a two-way programme in which the child recognizes the need to evacuate and informs mother about this. She, in turn, prepares herself to act at his convenience.

Mothers who set rigid times for evacuation for their children expect too much control from the newly-developed sphincter. The retention of faeces becomes a painful matter, which, together with the fear of losing control (thus engendering mother's disapproval), is highly anxiety-provoking to the child.

During the beginning phase of toilet training, mothers should

not punish and should allow children to make "mistakes". Otherwise, their attitude would make the child averse to an activity which should basically be pleasurable to him.

The activity of toilet training can be likened to the first bargaining possession which the child can use to "trade" for his mother's approval. Her attitude in this give-and-take process (which is his first experience) helps in setting his basic attitudes towards exchange, control, flexibility, and other associated activities linked with this task.

Although it is irrelevant for the purpose of this discussion to give a full outline of some of the aberrations that can occur during toilet training, it would be worthwhile to give a brief account of a few of these that can result from improper maternal attitudes.

If mother fusses over toilet training, cleans the child in a disgusted manner, or with a sense of urgency each time he soils, she can transfer such attitudes and anxieties to him. This sometimes results in the child reacting against the fear of soiling and dirtiness. In this case, compulsive over-cleanliness and hygiene become personality characteristics.⁵²

If a child is expected to exercise too much control over bowel movement during this period, it can sometimes engender the characteristic of inflexibility and rigidity in that the person feels the need for exaggerated control. Later, this habit of control could

well permeate most aspects of life as he learns to equate self-control and consequent anxiety reduction as a safe way of behaving. This extreme control (holding onto faeces) is duly repressed with exaggerated force. This results in a person not only being very controlled himself, but wanting to control his environment so as to keep anxiety at a minimum.

In contrast, a mother who is too flexible in her toilet training (by not setting limits) and who allows the child to expel whenever and wherever he wishes, is also doing harm. The most probable result of this will be that the child may feel anxious in later life when he needs to control some of his impulses. He fears that he will not be able to as he has never been adequately trained to do so.⁵³

Positively speaking, the anal phase helps the child to attain mastery over his muscular functions and results in feelings of genuine self-esteem if well handled by the mother. It represents the child's first attempt at being productive, controlled, and giving.⁵⁴

PHALLIC PHASE

After the anal stage is passed, the genital area becomes the chief erotogenic zone. The child becomes curious and explores his body in order to stimulate this newly-aroused pleasure zone. He takes delight in exhibiting, comparing, and talking about his genitals.

The "openness" quickly comes to an end when children begin to learn early in life that preoccupation with this area is not encouraged by adults. The fact that parents wear clothes especially to cover the genital areas, and the taboo against masturbation, both make the child wary of how he handles such matters. Some mothers mildly discourage their children, whereas others, themselves probably viewing manipulation of the sexual area as dirty and sinful, impose stricter prohibitions and threats, all of which contribute to the child's own impression of sexual activities. Severe threats of punishment can sometimes lead the child to be so fearful and anxious of any genital activity that, since this area brings only pain, he gives it up as a pleasurable task for the rest of his life thus sometimes causing frigidity or impotence.

Besides these more overt attitudes set up during the phallic stage, another phenomenon termed the "family romance" by Freud, also takes place.

The child of one sex is attracted to the parent of the opposite sex; that is, a female child is attracted to her father and a male child to his mother. The child at the same time realizes that he cannot possess the wanted parent for reasons of sexual and physical immaturity. Further, fear of loss of love from the parent of the same sex (with whom the child is transiently angry and of whom he is simultaneously jealous) is engendered. In boys, fear of being castrated by the father for having erotic feelings for the mother also threaten the child. In girls there is a

different emphasis. "Penis envy" predominates, and this ultimately causes the girl to identify with her mother.⁵⁵

In order to overcome and resolve this conflict, and to retain the love of both parents, the child gives up the desired parent as a sexual object and begins to become like the "competitive" parent (mother for girl, and father for boy) as a sublimated way of winning the other parent's love and the latter's acceptance.

In this way identification takes place. The child naturally feels guilty about having these sexual desires, and sometimes parents can make it difficult for the child to resolve these feelings if they are overly-seductive and play up to the child's fantasy. In such cases, the fantasy would become reality for the child as the object of desire is attainable and is not helping the resolution of this stage by resisting the child's "overtures".

Quite often a boy who has had to side with his mother when she was in conflict with her husband has difficulty in building sexual relationships as an adult. This could be traced back to childhood in that remnants of feelings of being the victor against his father in the quest for his mother's favour can lead to anxiety and guilt. Castration fears are re-aroused. Anxiety thus becomes associated with genital activities, and is called forth again each time sexual involvement is contemplated in later life. Thoughts of sexual involvement become crippled.

Women sometimes become hysterical and shy away from involved

sexual relationships when they experience seduction on the part of the father during this stage. Seduction is used in its broader sense and does not necessarily mean a full genital relationship. Even playfully intentional preference for the child may, for the child, take on a large proportion of anxiety because of projection of its own desires.

LATENCY STAGE

The latency stage follows the phallic stage. The chief activity of this stage is the extra-home socialization of the child. The child becomes more interested in friends and hobbies and begins to play a definite role in his small outside society. The fact that in most cultures the child is expected to be at school at this age helps in this process.⁵⁶

Mother, at this stage, should help to "wean" the child away from home and show interest in his increasing outside activities so that he feels secure in his dealings as he has her approval. The degree to which he would feel safe to interact with the outside world, and regard it as a safe place, depends on the security and fulfillment mother offered in the previous stages at home. In a healthy mother-child relationship, the child will feel secure in his tie to mother who acts as a comfortable base to whom he can return after testing himself out in the world.

An anxiety-ridden child will find difficulty in settling down to secondary relationships if he is doubtful and pained about the

primary one at home and if his past experiences give him the impression that human relationships are unrewarding and should therefore be avoided.

In most of the abnormal cases, mothers reported that their children found difficulty in separating from them during early school years. In addition, these children had poor relationships with peers.

Internally, this is the stage in which superego development takes place. It occurs as an aftermath of the torrid, instinct-driven, phallic phase during which strong control was required over the sexual and aggressive impulses.

The formation of the superego of conscience mainly comes about through the internalization of parental values, that is, what parents see as good and what they see as bad. The child normally conforms to parental standards to gain acceptance, approval, and congruency and to avoid punishment and rejection. Furthermore, he cannot afford to reject his parents on account of his need and dependency, the fear of going out into the world alone (for which he feels ill-equipped), and the fact that he thinks his parents know best and care most.⁵⁷

ADOLESCENT STAGE

According to Engel, adolescence can be defined "as the phase of psychological development during which full genital and reproductive maturity is reached". Biological maturity of the genital

areas and secondary sexual activity have to be brought under the control of the ego.⁵⁸

Along with these biological changes, old phallic conflicts with regard to parents become re-aroused. The adolescent has finally to solve the conflict of adopting parents as sexual partners and turn to the outside world for mates.

This period is difficult for mothers in that they have to watch their children gradually moving away from them. The "healthy" mother will allow the child to do this without making him feel guilty and without making him think he is obliged to "obey" because she reared him. She will allow him to use his increasing need for autonomy, and will view this as leading to better adjustment. She will not encourage him to stay by making him regress to dependence on her, or by being seductive.

The eventual sexual adjustment of the adolescent depends on how adequately he has resolved his phallic ties to his parents. If either parent continues with an unhealthy link to the child of the opposite sex, then the child will be afraid to exercise himself outside as every member of that sex will represent the "prohibited" parent. Fear of sexual activity is re-aroused and the child, as an adult, consequently avoids such contact.

Sexual attitudes are to a large extent dependent on parental values, transmitted consciously or unconsciously. In the final analysis, such values determine whether the new adult will regard

sex as something unpleasurable, clandestine, and unpleasant, or whether he will accept it with fullness and pleasure, and handle it with maturity.

E

VIEWS OF VARIOUS THEORISTS ON THE IMPORTANCE OF THE MOTHER-CHILD RELATIONSHIP FOR OVERALL PERSONALITY DEVELOPMENT

In this discussion, the term "personality" will be used broadly to describe a person's characteristic way of interacting with his environment which appears to be persistent throughout his lifetime.⁵⁹

Theorists, in studying personality, have attempted to explain the reasons for people having different personality patterns. For example, why do they react to stress differently? Culture as a conditioning factor in personality development has also been widely studied. Another area of interest has been the process underlying personality build-up and maintenance.

In reviewing the opinions on the reasons for personality development, there seems to be general consensus amongst theorists that it helps an individual to adjust to the demands of reality. Some of these are self-care to ensure self-preservation; the fulfilment of the cultural expectations of autonomy (which is a highly

valued attainment); and the individual's need to fit into society in an acceptable manner in order to avoid rejection.

The above-mentioned are objective long-term reasons seen from an adult theoretical point of view.

As an infant, however, one does not reason in this manner. There is a general consensus of opinion that the infant's initial motivation for interacting with his environment lies in the need to overcome the anxiety of being alone, helpless, and abandoned. It is important to note that the term "anxiety" does not necessarily denote neurotic pathological anxiety, but rather tension that is present to a healthy degree to act as a stimulus to progress. In fact, infants with too much anxiety or too little anxiety sometimes fail to progress in personality development as the former are made impotent by their fear and often lack the psychic energy for maturational growth; the latter are too comfortable in their present state, and see no need to face the frustration inherent in the process of growth.

Although theorists generally agree that anxiety is the chief stimulus for growth, theorists show considerable divergence in their views on the process of personality development which this anxiety triggers off.

Adler viewed the infant as feeling small and "inferior" on account of his physical size, lack of power to manipulate the environment, and a general feeling of helplessness against the

organized, powerful adult world. In order to overcome the anxiety generated by these "inferiorities" the infant strives to gain "superiority" socially and to attain autonomy so that he will no longer be so totally dependent and helpless.⁶⁰

Rank postulated that the birth process per se generates anxiety in the infant. He regarded this experience as being the most traumatic one in a person's life-time as it creates a tension that the individual seeks to master for the rest of his life. In later life, difficult situations which are anxiety-provoking re-awaken this original anxiety. Personality development aims at harnessing the "will" to overcome basic anxiety through control.⁶¹

Freud viewed personality development (formation of ego) as a means for the individual to channel his id energy constructively so that he can get his needs met and also to enable him to fit into society in an acceptable manner. Freud's view will be more fully explained later.

From the above it can be seen that anxiety about getting his needs met motivates the infant to establish contact and to maintain harmonious relationships with others in the environment. He learns from an early age that conforming behaviour is a useful means of gaining attention and fulfilling one's needs.

Some other broad aspects of personality formation that theorists have similar opinions on is that childhood is the most important socializing period and that the mother-child relationship

largely influences the upbringing of the child. A factor which aids her influence is her close and involved supervision of the child (a role which is often culturally assigned to her). On the part of the child, repeated experiences with mother help to reinforce certain modes of behaviour which aid his adjustment (in relation to her) in the most effective manner.

Bowlby succinctly summarizes the role of the mother in the socialization process of the child.

She orients him in space and time, provides his environment, permits the satisfaction of some of his impulses, restricts others. She is his ego and superego. Gradually he learns these arts himself and, as he does so, the skilled parent transfers the roles to him. This is a slow, subtle, and continuous process beginning when he first learns to walk and feed himself and not ending completely until maturity is reached.⁶²

The mother's role in socializing leaves the child vulnerable to any distortion in her personality; this might sometimes cause the child to achieve congruency in this relationship with her by following a similar "slant" in the same direction that her abnormal personality development has taken. Furthermore, quite often neurotic development of the parent requires the child to dovetail into this pattern.

The importance of the mother's influence and personality development is illustrated by the following quotation:

In dealing here with the embryology of the human mind.

one is struck by a similarity with the embryological development of the human body, during the course of which undifferentiated tissues respond to the influence of chemical organizers. If growth is to proceed smoothly, the tissues must be exposed to the influence of the appropriate organizer at certain critical periods. In the same way, if mental development is to proceed smoothly, it would appear to be necessary for the undifferentiated psyche to be exposed during critical periods to the influence of the psychic organizer — the mother.⁶³

Sometimes, as was seen from the sample under study, the influence of a healthy father-child relationship in which the father is a significantly influential person to whom the child is cathected can help to tone down the effects of a not so healthy mother-child relationship.

In reviewing the socialization process, theorists emphasize different factors. Some stress learning through "reward" in the form of approval of the parent and also repetition of these positive (or negative) experiences. Others stress the amount of instinctual gratification and frustration experienced which is said to be basic to the setting up of the psychic apparatus in the child. "Social" and "Interpersonal" theorists stress interpersonal relationships and cultural factors inherent in the socializing process. It is important to review all the factors stressed as this wide diversion of opinion could perhaps point to the fact that the recognized patterning of man's behaviour lies in all, or a combination of all, these factors. The SME method, with its Psycho-Social

History-taking procedure, reviews the total functioning of the individual. It has incorporated most of the different aspects emphasized, to give a holistic view of man.

In this discussion the psychoanalytical framework of personality development will be used as a basic framework of explanation and, at relevant points, the work of other theorists will be drawn on.

Freud devised a theoretical model for the structure of the psyche (mind) which he divided into id, ego, and superego. He viewed the personality development process as the emergence of the ego and superego from the basic id instinct with which the child is born. Socialization plays a crucial role in determining the direction and content of the ego and superego structure and development. (Another factor is that ego and superego development are "inextricably bound up with the child's primary human relationships; only when these are continuous and satisfactory can his ego and superego develop".) ⁶⁴

The id instinct represents a psychic mass of energy which helps an individual to fulfil the basic needs of the body. Some of the characteristics of the id are that it works according to the "pleasure principle" in that it aims only at attaining satisfaction for the individual regardless of place, time, and circumstances, almost in a primitive manner. It does not take reality into account, that is, consider the well-being of others when seeking satisfaction.

The ego emerges from the id after the child recognizes an external reality in mother. The ego aims at helping the individual to protect its self-interest and the interest of others as it is rational and considerate of long-term needs. It is also responsible for aiding the individual to move away from his barbaric self.

The id seeks pleasure, come what may, but the ego is concerned with discovering the most favourable and least dangerous method for satisfaction. The id is blind, but the ego takes into consideration the external world. Both the id and the ego are ruled by the pleasure-unpleasure principle. But in contrast to the id, the ego calculates the consequences of its behaviour. The id is bound by the necessity of seeking immediate gratification of instinctual demands, while the ego is capable of logical reasoning, of considering causal relations, and of learning by experience.⁶⁵

Ego development is crucial to mental health and for better adjustment to society. Individuals with poor ego development seem to have more problems in their social functioning and interaction with others. The ego (which helps to control, govern, and deal with the turbulent id) is less developed owing to unmet childhood needs which are necessary for healthy mental development. These people seem to be "tossed" psychically and socially to a greater extent than those with stronger egos. They have a weakly-constructed psychic apparatus to carry them over "the rough seas" created by unsatisfied needs, anxiety, and environmental stress. Some of the characteristics of persons with weak ego functioning (as reflected socially) are moving from job to job; the inability

to form stable sexual relationships (in which case they sometimes move from partner to partner without any real close emotional involvement); and lack of goal-directed behaviour (as can be seen in the "day-dreaming" behaviour of some school drop-outs).

In the sample under study, the degree of health of ego development is reflected by Diagnostic Percent Scores. The normal category, with better mother-child relationships and consequently healthier ego development generally, scored higher than the abnormal group with poorer mother-child relationships and less healthy ego development.

The superego (conscience) of the child develops at a later stage (during the latency period) in order to help the underdeveloped ego to deal with the powerful id instincts. The superego arises out of fear of punishment and rejection from significant people in the environment for unacceptable behaviour.⁶⁶ For example, most children do not see any harm in masturbation, but would refrain from doing so just because their mothers scold them each time they attempt such behaviour.

The superego embodies the ideals of the parent which the child has learned to abide by.⁶⁷ In most cases, children internalize these ideals, which remain even after the parents are no longer there to enforce them. Throughout life the individual, having had his standards of expectations set, will try to live by the ideals formulated in childhood. Some of the implications of superego

formation are that parental ideals might clash with the general social ones. This can be seen in the case of a child who regards stealing as an accepted activity on account of his parents having lived by such means.

In the opposite case, the parents might embody high ideals, so that the standards of expectation for the child are likewise high. Sometimes children are unable to achieve these parental standards through a lack of conducive circumstances. Parents who expect their children to achieve scholastically when they simply do not have the required intelligence to do so, engender in them feelings of failure, which in turn may result in low self-esteem and guilt for having let their parents down. Sometimes realistic rejection on the part of the parents and "imagined" rejection for having been a "let down" fill the child.

Religious parents, who are highly concerned about moral and amoral behaviour, can also engender deep feelings of guilt and fear in their children by strongly emphasizing the punishment and shame factors of "sinful" activities. In the sample of the abnormal group a mother, who herself had a very religious mother, has up to now not worked through her guilt involved in having an illegitimate child who is fourteen years old. This mother has consequently become a self-punishing, depressed, woman and is even more religious than before in an attempt to "undo" (through forgiveness) her past behaviour. As a reaction to her past, she seems to have set even higher moral standards for herself and her children in order to

prevent them from making the same "mistake" that she herself made, not knowing that she is most probably repeating her own dilemma.

An important factor which can contribute to healthy superego formation is a mother's flexibility whilst still maintaining an ideal. A mother who is flexible, who is understanding of circumstances, and prepared to allow "mistakes" by taking into consideration the limitations of being "human", helps the child to develop a realistic conscience. In this way, she inculcates flexible ideals which can later be rationally questioned and sometimes altered, if the need arises for better adjustment, without engendering unnecessary guilt.

Absolute ideals can create conflict and anxiety, especially when these standards cannot be met, or when environmental and cultural circumstances change and call for concomitant adaptation on the part of the individual.

The role of the mother in establishing the "fate" of the child cannot be over-emphasized. It is this factor that led Erich Fromm to say that a loving mother is a blessing to the life of an infant as the type of mother an infant is born to is left completely to chance (for better or for worse).⁶⁸

On the one hand, if the mother attends to the needs of her infant in a satisfactory manner, he does not have to cope with an unusual amount of anxiety which can hinder his ego development. On the other hand, if a child is not attended to properly and is

frustrated for long periods, he builds up anxiety which sets off a whole array of negative feelings (such as insecurity, fear and anxiety) which well up inside him. The child lives in a state of tension, constantly expecting pain. He thus remains in a state of psychological preparedness to deal with the situation through attack or withdrawal. In this way, he uses up more energy in maintaining his defences, leaving very little interest and energy to engage in outside exploratory behaviour. A well-known characteristic of neurotic and psychotic persons is their morbid pre-occupation with themselves to the exclusion of outside interests, as strong inner stimuli demand their interest and time. If a child has to live with anxiety, being in an anxious state becomes almost a habitual pattern of life. Even after the circumstances creating this anxiety have disappeared, i.e. when the child as an adult moves away from home, this "habit" of being anxious remains part of him. In later life, this tension is diffuse and inexplicable, and is carried over to other life situations, in which the individual feels an exaggerated sense of anxiety in relatively minor situations arising in the normal course of life. Furthermore, when in doubt about the outcome of a problem, he always seems to expect the worst and has a generally pessimistic outlook on life.

The amount of anxiety a child feels has two further implications for personality development.

The first of these is that a high tension level in the infant causes a pervasive feeling of "badness" within itself. The infant

does not have the reasoning capacities to see that its mother is the chief cause of its unhappiness. Since these feelings are generated, contained, and felt within itself, the infant thinks of itself as an unpleasant, pain-filled object.

Furthermore, the reactions of an impatient and unconcerned mother to an unhappy whining baby help to reinforce these feelings of being "bad" and troublesome. In this way, low self-esteem is engendered in the child, causing it to feel unworthy, useless, and undeserving of any of life's better fortunes.

In later years, this poor self-concept and anxiety could make a person feel a failure, which feeling can interfere with his capacity for routine tasks and social performances. Some examples are holding down a job, writing examinations, or meeting new people. Unless the person can work very hard at controlling his anxiety through mustering whatever ego-strength he has, and unless he has intelligence to cope with the situation, he is likely to fail at these tasks, thus further perpetuating his feelings of low self-esteem and unworthiness.

A frustrated, tense, and anxiety-ridden child sometimes spends much of his time being preoccupied with "internal" problems. This leaves very little effort to concentrate on external tasks such as school, friends, and pleasure. Furthermore, many of these emotionally-deprived or partly-deprived children try to meet their needs for affection and stimulation through engaging in auto-erotic

activities such as thumb-sucking and masturbation. In order to gain the attention of parents, children sometimes resort to other negative means, such as acting-out behaviour (temper tantrums), stealing, or developing psycho-somatic symptoms.

Types of behaviour patterns, such as those mentioned above, can be regarded as defences which meet secondary gains such as compelling attention, preventing the build-up of more anxiety, and helping with the discharge of tension. Defence patterns are first set up in relation to coping with mother, who to a certain extent not only determines the type of defence the child will be most accustomed to using, but also the extent to which he needs to apply these defences. The difference between a caring and an uncaring mother can be seen by the fact that the former would require her child to wait only for a short while before she attends to him, whereas the latter would only attend to her child after his cries have taken the form of a temper tantrum. The latter teaches her child that he has to show that he really is in need, by experiencing severe pain, before he gets attention.

Psychoanalytic theory, especially, lays stress on the inter-relationships between the mother and child in shaping its psychic functioning as she is responsible for satisfying or frustrating his primary and secondary needs. It is through her care that the child forms his basic impression of life as an experience to be challenged, overcome, and enjoyed; or else a weary strife-filled battle, in which one is perpetually faced with difficulty and

shackled by anxiety.

Other theorists emphasize, not only the mother-child relationship per se, but the whole Gestalt of interpersonal relationships in which father, siblings, and friends also play a vital role in influencing the conception of others and self in the individual. This seems a significant extension of the Freudian emphasis. An analysis of the case histories in this study shows that these other significant people are important in that they, too, afford approval and disapproval, and have expectations of the child, which shape his behaviour patterns,

Interpersonal relationships contribute to a child's image of himself as a person, in that the manner in which others communicate, respond, and react to him will govern his self-impression.⁶⁹ They will also affect his manner of relating to others outside his immediate circle. A child whose parents (and possibly his siblings too) have negative, critical attitudes towards him, could see himself as a hopeless, worthless person. He behaves according to this acquired self-image in the larger society. A child who has been treated with care and respect at home will demand similar respect and dignity outside the home circle. In this way he will protect his self-esteem and will not allow himself to be unnecessarily abused by others.

In addition to the more personal type of handed-down patterns of behaviour there are the broader cultural patterns inherent in

child-rearing attitudes -- goals and ideals which govern personality development and influence the socialization by others.

Erich Fromm and Karen Horney, both neo-Freudians, have done many studies and observations on this aspect. Karen Horney became convinced of its importance to personality development after her observation of different mental illnesses accompanying certain social attitudes associated with different historical periods. An example of this is the widespread prevalence of hysteria during the Victorian era, when sexual repression and denial as a social value was at its height.⁷⁰

Freud, too, emphasized the role of culture in determining the upbringing of the child. He says:

The parents' influence naturally includes not merely the personalities of the parents themselves, but also the racial, national, and family traditions handed on to them as well as the demand of the immediate social milieu which they represent.⁷¹

Cultural patterns are consciously and unconsciously created to maintain society and collective needs. They include formal and informal measures which act as guidelines for expected behaviour of members of the culture, and which are inculcated from an early age.

Broadly speaking, it can be said that society offers the same rewards for conformity as mother did in the small world of the child -- such as feelings of self-esteem, approval, acceptance, and a feeling of being needed. A child who feels a positive bond with

its mother will likewise have a positive bond with the world. A child who has a negative primary relationship tends to feel "let down", with pervasive feelings of mistrust towards those around him. He treats living grudgingly, as though it owes him a debt.

Besides inculcating values, the mother in her role as culture-bearer also influences the child to develop his internal perspective of society, as far as basic habits are concerned, according to the accepted social patterns. It must be borne in mind that the mother can only do this to the extent to which she has the child's interest at stake and to the extent of her own correct or incorrect perception of what behaviour ought to be. Other influential social cultural factors which might result in differing values being transferred to the child are standard of education of the mother, her socio-economic position, her religion, and the social system and values handed down by her parents.

Internalized cultural patterns become embedded in the child's mind through imitation identification and (as previously mentioned) the fear of punishment and rejection. Both mother and society approve and reject in a broadly similar manner, except that, within the family circle, mother's rejection has a more personal tone. Society isolates, ostracizes, exposes, and shames non-conformity; whereas success brings approval and feelings of being worthwhile.⁷²

A child who is made to feel worthless and rejected at home goes out into society as an adult and behaves in almost the same

rejection-seeking manner because of his feelings of hopelessness. In this way he almost unconsciously acts up to the image his parents have forecast for him and often finds himself in trouble. This is a clear indication of how interpersonal relations set the tone of a person's self-image, and whether a "good me" or "bad me" self-concept predominates. This, to a large extent, plays a part in deciding the manner in which the person invites the world to treat him.

In studying personality patterns of different cultural groups, it is not unusual to find differing goals and values which sometimes make sharp contrasts in adaptive patterns. A well-known example of cultural goal clash is the Eastern ideal of passivity and acceptance of life situations in contrast to the challenging and aggressive Western attitude. Both types of behaviour patterns are virtuous respectively to the culture concerned, and yet totally opposite in quality of adaptation.

Erikson, in his book "Childhood and Society", cites two examples of child-rearing patterns which prepare the child for socially-accepted values. Firstly, he sees a correlation between the Western system of timed schedules for child upbringing as seen in regulated feeding, bathing, bed-time, and toilet training, which he postulates as contributing to their obsessive need for punctuality and time organization in later years. This sharply contrasts to the leisurely way of child-rearing and general pace of life in other cultures. Secondly, he cites an example of an

American Indian tribe in which mothers frustrate the urge in their children to bite their nipple (during the oral aggressive stage) to such an extent that they turn 'blue in the face' from crying. The unconscious cultural aim of this act is to frustrate and dam up the id urge for aggression to such an extent that in adult life it would help to sharpen the attacking sense for hunting.

It is important to note that these processes are unconscious and not deliberately planned and proceeded with. These methods, evolved over years, are embodied in customs and taboos, as in the case of the Indian mother who most probably regards the biting of her nipple by the child as an unhealthy habit which should not be encouraged.⁷³

CHAPTER V

FINDINGS OF THE STUDY

PART I

INTRODUCTION

The study under investigation set out to determine the influence of the mother-child relationship on personality development and maturation.

In presenting the findings of the study, the same organizational framework will be used as is used in the Psycho-Social History outline. This outline, it will be recalled, covers the individual's total functioning, and includes his relationships to mother, father, significant others, his adjustment, stress experiences, developmental history, family functioning, and condition at birth.

It was hoped that the importance of the mother-child relationship and its influence on the individual's development and functioning would be illustrated by the correlations of the index score of this relationship and the scores of the other areas outlined above which reflect the individual's internal and external "environment".

For the sake of brevity and easier tabulation, the following abbreviations will be used throughout the rest of the work:-

N - Normal

A - Abnormal

MCR - Mother-Child Relationship(s)

FCR - Father-Child Relationship(s)

OCR - Other-Child Relationship(s)

IS - Index Score(s).

TABLE 11
Correlation between the Mother-Child Relationship Index Scores
and Significant Relationships Index Scores

M C R Index Scores	Significant Relationships Index Scores							
	0 - 0.99		1.00 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
0 - 0.83	-	26	-	3	-	-	-	29
0.84 - 1.99	-	3	3	3	2	-	5	6
2.00 - 3.00	-	-	3	-	27	-	30	-
All	-	29	6	6	29	-	35	35

Description of Table

The most striking correlation in the above table is that 26 abnormal cases with an MCR IS of 0 - 0.83 scored in the range of 0 - 0.99 for Significant Relationships.

These figures sharply contrast with 27 normal cases with an MCR IS of 2.00 - 3.00, who scored similarly (2.00 - 3.00) for Significant Relationships.

Three abnormal cases with an MCR IS of 0 - 0.83 scored up to 1.99 for Significant Relationships.

Six of the remaining abnormal cases with an MCR IS in the range of 0.84 - 1.99 scored 0 - 0.99 (three cases) and 1.00 - 1.99 (three cases) respectively for Significant Relationships.

Explanation of Table

The findings shown in Table 11 affirm the theoretical assumption that the mother-child relationship is a very significant factor in influencing the course and development of an individual's personality.

According to theory, the mother is the most important person in the child's world. She spreads her influence not only in respect of his material environment but also in the emotional and interpersonal relationships he has with other people. The individual's relationship with the mother is the original upon which later relationships are built.

The findings in this table, in which the 26 abnormal cases with a low MCR IS in the 0 - 0.83 range also scored in the lower range (0 - 0.99) for Significant Relationships, confirm that the mother-child relationship sets the pattern for other relationships.

The term Significant Relationships encompasses the Father/Client relationship, Others/Client relationship, and Mother/Client relationship.

Likewise, 27 normal cases with an MCR IS in the higher range of 2.00 - 3.00 scored in the range of 2.00 - 3.00 for Significant Relationships.

The scores of three of the abnormal families did not show this correlation. This can be explained by the fact that these

cases had particularly poor Father/Client relationships which considerably lowered the total score for Significant Relationships.

Two of the normal cases had an NCR IS of 0.84 - 1.99 and an unusual Significant Relationships IS of 2.00 - 3.00. This came about as a result of particularly healthy father-child relationships.

The findings of this table showing Significant Relationships are helpful in that, besides reflecting the importance of the mother as an important person, the father is also shown as a significant person who can tip the balance in determining the health or ill-health of the individual's interpersonal relationships.

The importance of the father will be dealt with in more detail towards the end of this chapter.

TABLE 12

Correlation between the Mother-Child Relationship Index Scores
and Diagnostic Percent Scores for Normal and Abnormal Cases
on a Comparative Basis

M C R Index Scores	Diagnostic Percent Scores							
	20 - 60		61 - 70		71 - 100		All	
	N	A	N	A	N	A	N	A
0 - 0.83	-	29	-	-	-	-	-	29
0.84 - 1.99	1	6	-	-	4	-	5	6
2.00 - 3.00	-	-	1	-	29	-	30	-
All	1	35	1	-	33	-	35	35

Description of Table

Table 12 shows that 29 abnormal cases with an MCR IS in the range of 0 - 0.83 had Diagnostic Percent Scores in the range of 20 - 60%.

The remaining six abnormal cases had an MCR IS of 0.84 - 1.99. All six of these cases had Diagnostic Percent Scores of 20 - 60%.

The normal cases show contrasting scores in that 29 normal cases with an MCR IS in the range of 2.00 - 3.00 had Diagnostic Percent Scores of 71 - 100%.

Of the remaining six normal families, five cases with an MCR IS of 0.84 - 1.99 had a Diagnostic Percent Score ranging between 71 - 100%.

Explanation of Table

Table 12 indicates that the mother-child relationship exerts an influence on the total personality development of the individual. This is reflected by the fact that for the whole sample there is a correlation between the Mother-Child Relationship IS and the Diagnostic Percent Scores. (The latter shows the level of personality maturation reached by the individual.)

In the abnormal group, 29 cases with an impoverished Mother-Child Relationship (range 0 - 0.83) had Diagnostic Percent Scores in the range of 20% to 60%. This implies poorer personality maturation and development. Poor mothering experiences are thus shown to make for immature personality development.

Conversely, the degree of health in the relationship with the mother correlates positively with the degree of health in personality development. The normal group (which was the control group) bears out this fact in that 29 cases with a higher Mother-Child Relationship IS range of 2.00 - 3.00 reveal Diagnostic Percent Scores ranging between 71 - 100%.

Poor fathering experiences in five cases, and brain damage in one other case, prevented healthy personality development, despite the fact that these six abnormal cases had slightly better mothering experiences than their counterparts.

In four of the normal cases with an MCR IS of 0.84 - 1.99, the

individuals seem to have had better fathering experiences which helped to make up for the deficit in the 'average' relationships with their mothers.

TABLE 13
A Further Breakdown of Diagnostic Percent Scores
showing correlation with the
Mother-Child Relationship Index Scores

Diagnostic % Scores	Mother-Child Relationship Index Scores							
	0 - 0.83		0.84 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
21 - 25	-	1	-	-	-	-	-	1
26 - 30	-	-	-	-	-	-	-	-
31 - 35	-	5	-	-	-	-	-	5
36 - 40	-	7	-	1	-	-	-	8
41 - 45	-	9	-	1	-	-	-	10
46 - 50	-	4	-	4	-	-	-	8
51 - 55	-	2	-	-	-	-	-	2
56 - 60	-	1	1	-	-	-	1	1
61 - 70	-	-	-	-	1	-	1	-
71 - 75	-	-	3	-	1	-	4	-
76 - 80	-	-	-	-	7	-	7	-
81 - 85	-	-	1	-	10	-	11	-
86 - 90	-	-	-	-	4	-	4	-
91 - 96	-	-	-	-	7	-	7	-
All	-	29	5	6	30	-	35	35

Description of Table

The table shows that the upper ranges of the Diagnostic Percent Scores are predominantly occupied by normal cases, while the lower ranges are occupied by abnormal cases.

Scores for the Mother-Child Relationship seem to be similarly clustered with abnormal cases occupying the lower ranges and normal cases occupying the higher ranges.

A striking feature of this table is the fact that there is a distinct break in the Diagnostic Percent Scores range of 56 - 60% with one normal family and one abnormal family occupying this range. Thereafter, the remaining 34 normal families scored above this range exclusively; likewise 34 abnormal families scored below this range.

Low Mother-Child Relationship IS and low Diagnostic Percent Scores (21 - 60%) seem to hold consistently for the abnormal cases in that 29 of the cases scored in the 0 - 0.83 range. The opposite holds for the normal cases with 30 having a Mother-Child Relationship IS of 2.00 - 3.00, and having corresponding higher Diagnostic Percent Scores ranging from 56 - 96%.

Explanation of Table

In Table 13, the abnormal cases are clustered at the lower end of the scale which reflects their poor MCR and consequent poor personality development.

There is a distinct break at the 56% - 60% range. From this pivotal point onwards all abnormal individuals score low, and normal individuals score higher.

Freudian theory leans heavily on the fact that the mother

forms the chief backdrop in the formation of one's personality to the extent that, if a child is to be treated for the problem he presents, the mother-child relationship is the most important area of investigation, prognosis, and treatment.

Prognosis, too, is based on the capacity of the mother to change and adjust to the recommended treatment plan in which she usually is the most important person, so that a similar adjustment will take place in the child.

In many cases, however, the father is of necessity drawn into the treatment as he too affects the child either directly or indirectly through influencing the mother's role performance.

TABLE 14A

**Diagnostic Percent Scores which determine
Likelihood for Treatment**

Treatment Possibilities		
Treatment Needed	Treatment Questioned	Treatment not Needed
0 - 60%	61 - 70%	71 - 100%

This table has been compiled from data communicated to the author by Mr. J.L. Stricklin, from whose recent experimental work they have been derived. It has been included in this study not as part of the findings but as an explanatory guide to the table which is to follow.

TABLE 14B

**Correlation between the Mother-Child Relationship Index Scores
and Diagnostic Percent Scores as outlined by
the SME Treatment Evaluation Chart**

Treatment Evaluation Chart	Mother-Child Relationship Index Scores							
	0 - 0.83		0.84 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
Treatment Needed								
0 - 60%	-	29	1	6	-	-	1	35
Treatment Questioned								
61 - 70%	-	-	-	-	1	-	1	-
Treatment not Needed								
71 - 100%	-	-	4	-	29	-	33	-
All	-	29	5	6	30		35	35

Description of Table 14B

After the SME Treatment Evaluation Chart had been applied to the sample under study it could be seen that 36 cases would require treatment because their diagnostic scores, in the 0 - 60% range, were low. Of these cases, 29 abnormal cases had an MCR IS range of 0 - 0.83. The remaining seven cases fell into the MCR IS range of 0.84 - 1.99.

The MCR IS in the group not requiring treatment (Diagnostic Percent Score range of 71 - 100) read as 2.00 - 3.00 for 20 of the normal cases. Only four normal cases had an MCR IS of 0.84 - 1.99.

Only one normal case was in the Treatment Questioned category; this was in the range 2.00 - 3.00 for MCR.

In the normal sample, 29 of the cases in the Treatment not Needed range scored 2.00 - 3.00 for the MCR.

In the five remaining normal cases, four had questionable mother-child relationships. In these cases it was essential to evaluate the mother-child relationship more closely and to review the father-child relationship to obtain a more precise evaluation for treatment purposes.

From these findings it can be concluded that individuals with very poor MCR IS (0 - 0.83) will almost certainly require treatment and that individuals with a very healthy relationship (2.00 - 3.00) will in all probability not require treatment.

For the 'middle' range of MCR IS (0.84 - 1.99), it is important firstly to assess the father-child relationship too to see whether this is capable of "making up" in the mothering process of the child (in which case it helps to promote and maintain mental health) or whether it worsens an already unsatisfactory mother-child relationship.

Explanation of Tables 14A and 14B

Table 14A is a borrowed explanatory table which evaluates the treatment possibilities (likelihood of cases qualifying for treatment) for the sample.

In Table 14B, the investigator is attempting to evaluate whether there is any correlation between the 'treatment possibilities' scores and the mother-child relationship. In this way, it is hoped to conclude the extent to which the mother-child relationship per se could be used as a guideline to determine whether a case requires treatment or not.

TABLE 15

**Correlation between the Mother-Child Relationship Index Scores
and Adjustment Index Scores**

M C R Index Scores	Adjustment Index Scores							
	0 - 1.14		1.15 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
0 - 0.83	-	29	-	-	-	-	-	29
0.84 - 1.99	1	5	3	1	1	-	5	6
2.00 - 3.00	-	-	4	-	26	-	30	-
All	1	34	7	1	27	-	35	35

Description of Table

Table 15 shows that 29 abnormal cases with an MCR IS range of 0 - 0.83 scored in the lowest range for Adjustment (0 - 1.14).

The findings in the above paragraph show a contrast to the normal cases with an MCR IS in the range of 2.00 - 3.00, of which 26 had a correlating high Adjustment IS of between 2.00 - 3.00.

In five of the remaining abnormal cases (0.84 - 1.99 MCR IS), the Adjustment IS was in the range of 0 - 1.14.

Explanation of Table

In the explanation of Table 12 it was seen that the

mother-child relationship affected the total personality development.

This study has also evaluated specific areas involved in personality development, one of these being the "Adjustment" the individual has achieved in coping with the psychological adaptation to his environment.

Since the mother forms the most important part of the environment during the child's most impressionable years, it stands to reason that the personality of the child will make a greater adjustment to accommodate her influence.

In order to test out the mothers' influence on the Adjustment scores of the individual cases, it was decided to see if any correlation existed between these two sets of scores, i.e. mother-child relationship and adjustment.

The table which was used for this purpose reflects positive results in that 29 abnormal cases (MCR IS, 0 - 0.83) scored in the range of 0 - 1.14 for Adjustment IS.

The control group had 26 cases with an MCR IS of 2.00 - 3.00, scoring in the range of 2.00 - 3.00 for Adjustment IS too.

From these results, it can be concluded that healthy adjustment is influenced by a positive environment in which the mother's influence is highly significant.

In the abnormal group, all the cases had poor mothering experiences which brought about poor adjustment patterns. A reason for this poor adjustment could be that these individuals were forced to use maladaptive defence mechanisms in order to protect themselves from the abnormal degree of stress and frustration engendered during the process of unhealthy mothering. Furthermore, these defences had to be applied to an abnormally high degree as their maladaptive use is relative to the amount of stress being dealt with. This exaggeration of defences distorts perception. Repeated experiences of stress and use of these defences reinforce the distortions until they become part of the personality make-up and habitual manner of coping with stress.

These faulty internalized processes of defending and reasoning are carried over to other relationships and experiences outside the home. These sometimes give rise to conflict in the individual as they come to clash with reality in which these acquired patterns are not applicable.

In this way the individual repeats his previous poor experiences and perpetuates his own abnormal adjustment pattern long after the need for it has passed.

TABLE 16
Correlation between the Mother-Child Relationship Index Scores
and Stress Index Scores

M C R Index Scores	Stress Index Scores					
	0 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A
0 - 0.83	-	29	4	4	4	29
0.84 - 1.99	1	6	4	-	5	6
2.00 - 3.00	3	-	27	-	30	-
All	4	35	31	-	35	35

Description of Table

29 abnormal cases in the MCR IS range of 0 - 0.83 scored in the range of 0 - 1.99 for Stress.

In the normal group, 27 cases (MCR IS, 2.00 - 3.00) scored in the 2.00 - 3.00 range for Stress.

Six of the remaining abnormal cases (MCR IS 0.84 - 1.99) fit into the lower range of the Stress category.

Explanation of Table

The area of Stress is also positively correlated with the Mother-Child Relationship IS.

The amount of stress a child has to cope with in his daily environment is to a large extent dependent on his Significant Relationships.

If a child has an unhappy mother-child relationship and father-child relationship, he will be tense, anxious, and angry for most of his childhood. As was seen in the theoretical discussion, during the early years the mother especially forms the chief part of the child's environment on account of her attending to his basic needs.

Difficulty in a relationship with the father as well increases the stress a child has to cope with.

The mother generally has the greatest power in frustrating the child, thus causing stress, or of satisfying him, and in this way preventing the build-up of stress. Her power is wielded because the child in its earliest formative stages is almost entirely dependent upon her — physically, emotionally, and culturally.

The table under discussion supports this view, in that 29 abnormal individuals in the first ranges for both Mother-Child Relationship and Stress scored very low.

The opposite holds for 27 normal individuals who fell into the highest range of scores.

In four of the normal cases which had an MCR IS of 0.84 - 1.99, they had (unlike the abnormal cases with a similar score) 2.00 - 3.00

in the area of Stress. In all four cases this is mainly due to a healthy father-child relationship, which helped to lessen the stress engendered by a 'not so healthy' mother-child relationship by fulfilling some of the emotional needs of these children.

TABLE 17

Correlation between the Mother-Child Relationship Index Scores
and Current Family Functioning Index Scores

M C R Index Scores	Current Family Functioning Index Scores					
	0 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A
0 - 0.83	-	27	-	2	-	29
0.84 - 1.99	-	5	5	1	5	6
2.00 - 3.00	1	-	29	4	30	-
All	1	32	34	3	35	35

Description of Table

In the abnormal group, 27 cases scored in the range of 0 - 1.99 for Current Family Functioning, whereas 29 of the normal cases scored in the range of 2.00 - 3.00.

Two abnormal cases scored in the 2.00 - 3.00 range for Current Family Functioning.

In the MCR IS range of 0.84 - 1.99, five abnormal cases scored in the range of 0 - 1.99 for Current Family Functioning, and five normal cases, with a similar MCR IS scored in the 2.00 - 3.00 range.

Explanation of Table

The mother is inextricably bound up with the totality of family functioning; not only because she is usually the one in charge of the household, but also because she is the emotional leader of the family. In most families it is she who sets the atmosphere or mood of optimism or pessimism inherent in the family set-up.

It is important to mention that it was also observed that the mother's role performance was largely influenced by her husband's relationship with her. In most of the abnormal cases in which the mothers did not function well, the parents seemed to have problems with their marriage, or, if the marriage did not show any open conflicts, there tended to be an undercurrent of aloofness between the spouses.

In some of the cases, the fact that the father did not meet the mother's emotional needs in the marriage made her turn to her children (sons in particular) for emotional support.

Children who were forced to give their mothers support were further alienated from their fathers which added to their problems. This phenomenon is especially dangerous in male children as it heightens the tension of their Oedipal conflict. In four abnormal cases, in which mother sought strong emotional support from their sons, this seems to have contributed to their children's lack of ability to resolve the Oedipal conflict.

Later problems of sexual adjustment presented themselves in their sons in that they were unable to establish sexual relationships with females. The cases under discussion are A.18, A.19, A.22, and A.23 — their ages ranged from 16 years to 22 years.

In most of the abnormal cases, family emotional interaction and closeness was lacking, the cause of this often arising from "walled off" parents. These parents had very little emotional and verbal communication with their family members.

In only three of the 35 abnormal cases, Current Family Functioning scores were in the 2.00 - 3.00 range. Three of these cases had different reasons for this unusual pattern. In case A.32, for example, the child was mentally retarded and this was the major cause for his poor personality development as he was in an otherwise healthy environment.

In the second case the parents of the child were divorced. His father later married and there was much more harmony in the new home. The stepmother took much more care over this child than his natural mother had done.

In the third case the parents were happily married, but the mother seemed to have had many problems which she unconsciously acted out through the child. This mother was brought up very rigidly and in the upbringing of her child was determined not to repeat her own experiences as a child. As a result, she was too non-directive and flexible in her child-rearing attitudes. This

seemed to have resulted in the child becoming an aimless dreamer, which affected his school performance. In fact, this mother had verbalized her own conscious effort not to bring up her child as strictly as her own mother had reared her; she seemed to have applied this reaction formation to an unhealthy degree in that she now allowed too much of 'freedom' and too little control in the upbringing of this child.

Generally, unsuitable family circumstances in the abnormal group can be seen in the fact that the 27 individuals fit into the lower range of the scale for Current Family Functioning. Better family circumstances seem to have dominated in the normal group as most of the families fell into the upper category.

TABLE 18

Correlation between the Mother-Child Relationship Index Scores
and Condition at Birth Index Scores

M C R Index Scores	Condition at Birth Index Scores							
	0 - 1.34		1.35 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
0 - 0.83	-	4	-	2	-	23	-	29
0.84 - 1.09	-	2	-	-	5	4	5	6
2.00 - 3.00	-	-	-	-	30	-	30	-
All	-	6	-	2	35	27	35	35

Description of Table

In the abnormal group, 23 cases scored between 2.00 and 3.00 for Condition at Birth. Six cases scored in the double range of 0 - 1.99. All 29 of these cases had an MCR IS in the range of 0 - 0.83.

In the normal sample, 30 in the 2.00 - 3.00 range for MCR IS scored in the same range for Condition at Birth.

Explanation of Table

In the abnormal group, 31 cases scored in the 1.35 - 3.00 range for Condition at Birth, and in the normal category 35 cases

scored in the range of 2.00 - 3.00. The difference is hardly significant, despite the fact that in the abnormal group there were slightly more cases with mild congenital problems.

In two of the abnormal cases, Condition at Birth caused serious adjustment problems in that one child was born with severe brain damage (IQ of 43), and the other case concerned a girl born with congenital deafness.

In the case of the boy (A.32), he was fortunately born to a healthy functioning mother who had the ego strength to cope with his behaviour. However, despite her ego strength she still found some difficulty initially in adjusting to him, and this consequently affected her relationship with him.

In the case of the deaf girl (A.20), she was born into a home in which the mother herself was inadequate and who found difficulty in coping with her older children (two of the older siblings are in institutions as a result of behaviour problems). The birth of this child (with communication problems) not only taxed the mother's impoverished emotional resources but was looked upon as an added burden. The child subsequently faced rejection, isolation, and lack of any emotional warmth from her mother. (MCR IS, 0.50).

In the case of the brain-damaged boy the diagnostic score was 46% and in the case of the deaf girl, 22%.

These two cases underline the point that a healthy functioning

mother can help towards worsening or improving the chances for better adjustment of handicapped children.

Less severe forms of stressful Condition at Birth were generally more predominant in the abnormal group and this was mainly caused through the mothers' unstable emotional state during pregnancy. A survey of the True/False questionnaire showed that most of the abnormal mothers were emotionally 'unstable' during their pregnancy.

Higher tension levels in the expectant mother resulted in the foetus being born with a concomitant high tension level which comes about through intra-uterine exchanges between mother and child.

It can be stated that more abnormal cases were born with a greater set-back at the very start of life than normal cases, as a result of their intra-uterine development phase within mothers who were more unstable.

TABLE 19
Normal and Abnormal Cases classified according to
Mother-Child Relationship Index Scores

Sample Groups	Mother-Child Relationship Index Scores							
	0 - 0.99		1.00 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
Abnormal	-	29	-	6	-	-	-	35
Normal	-	-	5	-	30	-	35	-
All	-	29	5	6	30	-	35	35

Description of Table

The above table shows that 29 of the abnormal cases scored in the 0 - 0.99 range for MCR.

In the normal group, 30 cases scored in the 2.00 - 3.00 range of the table. Five of the remaining normal cases scored in the range of 1.00 - 1.99.

In the abnormal group, six of the cases fit into the 1.00 - 1.99 range.

Explanation of Table

In this table it can be seen that in the MCR, 29 abnormal

cases scored in the lowest range, and that 30 normal cases scored in the highest range.

Clients of the former group had a low score because of their interaction with mothers who either did not attend adequately to their emotional needs, had neurotic parental attitudes towards child-rearing, or were incapable of mothering because they themselves had never experienced any positive mothering. It was not unusual to find a combination of these factors occurring in most of the cases.

Many of the mothers seemed immature and in most cases could not even adjust suitably to their marriage.

In case A.11, the mother was reared in an institution and later by an unpleasant stepmother in whose care she underwent much hardship. Later, this girl compulsively (acting out) became pregnant and tried to satisfy her own need to be mothered by intensely mothering the baby that was born. After a time, when she found that she was not deriving the emotional nurture that she had anticipated from this child, she became cruel, hard, and bitter towards him by punishing him severely and unconsciously wreaking vengeance on him for the deprivation she had suffered in her earlier years. The child naturally reacted with anger and acting-out behaviour which only perpetuated and justified the mother's attitude towards him. This mother received very little support from her husband, too, and tried to get all her emotional needs met through the child.

In this case it can be seen how an immature ego, which did not develop because of the lack of emotional nurture, had an impoverished capacity for giving to another person. The mother herself seemed to be in need of as much mothering as the child.

In another case, a mother with very low self-esteem tried to over-mother her child in order to prove to herself that she was at least capable as a mother. She did so much for the child that she became over-involved with him and lost sight of her real role. When the child did not react by being 'good' the mother felt 'let down' by the 'ungrateful' child, and showed her anger towards him which made the child even more stubborn and demanding. Because of her unconscious need to feel that she was a good mother, the focus of her attention to the child was born of a selfish motive, that is, she was so engrossed in her own role as the 'server' that she did not take the trouble to listen to her child emotionally and to move at his pace instead of hers.

In the analysis of the abnormal cases in general it became repeatedly evident that mothering an infant gives rise to the mother's old conflicts which she had had with her own mother, her old unfulfilled needs, and the renewal of the way in which she was mothered. All of the factors are collectively brought to bear upon the child.

In the normal cases, the mother-child relationships seem to be of a much better quality as 30 cases scored in the range of

2.00 - 3.00. Some of these mothers, too, had problems in their own mothering experiences but seemed to have coped with them in a much better manner as a result of their greater ego strength, motivation towards bearing children, and greater support from their husbands.

TABLE 20

A Comparison of the Index Scores of the Mother-Child Relationship
of the Normal and Abnormal Categories on an Individual Basis

Mother-Child Relationship Index Scores		
Case No.	Abnormal	Normal
1	.67	1.00
2	.33	2.00
3	.67	2.50
4	.83	2.50
5	.83	2.50
6	.67	3.00
7	.83	2.17
8	.83	2.67
9	1.00	1.67
10	1.17	3.00
11	.67	2.17
12	.50	2.17
13	.60	2.17
14	1.33	3.00
15	1.00	3.00
16	.33	1.83
17	.67	2.67
18	.33	2.00
19	.37	2.17
20	.50	2.33
21	.83	1.83
22	.67	2.50
23	.67	2.50
24	.50	2.33
25	.63	2.50
26	.67	2.67
27	1.00	1.83
28	.67	2.17
29	.50	2.17
30	.67	2.17
31	.17	2.50
32	1.67	2.83
33	.50	2.67
34	.83	2.00
35	.83	2.33

Description of Table

A comparison of the Mother-Child Relationship IS on an individual basis for abnormal and normal cases shows the normal to be consistently higher for all 35 cases.

Explanation of Table

Table 29 shows that all the abnormal cases have had worse mothering experiences than the normal cases on an individual comparative basis, and magnifies the results of Table 19.

TABLE 21

Assessment of Qualitative differences on a Quantitative basis
between Normal and Abnormal Cases for the Mother-Child Relationship
through analysis of statements marked as false
on the SIE True/False Questionnaire

Statements on the MCR	Answered False		
	Normal	Abnormal	All
# 1	2	34	36
2	2	15	17
3	14	32	46
4	19	32	51
5	5	35	40
6	10	31	41
7	10	34	44
8	0	4	4
9	7	33	40
10	6	22	28
11	1	22	23
12	11	13	24
13	11	33	44
14	3	32	35
15	13	34	47
16	15	32	47
17	4	33	37
18	4	11	15
All	137	482	619

* The actual statements (which appear as numbers 1 - 18 in this table) are outlined in the 'Explanation' which follows.

Description of Table

In this table the statements answered "False" for the abnormal and Normal groups are reviewed.

It can be seen that there are more questions answered false in the abnormal group (482) than in the normal group (137).

From the above it can be concluded that there was a greater lack of positive aspects in the mother-child relationship for the abnormal group than for the normal group.

The importance of specific statements in the questionnaire which contribute to a normal mother-child relationship as opposed to the absence of these factors in the abnormal group, can be evaluated by reviewing which of these statements occur most frequently in the normal group and least frequently in the abnormal group.

The result of this process shows the following statements in order of importance: 11, 1, 14, 17, 2, 5, 9, 10, 7, 6, 13, 13, 15, 3, 16, 4, 8, and 12.

Explanation of Table

In evaluating the mother-child relationship in the True/False Questionnaire, 18 statements pertaining to it were answered in respect of each individual, for both groups.

In both groups it was found that there were deficiencies in

the mother-child relationship when compared to the ideal sum of 18 statements which set out to evaluate this area.

Deficiencies as indicated by false answers were found to be more numerous in the abnormal group. In this group there was a total of 482 statements marked false and in the normal group only 137 such statements.

It was felt that the importance of some statements (representing factors inherent in a healthy mother-child relationship) exceeded the importance of others in the category. In an attempt to evaluate the factors in order of importance, the investigator decided to use the following assumption: that what was lacking in both groups almost equally (although this was not the case) would not be significant to development of normality; that which was most prevalent in the normal and severely lacking in the mother-child relationship in the abnormal sample was to be regarded as significant for normal development.

After subtracting the 'normal' false answers from the 'abnormal' false answers for each of the statements it was found that the following statements (designated as nos. 11, 1, 14, 17, 2, 5, 9, 10, 7, 6, 13, 18, 15, 3, 16, 4, 8, and 12) were most prevalent in normal cases and least prevalent in abnormal cases in order of decreasing importance.

These factors will be discussed individually below.

Statement 11

'The mother received positive emotional support from her husband during the client's first seven years of life.'

In analysing the results of this statement for the abnormal group it can be seen that it was marked false in 22 out of 35 cases, whereas in the normal group it was marked false only once. It can be concluded that this factor is very significant for a normal healthy personality development as it was a prevalent factor in the majority of the normal cases and absent in the majority of the cases in the abnormal group.

The overall importance of the father has been more thoroughly discussed in a table that follows (Table 23) in this chapter — with its importance to the mother-child relationship being clearly demonstrated.

Statement 1

'The mother's basic personality is conducive to good mothering.'

This question was answered false for the normal group in only two cases, and 34 times in the abnormal group. From this result it can be concluded that mothers with negative basic attitudes to mothering have greater chances of rearing children in the climate of impoverished mother-child relationships (with resultant poor personality development) than mothers with more positive basic attitudes to mothering.

One's attitude towards being a mother and mothering per se is dependent not only on how one experienced being mothered as a

child, but also on the emotional resources a mother has to feed to her child.

Statement 14

'A positive response to the mother during the developmental years is reflected in the client's history.'

This statement evaluates the nature of the predominant bond of the child to his mother; whether this was a hostile dependent bond or a positive relationship in which love and not anxiety was the predominating "tie". One also has to evaluate whether the child felt close to the 'good' mother in a secure, happy relationship, or whether he had to keep at a safe distance emotionally in order to avoid being hurt through lack of reciprocation on her part.

In 32 abnormal cases this statement was marked false; in the remaining three cases in which it had been marked true, there were unusual circumstances in two of which the child had 'changed' mothers (one was placed in foster care, the other's father remarried); in the third case, the child had brain damage as the chief cause of his personality problems, with an otherwise fairly strong mother "personality wise".

Statement 11

'Stage by stage during the maturational years, most of the client's needs to be mothered were met.'

This factor held true for the normal group 31 times, and only twice for the abnormal group.

This conclusion implies that maturational needs of the children which unfolded during their developmental years were satisfactorily fulfilled for the majority of the normal cases.

In the abnormal sample the needs that unfolded during the developmental years were not fulfilled satisfactorily. At some stage during their maturation these children were deprived of the satisfaction of their emotional needs. Consequently, their personality growth became stunted.

Further analysis of this factor from the histories show that although most of these abnormal cases had consistent mothering figures, their mothers, on account of their own personality deficits and other stress, began emotionally neglecting these children from birth (oral stage) onwards. The frustration engendered prevented the children from resolving this stage successfully and moving onto the next. They invariably entered this new stage with little ego capacity to cope with the additional stress. With accumulating stress these children became more difficult.

Usually the mother, in such cases, becomes more frustrated with the child's behaviour and adopts harsher attitudes which only perpetuate his problems until the situation gets out of control for both mother and child.

Statement 2

'The mother's cultural-socio-economic developmental background enhances her capacity to mother.'

In 15 of the abnormal cases this statement was marked false.

In this sample, these children have a double disadvantage of being emotionally and intellectually deprived. Cultural deprivation quite often means intellectual deprivation which worsens one's ability to solve emotional problems as intellectual capacity and insight are closely related.

In the normal sample this question was answered false twice. Both these cases had mothers who had come from a low socio-economic community (Observatory) and had low educational standards and limited vocabulary. Both these mothers however had happy marriages and offered their children adequate emotional fulfilment.

Statement 5

'The mother's attitudes towards the client do not interfere with her capacity to mother.'

In the abnormal sample this question was answered false 35 times. Examples of faulty maternal attitudes can sometimes be seen in mothers who view their child's acting-out behaviour as a deliberate attempt to antagonize and punish them and cannot see their own role in perpetuating these difficulties.

Sometimes these mothers were just indifferent or 'unaware' of the emotional needs of their children and regarded their attention-seeking more as a demand rather than a right to which the children were entitled.

In the normal group this question was answered false only five times.

Statement 9

'The mother has made a positive approach to discipline, with consistent and realistic limit-setting.'

The abnormal mothers were generally erratic in their discipline which quite often arose from their ambivalent attitudes towards their children.

In the abnormal group this question was answered false 33 times. Ambivalence arose when mothers on the one hand resented the emotional demands of their children and, on the other, wanted to be needed and loved by them. These feelings quite often affected the manner of their disciplining, as it became geared more to their own moods and level of stress. In this way 'behaviour' that a child would not normally be punished for because of the mother's clarity of perception (with a low anxiety level), will at other times become coloured with her own anger and this is vented onto the child. In this mood, severe punishment is meted out for relatively simple misbehaviour which was previously overlooked.

Statement 10

'Parents agree on discipline and limit-setting.'

This statement was answered false in 22 of the abnormal cases. This mainly arose from the fact that parents with unhappy marriages agreed on very few areas in their relationship.

Furthermore, in most of the cases of the abnormal group in which the statement read as true, it was found in a review of the histories that in most cases the father was indifferent to the

child's disciplinary needs and upbringing. Consequently he did not care about the manner in which the mother disciplined the child — his silence on the matter being more a manifestation of his negative attitude than an agreement with her mode of discipline.

In the cases in which both parents disagreed, it seemed that this was more a competition in which they attempted to win the child's attention and favour through leniency — as opposed to the other parent's firmness — rather than taking into account the interest of the child. In this way the value system of the child was affected in that he received conflicting standards from both parents.

Statement 7

'The mother's emotional giving has been adequate.'

This statement covers the level of personality maturity and resultant ego strength in the mother. It is generally accepted that the greater the maturity and ego strength the more capable she would be in giving to her child emotionally.

In 34 of the 35 abnormal cases this need was inadequately met. In the one case in which this statement was answered true, the child was brain injured. This congenital defect was the chief cause of his poor personality functioning rather than emotional deprivation.

In the 34 cases the mothers seemed unable to give their children adequate emotional support. This was mainly due to their own poor upbringing in which they themselves were emotionally deprived and were emotionally immature and still in need of mothering — hence little ego strength. Furthermore, they received very little

emotional support from their husbands which caused additional stress. These factors made it difficult for them to relate to their children without conveying the effects of this stress. Furthermore, the mothers were preoccupied with their own problems which made it difficult for them to give their full attention to child-rearing.

Generally, these children were seen by their mothers as making demands on their already highly frustrated egos and were viewed more as an additional problem to be dealt with.

A further point that can be added is that the mothers with immature personalities who also experienced stress in their marital life, thereby lacking support in the mothering role, are more likely to fall into the above group. This observation arises from the fact that some mothers in the normal group also had immature personalities. However, support from their husbands helped them to feel secure and they were thus able to constructively utilize whatever ego strength they had in the service of their families. This helped to lessen the effects of neurotic tendencies reaching the children, as most of the mothers' needs were met by their husbands.

Statement 6

'The mother has had no major physical or emotional trauma that interfere with her capacity to mother the client.'

In 31 cases (abnormal category) this statement was answered

false. Most of these mothers seemed to have experienced emotional traumas rather than physical traumas. This mainly arose from their own deprived upbringing, in which case they developed 'unhealthy' personalities and had little ego strength. This was clearly seen in their manner of rearing their own children.

Statement 13

'A good mothering experience is reflected in the client's personality.'

Dynamically speaking, this statement generally evaluates to what extent a person has internalized a 'good' or 'bad' mother.

The results of positive internalization are reflected in a general feeling of well-being, a healthy level of self-esteem, and the ability to adjust to the environment and function with as little frustration as possible.

If a person is unable to adjust suitably to work, friends and other aspects of his general functioning as a result of exaggerated anxiety (which is frequently a "carry-over" of infantile anxiety from not having one's needs met), then it could be said that he has incorporated a 'bad' mother.

Eleven clients in the normal group and 33 in the abnormal group seemed to have internalized the 'bad' mother. In almost all these cases the degree of severity of this internalization was gross in the abnormal group when compared to the normal group.

Statement 18

'The timeliness of the client's birth was positive for the mother.'

In the abnormal category there were 11 false statements, as compared to four in the normal category.

Of the 11 abnormal cases, there were three of unwanted children in which the mothers did not want them. In all three the children were born out of wedlock. In one of these cases the otherwise unwilling putative father married the mother for the sake of the child.

In all the normal cases the children were born in marriage and, although initially unplanned, were later welcomed.

Statement 15

'No major physical or emotional factor has interfered with the client's capacity to relate to his mother and to maintain normal maturation.'

In the abnormal group, 34 cases had difficulty in relating to their mothers, as compared to 13 in the normal category. Physical factors seemed to affect functioning in two cases, one case being of deafness, and the other of brain damage.

Statement 3

'The mother's attitude towards parenting enhances her functioning as a mother.'

In the abnormal category, 32 of the mothers seemed to have faulty perceptions on the manner of upbringing, treatment, and relationships with their children.

In the normal group there were 14 such mothers, although it

seems that their capacity for giving emotionally to the child helped to lessen the effects of their "not so healthy" attitudes.

Statement 16

'The client's response to discipline and limit-setting during the maturational years reflects adequate and positive maternal handling.'

In 32 abnormal cases this statement was marked false. In most of these cases the discipline was either too harsh, or inconsistent, or the child was faced with conflicting values received from both parents who did not agree on discipline.

Statement 4

'The mother has adequate self-esteem without depending primarily on the mother role for self-enhancement.'

In the abnormal group, 32 mothers seemed to depend on the children to prove that they were 'good' mothers through the ideal behaviour of their children, although they themselves did not always provide the essential conditions for a healthy development and consequent acceptable social adjustment.

When the children did not behave ideally, the mothers became angry, firstly with their children and, secondly, with themselves as ambivalent feelings of guilt, anger and disillusionment clouded their self-perception. Problem children, they felt, reflected their own inadequacy as parents, and this further lowered their self-esteem.

Statement 8

{The mother's physical giving has been adequate.}

Four of the abnormal cases have this marked false. All four of these cases seemed to have come from a low socio-economic background in which physical lack was inevitable. In all these cases it seemed to have worsened the problem of emotional deprivation for the child.

Statement 12

'No significant separations between mother and client occurred during the developmental years.'

In the abnormal category, this statement applied to 13 cases and, in the normal group, there were 11 such cases.

In the normal group there were no cases of gross physical separation between mother and child. This contrasts with the abnormal group.

Separations in the normal group were usually of a short-term nature which did not severely affect the children.

CONCLUSION

In analysing the results of this table, the investigator is aware that she did not thoroughly discuss the dynamic implications of each of these statements for personality development. This was deliberately left out as it was felt that the section on the theoretical study adequately covered each of these statements.

Furthermore, it must be mentioned that, although the normal cases did show negative results in this table, this category had not been as clearly discussed as the abnormal category.

A reason for this is that, although the normal cases did sometimes warrant false for each of the statements, the degree of application of each of these statements is not as significant as for the abnormal cases. For example, two mothers might punish their children 'severely'; this 'severity' however can be of different degrees, as can be seen in the comparison of a mother who burns her child and another who hits her child regularly. Despite the fact that they both are harmful, the former is more harmful than the latter.

Another general evaluation which can be made on this table is that in the abnormal group there was a greater chance of a combination of many negative factors having a negative cumulative effect on the child, whereas in the normal group there was a greater chance of a combination of positive aspects in the mother-child relationship undoing whatever few negatives might exist in such a relationship.

This can be seen in the fact that 12 out of 18 statements in the abnormal group fell into the 30-35 false group (statements 1, 3, 4, 5, 6, 7, 9, 13, 14, 15, 16, and 17), whereas in the normal group none of the statements fell into this range.

TABLE 22A
A Comparison of the Mother-Child Relationship and
the Father-Child Relationship Index Scores
for Normal and Abnormal Cases

Areas of Comparison	Index Scores							
	0 - 0.99		1.00 - 1.99		2.00 - 3.00		All	
	N	A	N	A	N	A	N	A
Mother-Child Relationship	-	29	5	6	30	-	35	35
Father-Child Relationship	-	27	7	8	28	-	35	35
All	-	56	12	14	58	-	70	70

Description of Table

The mother-child relationships and Father-child relationships for abnormal families are clustered in the 0 - 0.99 range, with 29 and 27 cases respectively.

In the normal group both parent-child scores are clustered in the 2.00 - 3.00 range of index scores, with 30 cases and 28 cases for mother-child relationship and father-child relationship, respectively.

Explanation of Table

An important outcome of this study, apart from reviewing the

significance of the mother in influencing the personality development of the child, is the striking influence of the father in both directly and indirectly controlling the mother-child relationship.

In Table 22A there seems to be significant correlation between a good mother-child relationship and a good father-child relationship and, conversely, a poor mother-child relationship and a poor father-child relationship. This is borne out by the fact that for the normal group 30 (MCR) and 28 (FCR) fell into the 2.00 - 3.00 range, whereas in the abnormal group 29 (MCR) and 27 (FCR) fell into the 0 - 0.99 range.

There is little doubt that in a family the MCR is acted upon and influenced by the FCR. The father can either support the mother's role or make it more difficult for her through determining the health or ill-health of the marital relationship.

TABLE 22B

A Comparison of the Mother-Child Relationship Index Scores
and the Father-Child Relationship Index Scores
for the Normal and Abnormal Categories

Areas of Comparison		Sample Categories		
		Abnormal	Normal	All
Mother-Child ^{Higher}	Father-Child	12	19	31
Father-Child ^{Higher}	Mother-Child	8	10	18
Mother-Child	Father-Child	15	6	21
<i>Index were identical</i>				
All		35	35	70

Description of Table

In 15 of the abnormal cases and six of the normal cases the index scores for MCR and FCR were the same.

In 12 abnormal cases and 19 normal cases the MCR was greater than the FCR.

In only eight abnormal cases and in ten normal cases was the FCR greater than the MCR.

Explanation of Table

Table 22B shows the FCR to be almost as important as the MCR.

Throughout this chapter the importance of the father in determining the outcome of personality development has been brought to the fore.

In cases in which the MCR was average (in both groups) the father's influence (whether positive or negative) helped to decide the final outcome of respective health or ill-health as far as personality development is concerned.

Furthermore, father has been seen as a person who is involved in the mothering process as well. In A.21, A.12, and A.18, the fathers were the most significant persons in the lives of their children for all three cases in which the mothers were incapable of looking after their children.

In the first case the mother (a university lecturer) regarded her career as her prime concern, and consequently regarded the demands of child-caring as burdensome — an attitude which she doubtless conveyed to the child through her abrupt manner of caring for him. The father spent most of his time mothering this child who, as a result of this, turned to him for affection.

In the second case the mother deserted and later divorced her husband — with the husband gaining custody of the child whom he had 'mothered'.

In the third case the mother was depressed (she later committed suicide), went out to work, and allowed her husband to care for the

child, who naturally became more attached to him. In this case there was definite role reversal.

The fact that the fathers' mothering occurred in all abnormal cases does indicate a partially negative picture. It must however be borne in mind that these are 'extreme' cases in which the mothers were barely able to make any contribution to the child's emotional sustenance.

Although total mothering by the father is not an ideal set-up, it is however better than not being taught (or given) love at all.

Generally, however, in 'less extreme' cases fathers can contribute to the emotional nurture of the child, without engendering any pathological effects.

Another factor which shows the importance of the father's indirect influence on the child can be seen in Table 21 where Statement 11 is the most important. It reads: 'The mother received positive emotional support from her husband during the client's first seven years of life'.

In the abnormal group there was a striking deficiency of this factor for the whole sample. Quite often, severe personality problems did not allow couples to adjust suitably to their marital set-up. An unhappy home set-up further frustrated an already anxious child and did not allow the mother to give her full attention to his upbringing.

Furthermore, the mother's dependency needs were not fulfilled by the father and resulted in her being tense and irritable for the most part of her married life.

PART 2

Analysis of Normal and Abnormal Cases On a Comparative Basis

The basic method of this approach has been to select the matched pairs of cases and examine them comparatively.

The main point of comparison has been the mother-child relationship. How, and to what extent, has it contributed to personality development in each case?

In the process of evaluating this basic relationship, other factors which influence it or are influenced by it have also been discussed -- such as family functioning and the amount of stress in the environment.

In the following pages, the normal and the abnormal member of each pair is examined comparatively. In doing this, the writer has tried to use the material in various ways instead of merely drawing attention to similarity or difference. This has been done not only to avoid monotony but to emphasize and explain different facets so as to achieve as many goals as possible. Some of those goals are to show how effectively the instrument has recorded the level of functioning in each of the areas, to show the effectiveness of the graph in demonstrating the personality maturational level and problem areas, and to explain specific aberrations in

abnormal personality development.

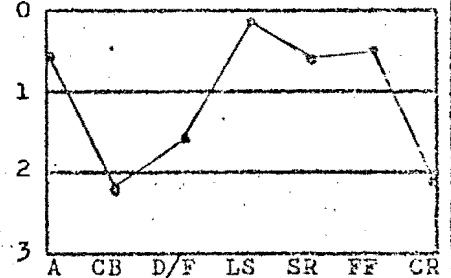
Sometimes a specific aspect of a case has been much more fully examined than others as a deliberate attempt to highlight such an aspect. At other times, only one aspect is commented on, to the exclusion of others, so as to avoid repetition of previously explained material which has been adequately demonstrated in other cases.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 1

SCORES				
	Raw	Index		
ADJUSTMENT.	5	.50		
CONDITION AT BIRTH.	7	2.33		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw Index			
Physical	21	2.65		
Behavioural	9	2.70		
Intellectual	8	1.20		
Emotional	3	.53		
Social	3	.69		
Total	44	1.57		
LACK OF STRESS EXPERIENCES. . .	2	.27		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw Index			
Mother/Client	4	.67		
Father/Client	3	.50		
Others/Client	2	.46		
Total	9	.55		
CURRENT FAMILY FUNCTIONING. . .	6	.50		
COMMUNITY RESOURCES	8	2.18		
Total Index Score		7.90		

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.50
CB	Index	2.33
D/F	Index	1.57
LS	Index	.27
SR	Index	.55
FF	Index	.50
Total		5.72
		32 %

RESOURCES SCORE

FF	Index	.50
CR	Index	2.18
Total		2.68
		45 %

P.S.I. SCORE 38 %

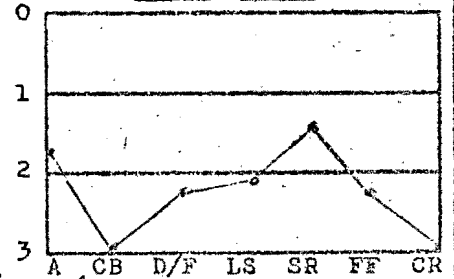
	Age	Sex	Race	Religion	Education	Father's Occupation
A.1	13y.4m.	F	W	Protestant	Std. VI	Machine minder
N.1	13y.2m.	F	W	Protestant	Std. V	Executive

PSYCHO-SOCIAL INDEX

Normal Case Number 1

SCORES				
	Raw	Index		
ADJUSTMENT.	17	1.70		
CONDITION AT BIRTH.	9	3.00		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw Index			
Physical	24	3.00		
Behavioural	9	2.70		
Intellectual	18	2.70		
Emotional	10	1.76		
Social	6	1.38		
Total	67	2.39		
LACK OF STRESS EXPERIENCES. . .	16	2.18		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw Index			
Mother/Client	6	1.00		
Father/Client	9	1.50		
Others/Client	9	2.27		
Total	24	1.47		
CURRENT FAMILY FUNCTIONING. . .	23	2.33		
COMMUNITY RESOURCES	11	3.00		
Total Index Score		16.07		

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	1.70
CB	Index	3.00
D/F	Index	2.39
LS	Index	2.18
SR	Index	1.47
FF	Index	2.33
Total		13.07
		73 %

RESOURCES SCORE

FF	Index	2.33
CR	Index	3.00
Total		5.33
		88 %

P.S.I. SCORE 77 %

A.1 and N.1

The score sheet of N.1 reflects a higher I.S. than that for A.1 in all the areas outlined. The graphs, too, show this pattern in that the normal case has a predominantly low-lying outline and, in the abnormal case, the graph generally runs along the top of the chart.

The Diagnostic Score of the normal case is much higher (73%) than that of the abnormal case (32%).

A comparison of the scores for the normal and abnormal cases is as follows:-

	N.1	A.1
Adjustment	1.70	.50
Condition at Birth	3.00	2.03
Development/Functioning	2.39	1.57
Stress	2.18	.27
Significant Relationships	1.47	.55
Current Family Functioning	2.33	.50

What are the chief underlying factors accounting for the different levels of personality maturity attained by these two otherwise "similar" individuals (i.e. regarding age, socio-economic level, sex, and education)?

Condition at Birth may be discounted as a factor, as both individuals do not have any significant congenital problems.

The sub-heading "Physical" under Development/Functioning

shows a similar degree of health for both individuals. It therefore cannot be regarded as a major factor in promoting or retarding personality development for either case.

Through a process of elimination there seems to be only one area left which can be regarded as determining the direction of personality growth towards either health or ill-health. This is the environmental influence in which Significant Relationships help in setting the emotional climate in which the child develops. In the normal case the client had easier relationships (reflected in the score of 1.47), whereas the abnormal case had more difficult relationships (reflected in the score of 0.55).

The Mother/Client relationship in the abnormal case is 0.67. The mother of this client was extremely controlling, manipulating the client to fulfil her own needs rather than to foster the child's well-being. She has a poor female identity and competes with her husband for the dominant role in the home. She is generally masculine and assertive and was described by her husband in the following manner:

"She is not the housewife type, and not maternal, but wants the best for her children."⁷⁴

She seems to have other emotional problems as well in that she is a chain-smoker, takes valium and librium regularly and experiences difficulty in adjusting to her marriage.

The child, in addition to having a poor MCR, also had a low

score for FCR (0.50) and OCR (0.46).

In the normal case, although the individual did not have an optimally healthy MCR (1.00), she nevertheless had good scores for FCR (1.50) and OCR (2.07), all of which helped to consolidate emotional support and reduce stress in the environment. The father is, to a great extent, able to meet some of the emotional needs of the child and in this way provides some mothering experience. Furthermore, the father's influence is also felt in the area of Current Family Functioning. His cooperation is necessary for the maintenance of a harmonious home life.

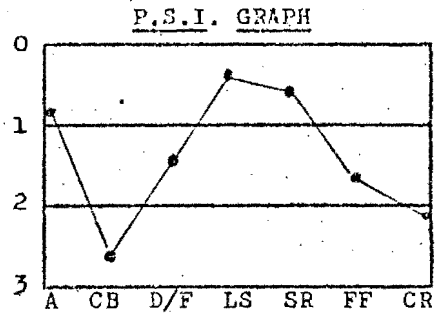
In the normal case the area of Current Family Functioning is rated as 2.33; in the abnormal case this area is rated 0.50.

We conclude that the abnormal case has experienced a greater degree of environmental stress (chiefly inherent in his close emotional ties) than the normal case which has basically healthier relationships.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 2

SCORES			
	Raw	Index	
ADJUSTMENT.	8	.83	
CONDITION AT BIRTH.	8	2.67	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	17	2.43	
Behavioural	7	2.10	
Intellectual	9	1.85	
Emotional	4	.71	
Social	3	.82	
Total	40	1.52	
LACK OF STRESS EXPERIENCES. . .	3	.47	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	2	.33	
Father/Client	0	.00	
Others/Client	7	1.61	
Total	9	.55	
CURRENT FAMILY FUNCTIONING. . .	21	1.75	
COMMUNITY RESOURCES	8	2.18	
Total Index Score		9.97	



DIAGNOSTIC SCORE		
A	Index	.83
CB	Index	2.67
D/F	Index	1.52
LS	Index	.47
SR	Index	.55
FF	Index	1.75
Total		7.79
		44 %

RESOURCES SCORE		
FF	Index	1.75
CR	Index	2.18
Total		3.93
		65 %

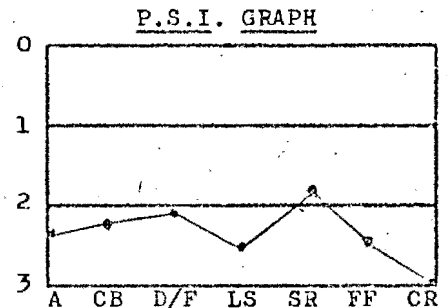
P.S.I. SCORE 48 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.2	8y.5m.	M	W	Protestant	Std. I	Foreman
N.2	8y.2m.	M	W	Protestant	Std. I	Developmental Fitter

PSYCHO-SOCIAL INDEX

Normal Case Number 2

SCORES			
	Raw	Index	
ADJUSTMENT.	23	2.38	
CONDITION AT BIRTH.	7	2.33	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	17	2.43	
Behavioural	8	2.40	
Intellectual	16	2.40	
Emotional	9	1.58	
Social	7	1.91	
Total	57	2.16	
LACK OF STRESS EXPERIENCES. . .	16	2.53	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	12	2.00	
Father/Client	10	1.67	
Others/Client	10	2.30	
Total	32	1.96	
CURRENT FAMILY FUNCTIONING. . .	31	2.58	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		16.94	



DIAGNOSTIC SCORE		
A	Index	2.38
CB	Index	2.33
D/F	Index	2.16
LS	Index	2.53
SR	Index	1.96
FF	Index	2.58
Total		13.94
		78 %

RESOURCES SCORE		
FF	Index	2.58
CR	Index	3.00
Total		5.58
		93 %

P.S.I. SCORE 81 %

A.2 and N.2

The diagnostic scores are 44% and 78% respectively for the abnormal and normal case.

There is a sharp contrast in the MCR scores, the abnormal case scoring 0.33 and the normal case 2.00.

The low MCR score in the abnormal case is aggravated by the fact that this child rated 0.00 for the FCR. If a poor mother-child relationship exists, at least a positive relationship with the father can help to contribute towards emotional sustenance of a child.

The mother of child A.2 is a woman of very low intelligence, aggravated by her emotional problems and personality immaturity.

A.2 and N.2 have somewhat different Conditions at Birth scores, A.2 with 2.67 and N.2 with 2.33. A.2 started off in life with better chances than N.2. The great difference in diagnostic scores in favour of N.2 points to the importance of environment as a determinant of healthy or unhealthy personality development.

N.2, with a healthier mother-child relationship, has experienced less stress in the environment than A.2. Stressful environmental conditions brought about by poor relationships can be seen in the area of Stress in which A.2 scored 0.47. N.2, with a Stress score of 2.53, shows better relationships with Significant people in his environment. He has had his needs met without much

frustration, and has had positive experiences with others as an individual who is worthy and capable.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 3

SCORES

	Raw	Index
ADJUSTMENT.	8	.80
CONDITION AT BIRTH.	6	2.00
DEVELOPMENT/FUNCTIONING		

	Sub-Scores			
	Raw	Index		
Physical	20	2.50		
Behavioural	8	2.40		
Intellectual	2	1.35		
Emotional	4	.71		
Social	4	.92		
Total	45		45	1.61

LACK OF STRESS EXPERIENCES.	6	.82

SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	4	.67		
Father/Client	4	.67		
Others/Client	4	1.53		
Total	14		14	.86

CURRENT FAMILY FUNCTIONING.	14	1.17

COMMUNITY RESOURCES	5	1.37

Total Index Score 8.63

P.S.I. GRAPH

Category	Score
A	1.2
CB	2.0
D/F	1.6
LS	1.2
SR	1.2
FF	1.2
CR	1.2

DIAGNOSTIC SCORE

A	Index	.80
CB	Index	2.00
D/F	Index	1.61
LS	Index	.82
SR	Index	.86
FF	Index	1.17
Total		7.26
		41 %

RESOURCES SCORE

FF	Index	1.17
CR	Index	1.37
Total		2.54
		42 %

P.S.I. SCORE 41 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.3	17y.2m.	F	W	Catholic	Std. IX	Retired Carpenter
N.3	17y.7m.	F	W	Protestant	Std. X	Surgeon

PSYCHO-SOCIAL INDEX

Normal Case Number 3

SCORES			Raw	Index
ADJUSTMENT.				
			25	2.50
CONDITION AT BIRTH.				
			9	3.00
DEVELOPMENT/FUNCTIONING				
	Sub Scores			
	Raw	Index		
Physical	24	3.00		
Behavioural	9	2.70		
Intellectual	20	3.00		
Emotional	14	2.46		
Social	14	3.00		
Total	80		80	2.86
LACK OF STRESS EXPERIENCES. . .				
			17	2.31
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	15	2.50		
Father/Client	14	2.33		
Others/Client	11	2.53		
Total	40		40	2.45
CURRENT FAMILY FUNCTIONING. . .				
			35	2.92
COMMUNITY RESOURCES				
			11	3.00
Total Index Score			19.04	

P.S.I. GRAPH

Category	Score
A	2.5
CB	3.0
D/F	2.8
LS	2.3
SR	2.4
FF	2.9
CR	3.0

DIAGNOSTIC SCORE

A	Index	2.50
CB	Index	3.00
D/F	Index	2.86
LS	Index	2.31
SR	Index	2.45
FF	Index	2.92
Total		16.04

90 %

RESOURCES SCORE

FF	Index	2.92
CR	Index	3.00
Total		5.92

98 %

P.S.I. SCORE 91 %

A.3 and N.3

A.3 and N.3 are females of similar age and background.

The Diagnostic Score for N.3 is, however, more than twice as good as that for A.3: 90% as against 41%.

A.3 has a low MCB I.S. (0.67), while N.3 scored 2.50 in this area.

From the scores on the face sheet the normal case seems to have received better mothering experiences as well as better fathering experiences. This pattern of healthy primary relationships acted as a forerunner for healthy secondary relationships, as can be seen in the OCB index score.

The quality of mothering that N.3 received is affected by the fact that her parents are happily married, a factor which often results in a contented, unanxious mother. A happy marriage engenders the cooperation of both parents in the upbringing of children.

In the case of A.3, the child had poor initial mothering experiences from her natural mother. This already insecure child had later to face the trauma of her mother's death (when she was ten years old) which served to heighten her insecurity and anxiety. Later, her father remarried and she had difficulty in adjusting to the new home circumstances.

A broken, insecure mothering experience both as an emotional

trauma (insecurity) and as a physical separation trauma (death of mother) seem largely to have contributed to her personality instability.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 4

SCORES

	Raw	Index
ADJUSTMENT.	11	1.10
CONDITION AT BIRTH.	7	2.33
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	23	2.88
Behavioural	8	2.40
Intellectual	9	1.35
Emotional	4	.71
Social	3	.69
Total	47	1.68
LACK OF STRESS EXPERIENCES. . .	11	1.50
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	5	.83
Father/Client	5	.83
Others/Client	5	1.15
Total	15	.92
CURRENT FAMILY FUNCTIONING. . .	19	1.58
COMMUNITY RESOURCES	11	3.00
Total Index Score		12.11

P.S.I. GRAPH

Category	Score
A	1.10
CB	2.33
D/F	1.68
LS	1.50
SR	1.92
FF	1.58
CR	3.00

DIAGNOSTIC SCORE

A	Index	1.10
CB	Index	2.33
D/F	Index	1.68
LS	Index	1.50
SR	Index	1.92
FF	Index	1.58
Total		9.11

51 %

RESOURCES SCORE

FF	Index	1.58
CR	Index	3.00
Total		4.58

77 %

P.S.I. SCORE

58 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.4	12y.0m.	M	W	Protestant	Std. IV	Unknown
N.4	12y.8m.	M	W	Protestant	Std. V	Foreman

PSYCHO-SOCIAL INDEX

Normal Case Number 4

SCORES

	Raw	Index
ADJUSTMENT.	25	2.50
CONDITION AT BIRTH.	6	2.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	22	2.75
Behavioural	10	3.00
Intellectual	20	3.00
Emotional	17	3.00
Social	12	2.76
Total	81	2.89
LACK OF STRESS EXPERIENCES. . .	16	2.18
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	15	2.50
Father/Client	14	2.33
Others/Client	11	2.53
Total	40	2.45
CURRENT FAMILY FUNCTIONING. . .	32	2.67
COMMUNITY RESOURCES	11	3.00
Total Index Score		17.69

P.S.I. GRAPH

Category	Score
A	2.50
CB	2.00
D/F	2.39
LS	2.18
SR	2.45
FF	2.67
CR	3.00

DIAGNOSTIC SCORE

A	Index	2.50
CB	Index	2.00
D/F	Index	2.39
LS	Index	2.18
SR	Index	2.45
FF	Index	2.67
Total		14.69

82 %

RESOURCES SCORE

FF	Index	2.67
CR	Index	3.00
Total		5.67

95 %

P.S.I. SCORE

85 %

A.4 and N.4

The MCR score for N.4 is 2.50 and the Diagnostic Score is 82%. The corresponding two figures for A.4 are 0.83 and 61% respectively.

These readings seem to illustrate the fact that the better the mother-child relationship, the greater the possibility of healthy personality development and vice versa.

Condition at Birth scores are 2.00 for N.4 and 2.33 for A.4, so that the abnormal case indeed started life at some advantage over the normal one.

A positive mother-child relationship can reduce the handicap of being born with a lower congenital capacity. Conversely, despite an average or good congenital capacity, a poor mother-child relationship can distort a potentially healthy personality.

Throughout the analysis of cases, the investigator found the mother-child relationship to be a frequent cause of determining the health or ill-health of personality development.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 5

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>5</u>	<u>.52</u>
<u>CONDITION AT BIRTH</u>	<u>8</u>	<u>2.67</u>

DEVELOPMENT/FUNCTIONING

	<u>Sub-Scores</u>			
	<u>Raw</u>	<u>Index</u>		
Physical	<u>18</u>	<u>2.57</u>		
Behavioural	<u>9</u>	<u>2.70</u>		
Intellectual	<u>8</u>	<u>1.20</u>		
Emotional	<u>3</u>	<u>.53</u>		
Social	<u>1</u>	<u>.27</u>		
Total	<u>39</u>		<u>39</u>	<u>1.48</u>

<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>7</u>	<u>1.11</u>

SIGNIFICANT RELATIONSHIPS

	<u>Sub-Scores</u>			
	<u>Raw</u>	<u>Index</u>		
Mother/Client	<u>5</u>	<u>.83</u>		
Father/Client	<u>6</u>	<u>1.00</u>		
Others/Client	<u>4</u>	<u>.92</u>		
Total	<u>15</u>		<u>15</u>	<u>.92</u>

<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>20</u>	<u>1.67</u>

<u>COMMUNITY RESOURCES</u>	<u>11</u>	<u>3.00</u>

Total Index Score 11.37

P.S.I. GRAPH

Category	Score
A	0.52
CB	2.67
D/F	1.48
LS	1.11
SR	0.92
FF	1.67
CR	3.00

DIAGNOSTIC SCORE

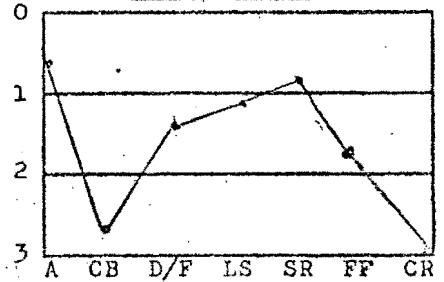
A	Index	<u>.52</u>	
CB	Index	<u>2.67</u>	
D/F	Index	<u>1.48</u>	
LS	Index	<u>1.11</u>	
SR	Index	<u>.92</u>	
FF	Index	<u>1.67</u>	
Total		<u>8.37</u>	<u>47 %</u>

RESOURCES SCORE

FF	Index	<u>1.67</u>	
CR	Index	<u>3.00</u>	
Total		<u>4.67</u>	<u>78 %</u>

P.S.I. SCORE 55 %

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.52
CB	Index	2.67
D/F	Index	1.48
LS	Index	1.11
SR	Index	.92
FF	Index	1.67
Total		8.37
		47 %

RESOURCES SCORE

FF	Index	1.67
CR	Index	3.00
Total		4.67
		78 %

P.S.I. SCORE 55 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.5	6y.5m.	M	W	Jewish	Sub. A	Dentist
N.5	7y.0m.	M	W	Jewish	Std. I	Consultant

PSYCHO-SOCIAL INDEX

Normal Case Number 5

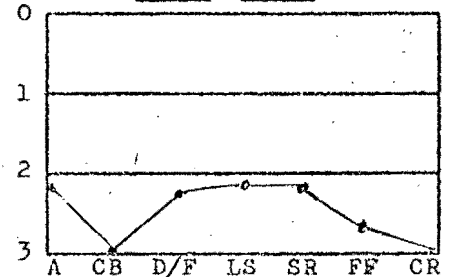
SCORES		
	Raw	Index
ADJUSTMENT.	21	2.17
CONDITION AT BIRTH.	9	3.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	20	2.86
Behavioural	3	2.40
Intellectual	18	2.70
Emotional	9	1.58
Social	6	1.64
Total	61	2.32
LACK OF STRESS EXPERIENCES. . .	14	2.21
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	15	2.50
Father/Client	12	2.00
Others/Client	8	1.84
Total	35	2.14
CURRENT FAMILY FUNCTIONING. . .	33	2.75
COMMUNITY RESOURCES	11	3.00
Total Index Score		17.59

P.S.I. GRAPH

Category	Score
A	2.17
CB	3.00
D/F	2.32
LS	2.21
SR	2.14
FF	2.75
CR	3.00

DIAGNOSTIC SCORE	
A	Index 2.17
CB	Index 3.00
D/F	Index 2.32
LS	Index 2.21
SR	Index 2.14
FF	Index 2.75
Total	14.59
82 %	
RESOURCES SCORE	
FF	Index 2.75
CR	Index 3.00
Total	5.75
97 %	
P.S.I. SCORE	
84 %	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.17
CB	Index	3.00
D/F	Index	2.32
LS	Index	2.21
SR	Index	2.14
FF	Index	2.75
Total		14.59
		82 %

RESOURCES SCORE

FF	Index	2.75
CR	Index	3.00
Total		5.75
		97 %

P.S.I. SCORE 84 %

A.5 and N.5

The Diagnostic Score for N.5 was 82% and for A.5 47%.

N.5's MCR score is 1.77 higher than A.5's. N.5 also had better fathering experiences.

Fathers play an important role within the Gestalt of interpersonal relationships. Besides contributing to the emotional support of mother and child, their approval or disapproval of the child per se helps in setting up his level of self-esteem.

In the case of A.5, the mother is unhappy in her marriage. She is depressed and seems to live within herself. The child, being unable to gain her attention through "normal channels" as she is so "walled off", has resorted to devious methods of gaining attention. Some of these are psychosomatic symptoms such as frequent colds, asthma, and enuresis which not only express his need for attention but also his high level of anxiety.

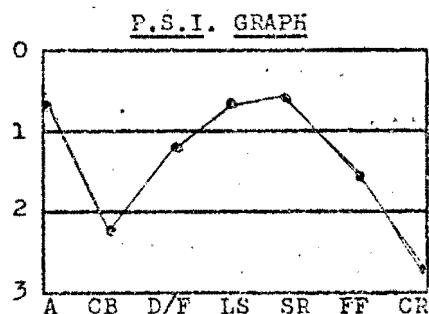
The father is inconsistent in disciplining the child. He is over-indulgent at times, and at other times physically beats the child over minor irritations.

A high level of anxiety which interferes with his social functioning is reflected in the child's Adjustment score of 0.52. Some of his specific adjustment problems are that he is disruptive in class, does not like being separated from his parents, deliberately breaks his glasses when angry, is bossy towards his friends, and finds difficulty in being a loser.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 6

SCORES				
	Raw	Index		
ADJUSTMENT.	5	.56		
CONDITION AT BIRTH.	7	2.33		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	13	1.86		
Behavioural	8	2.67		
Intellectual	2	.37		
Emotional	4	.71		
Social	4	1.09		
Total	31	1.26		
LACK OF STRESS EXPERIENCES. . .	4	.67		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	4	.67		
Father/Client	2	.33		
Others/Client	4	1.09		
Total	10	.63		
CURRENT FAMILY FUNCTIONING. . .	10	1.58		
COMMUNITY RESOURCES	10	2.73		
Total Index Score		9.76		



DIAGNOSTIC SCORE

A	Index	.56	
CB	Index	2.33	
D/F	Index	1.26	
LS	Index	.67	
SR	Index	.63	
FF	Index	1.58	
Total		7.03	39 %

RESOURCES SCORE

FF	Index	1.58	
CR	Index	2.73	
Total		4.31	72 %

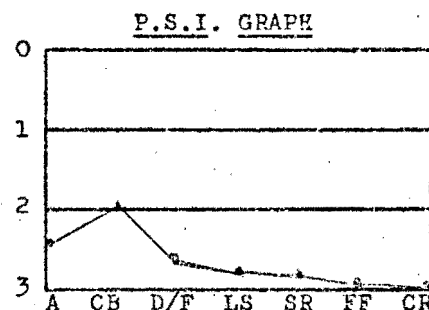
P.S.I. SCORE 47 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.6	4y.7m.	M	W	Jewish	Nursery	Manager, Retail Store
N.6	4y.9m.	M	W	Jewish	Nursery	Engineer

PSYCHO-SOCIAL INDEX

Normal Case Number 6

SCORES				
	Raw	Index		
ADJUSTMENT.	22	2.44		
CONDITION AT BIRTH.	6	2.00		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	21	3.00		
Behavioural	9	3.00		
Intellectual	15	2.82		
Emotional	12	2.11		
Social	10	2.73		
Total	67	2.71		
LACK OF STRESS EXPERIENCES. . .	17	2.83		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	10	2.00		
Father/Client	11	2.83		
Others/Client	12	3.00		
Total	47	2.94		
CURRENT FAMILY FUNCTIONING. . .	36	3.00		
COMMUNITY RESOURCES	8	2.18		
Total Index Score		18.10		



DIAGNOSTIC SCORE

A	Index	2.44	
CB	Index	2.00	
D/F	Index	2.71	
LS	Index	2.83	
SR	Index	2.94	
FF	Index	3.00	
Total		15.92	89 %

RESOURCES SCORE

FF	Index	3.00	
CR	Index	2.18	
Total		5.18	87 %

P.S.I. SCORE 87 %

A.6 and N.6

The diagnostic scores show a difference of 50% in favour of the normal case, stemming from more positive environmental socializing and inter-personal relationships. As the score sheet suggests, not only is the basic mother-child tie excellent, but so is the entire area of Significant Relationships.

Quite often a child that is secure at home, well accepted, and contented, finds it simple to adjust to outsiders as he is more confident of himself (positive self-esteem).

That the normal case had relatively less stress to cope with in the environment as a result of his better relationships with Significant Others in the environment is reflected in the Lack of Stress score of 2.83.

That A.6 had more stress to deal with in his environment as a result of his poor relationships with people (Significant Relationships 0.03) is reflected in the Stress score of 0.07.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 7

SCORES

	Raw	Index
ADJUSTMENT.	7	.70
CONDITION AT BIRTH.	4	1.33

DEVELOPMENT/FUNCTIONING

	Sub-Scores		Raw	Index
	Raw	Index		
Physical	17	2.13		
Behavioural	7	2.10		
Intellectual	6	.90		
Emotional	5	.88		
Social	4	.92		
Total	39		39	1.39

LACK OF STRESS EXPERIENCES. . .	8	1.09

SIGNIFICANT RELATIONSHIPS

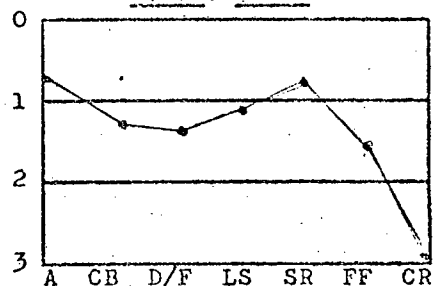
	Sub-Scores		Raw	Index
	Raw	Index		
Mother/Client	5	.83		
Father/Client	5	.83		
Others/Client	3	.69		
Total	13		13	.80

CURRENT FAMILY FUNCTIONING. . .	19	1.58

COMMUNITY RESOURCES	11	3.00

Total Index Score	9.89

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.70
CB	Index	1.33
D/F	Index	1.39
LS	Index	1.09
SR	Index	.80
FF	Index	1.58
Total		6.89
		39 %

RESOURCES SCORE

FF	Index	1.58
CR	Index	3.00
Total		4.58
		77 %

P.S.I. SCORE 48 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.7	14y.9m.	M	W	Protestant	Std. VII	Clerk
M.7	13y.4m.	M	W	Protestant	Std. VI	Diamond Polisher

PSYCHO-SOCIAL INDEX

Normal Case Number 7

SCORES

	Raw	Index
ADJUSTMENT.	17	1.70
CONDITION AT BIRTH.	7	2.33

DEVELOPMENT/FUNCTIONING

	Sub-Scores		Raw	Index
	Raw	Index		
Physical	19	2.38		
Behavioural	8	2.40		
Intellectual	16	2.40		
Emotional	12	2.11		
Social	10	2.30		
Total	65		65	2.32

LACK OF STRESS EXPERIENCES. . .	17	2.31

SIGNIFICANT RELATIONSHIPS

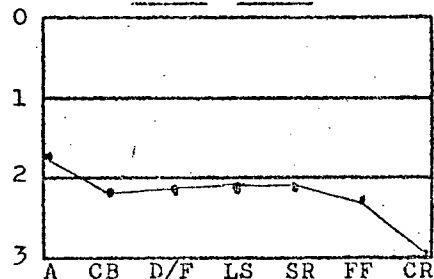
	Sub-Scores		Raw	Index
	Raw	Index		
Mother/Client	13	2.17		
Father/Client	12	2.00		
Others/Client	10	2.30		
Total	35		35	2.14

CURRENT FAMILY FUNCTIONING. . .	29	2.42

COMMUNITY RESOURCES	11	3.00

Total Index Score	16.22

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	1.70
CB	Index	2.33
D/F	Index	2.32
LS	Index	2.31
SR	Index	2.14
FF	Index	2.42
Total		13.22
		74 %

RESOURCES SCORE

FF	Index	2.42
CR	Index	3.00
Total		5.42
		90 %

P.S.I. SCORE 78 %

A.7 and N.7

In the abnormal case the client had undergone severe trauma at birth which is reflected in the Condition at Birth score of 1.33.

An analysis of the True/False questionnaire shows that he was anoxic at birth. This anoxia most probably caused minimal brain damage. The low score for Intellectual Functioning (0.90) which appears under the broader category of Development/Functioning seems to bear out this supposition.

Possible brain damage and poor mothering and fathering experiences (0.83 for both areas), have contributed to the stress that this child undergoes in his daily life.

He has a double disadvantage in that, in addition to having limited ego strength (through emotional deprivation), he lacks the intellectual capacity to bring about even minimum changes in his behaviour through insight. The term insight can be explained as one of the goals of intensive casework treatment in which intelligent understanding plays a crucial role in bringing about behaviour adjustment for oneself.

In the normal case the client had been 'blessed' not only with better Condition at Birth but also better parenting experiences resulting in greater ego strength to deal with whatever everyday stresses one comes up against in the general course of living.

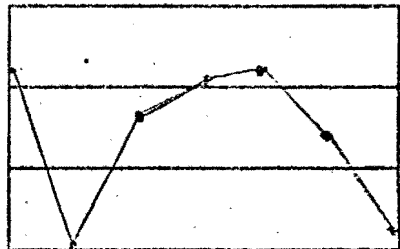
As a result of these contrasting conditions of life, the more

fortunate normal case reflects this in his level of personality maturation and development score which reads as 74%, in contrast to the less fortunate abnormal case which is reflected in his Diagnostic Score of 39%.

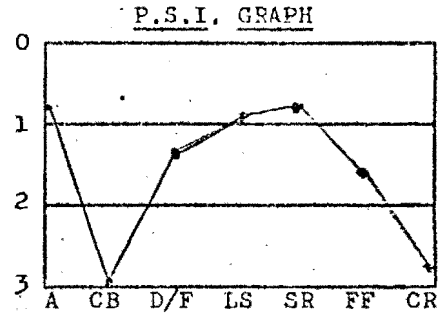
PSYCHO-SOCIAL INDEX

Abnormal Case Number 8

SCORES			
	Raw	Index	
ADJUSTMENT.	8	.83	
CONDITION AT BIRTH.	9	3.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	19	2.71	
Behavioural	5	1.50	
Intellectual	3	1.20	
Emotional	4	.71	
Social	3	.82	
Total	39		39 1.48
LACK OF STRESS EXPERIENCES. . .	6	.95	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	5	.83	
Father/Client	5	.83	
Others/Client	3	.69	
Total	13		13 .80
CURRENT FAMILY FUNCTIONING. . .	20	1.67	
COMMUNITY RESOURCES	10	2.73	
Total Index Score		11.46	

P.S.I. GRAPH	
0	
1	
2	
3	
A	
CB	
D/F	
LS	
SR	
FF	
CR	

DIAGNOSTIC SCORE	
A	Index .83
CB	Index 3.00
D/F	Index 1.48
LS	Index .95
SR	Index .80
FF	Index 1.67
Total	8.73 49 %
RESOURCES SCORE	
FF	Index 1.67
CR	Index 2.73
Total	4.40 73 %
P.S.I. SCORE 55 %	



DIAGNOSTIC SCORE		
A	Index	.83
CB	Index	3.00
D/F	Index	1.48
LS	Index	.95
SR	Index	.80
FF	Index	1.67
Total		8.73
		49 %

RESOURCES SCORE		
FF	Index	1.67
CR	Index	2.73
Total		4.40
		73 %

P.S.I. SCORE 55 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.8	11y.10m.	M	W	Protestant	Std. V	Managerial Secretary
N.8	10y. 5m.	M	W	Protestant	Std. III	Electronics Technician

PSYCHO-SOCIAL INDEX

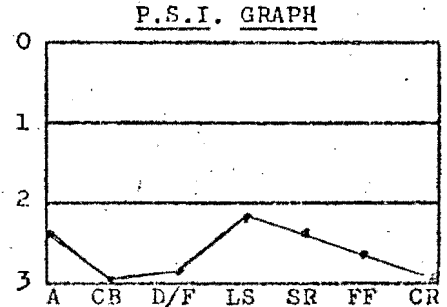
Normal Case Number 8

SCORES		
	Raw	Index
ADJUSTMENT.	24	2.48
CONDITION AT BIRTH.	9	3.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	20	2.86
Behavioural	8	2.40
Intellectual	20	3.00
Emotional	17	3.00
Social	11	3.00
Total	76	2.89
LACK OF STRESS EXPERIENCES. . .	14	2.21
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	13	2.67
Father/Client	12	2.00
Others/Client	11	2.53
Total	39	2.39
CURRENT FAMILY FUNCTIONING. . .	31	2.58
COMMUNITY RESOURCES	11	3.00
Total Index Score		18.55

P.S.I. GRAPH

Category	Score
A	2.48
CB	3.00
D/F	2.89
LS	2.21
SR	2.39
FF	2.58
CR	2.58

DIAGNOSTIC SCORE	
A	Index 2.48
CB	Index 3.00
D/F	Index 2.89
LS	Index 2.21
SR	Index 2.39
FF	Index 2.58
Total	15.55
87 %	
RESOURCES SCORE	
FF	Index 2.58
CR	Index 3.00
Total	5.58
93 %	
P.S.I. SCORE 89 %	



DIAGNOSTIC SCORE		
A	Index	2.48
CB	Index	3.00
D/F	Index	2.89
LS	Index	2.21
SR	Index	2.39
FF	Index	2.58
Total		15.55
		87 %

RESOURCES SCORE		
FF	Index	2.58
CR	Index	3.00
Total		5.58
		93 %

P.S.I. SCORE 89 %

A.S and N.S

In reviewing these two cases, one can see at a glance that these two individuals had set out in life with similar congenital capacities which is reflected in the Condition at Birth scores of 3.00 in both cases.

Later, however, the abnormal case seems to have experienced poor relationships with significant others in his environment which caused him much stress and, resultantly, retarded his potential for personality maturation. This fact is reflected in the low score he attained for Mother/Client and Father/Client Relationships of 0.83 in both instances.

Poor relationships at home seemed to have lessened his capacity to establish relationships outside his home environment. This fact is reflected in the Others/Client Relationship score of 0.69.

As is often the case with deprived children, low self-esteem and preoccupation with internal problems leave very little 'energy' for 'outside' interests. In this case this same pattern is reflected in the low scores for Social and Intellectual Functioning.

In the normal case, however, there is a much more positive MCR and FCR which, in most cases, invariably leads to rewarding relationships with others, as is reflected in the score of 2.53 for Others/Client Relationships.

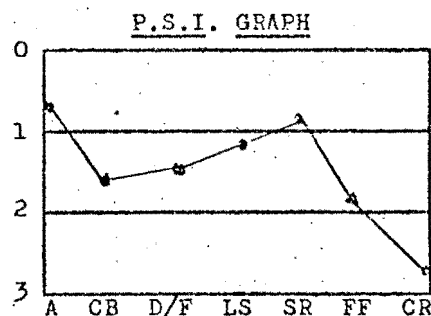
Positive adjustment in other areas of social functioning is shown in the areas of Emotional and Intellectual functioning, the scores of which read as 3.00 respectively.

This case is about the first one thus far which clearly reflects the importance of environmental conditioning on the personality development of individuals as both cases had an equal head-start as far as Conditions at Birth are concerned.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 9

SCORES				
	Raw	Index		
ADJUSTMENT.	6	.60		
CONDITION AT BIRTH.	8	2.67		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	15	2.38		
Behavioural	9	2.70		
Intellectual	9	1.35		
Emotional	4	.71		
Social	2	.46		
Total	43	1.53		
LACK OF STRESS EXPERIENCES. . .	9	1.22		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	6	1.00		
Father/Client	6	1.00		
Others/Client	4	.92		
Total	16	.98		
CURRENT FAMILY FUNCTIONING. . .	23	1.92		
COMMUNITY RESOURCES	10	2.73		
Total Index Score		11.65		



DIAGNOSTIC SCORE	
A	Index .60
CB	Index 2.67
D/F	Index 1.53
LS	Index 1.22
SR	Index .98
FF	Index 1.92
Total	8.92 50 %

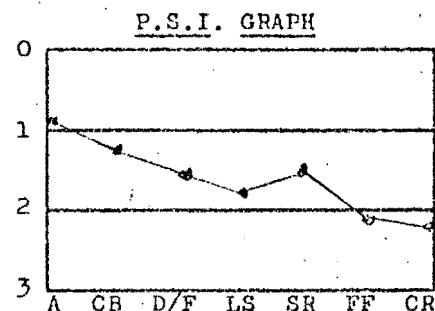
RESOURCES SCORE	
FF	Index 1.92
CR	Index 2.73
Total	4.65 78 %
P.S.I. SCORE	56 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.9	13y.7m.	M	W	Jewish	Std. VII	Company Director
N.9	13y.2m.	M	W	Jewish	Std. VI	Textile Technologist

PSYCHO-SOCIAL INDEX

Normal Case Number 9

SCORES				
	Raw	Index		
ADJUSTMENT.	9	.90		
CONDITION AT BIRTH.	7	2.33		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	18	2.25		
Behavioural	7	2.10		
Intellectual	9	1.35		
Emotional	5	.85		
Social	5	1.15		
Total	44	1.57		
LACK OF STRESS EXPERIENCES. . .	14	1.90		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	10	1.67		
Father/Client	3	1.33		
Others/Client	7	1.61		
Total	25	1.53		
CURRENT FAMILY FUNCTIONING. . .	25	2.08		
COMMUNITY RESOURCES	8	2.18		
Total Index Score		12.49		



DIAGNOSTIC SCORE	
A	Index .90
CB	Index 2.33
D/F	Index 1.57
LS	Index 1.20
SR	Index 1.53
FF	Index 2.08
Total	10.31 58 %

RESOURCES SCORE	
FF	Index 2.08
CR	Index 2.18
Total	4.26 72 %
P.S.I. SCORE	60 %

A.9 and N.9

The diagnostic scores show a relatively minor difference between the normal and abnormal case as A.9 reads as 50% and N.9 reads as 58%.

On account of this low diagnostic per cent score, N.9 is regarded as a case requiring treatment.

The respective scores for MCR were 1.00 and 1.67 for abnormal and normal.

The mother in the abnormal case was described in the Psycho-Social History as:

"Very protective and extremely tense and over-anxious over role of mother. She is unsure of herself and feels overwhelmed by her children as she has little to give emotionally."⁷⁵

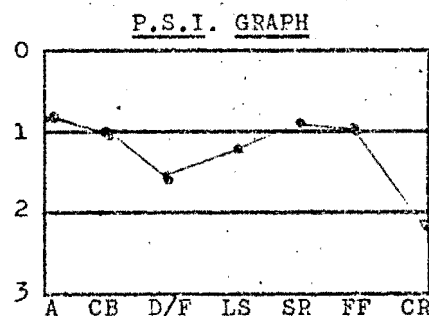
This mother received psychiatric treatment on two occasions.

The normal case, too, had many problems especially stemming from his Condition at Birth. These problems were aggravated by the Gestalt of not so healthy Significant Relationships.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 10

SCORES			
	Raw	Index	
ADJUSTMENT.	8	.83	
CONDITION AT BIRTH.	3	1.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	17	2.43	
Behavioural	7	2.10	
Intellectual	9	1.35	
Emotional	7	1.23	
Social	5	1.37	
Total	45	1.71	
LACK OF STRESS EXPERIENCES.	8	1.26	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	7	1.17	
Father/Client	2	.33	
Others/Client	7	1.61	
Total	16	.98	
CURRENT FAMILY FUNCTIONING.	12	1.00	
COMMUNITY RESOURCES	8	2.18	
Total Index Score		8.96	



DIAGNOSTIC SCORE		
A	Index	.83
CB	Index	1.00
D/F	Index	1.71
LS	Index	1.26
SR	Index	.98
FF	Index	1.00
Total		6.78
		38 %

RESOURCES SCORE		
FF	Index	1.00
CR	Index	2.18
Total		3.18
		53 %

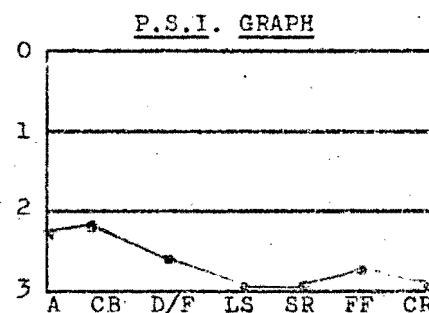
P.S.I. SCORE 43 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.10	10y.2m.	M	W	Protestant	Std. II	Unknown
N.10	11y.2m.	M	W	Protestant	Std. IV	Chemical Engineer

PSYCHO-SOCIAL INDEX

Normal Case Number 10

SCORES			
	Raw	Index	
ADJUSTMENT.	23	2.38	
CONDITION AT BIRTH.	7	2.33	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	21	3.00	
Behavioural	0	2.70	
Intellectual	20	3.00	
Emotional	14	2.48	
Social	9	2.46	
Total	73	2.78	
LACK OF STRESS EXPERIENCES.	19	3.00	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	13	3.00	
Father/Client	18	3.00	
Others/Client	13	3.00	
Total	49	3.00	
CURRENT FAMILY FUNCTIONING.	34	2.83	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		19.32	



DIAGNOSTIC SCORE		
A	Index	2.38
CB	Index	2.33
D/F	Index	2.78
LS	Index	3.00
SR	Index	3.00
FF	Index	2.83
Total		16.32
		91 %

RESOURCES SCORE		
FF	Index	2.83
CR	Index	3.00
Total		5.83
		97 %

P.S.I. SCORE 93 %

A.10 and N.10

The Diagnostic Score for the normal and abnormal cases are rated as 91% and 38% respectively.

The normal case has had an excellent MCR score of 3.00. This positive pattern seems to follow through for the other two areas of Significant Relationships as the total score for this area reads as 3.00.

Likewise, the graph shows an almost even pattern of high scores for the remaining areas. This supports the contention that if the basic close relationships are favourable, it is highly likely that the other areas of social functioning would also be favourable. This positive pattern can be seen in the following scores: Stress (3.00), Adjustment (2.38), and Development/Functioning (2.78).

Healthy basic emotional relationships and consequently healthy personality development seem to flourish in family settings which are characterized by harmony. This fact seems to be borne out by the Current Family Functioning score of this case which reads as 2.83.

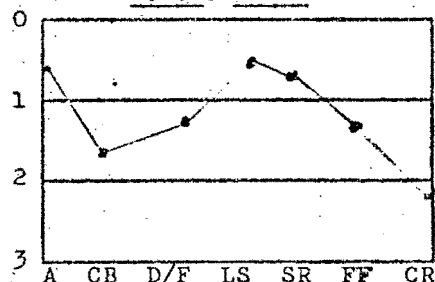
In the abnormal case especially traumatic Condition at Birth, a very poor FCR, and an unhappy home atmosphere resulting from a broken marriage seem to have been the chief causes of his poor personality functioning.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 11

SCORES				
	Raw	Index		
ADJUSTMENT.	6	.67		
CONDITION AT BIRTH.	5	1.67		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw Index			
Physical	16	2.29		
Behavioural	7	2.33		
Intellectual	5	.94		
Emotional	21	.35		
Social	2	.55		
Total	32	1.30		
LACK OF STRESS EXPERIENCES. . .	3	.50		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw Index			
Mother/Client	4	.67		
Father/Client	4	.67		
Others/Client	2	.50		
Total	10	.63		
CURRENT FAMILY FUNCTIONING. . .	16	1.33		
COMMUNITY RESOURCES	8	2.18		
Total Index Score		8.28		

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.67
CB	Index	1.67
D/F	Index	1.30
LS	Index	.50
SR	Index	.63
FF	Index	1.33
Total		6.10
		34 %

RESOURCES SCORE

FF	Index	1.33
CR	Index	2.18
Total		3.51
		58 %

P.S.I. SCORE 40 %

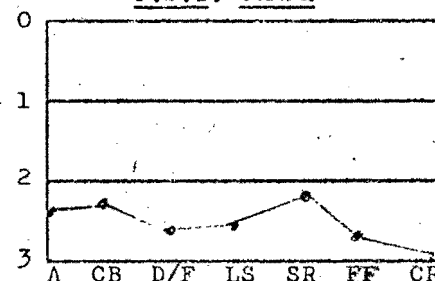
	Age	Sex	Race	Religion	Education	Father's Occupation
A.11	3y.8m.	M	W	Catholic	Nursery	High School Teacher
N.11	4y.0m.	M	W	Protestant	Nursery	Branch Manager

PSYCHO-SOCIAL INDEX

Normal Case Number 11

SCORES				
	Raw	Index		
ADJUSTMENT.	22	2.44		
CONDITION AT BIRTH.	7	2.33		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw Index			
Physical	20	2.86		
Behavioural	7	2.33		
Intellectual	16	3.00		
Emotional	14	2.43		
Social	13	3.00		
Total	63	2.76		
LACK OF STRESS EXPERIENCES. . .	16	2.67		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw Index			
Mother/Client	13	2.17		
Father/Client	15	2.50		
Others/Client	3	2.00		
Total	31	2.25		
CURRENT FAMILY FUNCTIONING. . .	33	2.75		
COMMUNITY RESOURCES	11	3.00		
Total Index Score		18.20		

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.44
CB	Index	2.33
D/F	Index	2.76
LS	Index	2.67
SR	Index	2.25
FF	Index	2.75
Total		15.20
		85 %

RESOURCES SCORE

FF	Index	2.75
CR	Index	3.00
Total		5.75
		97 %

P.S.I. SCORE 97 %

A.11 and N.11

The abnormal case has a Diagnostic Score of 34%. The graph reflects consistent overall low score areas.

Reviewing the chief factors which caused difficulty for this client, it can be seen that Condition at Birth (1.67) and Significant Relationships (0.63) contributed towards creating long-term stress (Stress 0.50). Stress, too, seems to have been prevalent in the area of Current Family Functioning which reads as 1.33. It is highly likely that the parents did not have a stable and happy marriage. This fact is borne out by a review of the Psycho-Social History.

A high degree of stress resulting from anxiety of not having one's needs met quite often affects the 'other' areas of a client's functioning. School achievement, relationships with friends, and participating in social activities are affected, as anxiety and lack of interest interfere with the capacity for full participation. The above point is reflected in the following low scores in the relevant areas of social functioning: Adjustment 0.67, Intellectual 0.94, Emotional 0.35, and Social 0.55.

A child with congenital problems and a poor mother/client relationship is at a double disadvantage in that at least if he had an 'understanding' mother, who could take into consideration his problems and handle him with extra care, tolerance, and love, he would have had less stress to cope with. In this way, she would

be 'improving' on his already present congenital problems rather than 'versening' them with improper handling.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 12

ANOMAL Case Number 12

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>10</u>	<u>1.03</u>
<u>CONDITION AT BIRTH</u>	<u>8</u>	<u>2.67</u>

DEVELOPMENT/FUNCTIONING

	<u>Sub-Scores</u>			
	Raw	Index		
Physical	21	3.00		
Behavioural	10	3.00		
Intellectual	14	2.10		
Emotional	5	.88		
Social	5	1.37		
Total	55		55	2.08

<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>10</u>	<u>1.58</u>

SIGNIFICANT RELATIONSHIPS

	<u>Sub-Scores</u>			
	Raw	Index		
Mother/Client	3	.50		
Father/Client	8	1.33		
Others/Client	9	2.07		
Total	20		20	1.22

<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>25</u>	<u>2.08</u>

<u>COMMUNITY RESOURCES</u>	<u>6</u>	<u>1.64</u>

Total Index Score 12.30

P.S.I. GRAPH

Category	Score
A	1.03
CB	2.67
D/F	2.08
LS	2.10
SR	1.58
FF	2.08
CR	1.64

DIAGNOSTIC SCORE

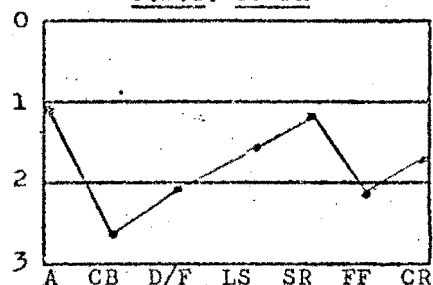
A	Index	1.03	
CB	Index	2.67	
D/F	Index	2.08	
LS	Index	1.58	
SR	Index	1.22	
FF	Index	2.08	
Total		10.66	60 %

RESOURCES SCORE

FF	Index	2.08	
CR	Index	1.64	
Total		3.72	62 %

P.S.I. SCORE 59 %

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	1.03
CB	Index	2.67
D/F	Index	2.08
LS	Index	1.58
SR	Index	1.22
FF	Index	2.08
Total		10.66
		60 %

RESOURCES SCORE

FF	Index	2.08
CR	Index	1.64
Total		3.72
		62 %

P.S.I. SCORE 59 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.12	6y.7m.	M	W	Protestant	Sub. A	Dental Surgeon
N.12	7y.7m.	M	W	Protestant	Sub. B	Civil Clerk

PSYCHO-SOCIAL INDEX

Normal Case Number 12

Normal Case Number 1

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>21</u>	<u>2.17</u>
<u>CONDITION AT BIRTH</u>	<u>9</u>	<u>3.00</u>
<u>DEVELOPMENT/FUNCTIONING</u>		
	Sub-Scores	
	Raw Index	
Physical	20 2.53	
Behavioural	9 2.70	
Intellectual	20 3.00	
Emotional	13 2.23	
Social	11 3.00	
Total	73	73 2.73
<u>LACK OF STRESS EXPERIENCES</u>	<u>14</u>	<u>2.21</u>
<u>SIGNIFICANT RELATIONSHIPS</u>		
	Sub-Scores	
	Raw Index	
Mother/Client	13 2.17	
Father/Client	12 2.00	
Others/Client	10 2.30	
Total	35	35 2.14
<u>CURRENT FAMILY FUNCTIONING</u>	<u>31</u>	<u>2.53</u>
<u>COMMUNITY RESOURCES</u>	<u>11</u>	<u>3.00</u>
Total Index Score		17.88

P.S.I. GRAPH

Category	Score
A	2.2
CB	2.0
D/F	2.2
LS	2.5
SR	2.5
FF	2.2
CR	2.0

DIAGNOSTIC SCORE

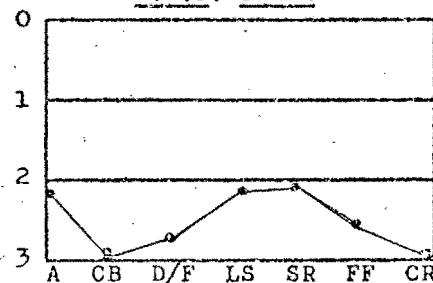
A	Index	2.17
CB	Index	3.00
D/F	Index	2.73
LS	Index	2.21
SR	Index	2.14
FF	Index	2.53
Total		14.88
		83 %

RESOURCES SCORE

FF	Index	2.53
CR	Index	3.00
Total		5.53
		93 %

P.S.I. SCORE 86 %

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.17
CB	Index	3.00
D/F	Index	2.73
LS	Index	2.21
SR	Index	2.14
FF	Index	2.53
Total		14.88
		83 %

RESOURCES SCORE

FF	Index	2.53
CR	Index	3.00
Total		5.53
		93 %

P.S.I. SCORE 86 %

A.12 and N.12

In the comparison of the graphs of the normal and abnormal clients, the first important point of difference is that the Diagnostic Score for the normal case reads as 83% and that for the abnormal case reads as 60%.

The abnormal score of 60% was the highest for its entire sample group.

In the abnormal case the MCR reads as 0.50 and the FCR reads as 1.33.

A review of the history of the case shows that the mother deserted the child and that the father was left to do most of the mothering. Even before the mother left home, she was an inadequate, incapable, person who took very little interest in the child.

Later the father remarried and the stepmother seems to be a much more caring person than the natural mother had been. The Current Family Functioning too improved with the remarriage of the father, as he seems to be able to live in greater harmony with his new wife.

The separation of the child from its natural mother, however, cannot be underplayed as children love even 'bad' mothers. This event in the child's life is in itself traumatic, and it would in all probability leave permanent scars. He will feel a sense of

having been let down by somebody he really needed and wanted at this vulnerable period of life. (If he resolves these negative feelings adequately through his stepmother, he will hopefully in the future feel safe to relate to females on a close emotional basis.) This attitude can perpetuate into adulthood, in which case his relationships with women will be poor.

However, an important change that his 'new environment' made was that his abnormal pattern of relating to mother to fit in with her personality was not perpetuated. The more stable marriage reduced the tension he had been used to at home.

The most positive factor in favour of this child's personality development, however, is that his father has been a stable, consistent, loving figure. He can be described as an emotional anchor to which the child has been permanently cathected, signifying at least some stability in the child's world.

The area of Significant Relationships reads as 1.22 and the score for the other 'dependent' areas seems to be almost in line with this, namely Stress 1.58 and Adjustment 1.03.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 13

SCORES

	Raw	Index
ADJUSTMENT.	11	1.14
CONDITION AT BIRTH.	5	1.67

DEVELOPMENT/FUNCTIONING

	Sub-Scores	
	Raw	Index
Physical	15	2.71
Behavioural	2	.60
Intellectual	9	1.35
Emotional	7	1.23
Social	1	.27

Total 38 1.44

LACK OF STRESS EXPERIENCES. . . 7 1.11

SIGNIFICANT RELATIONSHIPS

	Sub-Scores	
	Raw	Index
Mother/Client	0	0
Father/Client	0	0
Others/Client	5	1.15
Total	5	.31

CURRENT FAMILY FUNCTIONING. . . 18 1.50

COMMUNITY RESOURCES 5 1.37

Total Index Score 13.26

P.S.I. GRAPH

Category	Score
A	1.14
CB	1.67
D/F	1.44
LS	1.11
SR	1.31
FF	1.50
CR	1.37

DIAGNOSTIC SCORE

A	Index	1.14
CB	Index	1.67
D/F	Index	1.44
LS	Index	1.11
SR	Index	1.31
FF	Index	1.50
Total		7.17

35 %

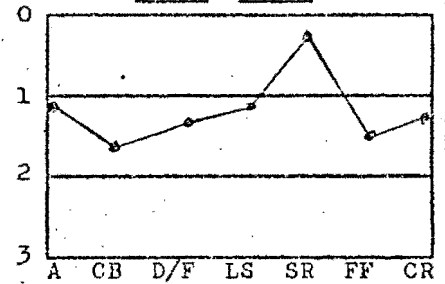
RESOURCES SCORE

FF	Index	1.50
CR	Index	1.37
Total		2.87

48 %

P.S.I. SCORE 64 %

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	1.14
CB	Index	1.67
D/F	Index	1.44
LS	Index	1.11
SR	Index	.31
FF	Index	1.50
Total		7.17
		35 %

RESOURCES SCORE

FF	Index	1.50
CR	Index	1.37
Total		2.87
		48 %

P.S.I. SCORE 64 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.13	9y.6m.	M	W	Catholic	Std. II	Armature Winder
N.13	10y.0m.	M	W	Protestant	Std. II	Machine Operator

PSYCHO-SOCIAL INDEX

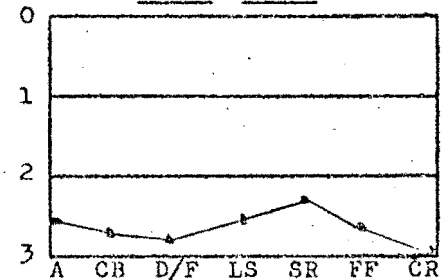
Normal Case Number 13

SCORES		
	Raw	Index
ADJUSTMENT.	25	2.58
CONDITION AT BIRTH.	8	2.67
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	21	3.00
Behavioural	9	2.70
Intellectual	20	3.00
Emotional	13	2.29
Social	11	3.00
Total	74	2.82
LACK OF STRESS EXPERIENCES. . .	16	2.53
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	13	2.17
Father/Client	15	2.50
Others/Client	10	2.30
Total	38	2.33
CURRENT FAMILY FUNCTIONING. . .	32	2.67
COMMUNITY RESOURCES	11	3.00
Total Index Score	18.60	

P.S.I. GRAPH	
0	
1	
2	
3	
A	
CB	
D/F	
LS	
SR	
FF	
CR	

DIAGNOSTIC SCORE	
A	Index 2.58
CB	Index 2.67
D/F	Index 2.82
LS	Index 2.53
SR	Index 2.33
FF	Index 2.67
Total	15.60
87%	
RESOURCES SCORE	
FF	Index 2.67
CR	Index 3.00
Total	5.67
95%	
P.S.I. SCORE 89%	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.58
CB	Index	2.67
D/F	Index	2.82
LS	Index	2.53
SR	Index	2.33
FF	Index	2.67
Total		15.60
		87 %

RESOURCES SCORE

FF	Index	2.67
CR	Index	3.00
Total		5.67
		95 %

P.S.I. SCORE 89 %

A.13 and N.13

In abnormal case No.13 the score for MCR reads as 0.00; the total score for Significant Relationships is 0.31, and the Diagnostic Score, which is also very low, reads as 35%.

Looking at the normal case, it can once more be seen that the consistency of the mother-child relationship is the major determinant of the personality development. The Mother/Client Relationship (2.17) correlates with a high Significant Relationships score which corresponds with a high Diagnostic Score of 87%. As can be seen from the score, the abnormal case received a very impoverished mothering experience. The mother was diagnosed as 'schizophrenic' and was later removed for long-term hospitalization.

At this stage, this child was placed in foster care. A change of environment, away from the unrealistic, destructive responses of his natural mother helped to improve his overall functioning and adjustment. The child has had more opportunity to communicate with others on a reality level. Had this child been left with his natural mother it is highly likely that he, too, would have developed into an uncommunicative, poorly adjusted person, as he has already shown signs of having incorporated some of her behaviour patterns.

This child received very little emotional support from his father, too, who left the mother when he was still very young.

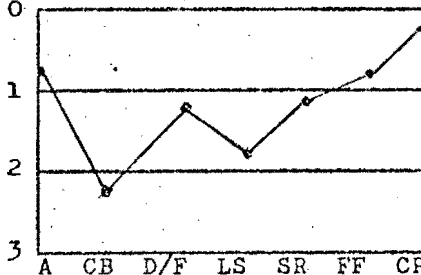
The fact that a father's 'mothering' can make a difference to the personality development of an individual can be seen in A.12 in which the father's presence (despite mothering absence) helped towards a 60% Diagnostic Score, as compared to this case in which the father, too, left the child (Diagnostic Score 35%).

N.13, which has a Diagnostic Score of 87%, again reflects a positive Mother/Client Relationship score of 2.17, a positive Condition at Birth score (2.67), and equally high scores in the other areas of the Psycho-Social Index graph.

In this case, the trend for healthy personality development to flourish with a good mother-child relationship, father-child relationship, and an invariably healthy family climate, is clearly reflected.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 14

SCORES				
	Raw	Index		
ADJUSTMENT.	7	1.72	P.S.I. GRAPH 	
CONDITION AT BIRTH.	7	2.33		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	18	2.57		
Behavioural	6	1.80		
Intellectual	4	.60		
Emotional	5	.88		
Social	2	1.55		
Total	35	35	1.32	
LACK OF STRESS EXPERIENCES. . .	11	1.74		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	8	1.33		
Father/Client	4	.67		
Others/Client	7	1.61		
Total	19	19	1.16	
CURRENT FAMILY FUNCTIONING. . .	10	.83		
COMMUNITY RESOURCES	1	.27		
Total Index Score			8.37	

DIAGNOSTIC SCORE		
A	Index	1.72
CB	Index	2.33
D/F	Index	1.32
LS	Index	1.74
SR	Index	1.16
FF	Index	.82
Total		8.10
		45%
RESOURCES SCORE		
FF	Index	.83
CR	Index	.27
Total		1.10
		18%
P.S.I. SCORE		
		40%

	Age	Sex	Race	Religion	Education	Father's Occupation
A.14	9y.7m.	M	C	Protestant	Std. II	Supervisor in Factory
N.14	10y.0m.	M	C	Protestant	Std. I	Priest

PSYCHO-SOCIAL INDEX

Normal Case Number 14

SCORES																			
	Raw	Index																	
ADJUSTMENT.	27	2.79	P.S.I. GRAPH <table border="1"><caption>P.S.I. GRAPH Data</caption><thead><tr><th>Category</th><th>Score</th></tr></thead><tbody><tr><td>A</td><td>2.79</td></tr><tr><td>CB</td><td>3.00</td></tr><tr><td>D/F</td><td>2.78</td></tr><tr><td>LS</td><td>2.53</td></tr><tr><td>SR</td><td>2.88</td></tr><tr><td>FF</td><td>2.92</td></tr><tr><td>CR</td><td>3.00</td></tr></tbody></table>	Category	Score	A	2.79	CB	3.00	D/F	2.78	LS	2.53	SR	2.88	FF	2.92	CR	3.00
Category	Score																		
A	2.79																		
CB	3.00																		
D/F	2.78																		
LS	2.53																		
SR	2.88																		
FF	2.92																		
CR	3.00																		
CONDITION AT BIRTH.	9	3.00																	
DEVELOPMENT/FUNCTIONING																			
	Sub-Scores																		
	Raw	Index																	
Physical	20	2.86																	
Behavioural	10	3.00																	
Intellectual	20	3.00																	
Emotional	13	2.29																	
Social	10	2.73																	
Total	73	2.78																	
LACK OF STRESS EXPERIENCES. . .	16	2.53																	
SIGNIFICANT RELATIONSHIPS																			
	Sub-Scores																		
	Raw	Index																	
Mother/Client	18	3.00																	
Father/Client	13	3.00																	
Others/Client	11	2.53																	
Total	47	2.88																	
CURRENT FAMILY FUNCTIONING. . .	35	2.92																	
COMMUNITY RESOURCES	11	3.00																	
Total Index Score		19.90																	

DIAGNOSTIC SCORE	
A	Index 2.79
CB	Index 3.00
D/F	Index 2.78
LS	Index 2.53
SR	Index 2.88
FF	Index 2.92
Total	16.90 95 %
RESOURCES SCORE	
FF	Index 2.92
CR	Index 3.00
Total	5.92 98 %
P.S.I. SCORE 96 %	

A.14 and H.14

The Diagnostic Score for this abnormal case reads as 45% and that for its corresponding normal case as 95%. The Mother/Client Relationship score for the normal case reads as 3.00 and that for the abnormal case reads as 1.33.

Some of the specific factors that helped the normal child score higher is that the mother herself received good mothering, and had much more capacity to give to her child emotionally.

She is happy in her marriage and in this way has her own emotional needs met. This aspect indirectly affects her role as mother in that she feels secure and supported by her husband whom she can trust and turn to for help whenever she requires it.

Child-rearing is seen as a joint responsibility to which both parents contribute. The father does not leave his function entirely to the mother. He helps in disciplining, plays with the children, and shows interest in their development.

The parents of the abnormal client had an unhappy marriage. They disagreed on discipline, with the father being too harsh and the mother too lenient. The mother did not get her own emotional needs met in the marriage, and attempts to get this met through the child placed additional strain on his developing ego as he himself still needed mothering and emotional support.

The mother herself had received very poor mothering. Ever

since she was thirteen years old she had taken care of her younger siblings and her own ill mother. Adult responsibilities at a very early age and very little positive mothering have resulted in immature personality development on her part.

The abnormal child had a particularly difficult relationship with his father (FCR 0.67) who was cold, aloof, and uninvolved in the family's emotional life. The mother's unusually close attachment to this child seems further to have antagonized the father and affected his relationship with the boy.

This abnormal case is a classic example of an unhappily married couple who became opposing forces in the fight for their child's love and attention.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 15

SCORES

	Raw	Index
ADJUSTMENT.	11	1.22
CONDITION AT BIRTH.	8	2.67

DEVELOPMENT/FUNCTIONING

Sub-Scores		Raw	Index
Physical	20	2.86	
Behavioural	7	2.33	
Intellectual	9	1.69	
Emotional	3	.53	
Social	2	.55	
Total	41	41	1.66

LACK OF STRESS EXPERIENCES. . .	9	1.50

SIGNIFICANT RELATIONSHIPS

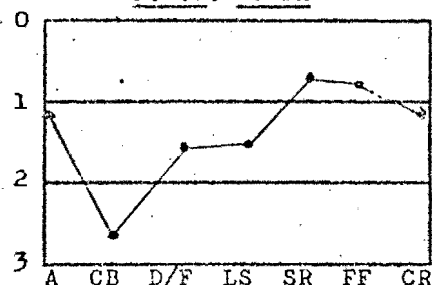
Sub-Scores		Raw	Index
Mother/Client	5	1.00	
Father/Client	2	.33	
Others/Client	4	1.00	
Total	12	12	.75

CURRENT FAMILY FUNCTIONING. . .	10	.83

COMMUNITY RESOURCES	4	1.09

Total Index Score	9.72

P.S.I. GRAPH



DIAGNOSTIC SCORE

A Index	1.22
CB Index	2.67
D/F Index	1.66
LS Index	1.50
SR Index	1.75
FF Index	.83
Total	8.63
	48 %

RESOURCES SCORE

FF Index	.83
CR Index	1.09
Total	1.92
	32 %

P.S.I. SCORE 47 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.15	4y.10m.	M	W	Protestant	Nursery	Manager of Firm
N.15	4y.11m.	M	W	Protestant	Nursery	Architect

PSYCHO-SOCIAL INDEX

Normal Case Number 15

SCORES

	Raw	Index
ADJUSTMENT.	22	2.44
CONDITION AT BIRTH.	9	3.00

DEVELOPMENT/FUNCTIONING

Sub-Scores		Raw	Index
Physical	21	3.00	
Behavioural	9	3.00	
Intellectual	18	3.00	
Emotional	13	2.29	
Social	10	2.73	
Total	69	69	2.80

LACK OF STRESS EXPERIENCES. . .	16	2.67

SIGNIFICANT RELATIONSHIPS

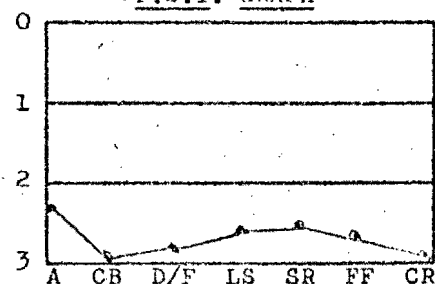
Sub-Scores		Raw	Index
Mother/Client	18	3.00	
Father/Client	11	1.83	
Others/Client	12	3.00	
Total	41	41	2.56

CURRENT FAMILY FUNCTIONING. . .	32	2.67

COMMUNITY RESOURCES	11	3.00

Total Index Score	19.14

P.S.I. GRAPH



DIAGNOSTIC SCORE

A Index	2.44
CB Index	3.00
D/F Index	2.80
LS Index	2.67
SR Index	2.56
FF Index	2.67
Total	16.14
	91 %

RESOURCES SCORE

FF Index	2.67
CR Index	3.00
Total	5.67
	95 %

P.S.I. SCORE 92 %

A.15 and N.15

In this abnormal case the score for MCR reads as 1.00 and for FCR as 0.33.

The parents of this child were divorced and the client lived with his mother. The father's total absence from home naturally leaves very little opportunity for the establishment of a positive relationship (even though he visited the child occasionally).

The absence of a father figure at this age is especially difficult for a male child as it affects his positive identification with the male figure and, furthermore, the Oedipal conflicts are heightened as the father is seen as a person who left because he was 'conquered' by the son in their 'struggle' for possession of mother.

In the normal case, the client's MCR of 3.00 clearly indicates a very healthy socialization experience. The FCR seems to be of an average standard, i.e. 1.63. This, however, does seem to have affected his overall personality functioning and development as all the other areas of the Psycho-Social Index show an exceptionally high score.

It can be concluded from this that a very healthy mother-child relationship can help to lessen the effects of a 'not so healthy' father-child experience.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 16

			SCORES		
			Raw	Index	
ADJUSTMENT.			8	.83	P.S.I. GRAPH
CONDITION AT BIRTH.			6	2.00	
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw	Index			
Physical	18	2.57			
Behavioural	8	2.40			
Intellectual	11	1.65			DIAGNOSTIC SCORE A Index .83 CB Index 2.00 D/F Index 1.90 LS Index 1.42 SR Index .55 FF Index .25 Total 6.95 39 % RESOURCES SCORE FF Index .25 CR Index 1.37 Total 1.62 27 % P.S.I. SCORE 40 %
Emotional	7	1.23			
Social	6	1.64			
Total	50		50	1.90	
LACK OF STRESS EXPERIENCES.			9	1.42	
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw	Index			
Mother/Client	2	.33			
Father/Client	1	.17			
Others/Client	6	1.68			
Total	9		9	.55	
CURRENT FAMILY FUNCTIONING.			3	.25	
COMMUNITY RESOURCES			5	1.37	
Total Index Score				8.32	

	Age	Sex	Race	Religion	Education	Father's Occupation
A.16	11y.5m.	M	W	Protestant	Std. II	Bus Conductor
N.16	11y.0m.	M	W	Protestant	Std. III	Customs Official

PSYCHO-SOCIAL INDEX

Normal Case Number 16

			SCORES		
			Raw	Index	
ADJUSTMENT.			14	1.44	P.S.I. GRAPH
CONDITION AT BIRTH.			8	2.67	
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw	Index			
Physical	17	2.49			
Behavioural	8	2.40			
Intellectual	12	1.80			DIAGNOSTIC SCORE A Index 1.44 CB Index 2.67 D/F Index 2.08 LS Index 2.21 SR Index 2.26 FF Index 2.33 Total 12.99 73 % RESOURCES SCORE FF Index 2.33 CR Index 3.00 Total 5.33 88 % P.S.I. SCORE 77 %
Emotional	9	1.58			
Social	9	2.46			
Total	55		55	2.08	
LACK OF STRESS EXPERIENCES.			14	2.21	
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw	Index			
Mother/Client	11	1.83			
Father/Client	10	2.67			
Others/Client	10	2.30			
Total	37		37	2.26	
CURRENT FAMILY FUNCTIONING.			28	2.33	
COMMUNITY RESOURCES			11	3.00	
Total Index Score				15.99	

A.16 and N.16

Both the abnormal and normal client come from similar backgrounds — socio-economically, culturally, and educationally.

The abnormal case, however, seems to have scored a very low Diagnostic Score of 39% while the normal case scored 73%. It is the writer's contention that this low score is caused by the client's poor relationships with significant people.

The index scores reflecting the specific areas inherent in personality formation show proportionately low scores for the abnormal case. The area of Significant Relationships (0.55) seems to have been especially traumatic for this child bringing about long-term stress (1.42).

The MCR shows a score of 0.33. The mother in this case became pregnant before marriage and made several unsuccessful attempts to abort the baby. Since the birth of this baby became inevitable, the 'father', who was under pressure from his in-laws, was forced to marry this woman. Their marriage now is a cold, antagonistic affair which is being maintained more for the financial security it affords the mother than for any other reason. The degree of instability of this family is well reflected in the Current Family Functioning score, which reads as 0.25.

The normal case is a good example of the prevalence of a healthy Father/Client Relationship (2.67). It is in fact even better than the mother-child relationship (MCR 1.83). A happy

marriage helps this mother perform averagely in her function. It is the opinion of the writer that she would have performed much more poorly had she not the support of her husband in their marriage and in child-rearing.

Personality-wise, she seems to be much more rigid with the children, more intent on discipline, and feels that children should not be 'spoilt' with too much affection. The father is warm, less rigid with discipline, and is more demonstrative in his affection towards the children.

The Diagnostic Score of 73% falls in the lower range of the normal sample group. This can most probably be attributed to the child's unfortunate early traumatic experience of becoming seriously ill with gastro-enteritis and the need to be hospitalized for two months, necessitating separation from his mother.

Viewed psychodynamically, this illness caused additional stress in that it occurred during the oral stage of development when the child's relationship with his mother had not yet 'jelled'. Separation from her disrupted this process and has accounted for the relatively low Diagnostic Score.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 17

			SCORES		
			Raw	Index	
ADJUSTMENT.			5	.56	P.S.I. GRAPH
CONDITION AT BIRTH.			3	1.00	
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw	Index			
Physical	15	2.14			
Behavioural	5	1.67			
Intellectual	3	.56			
Emotional	1	.13			
Social	2	.55			
Total	26		26	1.05	
LACK OF STRESS EXPERIENCES.			9	1.50	DIAGNOSTIC SCORE A Index .56 CB Index 1.00 D/F Index 1.05 LS Index 1.50 SR Index .69 FF Index 1.58 Total 6.38 36 % RESOURCES SCORE FF Index 1.58 CR Index 3.00 Total 4.58 77 % P.S.I. SCORE 45 %
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw	Index			
Mother/Client	4	.67			
Father/Client	4	.67			
Others/Client	3	.75			
Total	11		11	.69	
CURRENT FAMILY FUNCTIONING.			19	1.58	
COMMUNITY RESOURCES			11	3.00	
Total Index Score				9.38	

	Age	Sex	Race	Religion	Education	Father's Occupation
A.17	4y.3m.	M	W	Protestant	Nursery	Professor
N.17	5y.0m.	M	W	Protestant	Nursery	Consultant

PSYCHO-SOCIAL INDEX

Normal Case Number 17

			SCORES		
			Raw	Index	
ADJUSTMENT.			14	1.56	P.S.I. GRAPH
CONDITION AT BIRTH.			7	2.33	
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw	Index			
Physical	18	2.57			
Behavioural	6	2.00			
Intellectual	11	2.07			
Emotional	11	1.94			
Social	11	3.00			
Total	57		57	2.31	
LACK OF STRESS EXPERIENCES.			12	2.00	DIAGNOSTIC SCORE A Index 1.56 CB Index 2.33 D/F Index 2.31 LS Index 2.00 SR Index 2.75 FF Index 2.92 Total 13.87 78 % RESOURCES SCORE FF Index 2.92 CR Index 3.00 Total 5.92 98 % P.S.I. SCORE 81 %
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw	Index			
Mother/Client	16	2.67			
Father/Client	18	3.00			
Others/Client	10	2.50			
Total	44		44	2.75	
CURRENT FAMILY FUNCTIONING.			35	2.92	
COMMUNITY RESOURCES			11	3.00	
Total Index Score				16.87	

A.17 and N.17

In A.17 and N.17 both sets of parents are professional persons, all having graduated from university. Despite this intellectual 'equality' they seem to have offered their children vastly different parenting experiences. This is reflected in the fact that the normal child had a Diagnostic Score of 78% and the abnormal child a score of 36% for the same area.

In the abnormal case both the parents seem to have had less healthy personality developmental histories which has become evident in their manner of rearing their child. In this case, both the MCR and FCR scores read as 0.67.

Besides Significant Relationships causing stress, the area of Conditions at Birth also added to the anxiety of the child. That this cumulative anxiety has interfered with the client's social functioning is reflected in the Adjustment Score of 0.56, Intellectual Score of 0.56, Emotional Score of 0.18, and Social Score of 0.55.

The normal case is interesting in that the child had a congenital intestinal problem which became evident only during the anal stage. This problem resulted in the child having very little control over his bowel functioning. A problem such as this would frustrate any mother attempting to toilet-train her child. However, after medical examination, the parents found out the underlying cause of the problem. This new knowledge helped to give

them insight into his behaviour and to realize that the uncontrolled messing was not an act of defiance. However, insight into a situation such as this is not sufficient to overcome it — sometimes a mistaken notion exists that knowledge alone presupposes control over a situation.

In this case, in addition to insight (which was helped by her education in that she could intellectually grasp the first step) the mother had the ego strength and emotional capacity to tolerate the child's lack of control both for bowel movement and the resultant acting-out behaviour that became a symptom of the child as a result of uncontrolled anal aggression.

This child, despite his problem, has made very good adjustment outside the home which can be attributed to the sensitive and understanding handling by his mother.

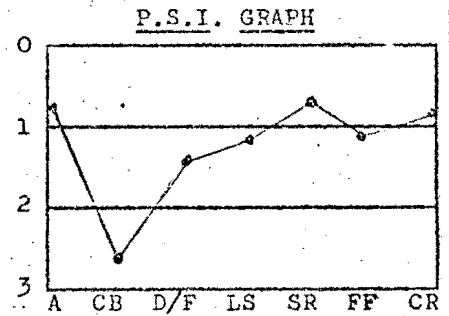
PSYCHO-SOCIAL INDEX

Abnormal Case Number 18

SCORES		
	Raw	Index
ADJUSTMENT.	6	.60
CONDITION AT BIRTH.	8	2.67
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	21	2.63
Behavioural	7	2.10
Intellectual	3	1.20
Emotional	4	.71
Social	1	.23
Total	41	1.46
LACK OF STRESS EXPERIENCES. . .	9	1.22
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	2	.33
Father/Client	2	.33
Others/Client	8	1.84
Total	12	.73
CURRENT FAMILY FUNCTIONING. . .	13	1.08
COMMUNITY RESOURCES	3	.82
Total Index Score		8.58

P.S.I. GRAPH	
0	
1	
2	
3	
A	
CB	
D/F	
LS	
SR	
FF	
CR	

DIAGNOSTIC SCORE	
A	Index .60
CB	Index 2.67
D/F	Index 1.46
LS	Index 1.22
SR	Index .73
FF	Index 1.08
Total	7.76 44 %
RESOURCES SCORE	
FF	Index 1.92
CR	Index .82
Total	2.74 45 %
P.S.I. SCORE 41 %	



DIAGNOSTIC SCORE		
A	Index	.60
CB	Index	2.67
D/F	Index	1.46
LS	Index	1.22
SR	Index	.73
FF	Index	1.08
Total		7.76
		44 %

RESOURCES SCORE		
FF	Index	1.92
CR	Index	.82
Total		2.74
		45 %

P.S.I. SCORE 41 %

Age	Sex	Race	Religion	Education	Father's Occupation
A.18	17y.7m.	M	C	Protestant	Unknown
N.18	17y.4m.	M	C	Protestant	Std. VIII

PSYCHO-SOCIAL INDEX

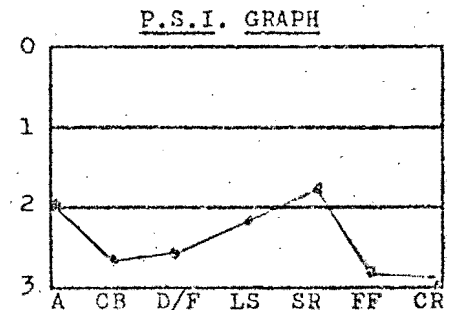
Normal Case Number 18

SCORES		
	Raw	Index
ADJUSTMENT.	20	2.00
CONDITION AT BIRTH.	8	2.67
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	24	3.00
Behavioural	10	3.00
Intellectual	17	2.55
Emotional	9	1.58
Social	11	2.53
Total	71	2.53
LACK OF STRESS EXPERIENCES. . .	17	2.31
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	12	2.00
Father/Client	11	1.83
Others/Client	7	1.61
Total	30	1.84
CURRENT FAMILY FUNCTIONING. . .	34	2.83
COMMUNITY RESOURCES	11	3.00
Total Index Score	17.18	

P.S.I. GRAPH

Category	Score
A	2.0
CB	2.6
D/F	2.7
LS	2.5
SR	2.8
FF	2.3
CR	2.3

DIAGNOSTIC SCORE		
A	Index	2.00
CB	Index	2.67
D/F	Index	2.53
LS	Index	2.31
SR	Index	1.84
FF	Index	2.83
Total		14.18
RESOURCES SCORE		
FF	Index	2.83
CR	Index	3.00
Total		5.83
P.S.I. SCORE		
		83 %



DIAGNOSTIC SCORE		
A	Index	2.00
CB	Index	2.67
D/F	Index	2.53
LS	Index	2.31
SR	Index	1.84
FF	Index	2.83
Total		14.18
		80 %

RESOURCES SCORE		
FF	Index	2.83
CR	Index	3.00
Total		5.83
		97 %

P.S.I. SCORE 83 %

A.18 and N.18

The graph of the normal case shows consistently high score points. In the abnormal case there are consistently low score points.

The P.S.I. scores for the normal case are proportionately higher than those for the abnormal case, except in the area of Condition at Birth in which both cases scored 2.67. Some of the scores are:

	N.18	A.18
Adjustment	2.00	.60
Development/Functioning	2.53	1.46
Stress	2.31	1.22
Significant Relationships	1.84	.73
Current Family Functioning	2.83	1.03
Community Resources	3.00	.82

The Diagnostic scores, too, show a proportionately high score for the normal case (80%), and a proportionately low score for the abnormal case (44%).

PSYCHO-SOCIAL INDEX

Abnormal Case Number 19

SCORES

	Raw	Index
ADJUSTMENT.	6	.60
CONDITION AT BIRTH.	8	2.67
DEVELOPMENT/FUNCTIONING		

Sub-Scores

Raw Index

Physical	18	2.25
Behavioural	8	2.40
Intellectual	5	.75
Emotional	5	.88
Social	2	.46

Total 38 38 1.36

LACK OF STRESS EXPERIENCES. . . 11 1.50

SIGNIFICANT RELATIONSHIPS

Sub-Scores

Raw Index

Mother/Client	2	.33
Father/Client	2	.33
Others/Client	1	.23
Total	5	.31

CURRENT FAMILY FUNCTIONING. . . 10 .83

COMMUNITY RESOURCES 5 1.37

Total Index Score 8.64

P.S.I. GRAPH

Category	Score
A	1.36
CB	2.67
D/F	1.36
LS	1.50
SR	2.25
FF	2.40
CR	2.25

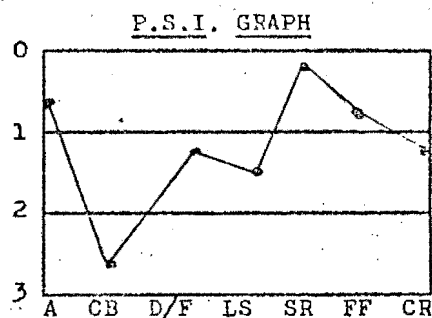
DIAGNOSTIC SCORE

A	Index	.60
CB	Index	2.67
D/F	Index	1.36
LS	Index	1.50
SR	Index	.31
FF	Index	.83
Total		7.27 41 %

RESOURCES SCORE

FF	Index	.83
CR	Index	1.37
Total		2.20 37 %

P.S.I. SCORE 41 %



DIAGNOSTIC SCORE		
A	Index	.60
CB	Index	2.67
D/F	Index	1.36
LS	Index	1.50
SR	Index	.31
FF	Index	.83
Total		7.27
		41 %

RESOURCES SCORE		
FF	Index	.83
CR	Index	1.37
Total		2.20
		37 %

P.S.I. SCORE 41 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.19	16y.Om.	M	W	Protestant	Std. VI	Railway Foreman
N.19	15y.Om.	M	W	Protestant	Std. VIII	Business Representative

PSYCHO-SOCIAL INDEX

Normal Case Number 19

Normal Case Number 1

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>17</u>	<u>1.70</u>
<u>CONDITION AT BIRTH</u>	<u>7</u>	<u>2.33</u>
<u>DEVELOPMENT/FUNCTIONING</u>		
	Sub-Scores	
	Raw	Index
Physical	23	2.83
Behavioural	7	2.10
Intellectual	11	1.65
Emotional	12	2.11
Social	7	1.61
Total	60	2.14

<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>15</u>	<u>2.04</u>

SIGNIFICANT RELATIONSHIPS

	Sub-Scores	
	Raw	Index
Mother/Client	13	2.17
Father/Client	12	2.00
Others/Client	8	1.84
Total	33	2.02

<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>25</u>	<u>2.17</u>

<u>COMMUNITY RESOURCES</u>	<u>11</u>	<u>3.00</u>

Total Index Score 15.40

P.S.I. GRAPH

Category	Raw Score	Index
A	17	1.70
CB	7	2.33
D/F	11	1.65
LS	12	2.11
SR	7	1.61
FF	12	2.11
CR	7	1.61

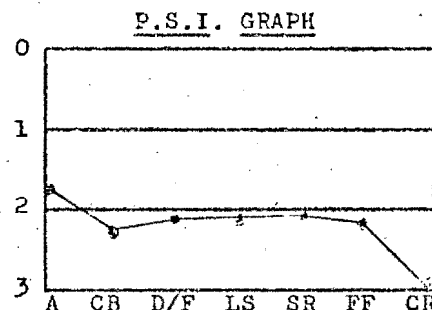
DIAGNOSTIC SCORE

A	Index	<u>1.70</u>
CB	Index	<u>2.33</u>
D/F	Index	<u>2.14</u>
LS	Index	<u>2.04</u>
SR	Index	<u>2.02</u>
FF	Index	<u>2.17</u>
Total		<u>12.40</u>
		<u>69 %</u>

RESOURCES SCORE

FF	Index	<u>2.17</u>
CR	Index	<u>3.00</u>
Total		<u>5.17</u>
		<u>87 %</u>

P.S.I. SCORE 74 %



DIAGNOSTIC SCORE		
A	Index	1.70
CB	Index	2.33
D/F	Index	2.14
LS	Index	2.04
SR	Index	2.02
FF	Index	2.17
Total		12.40
		69 %

RESOURCES SCORE		
FF	Index	2.17
CR	Index	3.00
Total		5.17
		87 %

P.S.I. SCORE 74 %

A.19 and N.19

In the abnormal case, the Current Family Functioning score is very low (0.83). This is mainly due to the parents' marital discord rather than to any other problem.

The marital discord reached such severe proportions that the child invariably became involved in it to the detriment of his healthy personality development. In this case, the MCR reads as 0.33. The chief aberration in this case is that the mother sought emotional support from her child, instead of fulfilling his needs for affection. She did this mainly by acting the helpless parent in her conflict with the father; she regressed to such a level of immaturity that her child had to protect and fight for her against his father. This only served to worsen an already poor father-child relationship as the child's supporting behaviour for the mother helped to justify and intensify the father's tyrannical attitudes towards him. The FCR reads as 0.33.

An impoverished ego resulting from very little affection and support from his Significant Others (0.23) and a high degree of Stress (1.50) contributed towards poor personality development which is reflected in the Diagnostic Score of 41%.

The better Significant Relationships (2.02) and less stressful experiences (Stress 2.04) of the normal case seem to contribute towards healthier personality development as reflected in the Diagnostic Score of 69%.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 20

SCORES

	Raw	Index
ADJUSTMENT.	2	.20
CONDITION AT BIRTH.	3	1.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw Index	
Physical	17	2.13
Behavioural	7	2.10
Intellectual	5	.75
Emotional	3	.53
Social	2	.40
Total	34	1.18
LACK OF STRESS EXPERIENCES. . .	3	.41
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw Index	
Mother/Client	4	.50
Father/Client	3	.30
Others/Client	2	.29
Total	9	.55
CURRENT FAMILY FUNCTIONING. . .	7	.58
COMMUNITY RESOURCES	8	2.18
Total Index Score		6.10

P.S.I. GRAPH

Category	Score
A	0.20
CB	1.00
D/F	0.41
LS	1.18
SR	0.55
FF	0.58
CR	2.18

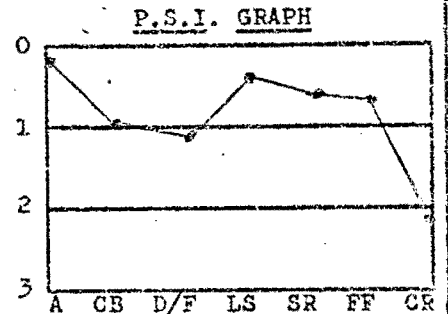
DIAGNOSTIC SCORE

A	Index	.20
CB	Index	1.00
D/F	Index	1.18
LS	Index	.41
SR	Index	.55
FF	Index	.58
Total		3.92
		22 %

RESOURCES SCORE

FF	Index	.58
CR	Index	2.18
Total		2.76
		47 %

P.S.I. SCORE 29 %



DIAGNOSTIC SCORE

A	Index	.20
CB	Index	1.00
D/F	Index	1.18
LS	Index	.41
SR	Index	.55
FF	Index	.58
Total		3.92
		22 %

RESOURCES SCORE

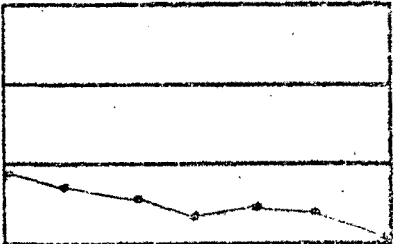
FF	Index	.58
CR	Index	2.18
Total		2.76
		47 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.20	24y.0m.	F	W	Unknown	School for Deaf	Railway labourer
N.20	22y.0m.	F	W	Protestant	Std. III	Clerk, Civil Service

PSYCHO-SOCIAL INDEX

Normal Case Number 20

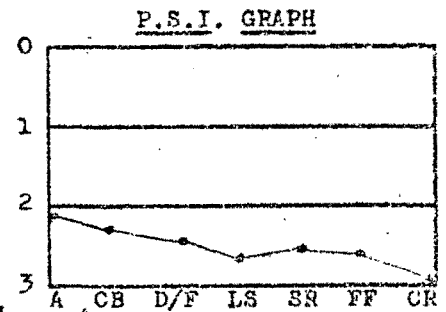
				SCORES			
				Raw	Index		
ADJUSTMENT.				22	2.20		
CONDITION AT BIRTH.				7	2.33		
DEVELOPMENT/FUNCTIONING							
	Sub-Scores						
	Raw	Index					
Physical	22	2.53					
Behavioural	8	2.40					
Intellectual	16	2.46					
Emotional	11	1.94					
Social	12	2.40					
Total	70		70	2.44			
LACK OF STRESS EXPERIENCES. . .				19	2.58		
SIGNIFICANT RELATIONSHIPS							
	Sub-Scores						
	Raw	Index					
Mother/Client	14	2.33					
Father/Client	16	2.67					
Others/Client	11	2.55					
Total	41		41	2.51			
CURRENT FAMILY FUNCTIONING. . .				31	2.58		
COMMUNITY RESOURCES				11	3.00		
Total Index Score				17.64			

P.S.I. GRAPH	
0	
1	
2	
3	
A	
CB D/F LS SR FF CR	

DIAGNOSTIC SCORE	
A	Index 2.30
CB	Index 2.33
D/F	Index 2.44
LS	Index 2.58
SR	Index 2.51
FF	Index 2.58
Total	14.64
82 %	

RESOURCES SCORE	
FF	Index 2.58
CR	Index 3.00
Total	5.58
93 %	

P.S.I. SCORE	
84 %	



DIAGNOSTIC SCORE

A	Index	2.30
CB	Index	2.33
D/F	Index	2.44
LS	Index	2.58
SR	Index	2.51
FF	Index	2.58
Total		14.64
		82 %

RESOURCES SCORE

FF	Index	2.58
CR	Index	3.00
Total		5.58
		92 %

A.20 and N.20

The normal case No.20 scored 82% for Diagnostic Score, and the abnormal case scored 22%.

In the abnormal case the total score very aptly reflects the degree of personality maturity attained by the client. This twenty-five year old girl was congenitally deaf (Condition at Birth score 1.00). Her deafness and inability to communicate, together with poor Significant Relationships (0.55), resulted in her living under frustrating conditions (Stress 0.41) which retarded her personality growth. Her Adjustment (0.20) too has been severely hampered by this double disadvantage.

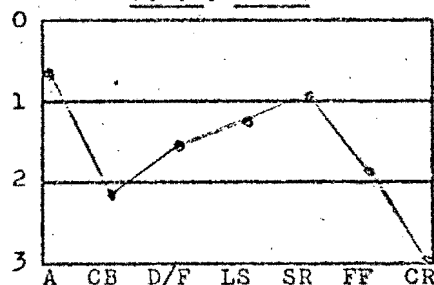
The normal case had better Significant Relationships (2.51) as well as better physical capacities to cope with the environment (Condition at Birth 2.33), and, as a result of this, has achieved much greater personality maturity and adjustment which can be seen in the pattern of the low-lying graph and Diagnostic Score of 82%.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 21

SCORES			
	Raw	Index	
ADJUSTMENT.	6	.67	
CONDITION AT BIRTH.	7	2.33	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	19	2.71	
Behavioural	7	2.33	
Intellectual	4	.75	
Emotional	5	.88	
Social	4	1.09	
Total	39	1.58	
LACK OF STRESS EXPERIENCES. . .	8	1.33	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	5	.83	
Father/Client	7	1.17	
Others/Client	4	1.00	
Total	16	1.00	
CURRENT FAMILY FUNCTIONING. . .	23	1.92	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		11.83	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.67
CB	Index	2.33
D/F	Index	1.58
LS	Index	1.33
SR	Index	1.00
FF	Index	1.92
Total		8.83
		49 %

RESOURCES SCORE

FF	Index	1.92
CR	Index	3.00
Total		4.92
		82 %

P.S.I. SCORE 57 %

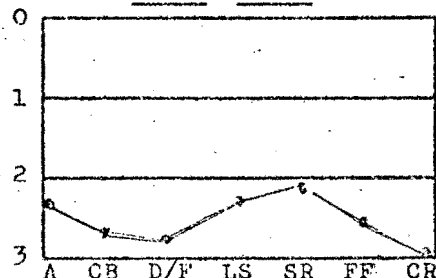
	Age	Sex	Race	Religion	Education	Father's Occupation
A.21	3y.3m.	M	W	Jewish	Pre-school	Architect
N.21	2y.4m.	M	W	Jewish	Pre-school	M.D.

PSYCHO-SOCIAL INDEX

Normal Case Number 21

SCORES			
	Raw	Index	
ADJUSTMENT.	22	2.44	
CONDITION AT BIRTH.	8	2.67	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	21	3.00	
Behavioural	7	2.33	
Intellectual	14	2.63	
Emotional	15	2.64	
Social	13	2.73	
Total	67	2.71	
LACK OF STRESS EXPERIENCES. . .	14	2.33	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	11	1.83	
Father/Client	12	2.00	
Others/Client	10	2.50	
Total	33	2.06	
CURRENT FAMILY FUNCTIONING. . .	32	2.67	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		17.83	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.44
CB	Index	2.67
D/F	Index	2.71
LS	Index	2.33
SR	Index	2.06
FF	Index	2.67
Total		14.88
		83 %

RESOURCES SCORE

FF	Index	2.67
CR	Index	3.00
Total		5.67
		95 %

P.S.I. SCORE 86 %

A.21 and N.21

In the abnormal case, the P.S.I. face-sheet shows that the Father/Client Relationship was much better than the Mother/Client Relationship. This is reflected in their respective scores of 1.17 and 0.83.

An analysis of the Psycho-Social History supports these scores in that it shows that the mothering of the child was carried out predominantly by the father. He bathed the child, put him to bed, etc. The child received positive emotional support from his father and was much more attached to him. The mother, although physically present in the home, spent very little time with her child. She rejected the child whom she felt interfered with her career. Mother was generally impatient with him. The child, as a result of her general neglect, tried to gain her attention through acting out behaviour which perpetuated and justified her rejection of him.

Current Family Functioning for this case is above average as can be seen in the score of 1.92. Looking at the marital relationship, the couple consider this aspect of their lives to be satisfactory; however, when one studies it dynamically, it seems that there are underlying neurotic needs. These neurotic needs dovetail and account for the satisfaction expressed by both partners. Role reversal exists as one of the aberrations. The wife sees her husband as weak and as one who leans on her for support. She appears

to be the controlling partner in the marriage.

Unlike most other abnormal families, there is a general absence of friction between parents in the home, thus reducing some of the stress. Despite this, however, the functioning per se of parents is not conducive to the upbringing of the child. He is confused as to who mother really is as her functions do not seem to define her as such. The father undertakes the bathing and dressing of the child, and the mother does very little.

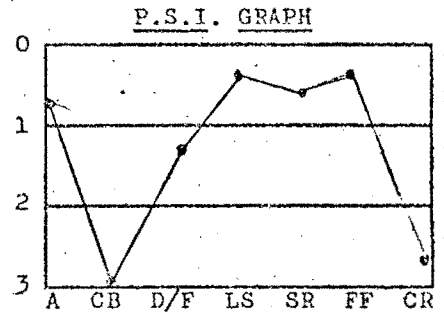
This case illustrates that although the father can do some mothering it is essential that the mother at least basically fills her role, as too much 'take over' by the father interferes with the child's correct perception of expectations he is entitled to from either parent, especially when both parents are physically present. It might also affect his male identification as the father seems to be the passive partner in the marriage.

In the normal case, the MCR and FCR scores are not excellent, but nevertheless the healthy balance of even above-average scores for both mother and father (1.83 and 2.00 respectively) helps towards the normal development of a child.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 22

SCORES			
	Raw	Index	
ADJUSTMENT.	6	.60	
CONDITION AT BIRTH.	9	3.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	19	2.38	
Behavioural	9	2.70	
Intellectual	6	.90	
Emotional	3	.53	
Social	4	.80	
Total	41	1.43	
LACK OF STRESS EXPERIENCES. . .	3	.41	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	4	.67	
Father/Client	3	.50	
Others/Client	2	.46	
Total	9	.55	
CURRENT FAMILY FUNCTIONING. . .	3	.43	
COMMUNITY RESOURCES	8	2.64	
Total Index Score	9.06		



DIAGNOSTIC SCORE

A	Index	.60
CB	Index	3.00
D/F	Index	1.43
LS	Index	.41
SR	Index	.55
FF	Index	.43
Total		6.42
		36 %

RESOURCES SCORE

FF	Index	.43
CR	Index	2.64
Total		3.07
		52 %

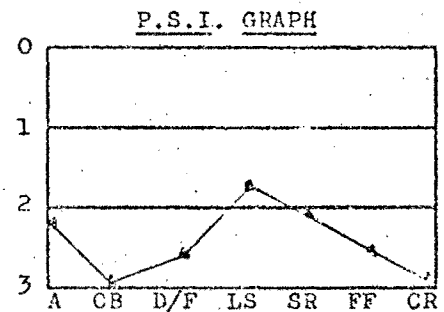
P.S.I. SCORE 44 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.22	22y.0m.	M	W	Jewish	Attends Univ.	Director in Industry
N.22	19y.9m.	M	W	Jewish	Attends Univ.	Traveller

PSYCHO-SOCIAL INDEX

Normal Case Number 22

SCORES			
	Raw	Index	
ADJUSTMENT.	23	2.30	
CONDITION AT BIRTH.	9	3.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	22	2.75	
Behavioural	10	3.00	
Intellectual	19	2.85	
Emotional	12	2.11	
Social	13	2.30	
Total	73	2.61	
LACK OF STRESS EXPERIENCES. . .	13	1.77	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	13	2.17	
Father/Client	13	2.17	
Others/Client	8	1.84	
Total	34	2.08	
CURRENT FAMILY FUNCTIONING. . .	31	2.58	
COMMUNITY RESOURCES	11	3.00	
Total Index Score	17.34		



DIAGNOSTIC SCORE

A	Index	2.30
CB	Index	3.00
D/F	Index	2.61
LS	Index	1.77
SR	Index	2.03
FF	Index	2.58
Total		14.34
		80 %

RESOURCES SCORE

FF	Index	2.58
CR	Index	3.00
Total		5.58
		93 %

P.S.I. SCORE 83 %

A.22 and N.22

In the abnormal case, the Diagnostic Score reads as 36% and, in the normal case, it reads as 80%.

In both the normal and abnormal cases, the persons concerned are only children. In the mother-child relationship per se, the normal case reflects a much better score of 2.17 than the abnormal case (0.67).

Qualitatively, the main problem with the abnormal case is that the mother was over-involved with her son emotionally, almost to the point of substituting this relationship for her marital one. She leant on him for care and support, especially in her conflicts with her husband. This siding with mother worsens an already estranged Father/Client Relationship (0.50). The father has always had poor communication with his family, both emotionally and verbally, and remains aloof.

Stress in the home is reflected in the Current Family Functioning score of 0.43, while Stress score reads as 0.41 (which reflects the more personal amount of stress this client encounters).

In the normal case, in which the mother received support from her husband, she did not have to turn to her son for aid as her dependency needs were already satisfactorily met. Further, this left her free to support him. She has been able to take much better care of her son, resulting in healthier personality development. The father, too, had a positive relationship with the child

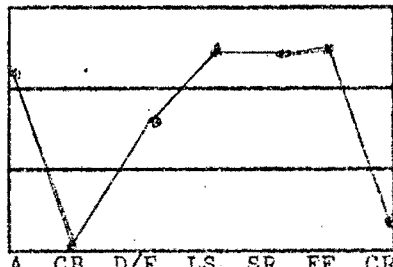
and cooperated with the mother in the child's care and upbringing.

The happier family climate is reflected in the Current Family Functioning score of 2.58, and the personal functioning of the client is shown in the Stress score of 1.77.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 23

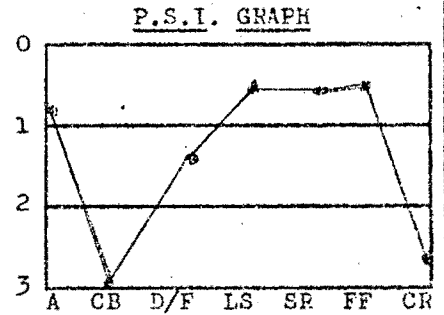
			SCORES			
			Raw	Index		
ADJUSTMENT.			8	.80		
CONDITION AT BIRTH.			9	3.00		
DEVELOPMENT/FUNCTIONING						
Sub-Scores						
Raw Index						
Physical	22	2.75				
Behavioural	3	2.40				
Intellectual	7	1.05				
Emotional	3	.53				
Social	2	.40				
Total	42		42	1.46		
LACK OF STRESS EXPERIENCES			4	.55		
SIGNIFICANT RELATIONSHIPS						
Sub-Scores						
Raw Index						
Mother/Client	4	.67				
Father/Client	4	.67				
Others/Client	1	.23				
Total	9		9	.55		
CURRENT FAMILY FUNCTIONING			3	.50		
COMMUNITY RESOURCES			10	2.73		
Total Index Score			9.59			

P.S.I. GRAPH	
0	
1	
2	
3	
A	
CB	
D/F	
LS	
SR	
FF	
CR	

DIAGNOSTIC SCORE	
A	Index .80
CB	Index 3.00
D/F	Index 1.46
LS	Index .55
SR	Index .55
FF	Index .50
Total	6.86 39 %

RESOURCES SCORE	
FF	Index .50
CR	Index 2.73
Total	3.23 53 %

P.S.I. SCORE	
46 %	



DIAGNOSTIC SCORE		
A	Index	.80
CB	Index	3.00
D/F	Index	1.46
LS	Index	.55
SR	Index	.55
FF	Index	.50
Total		6.86
		39 %

RESOURCES SCORE		
FF	Index	.50
CR	Index	2.73
Total		3.23
		53 %

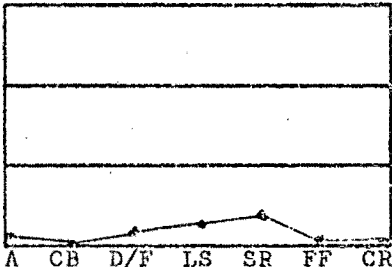
P.S.I. SCORE 46 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.23	22y.0m.	M	W	Protestant	Std. VI	Factory Worker
N.23	23y.0m.	M	W	Protestant	Std. X	Salesman

PSYCHO-SOCIAL INDEX

Normal Case Number 23

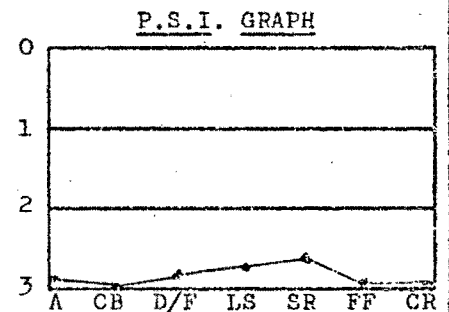
			SCORES			
			Raw	Index		
ADJUSTMENT.			29	2.90		
CONDITION AT BIRTH.			9	3.00		
DEVELOPMENT/FUNCTIONING						
	Sub-Scores					
	Raw	Index				
Physical	24	3.00				
Behavioural	9	2.70				
Intellectual	18	2.10				
Emotional	17	3.00				
Social	15	3.00				
Total	83		83	2.89		
LACK OF STRESS EXPERIENCES. . .			20	2.72		
SIGNIFICANT RELATIONSHIPS						
	Sub-Scores					
	Raw	Index				
Mother/Client	15	2.50				
Father/Client	16	2.67				
Others/Client	12	2.76				
Total	43		43	2.63		
CURRENT FAMILY FUNCTIONING. . .			36	3.00		
COMMUNITY RESOURCES.			11	3.00		
Total Index Score			20.14			

P.S.I. GRAPH	
0	
1	
2	
3	
	A CB D/F LS SR FF CR

DIAGNOSTIC SCORE	
A	Index 2.90
CB	Index 3.00
D/F	Index 2.89
LS	Index 2.72
SR	Index 2.63
FF	Index 3.00
Total	17.14
	96 %

RESOURCES SCORE	
FF	Index 3.00
CR	Index 3.00
Total	6.00
	100 %

P.S.I. SCORE	
	96 %



DIAGNOSTIC SCORE		
A	Index	2.90
CB	Index	3.00
D/F	Index	2.89
LS	Index	2.72
SR	Index	2.63
FF	Index	3.00
Total		17.14
		96 %

RESOURCES SCORE		
FF	Index	3.00
CR	Index	3.00
Total		6.00
		100 %

P.S.I. SCORE 96 %

A.23 and N.23

In the abnormal and normal cases, the Diagnostic Scores are 39% and 96% respectively.

The area of Significant Relationships reads as 0.55 for the abnormal and 2.63 for the normal.

The LCR for the abnormal case is 0.67, and for the normal case is 2.50.

Condition at Birth scores read as 3.00 for both cases.

From the above scores (since there are no congenital problems) it can be concluded that the environment, especially interpersonal relationships, have engendered stress in the abnormal case (Stress score, 0.55). The Stress score for N.23 is 2.72.

The family climate, too, in both cases reflects the degree of stress of the environment in that the abnormal case, with unhappily married parents, scored 0.50 for Current Family Functioning. In the normal case, where the parents were happily married, the Current Family Functioning score is rated as 3.00.

PSYCHO-SOCIAL INDEX

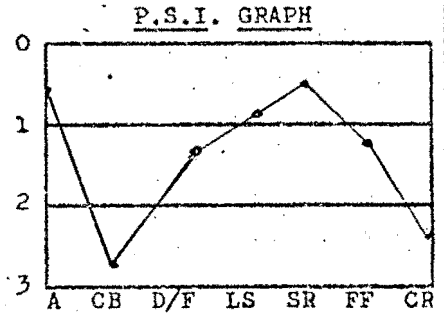
Abnormal Case Number 24

SCORES		
	Raw	Index
ADJUSTMENT.	5	.50
CONDITION AT BIRTH.	8	2.67
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	20	2.50
Behavioural	9	2.70
Intellectual	6	.90
Emotional	2	.35
Social	2	.40
Total	39	1.36
LACK OF STRESS EXPERIENCES. . .	7	.95
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	3	.50
Father/Client	3	.50
Others/Client	2	.46
Total	8	.49
CURRENT FAMILY FUNCTIONING. . .	16	1.33
COMMUNITY RESOURCES	9	2.46
Total Index Score		9.76

P.S.I. GRAPH

Category	Score (Index)
A	0.50
CB	2.67
D/F	1.36
LS	0.95
SR	0.49
FF	1.33
CR	2.46

DIAGNOSTIC SCORE		
A	Index	.50
CB	Index	2.67
D/F	Index	1.36
LS	Index	.95
SR	Index	.49
FF	Index	1.33
Total		7.30
		41 %
RESOURCES SCORE		
FF	Index	1.33
CR	Index	2.46
Total		3.79
		63 %
P.S.I. SCORE 47 %		



DIAGNOSTIC SCORE

A	Index	.50
CB	Index	2.67
D/F	Index	1.36
LS	Index	.95
SR	Index	.49
FF	Index	1.33
Total		7.30
		41 %

RESOURCES SCORE

FF	Index	1.33
CR	Index	2.46
Total		3.79
		63 %

P.S.I. SCORE 47 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.24	22y.0m.	F	W	Protestant	Univ. Graduate	Businessman
N.24	22y.11m.	F	W	Protestant	Post-Matric. Specialization	Lecturer

PSYCHO-SOCIAL INDEX

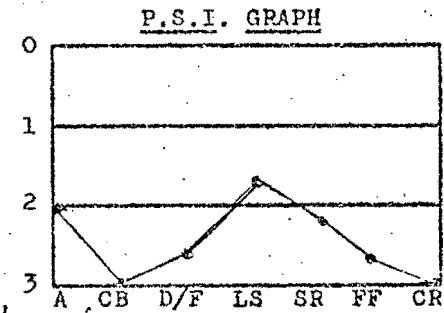
Normal Case Number 24

SCORES		
	Raw	Index
ADJUSTMENT.	20	2.00
CONDITION AT BIRTH.	9	3.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	23	2.68
Behavioural	9	2.70
Intellectual	13	2.70
Emotional	13	2.29
Social	11	2.20
Total	74	2.58
LACK OF STRESS EXPERIENCES. . .	13	1.77
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	14	2.33
Father/Client	12	2.00
Others/Client	9	2.07
Total	35	2.14
CURRENT FAMILY FUNCTIONING. . .	33	2.75
COMMUNITY RESOURCES	11	3.00
Total Index Score 17.24		

P.S.I. GRAPH

Category	Score
A	2.0
CB	3.0
D/F	2.6
LS	1.7
SR	2.7
FF	2.3
CR	3.0

DIAGNOSTIC SCORE		
A	Index	2.00
CB	Index	3.00
D/F	Index	2.58
LS	Index	1.77
SR	Index	2.14
FF	Index	2.75
Total		14.24
80 %		
RESOURCES SCORE		
FF	Index	2.75
CR	Index	3.00
Total		5.75
97 %		
P.S.I. SCORE 89 %		



DIAGNOSTIC SCORE

A	Index	2.00
CB	Index	3.00
D/F	Index	2.58
LS	Index	1.77
SR	Index	2.14
FF	Index	2.75
Total		14.24
		80 %

RESOURCES SCORE

FF	Index	2.75
CR	Index	3.00
Total		5.75
		97 %

P.S.I. SCORE 89 %

A.24 and N.24

The graphs of these two cases show contrasting patterns which reflect their respective levels of personality maturation and social functioning.

In the abnormal case, three of the graph points lie in the 0 - 1 zone, two lie in the 1 - 2 zone, and two of the remaining areas, namely Condition of Birth and Community Resources are plotted in the 2 - 3 zone.

In contrast, the normal case has six of its areas of functioning plotted in the 2 - 3 zone and only one in the 1 - 2 zone.

In a similar manner the peaks of the abnormal case stand much higher on the graph and those of the normal case much lower, showing lesser and greater degrees of normality for the respective cases.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 25

		SCORES			
		Raw	Index		
ADJUSTMENT.		7	.70	<u>P.S.I. GRAPH</u>	
CONDITION AT BIRTH.		9	3.00		
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw Index				
Physical	15	1.88			
Behavioural	9	2.70			
Intellectual	7	1.05			
Emotional	4	.71			
Social	4	.80			
Total	39		39	1.36	
LACK OF STRESS EXPERIENCES. . .		6	.82	<u>DIAGNOSTIC SCORE</u> A Index .70 CB Index 3.00 D/F Index 1.36 LS Index .82 SR Index .73 FF Index 1.14 Total 7.75 44 %	
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw Index				
Mother/Client	5	.83			
Father/Client	5	.83			
Others/Client	2	.46			
Total	12		12	.73	
CURRENT FAMILY FUNCTIONING. . .		8	1.14	<u>RESOURCES SCORE</u> FF Index 1.14 CR Index 2.64 Total 3.78 63 %	
COMMUNITY RESOURCES		8	2.64		
Total Index Score			10.39	<u>P.S.I. SCORE</u> 50 %	

	Age	Sex	Race	Religion	Education	Father's Occupation
A.25	58y.0m.	F	W	Protestant	Std. X	Manager
N.25	52y.0m.	F	W	Protestant	Std. IX	Business Representative

PSYCHO-SOCIAL INDEX

Normal Case Number 25

		SCORES			
		Raw	Index		
ADJUSTMENT.		22	2.20	<u>P.S.I. GRAPH</u>	
CONDITION AT BIRTH.		9	3.00		
DEVELOPMENT/FUNCTIONING					
	Sub-Scores				
	Raw Index				
Physical	24	3.00			
Behavioural	10	3.00			
Intellectual	20	3.00			
Emotional	16	2.82			
Social	13	2.60			
Total	83		83	2.89	
LACK OF STRESS EXPERIENCES. . .		16	2.18	<u>DIAGNOSTIC SCORE</u> A Index 2.20 CB Index 3.00 D/F Index 2.89 LS Index 2.18 SR Index 1.84 FF Index 1.83 Total 13.94 78 %	
SIGNIFICANT RELATIONSHIPS					
	Sub-Scores				
	Raw Index				
Mother/Client	15	2.50			
Father/Client	6	1.00			
Others/Client	2	.07			
Total	30		30	1.84	
CURRENT FAMILY FUNCTIONING. . .		22	1.83	<u>RESOURCES SCORE</u> FF Index 1.83 CR Index 3.00 Total 4.83 80 %	
COMMUNITY RESOURCES		11	3.00		
Total Index Score			16.94	<u>P.S.I. SCORE</u> 81 %	

A.25 and N.25

The graphs for both these cases clearly reflect their levels of personality maturation. The normal case, with a generally low-lying graph, scored a Diagnostic Score of 78%. The abnormal case, with predominantly higher points indicating overall low scores for all the areas of functioning the Psycho-Social Index attempted to measure, had a final Diagnostic Score of 44%.

Both the normal and abnormal individuals began life with similar congenital capacities which is reflected in their Condition at Birth score of 3.00. From this fact it can be concluded that the environmental circumstances under which these two persons were reared contributed to their differing personality patterns.

The area of Stress, in which the normal case scored 2.18 and the abnormal case 0.82, shows the different levels of frustration they encountered individually. In the abnormal case, this stress (judging from the scores) must have chiefly arisen in the area of interpersonal relationships as the Mother/Client Relationship score reads as 0.83, the Father/Client Relationship as 0.83, and the Others/Client Relationship as 0.46.

Unhealthy personality development seems to have affected her Intellectual, Emotional, and Social functioning which fact is reflected in her scores of 1.05, 0.71, and 0.80 respectively.

The functioning of the normal client who experienced far less stress in her upbringing (Stress 2.18) was at a much higher level

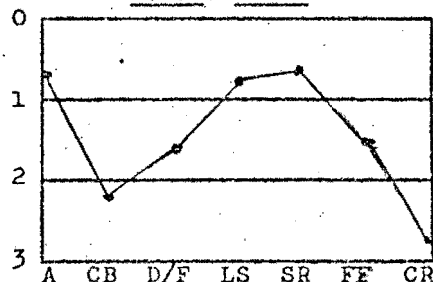
which is reflected in higher scores for the relevant areas. These areas are Intellectual, Social, and Emotional functioning which read as 3.00, 2.00, and 2.82, respectively.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 26

SCORES			
	Raw	Index	
ADJUSTMENT.	6	.60	
CONDITION AT BIRTH.	7	2.33	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw Index		
Physical	17 2.13		
Behavioural	8 2.40		
Intellectual	10 1.50		
Emotional	6 1.06		
Social	5 1.00		
Total	46	46	1.60
LACK OF STRESS EXPERIENCES.	6	.82	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw Index		
Mother/Client	4 .67		
Father/Client	6 1.00		
Others/Client	3 .69		
Total	13	13	.80
CURRENT FAMILY FUNCTIONING.	18	1.50	
COMMUNITY RESOURCES	10	2.73	
Total Index Score		10.38	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	.60
CB	Index	2.33
D/F	Index	1.60
LS	Index	.82
SR	Index	.80
FF	Index	1.50
Total		7.65
		43 %

RESOURCES SCORE

FF	Index	1.50
CR	Index	2.73
Total		4.23
		70 %

P.S.I. SCORE 50 %

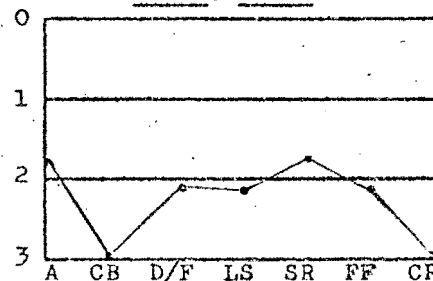
	Age	Sex	Race	Religion	Education	Father's Occupation
A.26	23y.0m.	F	W	Protestant	Univ. Graduate	Architect
N.26	24y.0m.	F	W	Jewish	Univ. Graduate	University Professor

PSYCHO-SOCIAL INDEX

Normal Case Number 26

SCORES			
	Raw	Index	
ADJUSTMENT.	28	2.80	
CONDITION AT BIRTH.	9	3.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw Index		
Physical	23 2.83		
Behavioural	10 3.00		
Intellectual	20 3.00		
Emotional	17 3.00		
Social	15 3.00		
Total	85	85	2.96
LACK OF STRESS EXPERIENCES.	18	2.45	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw Index		
Mother/Client	16 2.67		
Father/Client	16 2.67		
Others/Client	7 1.61		
Total	39	39	2.39
CURRENT FAMILY FUNCTIONING.	36	3.00	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		19.60	

P.S.I. GRAPH



DIAGNOSTIC SCORE

A	Index	2.80
CB	Index	3.00
D/F	Index	2.96
LS	Index	2.45
SR	Index	2.39
FF	Index	3.00
Total		16.60
		93 %

RESOURCES SCORE

FF	Index	3.00
CR	Index	3.00
Total		6.00
		100 %

P.S.I. SCORE 94 %

A.26 and N.26

The client in the abnormal case is a professional person and has been 'matched' with a normal professional person of similar age and socio-economic background.

The parents of both individuals are professional people, the mother and father of the abnormal client being a physician and an architect respectively. The mother and father of the normal case are a university lecturer and a university professor respectively.

The MCR in the abnormal case reads as 0.67, and that of the normal case as 2.67. A factor that worsens an already strained relationship between the abnormal mother and daughter is the poor marital relationship she has with her husband which causes additional stress in the environment.

In the normal case, in addition to a healthy mother-child bond, a harmonious atmosphere exists in the home which aids in promoting mental health.

Despite the intellectual abilities of all the individuals (both sets of parents and the clients -- the normal one being a university lecturer and the abnormal one being a social worker), they seem to have different emotional capacities which influence their overall social functioning. In the normal case, the mother is a warm, flexible, loving and giving person, whereas the abnormal mother can be described as an overly intellectual, abrupt, and un giving person.

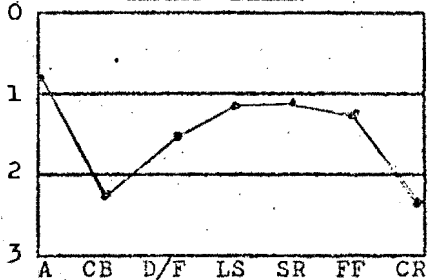
It is these respective characteristics of both mothers that have contributed to the emotional health of the normal case and the lack of health in the abnormal case.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 27

				<u>SCORES</u>			
				Raw	Index		
<u>ADJUSTMENT</u>				<u>7</u>	<u>.70</u>		
<u>CONDITION AT BIRTH</u>				<u>7</u>	<u>2.33</u>		
<u>DEVELOPMENT/FUNCTIONING</u>							
				<u>Sub-Scores</u>			
				Raw	Index		
Physical	<u>21</u>	<u>2.63</u>					
Behavioural	<u>5</u>	<u>1.50</u>					
Intellectual	<u>9</u>	<u>1.35</u>					
Emotional	<u>3</u>	<u>.53</u>					
Social	<u>4</u>	<u>.92</u>					
Total	<u>42</u>	<u>1.50</u>		<u>42</u>	<u>1.50</u>		
<u>LACK OF STRESS EXPERIENCES</u> . . .				<u>9</u>	<u>1.22</u>		
<u>SIGNIFICANT RELATIONSHIPS</u>							
				<u>Sub-Scores</u>			
				Raw	Index		
Mother/Client	<u>6</u>	<u>1.00</u>					
Father/Client	<u>7</u>	<u>1.17</u>					
Others/Client	<u>6</u>	<u>1.38</u>					
Total	<u>19</u>	<u>1.16</u>		<u>19</u>	<u>1.16</u>		
<u>CURRENT FAMILY FUNCTIONING</u> . . .				<u>15</u>	<u>1.25</u>		
<u>COMMUNITY RESOURCES</u>				<u>9</u>	<u>2.46</u>		
Total Index Score					<u>10.62</u>		

P.S.I. GRAPH



A	CB	D/F	LS	SR	FF	CR
1.70	2.33	1.50	1.32	1.16	1.25	2.46

<u>DIAGNOSTIC SCORE</u>			
A	Index	<u>.70</u>	
CB	Index	<u>2.33</u>	
D/F	Index	<u>1.50</u>	
LS	Index	<u>1.32</u>	
SR	Index	<u>1.16</u>	
FF	Index	<u>1.25</u>	
Total		<u>8.16</u>	<u>46 %</u>
<u>RESOURCES SCORE</u>			
FF	Index	<u>1.25</u>	
CR	Index	<u>2.46</u>	
Total		<u>3.71</u>	<u>62 %</u>
<u>P.S.I. SCORE</u> <u>51 %</u>			

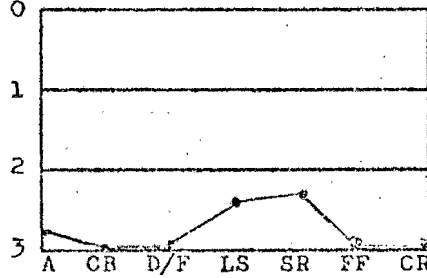
	Age	Sex	Race	Religion	Education	Father's Occupation
A.27	12y.7m.	M	W	Jewish	Std. V	Barrister
N.27	12y.9m.	M	W	Jewish	Std. VI	Director

PSYCHO-SOCIAL INDEX

Normal Case Number 27

<u>SCORES</u>			
	Raw	Index	
<u>ADJUSTMENT</u>	<u>17</u>	<u>1.70</u>	
<u>CONDITION AT BIRTH</u>	<u>9</u>	<u>3.00</u>	
<u>DEVELOPMENT/FUNCTIONING</u>			
	<u>Sub-Scores</u>		
	Raw	Index	
Physical	<u>24</u>	<u>3.00</u>	
Behavioural	<u>10</u>	<u>3.00</u>	
Intellectual	<u>12</u>	<u>1.80</u>	
Emotional	<u>7</u>	<u>1.23</u>	
Social	<u>6</u>	<u>1.38</u>	
Total	<u>59</u>	<u>59</u>	<u>2.11</u>
<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>16</u>	<u>2.18</u>	
<u>SIGNIFICANT RELATIONSHIPS</u>			
	<u>Sub-Scores</u>		
	Raw	Index	
Mother/Client	<u>11</u>	<u>1.83</u>	
Father/Client	<u>13</u>	<u>2.17</u>	
Others/Client	<u>5</u>	<u>1.15</u>	
Total	<u>29</u>	<u>29</u>	<u>1.77</u>
<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>27</u>	<u>2.25</u>	
<u>COMMUNITY RESOURCES</u>	<u>11</u>	<u>3.00</u>	
Total Index Score		<u>16.01</u>	

P.S.I. GRAPH



A	CB	D/F	LS	SR	FF	CR
1.70	3.00	2.11	2.18	1.77	2.25	3.00

<u>DIAGNOSTIC SCORE</u>		
A	Index <u>1.70</u>	
CB	Index <u>3.00</u>	
D/F	Index <u>2.11</u>	
LS	Index <u>2.18</u>	
SR	Index <u>1.77</u>	
FF	Index <u>2.25</u>	
Total	<u>13.01</u>	<u>73 %</u>
<u>RESOURCES SCORE</u>		
FF	Index <u>2.25</u>	
CR	Index <u>3.00</u>	
Total	<u>5.25</u>	<u>88 %</u>
<u>P.S.I. SCORE</u>		<u>77 %</u>

A.27 and N.27

In the abnormal case, the child under discussion is the only child. Being an only child has disadvantages, one of these being that some mothers tend to become over-involved in the care of the child and the child, in turn, having no siblings to play with, tends to limit his interaction to his parents.

In the abnormal case the above explanation seems to have applied to a pathological degree. This mother was anxious to bring up her child in the best possible manner. As a result of this, she became controlling of every aspect of his life. She left very little opportunity and time for the child to experiment, experience, and learn on his own. The situation was worsened by the fact that she did not have any other pastime (work or other children) to absorb her energy.

Her marital relationship with her husband, too, was a poor one and the child (spending so much of his time with them) invariably became involved in the cross currents underlying this marriage. The mother, being unable to have her dependency needs met in her marriage, turned to her son for fulfilment of these which caused further strain on him.

In the normal case, the patient had siblings which absorbed some of the mother's time and thereby helped in the wider and less intense distribution of her energy. Furthermore, she had a much better relationship with her husband which helped in fulfilling

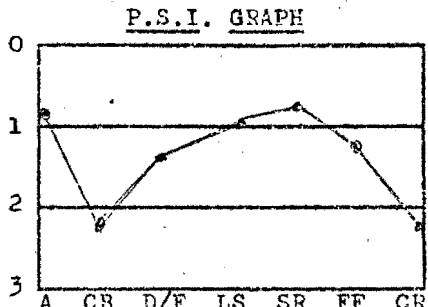
her emotional needs, instead of having to turn to her children for this support.

The Diagnostic Score of 46% for the abnormal case, as compared to the 73% of the normal case, shows the healthier adjustment of the latter.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 28

SCORES			
	Raw	Index	
ADJUSTMENT.	7	.78	
CONDITION AT BIRTH.	7	2.32	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	23	2.86	
Behavioural	6	2.00	
Intellectual	3	1.13	
Emotional	2	.85	
Social	1	.27	
Total	35	1.42	
LACK OF STRESS EXPERIENCES.	6	1.00	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	4	.67	
Father/Client	5	.83	
Others/Client	3	.75	
Total	12	.75	
CURRENT FAMILY FUNCTIONING.	16	1.33	
COMMUNITY RESOURCES	9	2.46	
Total Index Score		10.07	



DIAGNOSTIC SCORE	
A	Index .78
CB	Index 2.33
D/F	Index 1.42
LS	Index 1.00
SR	Index .75
FF	Index 1.33
Total	7.61 43 %

RESOURCES SCORE	
FF	Index 1.33
CR	Index 2.46
Total	3.79 63 %

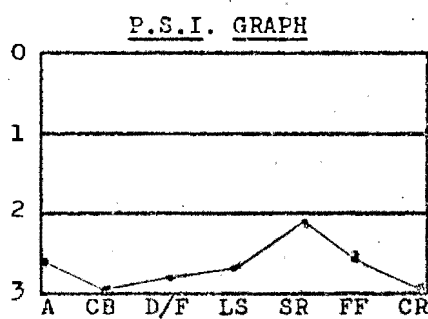
P.S.I. SCORE 48 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.28	3y.5m.	F	W	Protestant	Pre-school	Manager and skilled Mach-
N.28	5y.0m.	F	W	Protestant	Nursery	Int. Decorator /inist

PSYCHO-SOCIAL INDEX

Normal Case Number 28

SCORES			
	Raw	Index	
ADJUSTMENT.	24	2.67	
CONDITION AT BIRTH.	6	2.00	
DEVELOPMENT/FUNCTIONING			
	Sub-Scores		
	Raw	Index	
Physical	21	3.00	
Behavioural	6	3.00	
Intellectual	16	3.00	
Emotional	14	2.46	
Social	10	2.73	
Total	70	2.84	
LACK OF STRESS EXPERIENCES.	16	2.67	
SIGNIFICANT RELATIONSHIPS			
	Sub-Scores		
	Raw	Index	
Mother/Client	12	2.17	
Father/Client	11	1.83	
Others/Client	10	2.50	
Total	34	2.13	
CURRENT FAMILY FUNCTIONING.	31	2.58	
COMMUNITY RESOURCES	11	3.00	
Total Index Score		17.89	



DIAGNOSTIC SCORE	
A	Index 2.67
CB	Index 2.00
D/F	Index 2.34
LS	Index 2.67
SR	Index 2.13
FF	Index 2.58
Total	14.89 83 %

RESOURCES SCORE	
FF	Index 2.58
CR	Index 3.00
Total	5.58 93 %

P.S.I. SCORE 86 %

A.28 and N.28

The LCB score of the abnormal case reads as 0.07, as compared to that of the normal case which reads as 2.17. The Diagnostic Scores, too, show a concomitant difference in that the former case scored 43% and the latter 83%.

The mother of the abnormal case can be described as a tense, over-anxious person who perpetually worries about 'something' happening to her child. As a result of this, she continually and unnecessarily interferes in every aspect of the child's life (play, feeding, washing, etc.) to a pathological degree in order to 'protect' her.

She has obsessive qualities, too, in that she expects her child not, under any circumstances, to soil herself and is always morbidly conscious of germs and infection. She bathes, cleans, and disinfects her child more often than is needed.

The child seems to have internalized much of her mother's pathological behaviour in that she, too, is tense and anxious and attempts to dissipate some of this anxiety through frequent masturbation. Masturbation has become a severe symptom and has taken on such proportions that she privately and 'publicly' not only interferes with her genital organs but also rocks her pelvis to and fro. She also engages in ritual handwashing, has temper tantrums, and finds difficulty in separating from her mother.

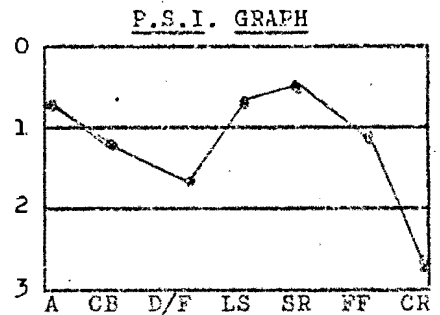
In contrast, the mother of the normal case, in addition to allowing the child a certain amount of freedom within the bonds of protectiveness, is not unduly concerned about the care of her child and consequently does not interfere in every facet of its life.

A healthier emotional life with a healthy mother seems to have provided a much better climate for the unfolding of the child's developmental capacities for which the total Index Score reads as 2.84, as compared to the 1.42 of the abnormal case.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 29

			<u>SCORES</u>			
			Raw	Index		
<u>ADJUSTMENT.</u>			6	.60		
<u>CONDITION AT BIRTH.</u>			4	1.33		
<u>DEVELOPMENT/FUNCTIONING</u>			<u>Sub-Scores</u>			
			Raw	Index		
Physical	23	2.88				
Behavioural	6	1.80				
Intellectual	11	1.65				
Emotional	5	.88				
Social	2	.46				
Total	47		47	1.08		
<u>LACK OF STRESS EXPERIENCES.</u>			5	.68		
<u>SIGNIFICANT RELATIONSHIPS</u>			<u>Sub-scores</u>			
			Raw	Index		
Mother/Client	3	.50				
Father/Client	3	.50				
Others/Client	2	.46				
Total	8		8	.49		
<u>CURRENT FAMILY FUNCTIONING.</u>			13	1.08		
<u>COMMUNITY RESOURCES</u>			10	2.73		
Total Index Score				8.59		

DIAGNOSTIC SCORE

A	Index	.80	
CB	Index	1.33	
D/F	Index	1.68	
LS	Index	.68	
SR	Index	.49	
FF	Index	1.08	
Total		5.86	33 %

RESOURCES SCORE

FF	Index	1.08	
CR	Index	2.73	
Total		3.81	63 %

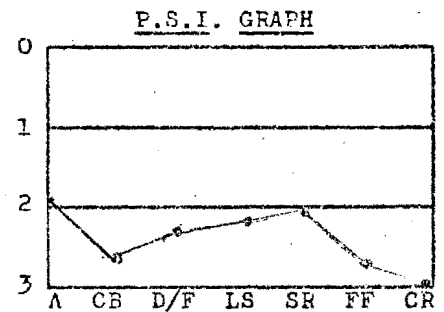
P.S.I. SCORE 41 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.29	13y.11m.	M	W	Protestant	Std. V	Buyer for electrical firm
N.29	14y. 0m.	M	W	Protestant	Std. VI	Supervisor at Post Office

PSYCHO-SOCIAL INDEX

Normal Case Number 29

			<u>SCORES</u>			
			Raw	Index		
<u>ADJUSTMENT.</u>			19	1.90		
<u>CONDITION AT BIRTH.</u>			8	2.67		
<u>DEVELOPMENT/FUNCTIONING</u>			<u>Sub-Scores</u>			
			Raw	Index		
Physical	22	2.75				
Behavioural	9	2.70				
Intellectual	17	2.55				
Emotional	8	1.41				
Social	11	2.52				
Total	67		67	2.39		
<u>LACK OF STRESS EXPERIENCES.</u>			17	2.31		
<u>SIGNIFICANT RELATIONSHIPS</u>			<u>Sub-Scores</u>			
			Raw	Index		
Mother/Client	12	2.17				
Father/Client	13	2.17				
Others/Client	8	1.84				
Total	34		34	2.08		
<u>CURRENT FAMILY FUNCTIONING.</u>			33	2.75		
<u>COMMUNITY RESOURCES</u>			11	3.00		
Total Index Score				17.10		

DIAGNOSTIC SCORE

A	Index	1.90	
CB	Index	2.67	
D/F	Index	2.39	
LS	Index	2.31	
SR	Index	2.08	
FF	Index	2.75	
Total		14.10	79 %

RESOURCES SCORE

FF	Index	2.75	
CR	Index	3.00	
Total		5.75	97 %

P.S.I. SCORE 83 %

A.29 and N.20

The abnormal patient scored a Diagnostic Score of 33% as compared to the normal patient who scored 79%.

The MCR of these cases differed vastly, in that the normal case scored 2.17 and the abnormal case scored 0.50. The qualitative differences in the mothers seem to lie in their varying capacities to give to their children emotionally. The normal mother seems to have far more ego strength and a capacity to give affection to her child. The abnormal mother had less capacity to do this due to her own personality problems which stunted her ability to care for her child adequately. Her personality problems are reflected in her feelings of low self-esteem and the fact that she remains isolated from friends in the neighbourhood. She seems to have a problem of relating to people in general which has been carried over from her childhood and has consequently affected her relationship with her children too.

Feelings of low esteem and an inability to relate to people are patterns which have also developed in the patient. He also has a very poor relationship with his father too (FCR, 0.50). This generally withdrawn child seems to be able "to relate better to pets than to people". A possible reason for this is that he has not learnt how to relate positively to people at home; furthermore, these primary relationships held little reward for the child and were more painful than pleasurable. As a result, in order to prevent himself from being further hurt, he has withdrawn

from all human contact.

In the normal case, the child seems to have had much better relationships with both his parents with whom he has had much warm emotional contact. The score for both these relationships is 2.17, as compared to the 0.50 (for both mother- and father-child relationships) in the abnormal case.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 30

SCORES

	Raw	Index
<u>ADJUSTMENT.</u>	<u>8</u>	<u>.83</u>
<u>CONDITION AT BIRTH.</u>	<u>8</u>	<u>2.67</u>

DEVELOPMENT/FUNCTIONING

	<u>Sub-Scores</u>			
	<u>Raw</u>	<u>Index</u>		
Physical	16	2.29		
Behavioural	7	2.10		
Intellectual	8	1.20		
Emotional	6	1.06		
Social	3	.82		
Total	40		40	1.52

<u>LACK OF STRESS EXPERIENCES. . .</u>	<u>11</u>	<u>1.74</u>

SIGNIFICANT RELATIONSHIPS

	<u>Sub-Scores</u>			
	<u>Raw</u>	<u>Index</u>		
Mother/Client	4	.67		
Father/Client	6	1.00		
Others/Client	7	1.61		
Total	17		17	1.04

<u>CURRENT FAMILY FUNCTIONING. . .</u>	<u>24</u>	<u>2.00</u>

<u>COMMUNITY RESOURCES</u>	<u>9</u>	<u>2.46</u>

Total Index Score	12.26

P.S.I. GRAPH

Category	Score
A	1.83
CB	2.67
D/F	1.52
LS	1.74
SR	1.04
FF	2.00
CR	2.46

DIAGNOSTIC SCORE

A	Index	.83
CB	Index	2.67
D/F	Index	1.52
LS	Index	1.74
SR	Index	1.04
FF	Index	2.00
Total		9.80

55 %

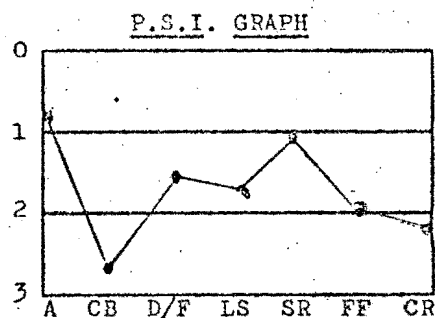
RESOURCES SCORE

FF	Index	2.00
CR	Index	2.46
Total		4.46

75 %

P.S.I. SCORE

59 %



DIAGNOSTIC SCORE	
A	Index .83
CB	Index 2.67
D/F	Index 1.52
LS	Index 1.74
SR	Index 1.04
FF	Index 2.00
Total	9.80 55 %

RESOURCES SCORE	
FF	Index 2.00
CR	Index 2.46
Total	4.46 75 %

P.S.I. SCORE 59 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.30	8y.0m.	M	W	Protestant	Std. I	Industrial Engineer
N.30	9y.7m.	M	W	Protestant	Std. II	Fitter and Turner

PSYCHO-SOCIAL INDEX

Normal Case Number 30

Normal Case Number 00

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>20</u>	<u>2.07</u>
<u>CONDITION AT BIRTH</u>	<u>9</u>	<u>3.00</u>
<u>DEVELOPMENT/FUNCTIONING</u>		
	Sub-Scores	
	Raw Index	
Physical	20 2.86	
Behavioural	8 2.40	
Intellectual	18 2.70	
Emotional	14 2.11	
Social	10 2.73	
Total	70	70 2.66
<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>14</u>	<u>2.21</u>
<u>SIGNIFICANT RELATIONSHIPS</u>		
	Sub-Scores	
	Raw Index	
Mother/Client	13 2.17	
Father/Client	10 1.67	
Others/Client	13 3.00	
Total	36	36 2.20
<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>33</u>	<u>2.75</u>
<u>COMMUNITY RESOURCES</u>	<u>11</u>	<u>3.00</u>
Total Index Score		17.89

P.S.I. GRAPH

Category	Score
A	2.07
CB	3.00
D/F	2.66
LS	2.21
SR	2.20
FF	2.75
CR	14.89

DIAGNOSTIC SCORE

A	Index	2.07
CB	Index	3.00
D/F	Index	2.66
LS	Index	2.21
SR	Index	2.20
FF	Index	2.75
Total		14.89

23 %

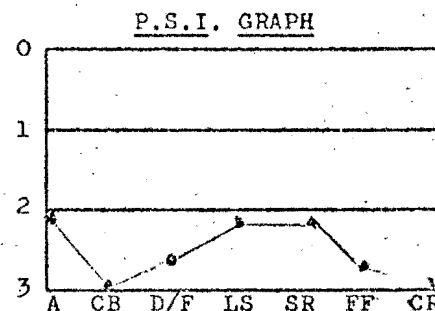
RESOURCES SCORE

FF	Index	2.75
CR	Index	3.00
Total		5.75

97 %

P.S.I. SCORE

86 %



DIAGNOSTIC SCORE	
A	Index 2.07
CB	Index 3.00
D/F	Index 2.66
LS	Index 2.21
SR	Index 2.20
FF	Index 2.75
Total	14.89 85 %

RESOURCES SCORE	
FF	Index 2.75
CR	Index 3.00
Total	5.75 97 %

P.S.I. SCORE 86 %

A.30 and N.30

The Diagnostic Score of the abnormal case reads as 55%, as compared to the normal case which reads as 83%.

The normal client, with greater personality maturation, scored higher for the Mother/Client Relationship (2.17), whereas the abnormal case, with poorer personality maturation, scored lower for the same area (0.67). The overall scores for Significant Relationships, too, seem to follow a similar pattern with the normal case scoring 2.20 and the abnormal 1.04. Healthier relationships with people in the environment allows the child to develop with less stress, in the environment. This fact is seen in the Stress score (2.21) in the normal case; the opposite holds true for the abnormal case who scored 1.74 for Stress.

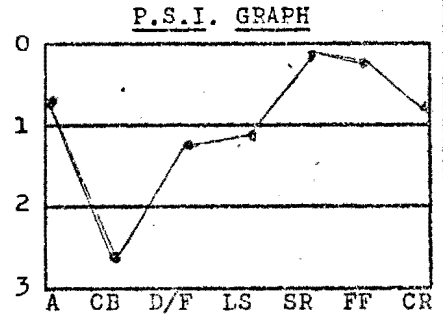
In the abnormal case, the mother-child relationship was considered unhealthy because of the mother's attitude toward child-rearing. She herself was brought up very strictly by her own mother and, as a reaction to this, was very lenient in her attitude towards her son. She did not set proper disciplinary limits for him. The child was left to his own devices, without much guidance and control, and consequently became disorganized in thought and activity. Too much responsibility at too early an age in being self-directing made him aimless and unable to guide his own energy constructively. This is reflected in the child's chief problem of having very little drive for goal-achievement and in finding difficulty in motivating himself to undertake and complete tasks.

assigned to him. This has affected his school progress and his ability to do things for himself at home.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 31

			<u>SCORES</u>			
			Raw	Index		
<u>ADJUSTMENT.</u>			7	.70		
<u>CONDITION AT BIRTH.</u>			8	2.67		
<u>DEVELOPMENT/FUNCTIONING</u>						
	<u>Sub-Scores</u>					
	Raw	Index				
Physical	21	2.63				
Behavioural	8	2.40				
Intellectual	6	.90				
Emotional	5	.88				
Social	1	.23				
Total	41		41	1.46		
<u>LACK OF STRESS EXPERIENCES.</u>			8	1.09		
<u>SIGNIFICANT RELATIONSHIPS</u>						
	<u>Sub-Scores</u>					
	Raw	Index				
Mother/Client	1	.17				
Father/Client	0	0				
Others/Client	1	.23				
Total	2		2	.12		
<u>CURRENT FAMILY FUNCTIONING.</u>			4	.93		
<u>COMMUNITY RESOURCES</u>			3	.82		
Total Index Score				7.19		

DIAGNOSTIC SCORE

A	Index	.70
CB	Index	2.67
D/F	Index	1.46
LS	Index	1.09
SR	Index	.12
FF	Index	.33
Total		6.37
		36 %

RESOURCES SCORE

FF	Index	.33
CR	Index	.82
Total		1.15
		20 %

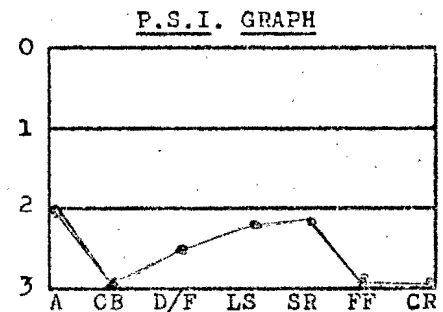
P.S.I. SCORE 35 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.31	14y.0m.	M	C	Protestant	Std. V.	Unknown
N.31	11y.0m.	M	C	Catholic	Std. III	Sales Clerk

PSYCHO-SOCIAL INDEX

Normal Case Number 31

			<u>SCORES</u>			
			Raw	Index		
<u>ADJUSTMENT.</u>			20	2.00		
<u>CONDITION AT BIRTH.</u>			9	3.00		
<u>DEVELOPMENT/FUNCTIONING</u>						
	<u>Sub-Scores</u>					
	Raw	Index				
Physical	24	3.00				
Behavioural	8	2.40				
Intellectual	19	2.86				
Emotional	10	1.76				
Social	8	2.07				
Total	70		70	2.50		
<u>LACK OF STRESS EXPERIENCES.</u>			17	2.31		
<u>SIGNIFICANT RELATIONSHIPS</u>						
	<u>Sub-Scores</u>					
	Raw	Index				
Mother/Client	15	2.50				
Father/Client	15	2.50				
Others/Client	7	1.61				
Total	37		37	2.26		
<u>CURRENT FAMILY FUNCTIONING.</u>			36	3.00		
<u>COMMUNITY RESOURCES</u>			11	3.00		
Total Index Score				18.07		

DIAGNOSTIC SCORE

A	Index	2.00
CB	Index	3.00
D/F	Index	2.50
LS	Index	2.31
SR	Index	2.26
FF	Index	3.00
Total		15.07
		85 %

RESOURCES SCORE

FF	Index	3.00
CR	Index	3.00
Total		6.00
		100 %

P.S.I. SCORE 87 %

A.31 and N.31

In this abnormal case, the child was an illegitimate baby who was neither planned nor wanted. To worsen matters, the mother is highly religious and viewed the birth of her baby as a "grave sin". Invariably her perception of this child after its birth tended to be coloured with negative feelings, as she consequently viewed it almost as a repayment for her sins.

After its birth, the child was left in the care of a young emotionally deprived and incapable stepsister as the mother had to go out to work. The stepsister also had negative feelings about her mother's pregnancy and consequent birth of this child and reacted to her feelings by grossly maltreating the child.

The child has grown up to be an anxiety-ridden young man who finds difficulty in concentrating on the task at hand. He has failed at school several times. His mother, being religious, has set very high standards for him as far as general behaviour and social expectations are concerned. The child, having little ego capacity on account of his difficult upbringing on the one hand and high expectations on the other, finds difficulty in being stable as he continually feels a failure, no matter how hard he tries. Being illegitimate, he does not have any relationship with his father. Peer and sibling relationships, too, are poor.

The total score for Significant Relationships reads as 0.12 which is extremely low. He has a Diagnostic Score of 30%.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 32

SCORES

	Raw	Index
ADJUSTMENT.	7	.72
CONDITION AT BIRTH.	3	1.00

DEVELOPMENT/FUNCTIONING

	Sub-Scores			
	Raw	Index		
Physical	15	2.14		
Behavioural	1	.30		
Intellectual	3	.45		
Emotional	5	.88		
Social	1	.27		
Total	25		25	.95

LACK OF STRESS EXPERIENCES. . .	10	1.58

SIGNIFICANT RELATIONSHIPS

	Sub-Scores			
	Raw	Index		
Mother/Client	10	1.67		
Father/Client	12	2.00		
Others/Client	5	1.15		
Total	27		27	1.65

CURRENT FAMILY FUNCTIONING. . .	29	2.42

COMMUNITY RESOURCES	5	1.37

Total Index Score	9.69

P.S.I. GRAPH

Category	Score (Index)
A	0.72
CB	1.00
D/F	0.95
LS	1.58
SR	1.65
FF	2.42
CR	1.37

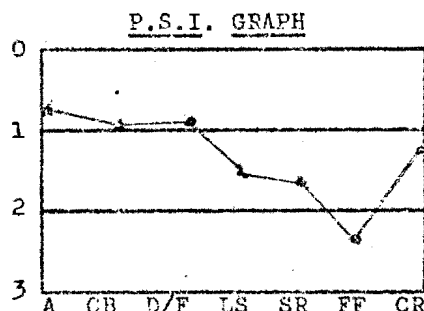
DIAGNOSTIC SCORE

A	Index	.72
CB	Index	1.00
D/F	Index	.95
LS	Index	1.58
SR	Index	1.65
FF	Index	2.42
Total		8.32
		46 %

RESOURCES SCORE

FF	Index	2.42
CR	Index	1.37
Total		3.79
		63 %

P.S.I. SCORE 47 %



DIAGNOSTIC SCORE	
A	Index .72
CB	Index 1.00
D/F	Index .95
LS	Index 1.58
SR	Index 1.65
FF	Index 2.42
Total	8.32 46 %

RESOURCES SCORE	
FF	Index 2.42
CR	Index 1.37
Total	3.79 63 %

P.S.I. SCORE 47 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.32	8y.2m.	M	C	Protestant	No schooling	Factory Worker
N.32	10y.5m.	M	C	Protestant	Std. III	Postman

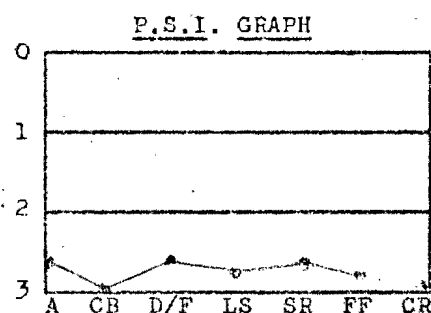
PSYCHO-SOCIAL INDEX

Normal Case Number 32

SCORES		
	Raw	Index
ADJUSTMENT.	25	2.58
CONDITION AT BIRTH.	9	3.00
DEVELOPMENT/FUNCTIONING		
	Sub-Scores	
	Raw	Index
Physical	21	3.00
Behavioural	19	2.00
Intellectual	19	2.85
Emotional	9	1.58
Social	9	2.46
Total	68	2.59
LACK OF STRESS EXPERIENCES. . .	18	2.84
SIGNIFICANT RELATIONSHIPS		
	Sub-Scores	
	Raw	Index
Mother/Client	17	2.83
Father/Client	17	2.83
Others/Client	3	2.07
Total	43	2.63
CURRENT FAMILY FUNCTIONING. . .	34	2.83
COMMUNITY RESOURCES	11	3.00
Total Index Score		19.47

P.S.I. GRAPH	
0	
1	
2	
3	
	A CB D/F LS SR FF CR

DIAGNOSTIC SCORE	
A	Index 2.58
CB	Index 3.00
D/F	Index 2.69
LS	Index 2.84
SR	Index 2.63
FF	Index 2.33
Total	16.47 92 %
RESOURCES SCORE	
FF	Index 2.33
CR	Index 3.00
Total	5.33 97 %
P.S.I. SCORE 94 %	



DIAGNOSTIC SCORE	
A	Index 2.58
CB	Index 3.00
D/F	Index 2.69
LS	Index 2.84
SR	Index 2.63
FF	Index 2.83
Total	16.47 92 %

RESOURCES SCORE	
FF	Index 2.83
CR	Index 3.00
Total	5.83 97 %

P.S.I. SCORE 94 %

A.32 and N.32

In the abnormal case, the child was referred to the Agency because of mental retardation. He was born with brain damage. It is this fact, rather than unhealthy mother-child relationship, which has caused abnormal personality development. His retardation has especially affected the areas of Adjustment (0.72) and Development/Functioning (0.95). His overall Diagnostic Score reads as 46%.

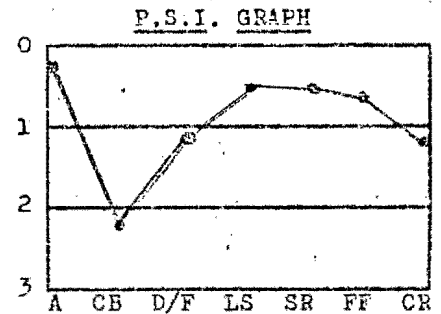
The normal case with normal Condition at Birth, had a Diagnostic Score of 92%. The MCR, too, was more favourable (2.83) than for the abnormal case (1.67). This could have been due to the normal mother being more motivated to interact on a healthy emotional level as she received better responses from her baby. In the abnormal case, however, the mother's concern for the child must have initially been more anxious than loving.

The abnormal mother, however, has tremendous ego strength in that she is taking care of the child at home (he is not institutionalized) and coping with her other children quite adequately. She has a good marital relationship with her husband which helps to support her in her difficult role.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 33

<u>SCORES</u>		
	Raw	Index
<u>ADJUSTMENT.</u>	4	.40
<u>CONDITION AT BIRTH.</u>	7	2.33
<u>DEVELOPMENT/FUNCTIONING</u>		
	<u>Sub-Scores</u>	
	Raw	Index
Physical	17	2.13
Behavioural	3	.90
Intellectual	10	1.50
Emotional	4	.71
Social	3	.69
Total	37	1.32
<u>LACK OF STRESS EXPERIENCES.</u>	4	.55
<u>SIGNIFICANT RELATIONSHIPS</u>		
	<u>Sub-Scores</u>	
	Raw	Index
Mother/Client	3	.50
Father/Client	2	.50
Others/Client	3	.69
Total	9	.55
<u>CURRENT FAMILY FUNCTIONING.</u>	8	.67
<u>COMMUNITY RESOURCES</u>	5	1.37
Total Index Score	7.19	



<u>DIAGNOSTIC SCORE</u>		
A	Index	.40
CB	Index	2.33
D/F	Index	1.32
LS	Index	.55
SR	Index	.55
FF	Index	.67
Total		5.82
		32 %

<u>RESOURCES SCORE</u>		
FF	Index	.67
CR	Index	1.37
Total		2.04
		33 %

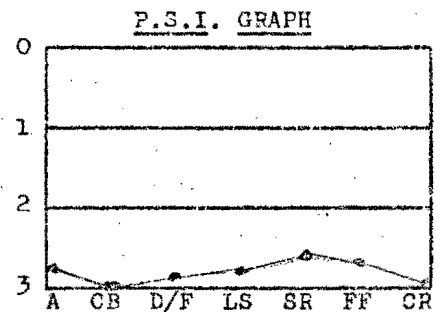
P.S.I. SCORE 35 %

	Age	Sex	Race	Religion	Education	Father's Occupation
A.33	17y.8m.	F	W	Protestant	Std. X	Farmer
N.33	15y.2m.	F	W	Protestant	Std. VIII	Station Foreman

PSYCHO-SOCIAL INDEX

Normal Case Number 33

<u>SCORES</u>		
	Raw	Index
<u>ADJUSTMENT.</u>	27	2.70
<u>CONDITION AT BIRTH.</u>	9	3.00
<u>DEVELOPMENT/FUNCTIONING</u>		
	<u>Sub-Scores</u>	
	Raw	Index
Physical	24	3.00
Behavioural	10	3.00
Intellectual	20	3.00
Emotional	15	2.64
Social	15	3.00
Total	82	2.93
<u>LACK OF STRESS EXPERIENCES.</u>	20	2.72
<u>SIGNIFICANT RELATIONSHIPS</u>		
	<u>Sub-Scores</u>	
	Raw	Index
Mother/Client	16	2.67
Father/Client	14	2.33
Others/Client	12	2.76
Total	42	2.57
<u>CURRENT FAMILY FUNCTIONING.</u>	32	2.67
<u>COMMUNITY RESOURCES</u>	11	3.00
Total Index Score	19.59	



<u>DIAGNOSTIC SCORE</u>		
A	Index	2.70
CB	Index	3.00
D/F	Index	2.93
LS	Index	2.72
SR	Index	2.57
FF	Index	2.67
Total		16.59
		93 %

<u>RESOURCES SCORE</u>		
FF	Index	2.67
CR	Index	3.00
Total		5.67
		95 %

P.S.I. SCORE 94 %

A.33 and N.33

The normal case scored 93% for overall personality maturation and the abnormal case scored 32%.

In the abnormal case, the area of Significant Relationships shows a very low score, 0.55, as compared to the normal case, 2.57.

The Mother/Client Relationship likewise showed a corresponding low score (0.50) for the abnormal client and, in the normal case, a corresponding increase (2.67).

In the abnormal case there were no specific severe Physical or Condition at Birth problems which could have caused retardation of personality growth, as these scores read as 2.13 and 2.33 respectively.

The only conclusive causative factor left is the area of Significant Relationships, and more specifically the Mother/Client Relationship as the mother is the person with whom the child interacted most during his early impressionable years.

A further analysis of the Mother/Client Relationship from the S.M.E. Summary Sheets shows that the mother was chronically depressed. This depression came on two months before the birth of this baby. The mother is a very religious, strict and rigid person.

The patient, being the eldest, had to attend to her sick mother

in addition to caring for her younger siblings.

One can question the amount of emotional sustenance she received for herself from her mother; especially since some of the characteristics of depressed people are withdrawal, uninvolvement with outside interests, passivity, and a lack of capacity for warm emotional interaction.

The client has now also become depressed, unmotivated, and has developed suicidal tendencies.

One can see that not only had she introjected her mother's behaviour, but that she also lacks the capacity to change this behaviour on account of lack of ego strength which comes about through emotional deprivation.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 34

SCORES

	Raw	Index
<u>ADJUSTMENT</u>	<u>11</u>	<u>1.14</u>
<u>CONDITION AT BIRTH</u>	<u>9</u>	<u>3.00</u>

DEVELOPMENT/FUNCTIONING

	Sub-Scores			
	Raw	Index		
Physical	20	2.86		
Behavioural	9	2.70		
Intellectual	3	1.20		
Emotional	5	.88		
Social	1	.27		
Total	43		43	1.64

<u>LACK OF STRESS EXPERIENCES</u> . . .	<u>3</u>	<u>1.26</u>

SIGNIFICANT RELATIONSHIPS

	Sub-Scores			
	Raw	Index		
Mother/Client	5	.83		
Father/Client	4	.67		
Others/Client	2	.49		
Total	11		11	.67

<u>CURRENT FAMILY FUNCTIONING</u> . . .	<u>12</u>	<u>1.00</u>

<u>COMMUNITY RESOURCES</u>	<u>7</u>	<u>1.91</u>

Total Index Score 10.62

P.S.I. GRAPH

Category	Score
A	1.14
CB	3.00
D/F	1.64
LS	1.26
SR	.67
FF	1.00
CR	8.71

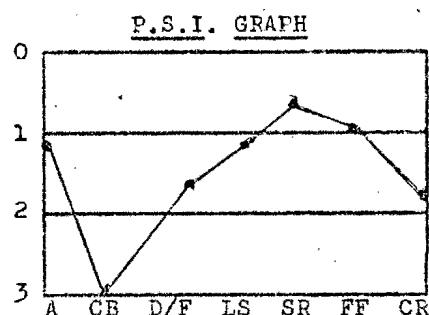
DIAGNOSTIC SCORE

A	Index	<u>1.14</u>	
CB	Index	<u>3.00</u>	
D/F	Index	<u>1.64</u>	
LS	Index	<u>1.26</u>	
SR	Index	<u>.67</u>	
FF	Index	<u>1.00</u>	
Total		<u>8.71</u>	<u>49 %</u>

RESOURCES SCORE

FF	Index	<u>1.00</u>	
CR	Index	<u>1.91</u>	
Total		<u>2.91</u>	<u>43 %</u>

P.S.I. SCORE 51 %



DIAGNOSTIC SCORE

A	Index	1.14
CB	Index	3.00
D/F	Index	1.64
LS	Index	1.26
SR	Index	.67
FF	Index	1.00
Total		8.71
		49 %

RESOURCES SCORE

FF	Index	1.00
CR	Index	1.91
Total		2.91
		43 %

P.S.I. SCORE 51 %

Age	Sex	Race	Religion	Education	Father's Occupation
A.34	6y.0m.	M	Jewish	Nursery	Accountant
N.34	4y.6m.	M	Jewish	Pre-school	Chartered Accountant

PSYCHO-SOCIAL INDEX

Normal Case Number 34

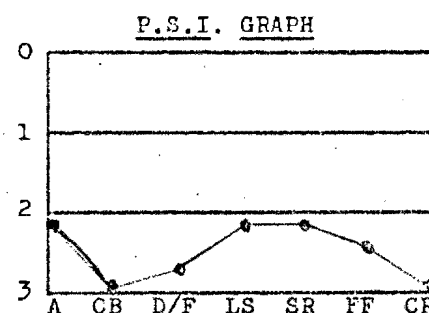
SCORES				
	Raw	Index		
ADJUSTMENT.	21	2.17		
CONDITION AT BIRTH.	9	3.00		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	20	2.86		
Behavioural	8	2.40		
Intellectual	20	2.00		
Emotional	13	2.29		
Social	9	2.46		
Total	70	2.66		
LACK OF STRESS EXPERIENCES.	14	2.21		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	12	2.00		
Father/Client	13	2.17		
Others/Client	1	2.53		
Total	26	3.66		
CURRENT FAMILY FUNCTIONING.	29	2.42		
COMMUNITY RESOURCES	11	3.00		
Total Index Score			17.60	

P.S.I. GRAPH	
0	
1	
2	
3	
	A CB D/F LS SR FF CR

DIAGNOSTIC SCORE	
A	Index 2.17
CB	Index 3.00
D/F	Index 2.66
LS	Index 2.21
SR	Index 2.20
FF	Index 2.42
Total	14.66
	82 %

RESOURCES SCORE	
FF	Index 2.42
CR	Index 3.00
Total	5.42
	90 %

P.S.I. SCORE	
	85 %



DIAGNOSTIC SCORE

A	Index	2.17
CB	Index	3.00
D/F	Index	2.66
LS	Index	2.21
SR	Index	2.20
FF	Index	2.42
Total		14.66
		82 %

RESOURCES SCORE

FF	Index	2.42
CR	Index	3.00
Total		5.42
		90 %

P.S.I. SCORE 85 %

A.34 and N.34

The abnormal case scored 0.83 for UCR, and the normal case scored 2.00.

In both cases there were no signs of physical or congenital problems which could have caused difficulty for normal growth taking place. In the abnormal case, however, despite this there seems to have been stress experienced in the environment, this being reflected in the Stress score of 1.26. In the normal case the Stress score reads as 2.21.

A comparison of the quality of mothering in both cases shows that, in the normal case, the client is fully accepted and cared for by his mother in a loving manner. In the abnormal case, however, the mother openly rejected her child.

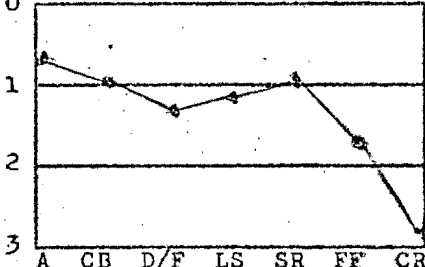
Inherent personality differences in both these mothers is reflected in the fact that the normal mother is generally pleasant in mood and has many friends socially, whereas the abnormal mother has very few friends, being virtually socially isolated.

From the above, it can be seen that the normal child grew up in an emotionally healthful environment and, consequently, had better personality functioning which is reflected in the Diagnostic Score of 82%, as compared to the abnormal case who had an emotionally poor environment, the Diagnostic Score being 49%.

PSYCHO-SOCIAL INDEX

Abnormal Case Number 35

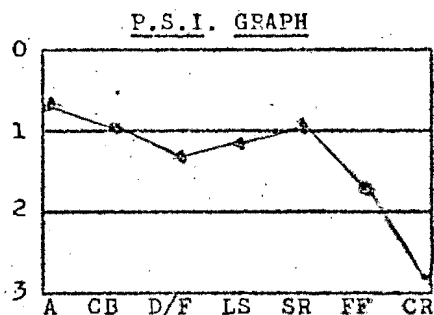
SCORES				
	Raw	Index		
ADJUSTMENT.	7	.70		
CONDITION AT BIRTH.	6	2.00		
DEVELOPMENT/FUNCTIONING				
	Sub-Scores			
	Raw	Index		
Physical	19	2.38		
Behavioural	8	2.40		
Intellectual	8	1.20		
Emotional	3	.53		
Social	2	.46		
Total	40	1.43		
LACK OF STRESS EXPERIENCES. . .	9	1.22		
SIGNIFICANT RELATIONSHIPS				
	Sub-Scores			
	Raw	Index		
Mother/Client	5	.83		
Father/Client	6	1.00		
Others/Client	4	.92		
Total	15	.92		
CURRENT FAMILY FUNCTIONING. . .	21	1.75		
COMMUNITY RESOURCES	10	2.73		
Total Index Score		10.75		

P.S.I. GRAPH	
0	
1	
2	
3	
	A CB D/F LS SR FF CR

DIAGNOSTIC SCORE	
A	Index .70
CB	Index 2.00
D/F	Index 1.43
LS	Index 1.22
SR	Index .92
FF	Index 1.75
Total	8.02
	45 %

RESOURCES SCORE	
FF	Index 1.75
CR	Index 2.73
Total	4.48
	75 %

P.S.I. SCORE	
	52 %



DIAGNOSTIC SCORE	
A	Index .70
CB	Index 2.00
D/F	Index 1.43
LS	Index 1.22
SR	Index .92
FF	Index 1.75
Total	8.02
	45 %

RESOURCES SCORE	
FF	Index 1.75
CR	Index 2.73
Total	4.48
	75 %

P.S.I. SCORE 52 %

Age	Sex	Race	Religion	Education	Father's Occupation	
A.35	17y.11m.	F	W	Protestant	Std. IX	Company Director
N.35	17y.9m.	F	W	Protestant	Std. X	Unknown

PSYCHO-SOCIAL INDEX

Normal Case Number 35

Normal Case Number 88

SCORES

	Raw	Index
ADJUSTMENT.	26	2.60
CONDITION AT BIRTH.	9	3.00
DEVELOPMENT/FUNCTIONING		
Sub-Scores		
Raw Index		
Physical	23	2.38
Behavioural	10	3.00
Intellectual	20	3.00
Emotional	16	2.82
Social	12	2.76
Total	81	2.89
LACK OF STRESS EXPERIENCES.	13	1.77
SIGNIFICANT RELATIONSHIPS		
Sub-Scores		
Raw Index		
Mother/Client	14	2.33
Father/Client	12	2.00
Others/Client	9	2.07
Total	35	2.14
CURRENT FAMILY FUNCTIONING.	32	2.67
COMMUNITY RESOURCES	11	3.00
Total Index Score		18.07

P.S.I. GRAPH

Category	Score
A	2.60
CB	3.00
D/F	2.89
LS	2.14
SR	2.67
FF	2.67
CR	3.00

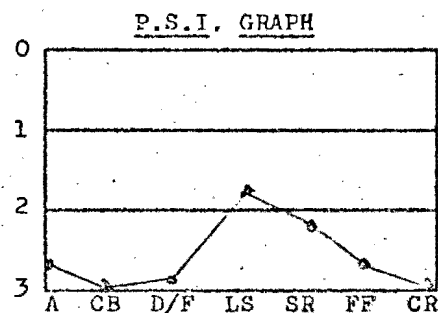
DIAGNOSTIC SCORE

A	Index	2.60
CB	Index	3.00
D/F	Index	2.89
LS	Index	1.77
SR	Index	2.14
FF	Index	2.67
Total		5.07
		85 %

RESOURCES SCORE

FF	Index	2.67
CR	Index	3.00
Total		5.67
		95 %

P.S.I. SCORE 87 %



DIAGNOSTIC SCORE	
A	Index 2.60
CB	Index 3.00
D/F	Index 2.89
LS	Index 1.77
SR	Index 2.14
FF	Index 2.67
Total	15.07
	85 %

RESOURCES SCORE	
FF	Index 2.67
CR	Index 3.00
Total	5.67
	95 %

P.S.I. SCORE 87 %

A.35 and N.35

In both these cases the girls concerned are 17+ years of age and appear to come from similar backgrounds.

However, their respective personality development seems to have taken divergent courses on account of their emotional environmental backgrounds. The relationship which forms the chief backdrop to the above, i.e. the Mother/Client Relationship reads as 0.80 for the abnormal case and as 2.33 for the normal case.

A qualitative analysis of the MCR shows that, in the abnormal case, the mother is a rigid person who sets very high expectations for her daughter, morally, socially, and intellectually. She punished the child severely, either through passive rejection or open aggression, when she did not meet these standards.

In contrast, the normal mother is a warm, understanding person who has allowed her child much flexibility as far as her expectations are concerned. Unlike the abnormal case she has not internalized a harsh, punishing, super ego which perpetually engenders fear of punishment and consequent anxiety which interferes with every facet of one's social functioning.

CHAPTER VI

CONCLUSION

The findings of this study are significant for two reasons. In the first place, they reinforce previous studies regarding the importance of the mother-child relationship. In the second place, they go further and provide quantitative data concerning the effects of the mother-child relationship.

There is an important difference between this study and the hitherto qualitative assessment studies which increase the chances of subjectivity, both in the writing up of the results by the researcher, and in the interpretation of the results by the reader.

In addition, this study has further highlighted the role of the father in affecting the mothering process. This may come about through his ability to give emotional support both to the child and to the mother. Literature generally, in the researcher's opinion, has underplayed the role of the father in the total mothering process.

A possible reason for this could be the need to stress the overwhelming importance of the mother per se as she predominantly socializes the child, so that attention has not properly been paid

to the variables that affect her.

A discussion of some of the practical uses of the present findings now ensues.

Since mothers influence their children's development to such a great extent, it would be ideal to assess the level of personality maturity of mothers at pre-natal clinics, hospitals, nursing homes, etc. This can be done through using either the MMPI (Minnesota Multiphasic Inventory) or the SME. Thereafter, having assessed all such mothers, those who have low scores can have "follow-up" work done as a preventative by trained staff (PSW's or Psychiatric Nurses) so that the vicious cycle of their own poor upbringing is not repeated with their children.

In this way, early detection and follow-up can prevent severe personality distortion in the child. It is a well-known fact that the younger the child and the earlier intervention (either in a preventive or treatment capacity) is initiated, the better the prognosis and chances of bringing about change. The personality of the child is still developing and is susceptible to influence. Furthermore, the child has not yet developed deeply embedded patterns of behaviour which are resistant to change.

The problem can also be attacked from the other end, as it were. Children experiencing difficulties with general life adjustment can be detected early in crèches, nursery schools, and schools, and similarly treated.

Preventive measures can also be done educationally, in which midwives, nursing staff, health inspectors, etc., could be trained more thoroughly than they presently are concerning the importance of a mother's influence on her child's life. In South Africa, it seems that these professions have up to now predominantly been equipped with knowledge on physical health measures and chiefly concentrate on this task.

Film shows, reflecting the distinction between the results of "healthy" and "unhealthy" child-rearing may be arranged at prenatal clinics in order to inculcate knowledge on these matters. Mothers attending psychiatric clinics, hospital psychiatric out-patient departments, and mental health clinics should have follow-up work done on their families in order to break the vicious cycle inherent in repetition of the experience of one's own upbringing. It has been stated by some authors that well-motivated neurotic parents can be helped to rear healthy children provided they make use of insight, control, knowledge, and understanding.

A survey of most mental institutions will reveal that a large proportion of the mentally ill come from lower-class, generally underprivileged strata of the population! The lives of these people quite often have the burden of inevitable stress and anxiety. In addition to their lack of material needs, they also lack education which further handicaps their ability to cope with their problems. A surprising number are unaware of the most widespread causes of insanity (i.e. anxiety), let alone knowing the way in

which mental ill-health can be prevented.

Information can be simplified and taught to voluntary lay-workers who can be trained to work amongst the underprivileged as educators. Knowledge should not remain as the guarded, secret possession of professional disciplines on the pretext of being "too complex" to be understood by lay people. The use of knowledge, in the final analysis, lies not in hoarding but in applying it for the betterment and upliftment of life itself.

It must be said that, in order to carry out all this work, trained personnel would be required. The more one can incorporate such specialized information, not only in post-graduate social work courses at institutions of higher education, but also in undergraduate courses, many more teachers and social workers who directly work with large number of people would be equipped with this kind of knowledge.

Some suggestions for future studies would be to assess the importance of the father's influence on the personality development of the child in order more fully to cover this relatively unexplored field.

There is another very interesting question that this research has suggested. The personality maturity of the mother might be fully measured by means of the SME, and thereafter the level of personality maturity in the identified patient might be measured to see the frequency with which neurotic parents rear neurotic

children. This study can go further and assess whether a particular "pathology type" (such as schizophrenia) in a parent propagates the same "pathology type" in the child.

Whatever new emphases may appear in subsequent studies by professionals in the field of mental health, it is safe to predict that the mother-child relationship, and the clusters of relationships associated with it, will continue to enjoy the closest attention and scrutiny.

APPENDIX A

NOTES TO CHAPTERS

- 1 This table has been compiled from data communicated to the author by Mr. J.L. Stricklin, from whose recent experimental work they have been derived.
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- 33 Ibid., pp.135-137.
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APPENDIX B

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APPENDIX C

RESEARCH DATA: TWO EXAMPLE CASES

Exhibit 1

Research Data — Abnormal Group

Case Example

SME Steps I, II, III, IV

A SYSTEMATIC METHOD
OF EVALUATING
CASE HISTORY DATA

S M E STEP I

GROUPS I, II, III, IVa

Ages Birth Through 20-11/12 Years With Family

(Copyright: J.L. Stricklin)

S M E STEP I

GROUPS I, II, III, IVa

Ages Birth Through 20-11/12 Years With Family

WORK SHEETS

Name Gary Miller Race/Sex
Birthdate 22/11/63 E M
Parents: Name Dr. and Mrs. N.A. Miller
 Address Cape Town
 Telephone

I. IDENTIFICATION:

Client: Aged 6 years 7 months. He is in Sub.A. He was expelled because he shows general immaturity of behaviour with frequent temper tantrums. He is an anxious child.
Father: ⁺30 years. He is a Dental Surgeon working in partnership with his father. He is divorced from the children's mother and is re-married. He has custody of the children.
Mother: Aged 27 years. The children's mother is a shorthand-typist. Is living in Durban with her parents. Entitled to see children three times a year.
Stepmother: ⁺28 years. Trained cardiac sister. Not working at present. Has been married before. Divorce finalized July '70.
Sibling: Born 16/11/65. Used to stutter; that has stopped now. No present problems with regard to discipline.

II. SOURCES:

1. Child guidance clinic files
2. Father interviewed
3. Stepmother interviewed.

III. PROBLEM AS SEEN BY PARENTS:

The father first contacted the clinic in regard to obtaining custody of the children.

Gary was presenting behaviour problems: (1) He was having violent temper tantrums during which he would lie on floor and kick and scream. (2) Is extremely disobedient and stubborn. Father and present stepmother have had to smack him frequently. He usually cries thereafter and often withdraws. (3) Has an over-active fantasy life and often has difficulty in distinguishing fact from fantasy. He tells lies frequently. (4) He is an anxious child. This is perhaps illustrated by the fact that he is very fidgety and distractable. Is very sensitive and often on the defensive. (5) Finds men safer than women.

Father feels he has given the children good care. He did most of the "mothering" as mother could not be bothered. Sees the mother's neglect as being the most important etiological factor. Gary was not planned and mother was extremely angry that she was pregnant. She expressed this often and disliked Gary as a result. She did not fulfil mothering role and left all care of children to father (physical and emotional). She ran around with other men.

The stepmother was more concerned about Gary's problems than the father. This is perhaps because of her need to be a good mother and wife, after the first mother's failure.

IV. PERSONAL:

Developmental:

At the time of conception and birth, the marriage was reasonably happy. Gary wasn't planned and the mother was very angry when she discovered she was pregnant. The pregnancy and labour were quite normal.

Developmental phases occurred at the normal time. Mother and father took part in toilet training. Gary has not shown eneuritic problems.

Hearing Loss:

Gary has shown no problems as regards hearing.

Health:

Health is good.

Speech:

Gary acquired speech at the normal age. His vocabulary is average.

Sleep:

Gary shares a room with Ian. He used to have nightmares, but has not had any for some time.

No other problems with sleep. Occasionally Gary is resistant about dressing in the morning.

Ability to do for self:

Gary manages to do for himself quite adequately. His stepmother has given the children an extra responsibility of cleaning their own shoes. They seem to enjoy this.

Gary helps stepmother with house chores and especially enjoys helping her bake.

Interests - Activities:

Gary spends most of his time playing with his toys either with Ian or with friends. He does not play alone. He also enjoys playing games requiring use of fantasy, e.g. mothers and fathers.

There seems to be significance in the fact that he was caught naked with the girl from next door on two occasions.

Peer Relationships:

Generally, Gary does not seem to have problems as regards peer relationships. He enjoys going to school and has friends there. At home he plays happily with the neighbours.

Sibling Relationships:

There is obvious sibling rivalry between Gary and Ian. Although they play together a lot of the time, Ian antagonizes Gary and the latter has often become very aggressive towards Ian. Stepmother says she has often discovered bruises on Ian. Gary expresses often that he hates Ian and even weeps about it. Mother disliked Gary and showed obvious preference for Ian. Stepmother, however, prefers Gary.

Other Significant Relationships:

Both children have extremely good relationships with paternal and maternal grandparents (latter are in Durban). Grandparents tend to spoil children and the maternal grandparents shower gifts on them.

Children were cared for by the maid while their mother was at home as mother could not be bothered.

Discipline:

Mother was capable of disciplining the children as she shouted and swore at them. This was mainly because she was not interested. Father disciplined the children during this time and generally they responded well. Currently the stepmother does the majority of the disciplining. Gary responds well but does lie sometimes and may sulk. She usually talks to them and then if they are very naughty she smacks them with a wooden spoon. Father disciplines them, if he is at home, by spanking them.

Fears - Unusual Habits:

Gary has had a history of temper tantrums. These were frequent (often a number of times a day) before his parents' divorce and for some time thereafter. Currently they only occur once a week at the most.

No other unusual fears or habits.

Education:

Gary is in Sub.A. Stepmother says he is an average pupil and manages well at school. He seems to like school.

Personality as seen by parents:

Stepmother sees Gary as a sensitive child who needs to be loved. She feels that he is very stubborn and can be disobedient. She says he can be very aggressive, especially towards Ian, and often is "sulky" and withdrawn after he has been reprimanded. Currently he shows affection, often hugs her and brings her gifts (e.g. Mother's Day card). Her affect is appropriate to her description and she is genuinely very fond of the child (identifies him with herself as a child). Father is also fond of Gary but tends to show preference for Ian.

V. FAMILY:

Parents are divorced. Father has custody of the children. Mother is living in Durban with parents. She sees the children three times a year.

Father:

Norman Miller, $\pm$ 30 years. University Degree Dental Surgeon. Is from a professional home; his father was also a dentist. His parents live on a small farm, he was brought up there. There marriage was not a happy one, the parents are not compatible and have always argued a lot. Three children in the family, Dr. Miller being the eldest.

He did very well at school, scholastically and in sport. At this time was rather shy with girls (perhaps as a result of a close relationship with his father). He then attended the Witwatersrand University and again did very well. He held responsible positions, e.g. chairman of residence committee. He lost his shyness of girls and got married when he left University.

Dr. Miller is an intellectual man who has a capacity for warmth and understanding as regards ego maturity. He seems capable of handling the id drives well, with perhaps some difficulty with sexual drives. This may be as a result of emotional closeness with his father. He feels the mother played the major role in Gary's problems.

Mother:

Wendy Miller, 27 years. Shorthand-typist. She is an only child from a very wealthy family. She was very spoilt as a child and got everything she wanted. Her parents were not happily married. When she married Dr. Miller, the marriage was reasonably stable for a number of years. Mother then became entirely disinterested in the children, the home, and her husband. She neglected the children, failing to do any mothering, left all housework and care of children to the maid and had numerous boy friends. When her husband started divorce proceedings, she did not attempt to obtain custody of the children and said they would be better off with father.

Stepmother:

Penny Miller, $\pm$ 28 years. Fully qualified cardiac sister. Her childhood was not happy. Although her parents had a stable marriage, her mother was rather irresponsible and failed in mothering role. She neglected the children emotionally. Mrs. Miller was married before and says the marriage was unsuccessful from beginning. She is an intellectual woman who has capacity to recognize her own feelings. She is very attractive and well-dressed and is easy to establish rapport with. Is very open and is a warm, friendly person.

Marital Relationship:

The first marriage, although reasonably stable during the first few years, was never entirely happy. Father says honeymoon was a "disaster"! Problems started coming to fore when question of disciplining children arose. Thereafter there was continual arguing. The second marriage, although very new (July 1970), seems to be very good. Stepmother did live with father for $\pm$ 3 months. They have good communication and recognize the importance of supporting each other in all spheres, at the same time being open. The relationship seems very warm.

PSYCHO-SOCIAL INDEX

S M E STEP II

SUMMARY WORK SHEETS

CLIENT'S NAME GARY MILLER M/F Male

D O B 22/11/63 AGE 6 yrs. 7 mths.

DESCRIPTION OF CLIENT:

Gary is the eldest child. He is in Sub. A. He seems to be of average intelligence. He appears physically healthy and 'normal'.

He has been referred to the Agency by his parents, especially his mother.

He is presenting behaviour problems.

DESCRIPTION OF CLIENT'S FAMILY:

Father: $\pm$ 30 years. He is a dental surgeon.

Mother: She is 27 years old. Before her marriage she worked as a shorthand-typist. She divorced father.

Stepmother: $\pm$ 28 years. Trained cardiac sister.

Sibling: Brother, born 16/11/65.

Religion: Protestant.

Upper Socio-economic Group.

B. Behavioural

There is general immaturity of behaviour on this child's part.

He used to stutter when original mother was around, but this seems to have been transient rather than permanent.

His developmental milestones were normal.

C. Intellectual

He seems to be of average intelligence; sometimes his reasoning becomes clouded when frustration and anxiety build up. Taking into account his low frustration tolerance level, this seems to happen more frequently than would be otherwise considered normal.

D. Emotional

He becomes extremely angry over minor irritations, for example when he wants something he cannot get immediately.

His mood patterns lack stability.

He can be demanding and aggressive and at other times very helpful.

E. Social

He has good peer relationships. He does fairly well at school, except that he is sometimes fidgety and lacks concentration.

He relates well to male authority but tends to find women unsafe.

STRESS

Neglect of mother makes for difficulty in his ability to trust people and this interferes in his forming close emotional ties with women.

Divorce of parents (separation) caused much unhappiness and anxiety in the home; especially in view of the fact that this occurred during his first six years of life.

Birth of sibling (he is extremely jealous of his younger brother).

Re-marriage of father -- this meant that he had to adjust to a totally new person in his environment.

SIGNIFICANT RELATIONSHIPSA. Mother/Client

Neglected child. Mother did not plan pregnancy. Extremely angry at his birth. She expressed her anger openly and showed dislike for the boy.

She had relationships with other men in the presence of the child.

Described by her husband as being an immature, irresponsible, and dependent person.

She found difficulty in disciplining the children and did this mainly by shouting and swearing. The child had a 'hostile-dependent' bond with her. He received very little emotional nurture as a result of her indifferent

attitude towards her responsibilities in general.

The children were mainly cared for by the maid in the earlier marriage.

She did not bother to seek custody of the children.

The mother was the only child of wealthy parents and was very 'spoilt' and got 'everything she wanted'.

Stepmother:

She seems to be much more concerned than the father about Gary. She seems to be a warm, responsible, person.

Gary seems to have built up a fairly positive relationship with her.

B. Father/Client

Gary is emotionally 'tied' to the father, who has custody of the children. He seems to be a much more mature person than the original mother. Father did most of the disciplining and mothering.

Father, however, seems to prefer the younger sibling to Gary.

Father himself had an unhappy childhood but seems to be much more responsible than mother.

C. Others/Client

Gary has suitable relationships with peers. Is well liked by paternal and maternal grandparents. He has a positive relationship with stepmother.

He is however inclined to be very jealous of his younger brother.

CURRENT FAMILY FUNCTIONING

- Gary: Helps mother with chores and baking. He has some capacity to build relationships. He manages well at school.
- Gary is still quite young and has the capacity to make changes.
- Stepmother: She is eager to help Gary. Her ego strength should allow her to make some very positive contributions to Gary's improvement.
- Father: The patient has at least had a stable and long-term relationship with the father who is warm, and who has fulfilled some of his mothering needs.
- Marriage: The present marital set-up is a happy one.
- The parents are socially and culturally well-off.
- Grandparents: The grandparents lend positive support to this family.

COMMUNITY RESOURCES

1. Child Guidance Clinic:
 - (a) Counsellors for parents.
 - (b) Play therapy for Gary.

- T 2. No history of developmental retardation in sitting is known.
- T 3. No history of developmental retardation in crawling is known.
- T 4. No history of developmental retardation in walking is known.
- T 5. No history of developmental retardation in speech/language is known.
- T 6. No history of developmental retardation in toilet training is known.
- T 7. No history of developmental retardation in academic/scholastic learning is known.
- T 8. No history of failure in gaining age-appropriate autonomous functioning is known.
- T 9. No failure in acquiring appropriate self-help skills is known.
- T 10. No indications of failure in gaining any other age-appropriate motor skill is known.

C. Intellectual

- T 1. No sign of inability in academic/scholastic learning is known.
- T 2. No sign of inability to think abstractly is noted.
- 3. No sign of inability to adjust or adapt to the environment is noted.
- 4. No sign of inability to form close, lasting relationships is noted.
- T 5. No sign of inability to reason is noted.
- T 6. No sign of memory loss of recent experiences is noted.
- T 7. No sign of memory loss of past experiences is noted.
- T 8. No sign of difficulty in learning verbal skills is noted.
- T 9. No sign of difficulty in learning mathematical, reading or spelling skills is noted.
- 10. No sign of retardation in the development stages is noted.
- T 11. No sign of difficulty in performing self-help tasks is noted.
- T 12. No sign of difficulty in reality-testing is noted.
- T 13. No sign of difficulty in relating parts of a problem or a situation to the whole is noted.
- 14. No sign of difficulty in analysing a problem or a situation and dealing with the parts in a realistic manner is noted.
- 15. No sign of difficulty in self-awareness of strengths and weaknesses is noted.
- T 16. No sign of lack of capacity to act purposefully is noted.
- T 17. No sign of inability to think rationally is noted.
- 18. No sign of inability to assume responsibility is noted.
- T 19. No sign of difficulty in communication is noted.
- T 20. No other sign of difficulty in intellectual functioning is noted.

13. A good mothering experience is reflected in the client's personality.
14. A positive response to the mother during the developmental years is reflected in the client's history.
15. No major physical or emotional factor has interfered with the client's capacity to relate to his mother and to maintain normal maturation.
16. The client's response to discipline and limit-setting during the maturational years reflects adequate and positive maternal handling.
17. Stage by stage during the maturational years, most of the client's needs to be mothered were met.
18. The timeliness of the client's birth was positive for the mother.

B. Father/Client (Note: Surrogate fathers should be evaluated in this section)

1. The father's basic personality is conducive to good fathering.
- T 2. The father's cultural-socio-economic developmental background enhances his capacity to parent the client.
3. The father's attitudes towards parenting enhance his functioning as a father.
- T 4. The father has adequate self-esteem without depending primarily on the father role for self-enhancement.
5. The father's attitudes towards the client do not interfere with his capacity to father.
6. The father has had no major physical or emotional trauma that interfere with his capacity to father the client.
7. The father's emotional giving has been adequate.
8. The father's physical giving has been adequate.
9. The father has made a positive approach to discipline, with consistent and realistic limit-setting.
10. Parents agree on discipline and limit-setting.
11. The father received positive emotional support from his wife during the client's first seven years of life.
- T 12. No significant separations between father and client occurred during the developmental years.
13. A good fathering experience is reflected in the client's personality.
- T 14. A positive response to the father during the developmental years is reflected in the client's history.
- T 15. No major physical or emotional factor interfered with the client's capacity to relate to his father and to maintain normal maturation.
- T 16. The client's response to discipline and limit-setting during the maturational years reflects adequate and positive paternal handling.
- T 17. Stage by stage during the maturational years, most of the client's needs to be fathered were met.
- T 18. The timeliness of the client's birth was positive for the father.

C. Others/Client

1. Birth of sibling(s) did not produce unusual stress in the client.
- T 2. Ordinal position among siblings has not been stressful to the client.
3. Interaction between client and siblings has been primarily positive.
4. Client and siblings have not experienced an unusual degree of rivalry.
5. No evidence of "favouritism" of one child in the family is indicated.
- T 6. The client's capacity to share with peers is age-appropriate.
- T 7. The client's capacity to be a part of a group is age-appropriate.
- T 8. The client's choice of friends according to sex is age-appropriate.
- T 9. The client's choice of friends according to sex is age-appropriate.
- T 10. The chronological ages of peers is appropriate for the client's age and educational attainment level.
- T 11. The client has gained the capacity to stand up for himself and protect his rights among peers.
- T 12. The client is not unduly concerned about peers' feelings and attitudes towards him, i.e. his self-esteem does not primarily depend upon positive evaluation by others.
- T 13. The client's relationship with any significant person (other than parents, siblings and peers) shows no negative influence upon the client's personality.

CURRENT FAMILY FUNCTIONING - SECTION "a" (This section to be completed for clients, regardless of age, who live in a family group. Evaluate current family dynamics.)

- T 1. Family functioning is enhanced by the mother's basic personality.
- T 2. Family functioning is enhanced by the father's basic personality.
- T 3. Family functioning is enhanced by the parents' marital relationship.
- T 4. Family functioning is enhanced by the family's cultural experiences.
5. Family functioning is enhanced by the family's religious practices.
- T 6. Family functioning is enhanced by the family's socio-economic status.
- T 7. Family functioning is enhanced by the intelligence of the parents.
- T 8. The mother has sufficient motivation to use assistance outside the family when it is needed.
- T 9. The father has sufficient motivation to use assistance outside the family when it is needed.

10. Family functioning is enhanced by the presence of extended family members living in the same household.
- T 11. Family functioning is enhanced by the father's vocational experience.
- T 12. Family functioning is enhanced by the mother's activities outside the family which increase her self-esteem.
- T 13. Family values and standards of the parents are compatible.
14. Family functioning is enhanced by the influence of the mother's parents.
- T 15. Family functioning is enhanced by the influence of the father's parents.
16. Family functioning is enhanced by the mother/client relationship.
- T 17. Family functioning is enhanced by the father/client relationship.
18. The family has sufficient strength to deal with stressful situations which arise in most families.
19. No indication of breakdown in family equilibrium as evidenced by symptoms of maladjustment of any family member, is indicated.
- T 20. Parents adequately meet one another's sexual needs.
21. Parents adequately meet one another's dependency needs.
22. Parents adequately meet one another's needs for closeness.
- T 23. Family functioning is enhanced by the allocating of roles (among family members) in order to meet the economic needs of the family.
- T 24. Family functioning is enhanced by the allocating of roles (among family members) in order to meet the emotional needs of the family.
- T 25. No evidence of neurotic interaction among family members (in order to maintain family equilibrium) is indicated.
- T 26. Individual family member's goals for the family group are compatible.
- T 27. Communication between parents and children in the family has not been adversely affected by a "generation gap".
- T 28. Family equilibrium has not been disrupted by financial trauma.
- T 29. Family equilibrium has not been disrupted by health trauma.
- T 30. Parents are not physically or emotionally separated by current situational trauma.
31. A sense of unity and pride exists in the family.
32. Verbal communication among family members is adequate.
33. Feeling communication among family members is adequate.
- T 34. An appropriate attitude of optimism for the future permeates the family.
- T 35. No evidence exists of the family having been established under traumatic circumstances, or that the marriage was a "forced" one.
- T 36. Family interaction enhances the individual functioning of each family member.

Exhibit 2

Research Data -- Normal Case

Case Example

SME Steps I, II, III, IV

A SYSTEMATIC METHOD
OF EVALUATING
CASE HISTORY DATA

S M E STEP I

GROUPS I, II, III, IVa

Ages Birth Through 20-11/12 Years With Family

(Copyright: J.L. Stricklin)

PSYCHO-SOCIAL INDEX

S M E STEP II

SUMMARY WORK SHEETS

CLIENT'S NAME STEPHEN M/F Male

D O B _____ AGE 7 yrs. 7 mths.

DESCRIPTION OF CLIENT:

Stephen is the eldest child. He is in Sub. B. His parents feel he is an intelligent child. He appears physically and emotionally normal.

DESCRIPTION OF CLIENT'S FAMILY:

Father: 34 years old. Civil servant (clerical - Government). He matriculated and later attended a Technical College for shorthand and typing. He is currently completing his B.Com. degree.

Mother: Age 33. She is a trained nursing sister. Has been a housewife ever since Stephen was born.

Siblings: A sister aged 6 years 3 months.
A brother aged 21 months.

Religion: Protestant.

They maintain an average standard of living.

ADJUSTMENT

As an infant S. had colic and other feeding problems. At 18 months he had trouble sleeping; parents learned to leave the light on in his room and this continues. He has frequent nightmares and mother often lies with him until he goes to sleep.

S. sometimes finds difficulty in separating from his parents, who have thought that they should never leave the children, but he has no problems currently.

In the past S. has ignored his mother when she called him to come in and she has difficulty controlling him. He will always say he is sorry after he has been corrected.

None of Stephen's problems are very severe, and he has never been referred for any behavioural or adjustment problems.

CONDITION AT BIRTH

S. has no congenital problems. Gestation period was full-term.

Mother planned and welcomed birth of baby.

DEVELOPMENT/FUNCTIONINGA. Physical

severe

He does not have any/physical or health problems.

He had a tonsilectomy at 5 years.

Has had frequent sore throats and colds.

B. Behavioural

S. was born two years after his parents' marriage. He was breast-fed up to six months; had frequent colic in the first three months. Bottle-fed until three years and then kept his dummy until aged four. S. had difficulty moving over to solid foods.

Mother found difficulty in toilet training this child. He was bowel trained at 30 months. He occasionally wets his bed at night.

S. sat alone at seven months, crawled at nine months, and walked at one year.

C. Intellectual

He is seen by his parents as doing especially well in academic studies. He seems to have age-appropriate reasoning capacities.

S. is currently in Sub. B. and has always done above-average work.

D. Emotional

He sometimes becomes unduly anxious over 'normal' situations; this however is not chronically ingrained. He is an affectionate child, especially towards his mother but tends to maintain a distance from his father. This is understandable as father himself is a 'walled-off' person who does not encourage close emotional ties.

His mood patterns appear to be quite consistent.

- T5. Paternal attitudes towards the client were not stressful.
- T6. The client's overall relationship with his father was not stressful.
- 7. No evidence that the father has been too involved with the client during the maturation process (thus too stimulating) is noted.
- T8. No history of overly-stimulating sexual experiences is known.
- T9. No evidence that birth of siblings or relationships with siblings have been overly-stressful.
- 10. No evidence exists that the move from home to peer relationships was overly-stressful.
- T11. No evidence exists that relationships with significant persons besides parents or siblings has been overly-stressful.
- T12. No history of traumatic separations from the mother is known.
- T13. No evidence of overly-stressful illnesses exists.
- 14. No evidence of physical trauma exists.
- T15. No evidence exists that the developmental move from home to school was overly-stressful.
- T16. No evidence exists that experiencing parental marital discord was stressful.
- T17. No evidence exists that family socio-economic standing has been stressful.
- T18. No evidence exists that family religious influences has been stressful.
- T19. No evidence exists that other cultural factors have been stressful.

SIGNIFICANT RELATIONSHIPS

- A. Mother/Client (Note: Surrogate mothers should be evaluated in this section.)

- T1. The mother's basic personality is conducive to good mothering.
- T2. The mother's cultural-socio-economic developmental background enhances her capacity to mother.
- T3. The mother's attitude towards parenting enhance her functioning as a mother.
- 4. The mother has adequate self-esteem without depending primarily on the mother role for self-enhancement.
- T5. The mother's attitudes towards the client do not interfere with her capacity to mother.
- 6. The mother has had no major physical or emotional trauma that interfere with her capacity to mother the client.
- 7. The mother's emotional giving has been adequate.
- T8. The mother's physical giving has been adequate.
- 9. The mother has made a positive approach to discipline, with consistent and realistic limit-setting.
- T10. Parents agree on discipline and limit-setting.
- T11. The mother received positive emotional support from her husband during the client's first seven years of life.
- T12. No significant separations between mother and client occurred during the developmental years.

S M E STEPS V AND VI

DEVELOPMENTAL DYNAMIC DIAGNOSTIC STATEMENT

S. demonstrates some overly developed feelings of anger and aggression towards others which likely stem from his parents' too high expectations, harsh hidings coupled with inconsistent handling. He is showing signs of anxiety and general insecurity which seem to be lifelong in nature. He is too involved with his mother and has not developed the desire to function autonomously to as great a degree as he should. One wonders if he is not now experiencing real castration anxiety and difficulty in resolution of the oedipal situation.

Stephen's problems do not appear serious enough at this time for therapeutic intervention.

APPENDIX D

SME Steps I, II, III, IV

Examples of Working Materials

Exhibit 1

SME Step 1

Psycho-Social History Collection Guide

Age Groups I, II, III, IVa

Psycho-Social History

Groups I, II, III, IVa

Child

Race/Sex

Address

Telephone

Describe the client, giving significant facts, including his age in years and months, educational experiences, health, adopted, etc. Give reason for referral with major signs and symptoms and by whom referred. State the purpose of the social history.

List the siblings, giving pertinent information as to birth-date, current school placement, significant health matters, personality, particular problems.

II. SOURCES:

III. PROBLEM AS SEEN BY PARENTS:

What ideas do they have about the problems, their cause and

what they should do about them?

What part do the parents believe they play in the client's problems?

What do the parents most fear may be wrong with the child?

What efforts have the parents made, and what success to correct the child's problems?

How realistic are the parents in their view of the problems?

What do the answers tell you about the parents' attitudes toward the child?

Report all significant attitudes and statements given by the informants pertaining to the client. It is important to allow the informant freedom of expression and enough time to focus on significant material. The interviewer should be attuned to unanswered questions the parents may bring up at this point.

What do the parents think has contributed to the client's signs and symptoms?

What has motivated the parent to seek help at this particular time?

What specifically is the parent asking from this agency?

How has the parent handled his feelings about the client's problems?

How motivated is the parent for help?

How much plasticity is presented in the parent at the present so that the client's environment might be changed?

Where has the parent been previously to ask for help? Was he satisfied with this help? Did he use it appropriately?

How long has the parent been concerned about the client's problems?

When were the problems first noted?

How serious does the parent think the problems are?

What affect does the parent demonstrate as he talks about the child's problems? Is the affect appropriate?

What attitude does the parent demonstrate about the child as he talks about the child's problems?

What is the parent telling you about himself and his way of dealing with problems?

Does the parent understand the purpose of your Centre and the procedures in the child's evaluation?

Is he realistic in his expectations of the Centre?

IV. PERSONAL:

DEVELOPMENTAL: Give significant pre-natal history, particularly any problems which the mother may have had during the pregnancy.

Give gestation of pregnancy and birth weight of child, any abnormalities noted at birth.

What was going on in the marriage and family at the time the child was conceived and born?

What was the mother's attitude about being pregnant? How does she feel about her attitude toward pregnancy since the child has a problem?

List developmental phases, with special regard to feeding. Was the child breast fed or bottle fed? Any presence of colic or other feeding difficulties?

What were the child's health experiences during infancy?

How does mother remember the child's personality as an infant? Did he want to be held? Did he cry a great deal? How did mother react to his personality?

List developmental phases of sitting alone, walking unaided, speech, toilet training.

What was mother's approach to toilet training? If mother began training quite early and was rigid or forceful in her approach, does this mean she has high expectations of the child or is she a rigid, compulsive mother? How did the child react to mother's approach to toilet training?

List any significant delays in maturation approach.

Any history of enuresis in the child or siblings?

Does the mother see this child as slower or faster in development than siblings?

How does mother account for the difference?

Hearing Loss: This should be present as a separate heading only if this area enters into this particular client's history. If so, all information as to where the child has been tested, the results, whether or not the child is able to use a hearing aid and if so, to what advantages?

Give child's response with and without the hearing aid in decibels.

At what age did the child begin wearing a hearing aid?

When was the hearing loss first diagnosed?

What has been the parents' response to the loss of hearing in the child?

Health: Give briefly the medical history, listing only the

significant occurrences.

List not only the event but the age at the time it occurred.

Give the final outcome of the illness if known.

Give the current height and weight of the patient.

What part could poor health play in etiology?

Speech: This area should cover development of speech, acquisition of language, noting particularly any difficulties in communication.

Give the parents' version of the development of speech and its adequacy now.

Give examples of the child's speech.

Sleep: Where has the child slept all his life?

Is he afraid to sleep alone?

Does he have nightmares or night terrors?

Does he ever try to get up and get into bed with the parents; if so, do they allow this?

Does he wander about the house at night?

Must the light be left on?

Does he see ghosts or monsters?

Any difficulty going to sleep or waking up very early in the morning?

Does he take a nap during the day?

Any peculiarities in sleep, i.e., needing the presence of another family member, a blanket, sucking his thumb, rocking to and fro, nocturnal enuresis, masturbation?

Give usual bedtime and time of arising.

Ability to do for self: What is the child able to do for himself currently in terms of bodily needs, i.e., toilet, dressing himself, brushing his teeth, picking out his clothes, feeding himself with knife, fork or spoon, accepting responsibility for home chores.

What is the parents' attitude about what the child is able to do for himself? Does the mother have need to do more for the child than he actually needs?

Is the child's ability in line with his chronological age and experiences?

Do health factors enter into what he is currently able to do?

Interests - Activities: How does the child spend his time?

What interests him most?

Does he play inside or outside most of the time?

Does he play with other children or play alone?

Are the toys he chooses age appropriate?

Any evidence of fear of tricycle or bicycle?

Is the child generally active or passive?

Is the child separated from mother and can he do this freely while playing?

What personality traits does the child exhibit by the nature of his activities?

What part do the parents play in directing the child's activities and interests?

Peer Relationships: To what extent does the child have opportunity to play with peers?

Is he able to get along? Will he protect himself?

Does he play with older, younger, or children his own age?

Does he have any close friends?

Should he have a chum at this stage of development?

Is he a leader or a follower?

Can he be led by peers into activities forbidden by the parents?

Where does he play with peers? Can he separate from mother?

Sibling Relationships: What attitude do the siblings express about the client? Are they protective? Any evidence of sibling rivalry?

How has the client's problem affected the siblings?

Do the parents relate any differently to this child than to the others?

Other Significant Relationships: Has the client spent any time with other relatives, i.e., grandparents, aunts, uncles?

Did these persons become surrogate parents?

What contact does the client have now with these significant people?

What are the personalities of the significant persons in the life of the client?

At what age did the client have most contact with these significant relationships?

Discipline: What is the parents' basic attitude toward discipline or limit setting as it relates to child rearing?

Is this the same way their parents disciplined them, or is there a reaction formation at work?

Do the parents agree to discipline or limit setting?

Whos has taken the most active part in disciplining the client?

What has been the client's response to discipline or limit setting?

Is he easily frustrated?

After a spanking, does he cry for long periods of time, go off to his room alone, return to the forbidden behaviour?

Fears - Unusual Habits: Has the child ever been afraid of anything?

Is there a pattern to the type of fears?

Are his fears unusual for a child his chronological age?

Does he have any unusual habits, i.e. nail biting,

masturbation, thumb sucking, temper tantrums, compulsive routines?
Does he pick wool from sweaters, pick at his nose or pull his ears?

Has he ever been a head rocker?

Education: Give details of nursery, kindergarten, pre-school experiences, grades and adjustment to classroom and peers.

Personality as seen by parents: Give the parents an opportunity to describe in their own words the child and what he is like.

Be aware of the parents' response to the things they are saying about the child.

Is the parents' affect appropriate to the description?

What is the parents' basic attitude toward the child?

Does either parent feel negative toward the child? How appropriate is this in the light of the child's behaviour?

Does the parents' description correlate with the interviewer's impression of the child as described in the history?

Do the parents see the child the same way? If not, what are the differences? Why do they not see him the same way?

What else does the parents' description tell you about their relationships with the child.

V. FAMILY:

If this is a single-parent family or one with a step-parent, this should be stated.

Information about the natural parent should be given as well as information about the step-parent.

Information about the natural parent should be given if the child is adopted as well as information about the adoptive parents.

Father: Give a brief description of father in terms of age, education, employment.

Describe father's physical appearance and his personality.

What are his particular strengths and weaknesses?

How intelligent is he?

How does he handle problems?

What is his mood and general affect?

How does he relate to the interviewer?

Give a brief thumbnail sketch of the father's life. Include a description of his parents' personalities. How does he remember his youth?

Be aware of the part his experiences play in his present attitudes.

Which parent has he identified with?

Which one does he remember as the stronger parent?

Any evidence of a hostile-dependent relationship with either parent?

Give a description of father's health history.
What are his interests and activities apart from work?
What is his relationship to the client?
What is his general attitude about the patient's problem?
How does he see the problem and what help does he want with it?
What questions does he want the evaluation to answer?
How does the father see his wife?
What are his thoughts on her relationship with the client?
Does he support what she is doing as a mother?
Does he give any hint as to problems which the mother may be having in her adjustment to life?
How does he see the marital relationship?

Mother: Give the same information about the mother as listed above pertaining to father.

Be particularly aware of the mother's thinking and attitudes about her role as a mother and as a wife.

Is she inclined to put the children first at the expense of her relationship with her husband? Why would she need to do this?

How closely attached to her own parents is this mother?
Particularly, what are her feelings about her mother?

Does she have any interests outside the home?

What friends does she have apart from the family?

Marital Relationship: How long married and any previous marriages?

Be aware of unusual or disconcerting circumstances, such as this being a forced marriage.

How long did they go together?

Why did they marry each other?

What do they do together?

How well do they communicate?

How do they communicate? Verbally? Non-verbally?

What are the primary areas in which they have had to make adjustment?

How satisfactory has been the sexual adjustment?

Who is the stronger parent?

What are their basic attitudes about their individual roles in the marriage?

What are their attitudes about child rearing?

What expectations do they have for their children and from each other? Are they realistic?

What part does the marital relationship play in the problems which the client is exhibiting?

VI. IMPRESSIONS:

Be able to describe why the client is exhibiting the particular signs and symptoms which he is currently displaying.

Support your impressions on the basis of family dynamics or state that these have no real bearing on the etiology of the client's problems.

Describe this family's personality and present functioning -- make a family diagnosis.

Are there environmental pressures currently present which play a part in this?

In describing the family personality, pay particular attention to group dynamics -- roles fulfilled by each member and strengths and weaknesses of the group. What cultural values influence each parent from their original families, and are these compatible? What role adjustments are necessary in this particular family and how well does each member adjust to the changes, i.e., a father who travels in his work? Describe family communication system. Is it open and verbal or non-verbally directed? Does the client get dual messages?

What is the prognosis in terms of possibility of change in this family? How can this best be accomplished?

What approaches should be taken in dealing with these parents?

What approach should be taken in interpreting the findings of the evaluation?

How can the family strengths be used to the advantage of the client and the improvement of his condition?

Is there sufficient information to make diagnosis at this time or are further diagnostic procedures called for? For example, does the child need an EEG or a complete neurological?

If the child is to be referred to the psychologist, what specific questions should be answered?

Recommendations: Be very specific in listing the next steps that should be taken in working with this family.

Who should make the interpretation?

List any community resources that may be available to this family and how they could be used for the client's benefit.

If there are underlying, basic family problems that need to be corrected, who could best accomplish this?

Be aware of the family's financial resources and the geographic location of the home in making referral to other resources.

Exhibit 2

SIE Step 1

PSH Collection Guide
Age Groups IVb, Va, Vb

S M E STEP I

Collection Guide

Adult ..

Race/Sex

Address**Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone****Telephone**

client's problems?

What do the informants most fear may be wrong with the client?

What efforts have the informants made, and what success to correct the client's problems?

How realistic are the informants in their view of the problems?

What do the answers tell you about the informants' attitudes toward the client?

Report all significant attitudes and statements given by the informants pertaining to the client. It is important to allow the informant freedom of expression and enough time to focus on significant material. The interviewer should be attuned to unanswered questions the informant may bring up at this point.

What do the informants think has contributed to the client's signs and symptoms?

What has motivated the informant to seek help at this particular time?

What specifically is the informant asking from this agency?

How has the informant handled his feelings about the client's problems?

How motivated is the informant for help?

How much plasticity is presented in the informant at the present so that the client's environment might be changed?

Where has the informant been previously to ask for help?
Was he satisfied with this help? Did he use it appropriately?

How long has the informant been concerned about the client's problems?

When were the problems first noted?

How serious does the informant think the problems are?

What affect does the informant demonstrate as he talks about the client's problems? Is the affect appropriate?

What attitude does the informant demonstrate about the client as he talks about the client's problems?

What is the informant telling you about himself and his way of dealing with problems?

Does the informant understand the purpose of your Centre and the procedures in the client's evaluation?

Is he realistic in his expectations of the Centre?

Give informant's description of the onset and development of the client's problems, noting particularly precipitating factors and all signs and symptoms of mal-adaptive functioning.

IV. PERSONAL:

DEVELOPMENTAL: Give significant pre-natal history, particularly any problems which the mother may have had during the pregnancy.

Give gestation of pregnancy and birth weight of child, any abnormalities noted at birth.

What was going on in the marriage and family at the time the child was conceived and born?

What was the mother's attitude about being pregnant? How does she feel about her attitude toward the pregnancy since the child has a problem?

List developmental phases, with special regard for feeding. Was the child breast fed or bottle fed? Any presence of colic or other feeding difficulties?

What was the child's health experience during infancy?

How does mother remember the child's personality as an infant? Did he want to be held? Did he cry a great deal? How did mother react to his personality?

List developmental phases of sitting alone, walking unaided, speech, toilet training.

What was mother's approach to toilet training? If mother began training quite early and was rigid or forceful in her approach, does this mean she has high expectations of the child or is she a rigid, compulsive mother? How did the child react to mother's approach to toilet training?

List any significant delays in maturation.

Any history of enuresis in the child or siblings?

Does the mother see this child as slower or faster in development than siblings?

How does mother account for the difference?

Hearing Loss: This should be present as a separate heading only if this area enters into this particular patient's history. If so, give all information as to where the patient has been tested, the results, whether or not the client is able to use a hearing aid and if so, to what advantage?

Give client's response with and without the hearing aid in decibels.

At what age did the client begin wearing a hearing aid?

When was the hearing loss first diagnosed?

What have been the informants' responses to the loss of hearing in the client?

Health: Give briefly the medical history, listing only the significant occurrences.

List not only the event but the age at the time it occurred.
Give the final outcome of the illness if known.
Give the current height and weight of the client.
What part could poor health play in etiology?

Speech: This area should cover development of speech, acquisition of language, noting particularly any difficulties in communication.

Give the informants' versions of the development of speech and its adequacy now.

Give examples of the client's speech.

Sleep: Where did the client sleep as a child?
Has he/she ever been afraid to sleep alone?
Any history of nightmares or night terrors?
Did the client ever attempt to sleep with his parents, and if so, did they allow this?
Any history of wandering about the house at night, unable to sleep?
Did clients ever see ghosts or monsters?
Any history of difficulty going to sleep or waking very early in the morning?
Did client ever need presence of another family member or for instance a favourite blanket to get to sleep?
Was there any evidence of thumb sucking, rocking to and fro, nocturnal enuresis, masturbation?
Give usual current sleep patterns.

Ability to do for self: During development as a child, did the client progress as rapidly as he should in caring for physical needs, use of knife and fork, accepting responsibility for home chores?

Is the client in any way dependent on others currently for his physical needs?

Interests - Activities: Describe client's life pattern re: childhood play activities, adolescent group experiences, school clubs, employee organisations, religious and political activities. What has been the client's social development? Does this reflect and correlate with his experience with his mother in early life? How does the client spend his time currently?

Peer Relationships: Describe the client's history in terms of closeness to and getting "connected" with significant persons? Has he ever had close friends?

Sibling Relationships: Describe the client's interaction with siblings from early childhood; any rivalry present? How do they relate currently? Who is client closest to and why?

Other Significant Relationships: Describe the client's interaction with significant persons not mentioned elsewhere, i. e. aunt, surrogate parent, grandparent, baby sitter or "nanny".

What contact does the client have now with these significant people?

What are the personalities of the significant persons in the life of the client?

At what age did the client have most contact with these significant relationships?

Discipline: What was the parent's basic attitude toward discipline or limit setting as it related to child rearing?

Was this the same way their parents disciplined them, or was there a reaction formation at work?

Did the parents agree to discipline or limit setting?

Who took the most active part in disciplining the client?

What was the client's response to discipline or limit setting?

Was he easily frustrated?

After a spanking, did he cry for long periods of time, go off to his room alone, or return to the forbidden behaviour?

Fears - Unusual Habits: Was the client ever afraid of anything?

Was there a pattern to the type of fears?

Were his fears unusual for a child his chronological age?

Did he have any unusual habits, i.e., nail biting, masturbation, thumb sucking, temper tantrums, compulsive routines?

Did he pick wool from sweaters, pick at his nose or pull his ears?

Was he ever a head rocker?

Describe current fears or phobias in detail as to time and place of occurrence and evaluate as a symptom in the current maladjustment.

Education: Give details of nursery, kindergarten, pre-school experiences, grades and adjustment to classroom and peers.

Occupational history: Describe fully the client's work history and explain what this says about his ego functioning.

Personality as seen by Informants: Give the informants an opportunity to describe in their own words the patient and what he is like.

Be aware of the informants' responses to the things they are saying about the client.

Are the informants' affects appropriate to the situation?

What are the informants' basic attitudes toward the client?
Do the informants feel negative toward the client? How appropriate is this in the light of the patient's behaviour?
Do the informants' descriptions correlate with the interviewer's impression of the client as described in the history?
Do the informants see the client the same way? If not, what are the differences? Why do they not see him the same way?
What else do the informants' descriptions tell you about their relationships with the client?

V. CLIENT'S FAMILY:

If this is a single-parent family or one with a step-parent, this should be stated.

Information about the natural parent should be given as well as information about the step-parent.

Information about the natural parent should be given if the child is adopted as well as information about the adoptive parents.

Client's Father: Give a brief description of father in terms of age, education, employment.

Describe father's physical appearance and his personality.

What are his particular strengths and weaknesses?

How intelligent is he?

How does he handle problems?

What is his mood and general affect?

How does he relate to the interviewer?

Give a brief thumbnail sketch of the father's life. Include a description of his parents' personalities. How does he remember his youth?

Be aware of the part experiences play in his present attitudes.

Which parent has he identified with?

Which one does he remember as the stronger parent?

Any evidence of a hostile-dependent relationship with either parent?

Give a description of father's health history.

What are his interests and activities apart from work?

What is his relationship to the client?

What is his general attitude about the client's problem?

How does he see the problem and what help does he want with it?

What questions does he want the evaluation to answer?

How does the father see his wife?

What are his thoughts on her relationship with the client?

Does he support what she is doing as a mother?

Does he give any hint as to problems which the mother may be

having in her adjustment to life?

How does he see the marital relationship?

Client's Mother: Give the same information about mother as that listed above pertaining to father.

Be particularly aware of the mother's thinking and attitudes about her role as a mother and as a wife.

Is she inclined to put the children first at the expense of her relationship with her husband? Why would she need to do this?

How closely attached to her own parents is this mother?

Particularly, what are her feelings about her mother?

Does she have any interests outside the home?

What friends does she have apart from the family?

Client's. Parents' Marital Relationship: How long married and any previous marriages?

Be aware of unusual or disconcerting circumstances, such as this being a forced marriage.

How long did they go together?

Why did they marry each other?

What do they do together?

How well do they communicate?

How do they communicate? Verbally? Non-verbally?

What are the primary areas in which they have had to make adjustment?

How satisfactory has been the sexual adjustment?

Who is the stronger parent?

What are their basic attitudes about their individual roles in the marriage?

What are their attitudes about child rearing?

What expectations do they have for their children and from each other? Are these realistic?

What part does the marital relationship play in the problems which the client is exhibiting?

Client's Spouse (or ex): Give a sketch of her life history including as much as possible about her parents, siblings, education, occupation, social activities and characterological make up. See information under father and mother for additional guidelines.

Client's. Marital Relationship: Use information under parents' marital relationship as a guide.

VI. IMPRESSIONS: If client is an adult - first give a description of the client including physical characteristics, mannerisms, manner of relating to you, primary defence mechanisms in use, personality before current onset of problems, precipitating factors to current symptoms.

Explain client's symptoms in terms of ego maturation, habitual coping patterns, degree of anxiety and defence mechanisms seen as pathological, (i.e. delusions, hallucinations).

Explain current and past life stresses from environmental experiences and the part significant persons in client's life play in the development of current signs and symptoms of poor life functioning and/or emotional illness.

Be able to describe why the client is exhibiting the particular signs and symptoms which he is currently displaying.

Support your impressions on the basis of family dynamics or state that these have no real bearing on the etiology of the client's problems.

Describe this family's personality and present functioning -- make a family diagnosis.

Are there environmental pressures currently present which play a part in this?

In describing the family personality, pay particular attention to group dynamics -- roles fulfilled by each member and strengths and weaknesses of the group. What cultural values influence each parent from their original families, and are these compatible? What role adjustments are necessary in this particular family and how well does each member adjust to the change, i.e. a father who travels in his work? Describe family communication system. Is it open and verbal or non-verbally directed? Does the client get dual messages?

What is the prognosis in terms of possibility of change in this family? How can this best be accomplished?

What approaches should be taken in dealing with these parents?

What approach should be taken in interpreting the findings of the evaluation?

How can the family strengths be used to the advantage of the client and the improvement of his condition?

Is there sufficient information to make a diagnosis at this time or are further diagnostic procedures called for? For example, does the child need an EEG or a complete neurological?

If the child is to be referred to the psychologist, what specific questions should be answered?

Recommendations: Be very specific in listing the next steps that should be taken in working with this family.

Who should make the interpretation?

List any community resources that may be available to this family and how they could be used for the client's benefit.

If there are underlying, basic family problems that need to be corrected, who could best accomplish this?

Be aware of the family's financial resources and the geographic location of the home in making referral to other resources.

Exhibit 3

**SME Step II
Summary Work Sheets**

PSYCHO-SOCIAL INDEX

S M E STEP II

SUMMARY WORK SHEETS

CLIENT'S NAME _____ M/F

D O B _____ AGE _____

DESCRIPTION OF CLIENT:

DESCRIPTION OF CLIENT'S FAMILY:

ADJUSTMENT

CONDITION AT BIRTH

DEVELOPMENT/FUNCTIONING

A. Physical

B. Behavioural

C. Intellectual

D. Emotional

E. Social

STRESS

SIGNIFICANT RELATIONSHIPS

A. Mother/Client

B. Father/Client

C. Others/Client

CURRENT FAMILY FUNCTIONING

COMMUNITY RESOURCES

S M E STEP IV

PSYCHO-SOCIAL INDEX

		<u>SCORES</u>	
		<u>Raw</u>	<u>Index</u>
<u>ADJUSTMENT</u>		_____	_____
<u>CONDITION AT BIRTH</u>		_____	_____
<u>DEVELOPMENT/ FUNCTIONING</u>			
	<u>Sub Scores</u>		
	<u>Row Index</u>		
Physical	_____	_____	
Behavioural	_____	_____	
Intellectual	_____	_____	
Emotional	_____	_____	
Social	_____	_____	
Total	_____	_____	_____
<u>STRESS</u>		_____	_____
<u>SIGNIFICANT RELATIONSHIPS</u>			
	<u>Sub Scores</u>		
	<u>Row Index</u>		
Mother / Client	_____	_____	
Father / Client	_____	_____	
Others / Client	_____	_____	
Total	_____	_____	_____
<u>CURRENT FAMILY FUNCTIONING</u>		_____	_____
<u>COMMUNITY RESOURCES</u>		_____	_____
Total Index Score		_____	_____

P.S.I. GRAPH

A CB D/F S SR FF CR

DIAGNOSTIC SCORE

Total Index _____

CR Index _____

Total _____ %

RESOURCES SCORE

FF Index _____

CR Index _____

Total _____ %

P.S.I. SCORE _____ %

CLIENT'S NAME _____ M/F D.O.B. _____ AGE _____

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Informants: _____

Examiner: _____

Date: _____

S M E STEPS V AND VI

DEVELOPMENTAL DYNAMIC DIAGNOSTIC STATEMENT

S M E STEP VII

RECOMMENDATIONS

Exhibit 4

SME Step III

Age Groups I and Vb

(Collectively include questions for all age groups)

PSYCHO-SOCIAL INDEX

S M E STEP III

GROUP III

Ages 6 Through 11-11/12 Years

Each Statement is to be marked TRUE or FALSE:

ADJUSTMENT

1. No indications of physical dysfunctioning are known.
2. No indications of maladaptive psychological functioning are known.
3. No indications of personality maturational retardation (or deviation) are known.
4. No difficulty handling anxiety, frustration, guilt or tension (manifesting itself in symptom formation) is known.
5. No fears or phobias are known.
6. No excessive withdrawal is noted.
7. No excessive aggression is noted.
8. No inappropriate personality responses to significant persons is noted.
9. Mood patterns are predominately appropriate to situations.
10. No significant conflicts in interpersonal relationships are noted.
11. No failure in academic/scholastic achievement is noted.
12. No retardation in motor development is noted.
13. No immaturity in emotional development is noted.
14. No immaturity in social development is noted.
15. No immaturity in intellectual development or functioning is noted.
16. Observed symptoms of maladjustment are situational rather than chronic.
17. The premorbid personality was essentially healthy and mature.
18. Onset of observed symptoms was sudden.
19. No psychosomatic symptoms are noted.
20. No signs of poor self-esteem are noted.
21. No indications of a poor self-concept are noted.
22. No difficulty in speech and/or communication is noted.
23. No difficulty in age-appropriate autonomous functioning is noted.
24. No sign of hallucinating is noted.
25. No sign of deluding is known.
26. No difficulty in reality-testing and/or confused thinking is noted.

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27. No sign of other maladaptive defence mechanisms or personality coping patterns is noted.
28. No sign of difficulty in basic trust of others and in the capacity to form lasting, close relationships is noted.
29. The client positively participates in his family group.

CONDITION AT BIRTH

1. The gestation period was within normal limits.
2. There was nothing significantly unusual about the client's birth.
3. There were no known birth injuries.
4. No congenital defects were noted at birth.
5. At birth no difficulty with breathing was reported.
6. The mother was free of physical symptoms during the prenatal period.
7. The mother was free of emotional symptoms during the prenatal period.
8. No hereditary defects (from either of the parent's families) are suspected.
9. No evidence of congenital defects appear in the post-natal developmental history.

DEVELOPMENT/FUNCTIONING

A. Physical

1. No indication of hormonal malfunctioning is known.
2. Weight-height proportions are within normal limits.
3. No maldevelopment of sexual organs is known.
4. No evidence of visual dysfunctioning is known.
5. No sign of communication dysfunctioning is known.
6. No sign of hearing dysfunctioning is known.
7. No sign of other sensory dysfunctioning is known.
8. No sign of heart dysfunctioning is known.
9. No sign of digestive-tract dysfunctioning is known.
10. No sign of brain dysfunctioning is known.
11. No sign of other central nervous system dysfunctioning is known.
12. No sign of lung dysfunctioning is known.
13. No sign of muscular dysfunctioning is known.
14. No sign of skeletal malformation is known.
15. No sign of other organ dysfunctioning is known.
16. No difficulty in elimination of feces is known.
17. No difficulty in elimination of urine is known.
18. No lack of vitality is indicated.
19. No indication of impairment of memory is noted.
20. No indication of confused thinking is noted.
21. No difficulty in ambulation is known.

B. Behavioural

1. No history of developmental retardation in feeding is known.

2. No history of developmental retardation in sitting is known.
3. No history of developmental retardation in crawling is known.
4. No history of developmental retardation in walking is known.
5. No history of developmental retardation in speech/language is known.
6. No history of developmental retardation in toilet training is known.
7. No history of developmental retardation in academic/scholastic learning is known.
8. No history of failure in gaining age-appropriate autonomous functioning is known.
9. No failure in acquiring appropriate self-help skills is known.
10. No indications of failure in gaining any other age-appropriate motor skill is known.

C. Intellectual

1. No sign of inability in academic/scholastic learning is known.
2. No sign of inability to think abstractly is noted.
3. No sign of inability to adjust or adapt to the environment is noted.
4. No sign of inability to form close, lasting relationships is noted.
5. No sign of inability to reason is noted.
6. No sign of memory loss of recent experiences is noted.
7. No sign of memory loss of past experiences is noted.
8. No sign of difficulty in learning verbal skills is noted.
9. No sign of difficulty in learning mathematical, reading or spelling skills is noted.
10. No sign of retardation in the development stages is noted.
11. No sign of difficulty in performing self-help tasks is noted.
12. No sign of difficulty in reality-testing is noted.
13. No sign of difficulty in relating parts of a problem or a situation to the whole is noted.
14. No sign of difficulty in analysing a problem or a situation and dealing with the parts in a realistic manner is noted.
15. No sign of difficulty in self-awareness of strengths and weaknesses is noted.
16. No sign of lack of capacity to act purposefully is noted.
17. No sign of inability to think rationally is noted.
18. No sign of inability to assume responsibility is noted.
19. No sign of difficulty in communication is noted.
20. No other sign of difficulty in intellectual functioning is noted.

D. Emotional

1. There is age-appropriate capacity to tolerate frustration.
2. There is no need to avoid situations which are stimulating.
3. There is a capacity to handle stimulation without emotional outbursts.
4. Emotional responses are appropriate to situations.
5. Feelings of anxiety are appropriate to situations.
6. Feelings of guilt are appropriate to situations.
7. Feelings of tension and/or frustration are appropriate to situations.
8. There is age-appropriate bowel control.
9. There is age-appropriate bladder control.
10. Types of expression of anger are appropriate to situations.
11. Types of expression of anger are age-appropriate.
12. Degree of expression of anger is age-appropriate.
13. Type of sexual expression is appropriate to situations.
14. Frequency of sexual expression is appropriate.
15. There is an age-appropriate capacity to postpone gratification and satisfaction.
16. There is healthy balance between optimism and pessimism.
17. Overall emotional maturation and functioning is age-appropriate.

E. Social

1. Capacity for intimate interpersonal relationships is age-appropriate.
2. Responses to and expectations of authority figures are age-appropriate.
3. There is a capacity for basic trust in others.
4. Object-choices for expressions of anger are appropriate.
5. Capacity to be a part of a peer group is appropriate.
6. Capacity to work co-operatively with others is appropriate.
7. Capacity to share is appropriate.
8. Capacity to participate in heterosexual social activities is appropriate.
9. Competition in interpersonal relationships is appropriate.
10. Dependency in interpersonal relationships is appropriate.
11. Overall behaviour is generally socially acceptable.

STRESS

1. No sign of congenital defect is noted.
2. Maternal attitudes towards the client were not stressful.
3. The client's overall relationship with his mother was not stressful.
4. No evidence that the mother has been too involved with the client during the maturation process (thus too stimulating) is noted.

5. Paternal attitudes towards the client were not stressful.
6. The client's overall relationship with his father was not stressful.
7. No evidence that the father has been too involved with the client during the maturation process (thus too stimulating) is noted.
8. No history of overly-stimulating sexual experiences is known.
9. No evidence that birth of siblings or relationships with siblings have been overly-stressful.
10. No evidence exists that the move from home to peer relationships was overly-stressful.
11. No evidence exists that relationships with significant persons besides parents or siblings has been overly-stressful.
12. No history of traumatic separations from the mother is known.
13. No evidence of overly-stressful illnesses exists.
14. No evidence of physical trauma exists.
15. No evidence exists that the developmental move from home to school was overly-stressful.
16. No evidence exists that experiencing parental marital discord was stressful.
17. No evidence exists that family socio-economic standing has been stressful.
18. No evidence exists that family religious influences has been stressful.
19. No evidence exists that other cultural factors have been stressful.

SIGNIFICANT RELATIONSHIPS

- A. Mother/Client (Note: Surrogate mothers should be evaluated in this section.)

1. The mother's basic personality is conducive to good mothering.
2. The mother's cultural-socio-economic developmental background enhances her capacity to mother.
3. The mother's attitude towards parenting enhance her functioning as a mother.
4. The mother has adequate self-esteem without depending primarily on the mother role for self-enhancement.
5. The mother's attitudes towards the client do not interfere with her capacity to mother.
6. The mother has had no major physical or emotional trauma that interfere with her capacity to mother the client.
7. The mother's emotional giving has been adequate.
8. The mother's physical giving has been adequate.
9. The mother has made a positive approach to discipline, with consistent and realistic limit-setting.
10. Parents agree on discipline and limit-setting.
11. The mother received positive emotional support from her husband during the client's first seven years of life.
12. No significant separations between mother and client occurred during the developmental years.

13. A good mothering experience is reflected in the client's personality.
14. A positive response to the mother during the developmental years is reflected in the client's history.
15. No major physical or emotional factor has interfered with the client's capacity to relate to his mother and to maintain normal maturation.
16. The client's response to discipline and limit-setting during the maturational years reflects adequate and positive maternal handling.
17. Stage by stage during the maturational years, most of the client's needs to be mothered were met.
18. The timeliness of the client's birth was positive for the mother.

B. Father/Client (Note: Surrogate fathers should be evaluated in this section)

1. The father's basic personality is conducive to good fathering.
2. The father's cultural-socio-economic developmental background enhances his capacity to parent the client.
3. The father's attitudes towards parenting enhance his functioning as a father.
4. The father has adequate self-esteem without depending primarily on the father role for self-enhancement.
5. The father's attitudes towards the client do not interfere with his capacity to father.
6. The father has had no major physical or emotional trauma that interfere with his capacity to father the client.
7. The father's emotional giving has been adequate.
8. The father's physical giving has been adequate.
9. The father has made a positive approach to discipline, with consistent and realistic limit-setting.
10. Parents agree on discipline and limit-setting.
11. The father received positive emotional support from his wife during the client's first seven years of life.
12. No significant separations between father and client occurred during the developmental years.
13. A good fathering experience is reflected in the client's personality.
14. A positive response to the father during the developmental years is reflected in the client's history.
15. No major physical or emotional factor interfered with the client's capacity to relate to his father and to maintain normal maturation.
16. The client's response to discipline and limit-setting during the maturational years reflects adequate and positive paternal handling.
17. Stage by stage during the maturational years, most of the client's needs to be fathered were met.
18. The timeliness of the client's birth was positive for the father.

C. Others/Client

1. Birth of sibling(s) did not produce unusual stress in the client.
2. Ordinal position among siblings has not been stressful to the client.
3. Interaction between client and siblings has been primarily positive.
4. Client and siblings have not experienced an unusual degree of rivalry.
5. No evidence of "favouritism" of one child in the family is indicated.
6. The client's capacity to share with peers is age-appropriate.
7. The client's capacity to be a part of a group is age-appropriate.
8. The client's choice of friends according to sex is age-appropriate.
9. The client's choice of friends according to sex is age-appropriate.
10. The chronological ages of peers is appropriate for the client's age and educational attainment level.
11. The client has gained the capacity to stand up for himself and protect his rights among peers.
12. The client is not unduly concerned about peers' feelings and attitudes towards him, i.e. his self-esteem does not primarily depend upon positive evaluation by others.
13. The client's relationship with any significant person (other than parents, siblings and peers) shows no negative influence upon the client's personality.

CURRENT FAMILY FUNCTIONING -- SECTION "a" (This section to be completed for clients, regardless of age, who live in a family group. Evaluate current family dynamics.)

1. Family functioning is enhanced by the mother's basic personality.
2. Family functioning is enhanced by the father's basic personality.
3. Family functioning is enhanced by the parents' marital relationship.
4. Family functioning is enhanced by the family's cultural experiences.
5. Family functioning is enhanced by the family's religious practices.
6. Family functioning is enhanced by the family's socio-economic status.
7. Family functioning is enhanced by the intelligence of the parents.
8. The mother has sufficient motivation to use assistance outside the family when it is needed.
9. The father has sufficient motivation to use assistance outside the family when it is needed.

10. Family functioning is enhanced by the presence of extended family members living in the same household.
11. Family functioning is enhanced by the father's vocational experience.
12. Family functioning is enhanced by the mother's activities outside the family which increase her self-esteem.
13. Family values and standards of the parents are compatible.
14. Family functioning is enhanced by the influence of the mother's parents.
15. Family functioning is enhanced by the influence of the father's parents.
16. Family functioning is enhanced by the mother/client relationship.
17. Family functioning is enhanced by the father/client relationship.
18. The family has sufficient strength to deal with stressful situations which arise in most families.
19. No indication of breakdown in family equilibrium as evidenced by symptoms of maladjustment of any family member, is indicated.
20. Parents adequately meet one another's sexual needs.
21. Parents adequately meet one another's dependency needs.
22. Parents adequately meet one another's needs for closeness.
23. Family functioning is enhanced by the allocating of roles (among family members) in order to meet the economic needs of the family.
24. Family functioning is enhanced by the allocating of roles (among family members) in order to meet the emotional needs of the family.
25. No evidence of neurotic interaction among family members (in order to maintain family equilibrium) is indicated.
26. Individual family member's goals for the family group are compatible.
27. Communication between parents and children in the family has not been adversely affected by a "generation gap".
28. Family equilibrium has not been disrupted by financial trauma.
29. Family equilibrium has not been disrupted by health trauma.
30. Parents are not physically or emotionally separated by current situational trauma.
31. A sense of unity and pride exists in the family.
32. Verbal communication among family members is adequate.
33. Feeling communication among family members is adequate.
34. An appropriate attitude of optimism for the future permeates the family.
35. No evidence exists of the family having been established under traumatic circumstances, or that the marriage was a "forced" one.
36. Family interaction enhances the individual functioning of each family member.

COMMUNITY RESOURCES

1. Immediate availability of services is compatible with the severity of the client's problems.
2. Family strengths and motivation are sufficient to help the client.
3. Family motivation is sufficient to make use of community resources.
4. Availability of community agency services are compatible with the identified needs of the client.
5. No complicating factors prevent the client's receiving help from community resources, i.e. long waiting lists.
6. Extended family members are available to help the client and/or his family.
7. A religious institution and clergy are available to help the client and/or his family.
8. Type of help needed and wanted by the client and his family is compatible with available community resources.
9. No unchangeable constitutional problem is exhibited by the client.
10. Community resources are available to improve constellation problems.
11. Close friend(s) are available to help the client and/or his family.

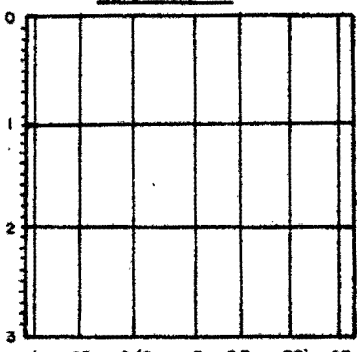
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Exhibit 5

SME Step IV

S M E STEP IV

PSYCHO-SOCIAL INDEX

			<u>SCORES</u>		
			<u>Raw</u>	<u>Index</u>	
<u>ADJUSTMENT</u>			_____	_____	<u>P.S.I. GRAPH</u> 
<u>CONDITION AT BIRTH</u>			_____	_____	
<u>DEVELOPMENT/ FUNCTIONING</u>					
	<u>Sub</u>	<u>Scores</u>			
	<u>Raw</u>	<u>Index</u>			
Physical	_____	_____			
Behavioural	_____	_____			
Intellectual	_____	_____			
Emotional	_____	_____			
Social	_____	_____			
Total	_____	_____	_____	_____	
<u>STRESS</u>			_____	_____	
<u>SIGNIFICANT RELATIONSHIPS</u>					
	<u>Sub</u>	<u>Scores</u>			
	<u>Raw</u>	<u>Index</u>			
Mother/ Client	_____	_____			
Father/ Client	_____	_____			
Others/ Client	_____	_____			
Total	_____	_____	_____	_____	
<u>CURRENT FAMILY FUNCTIONING</u>			_____	_____	
<u>COMMUNITY RESOURCES</u>			_____	_____	
Total Index Score			_____	_____	

		<u>DIAGNOSTIC SCORE</u>						
		Total Index _____						
		- CR Index _____						
		Total _____ %						
		<u>RESOURCES SCORE</u>						
		FF Index _____						
		CR Index _____						
		Total _____ %						
		<u>P.S.I. SCORE</u> _____ %						

CLIENT'S NAME _____ M/F D.O.B. _____ AGE _____

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Informants: _____
 Examiner: _____
 Date: _____