PROBLEMS OF FATHERLESS CHILDREN: A COMPARATIVE STUDY OF MATERNAL ATTITUDES AND BEHAVIOR OF PROBLEM CHILDREN IN FATHERLESS AND PHYSICALLY INTACT FAMILIES

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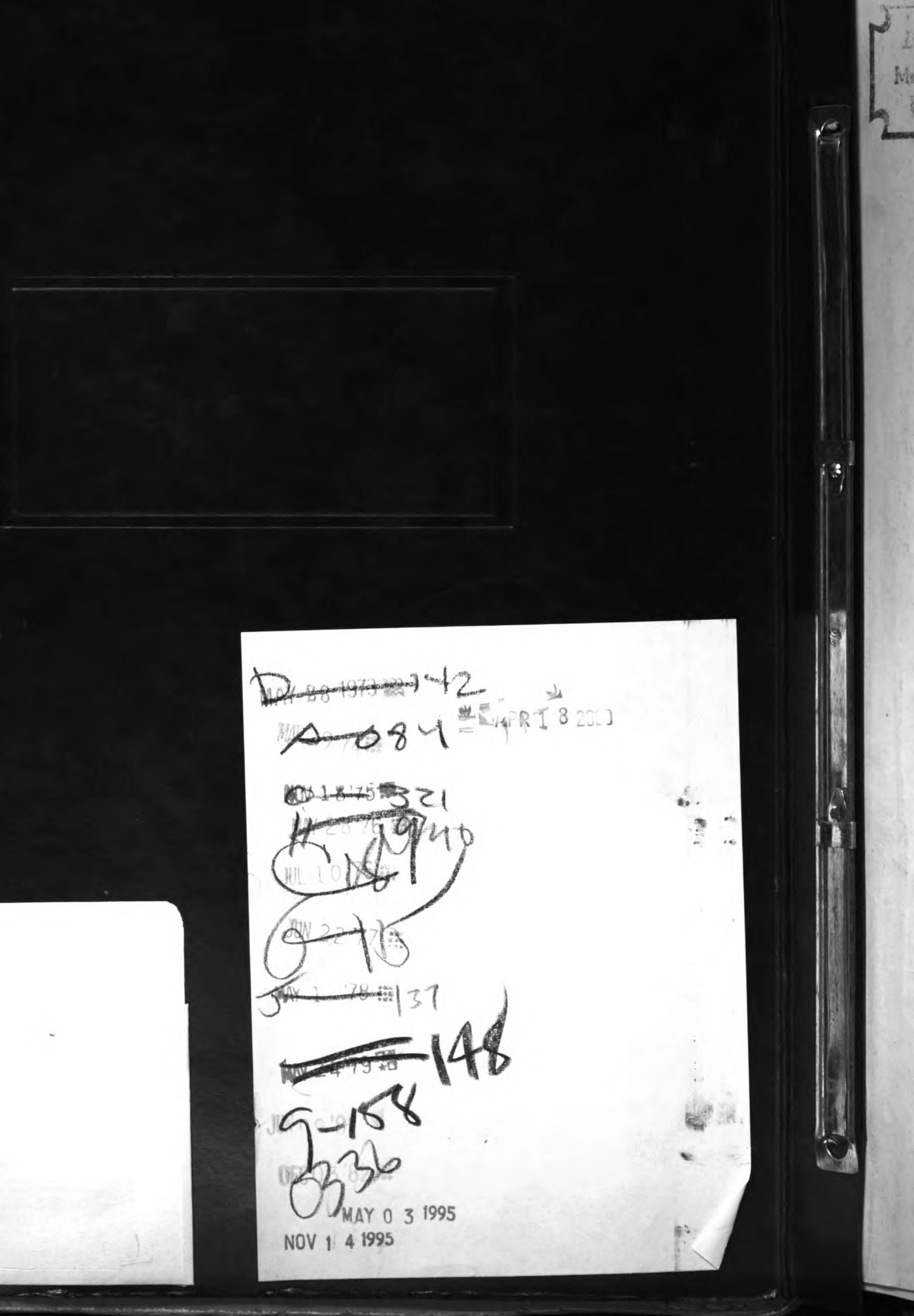

THE PROBLEMS OF FATHERLESS CHILDREN:

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A PROJECT REPORT

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CHAPTER I

INTRODUCTION

In recent years there has been a growing awareness of the psychological role of the father in the personal and social adjustment of the child. O. Spurgeon English,[1] in an article referring to this psychological role, mentioned the need for research in this area and suggested that in part, this might be accomplished through a study of fatherless families.

In discussing the role of the father, English[2] and Josselyn[3] as well, point out that one of the father's principal functions is to provide support for his wife in her role as mother. If this be true, then there may well be in fatherless families, where this support is lacking, a change in the role of the mother and the pattern of her mothering; this change may create difficulties

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[1]O. Spurgeon English, "The Psychological Role of the Father in the Family," Social Casework, Vol.XXXV, 1954,328.

[2]English, Ibid., p. 325.

[3]Irene Josselyn, "The Psychology of Fatherliness," Smith College Studies in Social Work, Vol. 26,(1956) pp. 1-14.

for the development of one or more of her children.

Ruth J. Peterson, in an article entitled, "Understanding the Reactions of Fatherless Families," speaks of the difficulties that fatherless youngsters have as resulting from "the lack of emotional balance" in these families:

> "The high proportion of children in fatherless families who come to the attention of social agencies and public authorities because of learning problems, poor social adjustment, or anti-social or delinquent behavior, is indicative of the lack of emotional balance within such families. This lack in turn, has disrupted the normal processes of emotional growth for the individual members of the family."[4]

Assuming then, that one of the father's principal functions in the family is to provide physical and emotional support for the mother, it must be concluded that without the presence of the father, the mother's role is likely to change; further, this changed role may well interfere with the mother-child interrelationships and affect the child's personal and social adjustment.

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[4]Ruth J. Peterson, "Understanding the Reactions of Fatherless Families," The Significance of the Father, New York: Family Service Association of America, (1959)

From these assumptions three major hypotheses were drawn:

1. A mother from a one-parent family, being deprived of the emotional and physical support of her husband, will reflect this loss in a rejecting attitude toward her child.

2. The child from the fatherless family will display a significantly greater amount of aggression and/or conduct disorder than a child from a physically intact family.

3. Aggressive behavior or conduct disorders will occur more frequently in the cases in which the mother has a rejecting attitude.

A study of fatherless children, and the inter-relationship of child and mother in such circumstances, would appear to have many values: (1) findings hopefully would show a pattern of dynamics that would assist in diagnostic assessments of the problems of both mothers and children of fatherless families; (2) findings would provide the social planner with information to assist in alleviation and prevention of the problems of such families; and, (3) the study would be a supplement to present knowledge about the significance of the father in the family.

It seemed logical that a study of such families might well begin in the Child Guidance setting, since children experiencing difficulties in personality development would likely be seen there. In field work

placement at the Lansing and Kalamazoo Child Guidance Clinics the writers had the opportunity to examine the case records of fatherless children, reviewing both factual face sheet data about the family and its make-up, and the relationships and family difficulties revealed in the case material. From these settings, it was possible to assess and analyze the difficulties of this atypical, though not uncommon, family pattern, and to compare the findings of each clinic. The use of the two clinics was seen as an advantage in that comparable findings would thus be more generalizable and significant.

Since the Lansing and Kalamazoo Clinics are both organizations whose major framework is set up by the State Department of Mental Health, their programs and operational procedures are similar in many respects. Therefore, to simplify the presentation of the clinical settings in which this study was conducted, the program of the Lansing Child Guidance Clinic will be presented in detail and this presentation will be followed by a presentation of those aspects of the Kalamazoo program which differ from the administrative procedures and make-up of the Lansing Clinic.

The Lansing Child Guidance Clinic offers diagnostic and treatment services on an out-patient basis for

children showing emotional difficulty in that they are unable to adjust adequately to their homes, school, community or selves. Whenever possible, both the parents and the child are seen in order to affect an adjustment in all concerned. This procedure is warranted by the relative ineffectiveness of treating the child only, inasmuch as he normally returns to the family milieu. In general, the clinic fosters children's mental health by providing information and educational services for the general public through program planning, presenting public lectures, or leading group discussions. The clinic not only participates in community planning and coordination, but also provides consultation services with other agencies, including physicians. These include consultations regarding other agency cases, consultations with agencies regarding other problems of a general nature, interpretation of clinic policy to agencies, attendance at staff meetings of other community agencies, and annual meetings with coincidental reports.

The clinic, formerly known as Lansing Children's Center, Inc., was opened in 1938 by the Ingham County Council of Social Welfare and became a branch of Michigan's Mental Health Program. This step resulted from a survey by the National Probation Association relative to the

prevention of delinquency, a pattern characteristic of the child guidance movement in general. Its function was essentially diagnosis, treatment, prevention, and education.[5]

The clinic is a joint state and local project supported by funds received from state taxes through the Michigan Department of Mental Health and local sources, e.g., the Community Chest, school boards, and boards of supervisors. An advisory board, composed of citizens of the area served, acts as a liaison between the community and the professional staff. Inherent in the duties of the Board is the responsibility for the raising of local funds. The Clinic does not utilize the fee system, but gifts to the Clinic by those served are accepted.[6]

Referrals are accepted from the four counties which the clinic is designated to serve: Ingham, Eaton, Clinton, and Livingston.

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[5]Marcella Jean Gast, "A Child Guidance Clinic as a Social Resource in a Small Metropolitan Community" (Unpublished Project for Master's Degree, Department of Social Work, Michigan State College, 1947).

[6]Marouf Hasian and Franklyn Wosek, "A Comparative Study of Psychosocial Characteristics of Parents of Sixty Families Who Continued or did not Continue Recommended Treatment at the Lansing Child Guidance Clinic" (Unpublished Project for Master's Degree, School of Social Work, Michigan State University, 1959).

Referrals are accepted for children from birth until they graduate from high school or through the age of sixteen, if they no longer attend school.

The team approach is employed by the professional staff composed of a psychiatrist-director, a half-time psychiatrist, four psychiatric social workers, two psychologists, three students in social work, and two students in psychology.

Only problems which indicate that a child has some emotional difficulty are accepted as referrals; whereas other problems, such as a severe organic difficulty, are considered as inquiries. Frequently the referrals are made by a physician, a school, or other agency. In such instances, the parents are encouraged to personally contact the agency. After the referral is made, it is reviewed by the chief psychiatric social worker, administrative assistant, who:

1. may call the parents for further information or discussion and may refer them to another agency;

2. may call the original referral source for further information or discussion;

3. may obtain further information from community agencies and institutions, if permission is granted by the parents;

4. may, depending on whether or not the referral is a typical one, decide the approximate time for the diagnostic study;

5. and may occasionally assign a case to a social worker for one or more interviews with the parent for clarification of the difficulty so that an appropriate disposition may be made, such as referral to another community agency or planning for further clinic service.

The referral is then placed on the diagnostic evaluation waiting list. Appointments for the intake process or diagnostic study, which includes the interview with the parents by the psychiatric social worker, psychiatric examination of the child by the psychiatrist, and psychological testing of the child by the psychologist, are scheduled according to the problem involved and/or community concern.

A new referral may be seen within a week, two weeks, a month, or perhaps not for a year. The waiting period is due to the large area served and the many children referred compared to the size of the staff. New referrals are generally categorized as "emergency", "ahead", "regular". An attempt is made to apportion time among the three categories. Approximately six diagnostic studies are completed a week. While an attempt is made

to schedule two emergencies, two ahead, and two regular, this is often altered by the following points:

1. Re-referrals are seen ahead.

2. Long standing chronic cases may need to wait a longer period of time.

3. Emergency situations are put in as soon as possible. This may refer to children with acute anxiety attacks, acute depression, uncontrollable behavior, etc.

4. Community agencies, who are referring for further study and recommendations, are generally scheduled within a month to two months and according to the time when the agency reports are received by the clinic.

The diagnostic study is completed within one to four weeks. Each case is then staffed by the team members involved within one to four weeks following the completion of the study. Members from other community resources, with permission of the parents, are invited to the staff conference. These include Visiting Teachers, Family Service, Court, and others. School personnel and community representatives not trained in case service come to the last half hour of the staff conference after confidential material has been discussed by the staff. One hour is scheduled for each staff conference, the purpose of which is to reach a

tentative diagnosis and make plans for helping the child. The parents are seen by the social worker within one to two weeks after the staff conference for a discussion of clinic findings and recommendations.

The program of the Kalamazoo Child Guidance Clinic is essentially the same as that of the Lansing Clinic; only the major differences in history, organization and program will be cited here.

Established in 1942 under the name of the Kalamazoo Children's Center, the program served a nine county area of Southwestern Michigan. This area was later cut down to the present five county service area of Allegan, Barry, VanBuren, St. Joseph and Kalamazoo counties. The staff now includes: a psychiatrist-director, a chief psychiatric social worker, who is also administrative assistant, a half-time psychiatrist, a psychologist, three social workers, three student social workers, and a half-time volunteer speech therapist.

In the year 1959, support for the program was garnered from forty-six different local sources in addition to the State Department of Mental Health; primary among these sources were the boards of supervisors of the five counties, the boards of education, and the Community Chests within the area.

By assignment of a particular staff worker to each county for purposes of liaison and communication, an attempt has been made by the clinic to personalize its relationship with the counties served, and with the referral sources within these counties. Further, still attempting to provide more service, the clinic has inaugurated the use of pre-intake forms to the parents, the physician, and the teacher of the child. The parents alone decide whether or not they wish to use these forms and service is not denied if they elect not to send the questionnaires to the physician and the teacher.

The waiting period from the time of referral of the problem to the Clinic until intake varies from three to six months, depending on the county involved. Those counties presenting the greatest need for service, as measured by the number of referrals, will have the greatest number of new cases seen per month. This waiting list, and the number of new cases seen per year, is further controlled by the use of a "screening week" which is held semi-annually, or as needed to maintain a constant level of new cases per year. "Screening week" is a week in which regular treatment interviews are suspended and all new cases are seen by the staff, to determine the need for service by the clinic, referral to

other more appropriate agencies or interpretation and closing of the case. Approximately five hundred new cases are seen annually, or ten cases per week.

Two waiting lists are maintained by the clinic: the regular list and the emergency list; the emergency list is composed of problems in which the child is potentially dangerous to himself or others, or in which the child is, for one reason or another, staying away from or being excluded from regular school attendance.

As in the Lansing Clinic, the diagnostic study consists of psychiatric social history, psychological examination, and psychiatric evaluation; however, this year, speech evaluation has been used to provide a new dimension to the study of each child seen. This total clinical evaluation involves about six and a half hours of professional staff time and takes from one to three weeks to accomplish.

However, not every child is seen for full diagnostic study. The social worker, who sees the parent at intake, together with the psychologist, who has examined the child determine the need for psychiatric evaluation. If they feel that the problem is inappropriate for clinic service, they may refer the family to another, more appropriate agency. If they feel that the dynamics of

the situation are clear and adequately understood, they may have the case assigned for treatment in the clinic. Or they may make interpretation and suggestions to the parents and close the case, if this appears to be indicated.

In the event that the social worker and the psychologist send the case on to the psychiatrist for evaluation, they include their own evaluations of the case and their recommendations. The psychiatrist, after making his own evaluation and considering the recommendations of the other disciplines, makes the case recommendations. No formal staffing is held unless one of the members of the clinic team requests it.

As in the Lansing Clinic, disposition of cases after diagnostic study is dependent upon the findings and recommendations of the study. In the event that the case is to be kept for treatment within the clinic, the administrative assistant makes assignment of the parent or parents to one staff person, and of the child to a second staff person; any one of the disciplines may be assigned to do treatment. Treatment interviews are generally bi-weekly, although, at the discretion of the worker, they may be scheduled more often.

CHAPTER II

REVIEW OF THE LITERATURE

"If the old bird dies, the eggs are addled."

- Ama-Xosa, a Bantu tribe proverb

Numerous studies related to the present study, reflect a growing concern in the general area of mother-child relationships when the father is permanently absent from the home. Much of the literature on parent-child relationships is nonexperimental in nature. On the whole it lacks the precision and the accuracy that is necessary for diagnosis, therapy, and prediction. However, it is suggestive of trends in the relationships between the child's home environment and his behavior.[1] Schaefer and Bell[2] point out that the current interest in the influence of the parent-child relationships upon the personality development of the child has arisen primarily through

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[1]Marian J. Radke, The Relation of Parental Authority to Children's Behavior and Attitudes, (Minneapolis: The University of Minnesota Press, 1946) p.3.

[2]Earl S.Schaefer and Richard Q. Bell, "Development of a Parental Attitude Research Instrument", Child Development, Vol. XXIX, No. 3, (September, 1958) p. 339.

studies of families by child guidance clinics.

One such study, done at the Judge Baker Guidance Center in Boston, compared twenty problem boys who lived alone with their mothers with a control group of twenty problem boys who lived with both parents. It was found that more of the boys living with their mothers tended to be delinquent in their behavior and aggressive in their personalities. Those living with both parents tended to be inhibited, socially or intellectually, in their behavior and withdrawn in their personalities.[3]

In another study, done at the Worcester Youth Guidance Center, Wylie and Delgado[4] were impressed by similarities in a number of cases of aggressive, fatherless boys. Their study of twenty cases revealed that nearly all of the boys did poorly in school, half were enuretic, and one-fourth soiled. The absent fathers were looked upon by the mothers as being bad; the boys were viewed as being like their fathers, and assumed some of the father's role in the home. The relationship between

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[3]Ruth E. Allen, "Problem Boys Who Lived Alone with Their Mothers", Smith College Studies in Social Work, Vol. XIII (1942), p. 157.

[4]Howard L. Wylie and Rafael A. Delgado, "A Pattern of Mother-Son Relationships Involving the Absence of the Father", American Journal of Orthopsychiatry, Vol. XXIX (July, 1959) pp. 644-46.

mother and son was intense, highly sexualized and full of hostility. In some cases it was noted that mother and son wrestled together, and in almost half of the cases, mother and son slept together. It was also concluded that the mothers came for help only at times of crisis and under external pressure; most of them discontinued treatment early. Those who remained were very difficult to treat.

In addition to clinical studies of father-separated homes, the broken home has been studied by researchers seeking the causes of delinquency. In their findings they conclude that the broken home is relatively insignificant in relation to delinquency. Sherman[5] found that only about twenty-five percent of the children in broken homes present problems, from the standpoint of the clinic, and Hirsch[6] reported that the proportion of siblings who are delinquent among cases from broken homes is about the same as the proportion among cases from unbroken homes. Campbell[7] found that neither school

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[5]Baruch Sherman, "The Behavior of Children from Broken Homes", American Journal of Orthopsychiatry, Vol. V (Jan., 1935) pp. 11-18.

[6]N. D. M. Hirsch, Dynamic Causes of Juvenile Crime, (Cambridge: Sci-Art, 1937).

[7]Marian Campbell, "The Effect of Broken Home upon the Child in School", Journal of Educational Sociology, Vol. V. (Jan., 1932) pp. 274-281.

achievement nor conduct was affected appreciably by a break in the home after the immediate stress had passed.

Although coming from a broken home was not in itself felt to be very significant, the quality of the parent-child relationship was considered to be of crucial importance. Burt[8] concluded that defective discipline was present six and nine-tenths times as frequently in the homes of delinquents as of non-delinquents. Included among the forms of defective discipline was the lack of discipline due to the absence of the parent. The Gluecks[9] found "unsuitable" supervision by the mother in the homes of sixty-four percent of the delinquent children and in the homes of only thirteen percent of the non-delinquents.

Since the most extensive and intensive social interactions of the child during crucial developmental stages occur within the family and especially with the mother, the mother-child relationship is of major importance in personality development. The importance of maternal attitudes to the development of the child has been generally accepted.

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[8]Cyril Burt, The Young Delinquent, Fourth Edition, (London: University of London Press, 1944).

[9]Sheldon and Eleanor Glueck, Unraveling Juvenile Delinquency, (New York: The Commonwealth Fund, 1950) pp. 113, 131.

> Bettelheim[10] has pointed out that if parents, who rigidly attempt to impose accelerated developmental goals upon children, are told that early toilet-training is undesirable, they may delay such training but may continue to accelerate the child in talking, reading, and other important areas of development. This example illustrates that an underlying attitude may influence a great variety of parent behaviors.[11]

Nonexperimental reports agree that the influence of the home is exceedingly great in the life of the child because of the primacy, pervasiveness, and long duration of its contacts with him.[12] Teagarden[13] states that ". . . all manner of behavior deviations can be and often are accounted for by the subtleties of home relationships."

In conjunction with the above, Gardner[14] has pointed out that changes may frequently occur in the maternal attitude toward the child following separation from the husband. Included among these changes were: (1) the child

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[10]B. Bettelheim, "Mental Health and Current Mores", American Journal of Orthopsychiatry, Vol. XXII (1952), pp. 76-78.

[11]Schaefer and Bell, op.cit., p. 340.

[12]Radke, op. cit., p. 3.

[13]F. Teagarden, Child Psychology for Professional Workers, (New York: Prentice-Hall, Inc., 1940), p. 229.

[14]George E. Gardner, "Separation of the Parents and the Emotional Life of the Child", Mental Hygiene, Vol. XL (1956) pp. 60-61.

may suddenly become an economic or social burden; (2) the presence of the child may be a continuing example to the mother of her own deficiencies--notably her failure in her attempt to maintain a home, to satisfy a husband, to be a completely adequate wife and mother; the child becomes a continual reminder and reactivator of these doubts and fears; and (3) directly associated with these changed attitudes toward the child is the tendency for the mother to identify the child with the absent husband, and particularly to identify the child with all the bad and undesirable aspects of the father's make-up. In short, the child may become an economic, social, and emotional burden to the mother and he begins to realize it. In most instances this child will fight back with hyperaggressiveness, hostility, and insubordination. On the other hand, it sometimes happens that the mother's changed attitude is one of increased acceptance and overwhelming devotion to the child. In her attempt to show herself as an adequate parent, she may become oversolicitous and overprotective of the child. In the absence of the father, the child becomes "the single, all-inclusive, libidinal investment that the mother makes, to the exclusion of an investment of any part of herself in other people or other interests."

Levy[15] indicated that maternal overprotectiveness may take several forms: "where maternal overprotection is primarily and successfully domineering in character, submissive traits result--obedience, authority-acceptance, dependence on others; in boys, effeminacy. When primarily indulgent in character, aggressive traits result --authority-reception, commanding, bullying, and'lime-light' behavior."

Greenbaum[16] concluded that the behavior of rejected children was more extreme than that of their non-rejected siblings; that the presence of a maternal feeling of rejection toward children who were referred to a clinic was a major factor in the development of behavior pathology.

Zimmerman,[17] treating the problems of five and six year old children, stated that the aggressive children tended to have overprotecting or rejecting mothers; the

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[15]David Levy,"A Method of Integrating Physical and Psychiatric Examination, with Special Studies of Body Interest, Overprotection, Response to Growth and Sex Differences", American Journal of Psychiatry, Vol. IX (July, 1929) pp. 169-170.

[16]Richard S. Greenbaum, "The Influence of Certain Maternal Attitudes on the Behavior of Rejected Children," Dissertation Abstract (University of Florida (1954), p. 2124.

[17]A. Zimmerman, "Parental Adjustment and Attitudes in Relation to the Problems of Five and Six Year Old Children," Smith College Studies in Social Work, Vol. I (1931), pp. 406-07.

timid children, oversolicitous or overanxious mothers. Figge[18] pointed out from a study of maternal rejection, that the problems for which the rejected child was referred were more frequently of the aggressive, rebellious type. Gorlow and Katkovsky[19] stated that for most cases labeled "rejection", the actual treatment was likely to be indifference and denial of affection, rather than an active dislike for the child. Various studies of rejection by parents seemed agreed that the result is likely to be an aggressive, suspicious, destructive child.

English pointed out that in order for mothers to develop proper and consistent attitudes toward their children, there are certain contributions that a father should make.

> In his role he may not seem to be directly "fathering" his children--yet actually he is doing so. His strength and power are passing through the mother to the child or children. He is keeping her in the mood for her job by consistently providing material comfort for her through his labor. He gives her security and freedom from anxiety about food, clothing,

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[18]M. Figge, "The Etiology of Maternal Rejection: A Study of Certain Aspects of the Mother's Life", Smith College Studies in Social Work, Vol. I (1931), p. 407.

[19]Leon Gorlow and Walter Katkovsky, Readings in the Psychology of Adjustment, (New York: McGraw-Hill Book Company, Inc., 1959) p. 278.

> and shelter. Further, he shows an interest in her activity, her creativeness, her work, and her needs, both emotional and physical. He loves "her" in that he satisfies her, stimulates her, comforts her, and assists her in the realization of her personality. This he does uniquely, as a male, in the fulfillment of his role in society. A maid, a sister, a friend, or a mother can perform these duties only partially, and it is neither socially acceptable nor biologically consistent for them to be done by a person other than the father of her child.
>
> Since the pattern of society is heterosexual, a woman, if she is normal, can accomplish a more complete emotional fulfillment and wholesome personality growth through the father of her child than from any other source.[20]

Therefore, the father cannot afford to be a nonentity in the family. He cannot leave child rearing to a strictly feminine environment. Such an environment would be likely to produce distorted personalities. English further suggests that there are at least eight variants of the father's role:

1. Companion and inspiration for the mother;
2. Ego ideal for masculine love, ethics, and morality;
3. Awakener of the emotional potential of his child;
4. Beloved friend and teacher to his child;
5. Model for social and vocational behavior;
6. Stabilizing influence for solution of the oedipus complex;

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[20] O. Spurgeon English, "The Psychological Role of the Father in the Family," Social Casework, Vol. XXXV, 1954, p. 325.

7. Protector, mentor, and hero for the grade school child; and

8. Counselor and friend for the adolescent.[21]

Bartemeier[22] stated that to give consistently to her child the love which he needs, a woman needs the consistent love of her husband and the certainty of his love for their child.

Gardner[23] stated that parental relationships are necessary to the child in the formation of both his concept of self and his concept of human beings. He selected for consideration the deleterious effect of a prolonged or permanent father absence upon these concepts, since the prototype of the broken home is that where the father is absent and the mother has the sole care of the children. In talking about father-separated children, he points out multi-conflicts which beset the children at various stages of development when they realize that they are different from other children. They are different in the sense that they have no fathers living

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[21] Ibid., pp. 328-29.

[22] L. Bartemeier, "The Contribution of the Father to the Mental Health of the Family," The American Journal of Psychiatry, Vol. CX, 1953, p. 279.

[23] Gardner, op. cit., pp. 53-59.

in the home. The father, who left the home when the child was younger than three years of age, leaves the child with thoughts of worthlessness and gives him a warped picture of reality and the male figure. The child feels that he must have been and still is of little worth or his father would never have left. There is also a questioning of the absolute worth of his mother, for she too was left. This effect is compounded when the mother attempts to explain the father's absence to the child. Insecurity prevails. The child feels that if the father can abandon the family, the mother may also do the same. There is also the possible deduction that the child thinks that he is the cause of the parental separation. In adolescence, there is another surge of anxiety, if the mother has given the child a spurious explanation as to the cause of the father's absence, such as telling the child that the father is dead when he actually deserted or divorced. The adolescent may wonder if he is an illegitimate child.

Gardner further stated that to the child at any age --and particularly in earliest childhood--the parents are the source of life itself in the form of food and clothes--the one single factor of basic significance in establishing within him a sense of security and in indicating probable continuing survival. He predicates

his physical integrity, including later his sense of anatomical integrity, upon the presence of parents, who will care for his bodily needs and will protect him from aggressive and mutilative attacks by others. Having experienced the trauma of a broken home, the child will be forced to consider love relationships as extremely conditional and capricious, and his reluctance to enter himself into such relationships and his attitude toward them when he does may be patternized at the time of his parents' separation and lead to considerable future distress.

The case of a young boy of five years was presented by Margaret L. Meiss[24] as a psychoanalytic interpretation of a child who lost his father during the oedipal period. This particular child, suffering from severe insomnia, anxiety about his mother, and obsessive thoughts about his angry father, lost his father through death when he was three years and three months of age. Aggressive feelings toward the father had already been present. Analysis revealed that the child conceived of his father as an omniscient, angry, and avenging figure who disapproved of masturbation and threatened castration. He

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[24]Margaret L. Meiss, "The Oedipal Problem of a Fatherless Child," The Psychoanalytic Study of the Child, Vol. VII (New York: International Universities Press, Inc., 1952) pp. 216-29.

also thought of his father as reunited with the mother at night (hence the insomnia), and he felt that this reunion would eventually become permanent and take his mother from him forever. This study presented the dynamics resulting from the loss of the father during the period of the child's life when he felt omnipotent. Tremendous guilt resulted from his destructive desires.

In summary, then, the literature has emphasized the importance of the home experience, and particularly, the quality of the mother-child relationship in the development of the child. The mother-child relationship was found to be of more importance than the broken home.

The most frequently discussed maternal attitude --rejection--was seen by most authors as leading to aggression, hostility, and rebelliousness in the child and was considered a major factor in behavior pathology. Overprotectiveness, too, was seen as resulting in dominating, aggressive behavior. Levy, however, sees overprotectiveness as either dominating or submissive, the former leading to submissive behavior on the part of the child, and the latter, to dominating behavior.

Fathering is seen as essential to the mother's role with the child, as well as with providing the child with a masculine ideal and model. He also is seen as the

provider and stabilizer of the total family constellation. His role is further defined as essential to the child's concept of self and self-worth, playing a significant part in the socialization and in the ability of the child to enter into relationships with others.

In the absence of the father, the mother's role in the development of the child takes on even greater significance. In the few studies in which this role was assessed, a hostile and often highly sexualized relationship was encountered, with aggressive and rebellious behavior most often resulting in the children. The majority of the writers felt that a probable change had occured in the maternal attitude as a result of the loss of the husband and father, and the concommitant loss of physical and emotional support. Actual change in maternal attitude was not really demonstrated in any of these studies.

CHAPTER III

METHODOLOGY

Selection of Cases for Study

After having reviewed the current thinking on the subject it was felt that fatherless families could be studied best in comparison with families in which the father was present. It was also decided, after surveying the records of fatherless families in each clinic, that all of the fatherless children whose cases were opened and closed between January 1, 1956 and December 31, 1958 should be included in the study group. A control group of 40 cases was selected at random from this same period of time, 20 cases from each clinic.

In the study group only those cases were included in which there was no father in the home at the time of referral to the clinic. The term, "father", was interpreted to mean no father, step-father, grandfather or other male living in the home with whom the child might relate, as a father-figure or father-substitute. Secondly, only those cases which had received a complete diagnostic

study were included for study in either group. (A complete diagnostic study included: a psychiatric social history, a psychological examination, and a psychiatric evaluation.) The number of cases seen during 1956 to 1958 which met the requirements for inclusion in the study group was ninety-one; forty-five of these cases were from the Lansing Child Guidance Clinic, and forty-six cases were from the Kalamazoo Child Guidance Clinic.

In selecting the control group sample, only those were included in which the child's natural father and mother were present in the home at the time of referral. Thus, all cases were eliminated in which there was a step-mother, a step-father, or adoptive parents.

Preparation of Schedule

The schedule was devised jointly by both writers. It was divided into three main categories: (1) general information (face sheet data), (2) inter-disciplinary recorded material of parent-child relationships as measured by certain psychosocial factors, and (3) clinic assessment (closing sheet data). In devising the schedule, the writers analyzed a number of cases individually, selecting all the responses or items appropriate to the questions being asked, e.g., employment, ADC, alimony, etc. as items essential to any question

regarding source of income of the mother. Secondly, five cases were selected at random and were analyzed by each writer to assure consistency and common interpretation of items.

The face sheet included ten items of information: parents' age, religion and education; child's age, sex, religion, ordinal position in the family, and number of children living in the home; problem(s) for which the child was referred and the source of referral. In some cases, various items of information on the face sheet were not recorded. In such instances, the classification "not recorded" was added to the identifying categories.

Parents' ages were recorded in terms of the age given on the date of intake. "Religion" was classified into: Catholic, Protestant, Jewish, and Other. "Education" was classified into the following: elementary, some high school, high school, some college, and college.

With regard to the child's age, the age intervals used were calculated according to the age of the child on the date of intake. The classification, used for recording the child's "ordinal position" in the family was as follows: oldest, youngest, intermediate, and only. In conjunction with this, the number of children in each home was listed and grouped according to numerical intervals.

Such a measure would point out a reality factor which the woman without a husband must face.

The presenting problem was based on the Michigan State Department of Mental Health classification. This classification includes the following categories:

1. Conduct Disorder--anti-social behavior, including truancy, stealing, defiance, running away, temper tantrums, cruelty, overly aggressive behavior, and sex offenses.

2. Habit Disorders--enuresis, nail biting, thumb-sucking, masturbation and tics.

3. Personality Problem--chronic unhappiness, pre-psychotic symptoms including withdrawal, day dreaming, depression, fears, anxiety, inferiority and poor social adjustment.

4. Learning and Developmental Problem--for educational disabilities, (such as slowness in academic learning or special subject disabilities).

5. Functional--any physical complaint without an organic condition, such as blindness or anesthesia.

6. Other.

Classifications used for determining the source of referral were as follows: physician, parent, self, school, juvenile court, public agency, private agency, police department, and other. In one case, a fourteen year old girl referred herself. The parents were later seen for diagnostic study.

Items furnished by the recorded case material

included: mother's source of income, reason for the father's absence, father's contact with family, child's age at the time of father separation, intelligence, sleeping arrangements, and maternal attitude.

The mother's source of income included the following: employment only, ADC only, ADC and employment, employment and other, ADC and other, and other only.

The reason for the father's absence was classified according to death, divorce, desertion, separation, prison, mental hospital, and unwed mother. In no case was the father's absence due to military service. The father's contact with the family was categorized as: frequent contact (regular), some contact (erratic), and no contact.

The child's age at the time of father separation was grouped in age intervals as follows: Pre-natal to five years, six to eight years, nine to eleven years, twelve to fourteen years, and unknown.

The child's intelligence was categorized as follows: very superior (130 and up), superior (120-129), bright normal (110-119), average (90-109), dull normal (80-89), borderline (70-79), and mentally defective (69 and below).

The child's sleeping arrangements consisted of the following categories: own bedroom, shares bedroom with

siblings, shares bedroom with mother, shares bed with mother, and unknown.

"Clinic assessment" consisted of two main categories: diagnostic classification and recommendation. The diagnostic classification was considered to be one of the most important items on the schedule, for this assessment could only be made after evaluation of the professional contributions of each of the three disciplines. The diagnostic classification was the outcome of a total evaluation of the child in relationship to his environment, and is therefore necessarily differentiated from the categories used to order the presenting problems (conduct, habit, personality, etc.). The diagnostic classification was broken down into ten categories: brain syndrome with convulsive disorder, all other brain syndromes, mental deficiency, psychotic disorder, psychosomatic disorder, psychoneurotic disorder, personality disorder, situational personality disorder, essentially healthy,and undiagnosed. In no case was there found the diagnosis "essentially healthy".

Clinic "recommendation" was classified according to three categories: treatment, referral to other agency or resource, and interpretation only.

Maternal Attitude

Both writers conceived of the "maternal attitude" as an acquired tendency of a mother to react toward her child in a constant manner. Each attitude, then, is indicative of a need-disposition on the part of the mother, and reflects emotional, cognitive, and motivational elements.[1]

The maternal attitude was rated by the use of two scales. The first scale (Figure 1) measured the amount of rejection or acceptance shown by a mother toward the child referred for help; the second scale (Figure 2) measured the amount of control exercised over the child or the amount of autonomy permitted the child.

Fig. 1. -The Dimension of Love Vs. Hostility

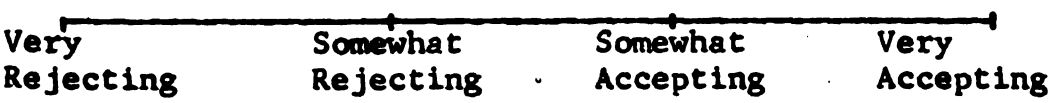
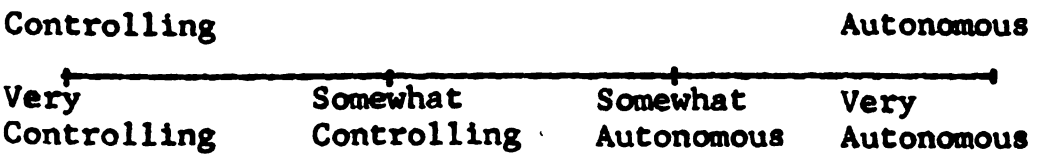


Fig. 2. - The Dimension of Autonomy Vs. Control



On the basis of interviews recorded by the staff persons,who had seen the mother in the clinics,each

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[1]Schaefer and Bell, op. cit., p. 340.

mother in the total sample were rated for their attitudes on each of the two scales. Value judgement of the rater was used to select the predominant attitude described in the case material. In those instances where it appeared that neither of the polar attitudes on a given scale predominated, the mother's attitude was classified as inconsistent. Such a classification occurred only once in each of the groups studied.

In arriving at quasi-definitions of the various positions on each scale, the writers read through a number of cases, selecting from the records descriptive words and phrases relating to rejection, autonomy, acceptance and control on the part of the mother. Assessment of these terms and phrases permitted the development of a range of concepts, and the use of descriptive phrases found in the records were used as anchor points along the scales.

Thus rejection was described by the various clinic recorders as "Perception of the child as a burden", or, "physical and emotional neglect", or, "overt rejection",etc. Physical and emotional neglect were used as indicative of a "very rejecting" attitude on the part of the mother. Another example of a very rejecting attitude was a mother's refusal to acknow-

ledge her child because of illegitimacy, and frequently requesting boarding care.

Antagonistic demanding, or ignoring, on the part of the mother, were used as anchor points for a "somewhat rejecting" attitude. Some other phrases indicative of a somewhat rejecting attitude were: "nagging", "indifferent", "punitive", "apathetic to needs", "consistently emphasized negative qualities", and "perceives son as a reminder of marital failure".

Anchor points chosen for the "somewhat accepting" attitude were protective, or sharing activities and interests. A few of the phrases, indicative of this attitude were: "encourages sociability", "indulgent", and, "expresses warmth and affection toward child".

Positive evaluation of the child, and child-centeredness, were selected as models of a "very accepting" attitude. Some records indicated the mother planning for and with the child, giving freely of her time and energy.

On the autonomous vs. control scale, the anchor point for "very autonomous" was detached and allowing-excessive freedom. These were the only examples found among the cases.

Both laxity in discipline and indifference, and

encouraging independent thinking, were selected as anchor points for the "somewhat autonomous" attitude. Examples found were primarily negative aspects of the attitude; e.g., indifferent, "insensitive to needs", etc. As implied by the anchor point, the positive expression of some autonomy would be the fostering of independence within the realm of the child's emotional development.

"Somewhat controlling" attitudes used as anchor points were: Pushing intellectual or social achievement and restricting child's social growth to meet mother's narcissistic needs. Examples of this found in the cases were: "mother will not allow daughter to wear sweaters, accept dates,---"; "mother requires son to study after school and on weekends---", "pressures him to achieve", and "mother has difficulty accepting John's maturation".

The anchor point for a "very controlling" attitude was complete and rigid prevention of independent behavior. Examples found: infantilization--"she talks about Jim (age 16) as if he were a pre-schooler".

Each writer encountered one case in which he was unable to make a judgment on one or another of the dimensional scales. In these instances the maternal

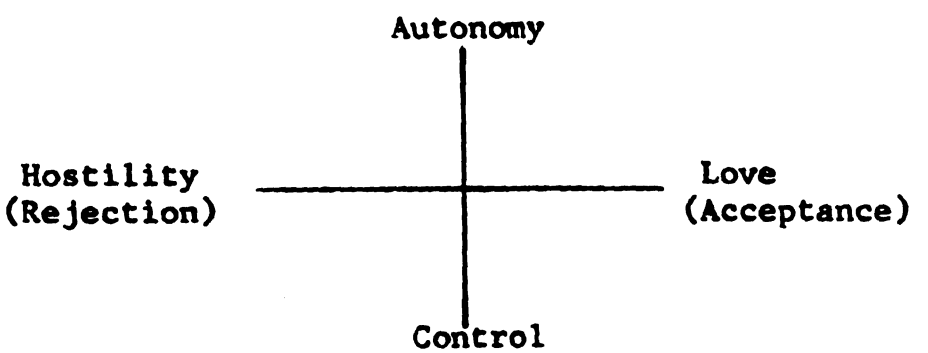
attitude was classified as undetermined.

After the rating of each mother was completed on both of the dimensional scales, the two scales were ordered (Figure 3) in such a way that the polar positions formed a universe of content circumscribing the social and emotional behavior of a mother toward an individual child.

Thus, from the combination of the two scales a single maternal attitude can be derived, which shows a relationship between two neighboring polar positions. For example, a mother rated as "somewhat accepting and somewhat controlling" would be assigned an attitude in the controlling-accepting quadrant, possessing qualities of both polar positions. If a mother were rated "very controlling" and "somewhat accepting" her resultant attitude would fall within the same quadrant, but would correlate more highly with control than acceptance.

Figure 3

A Two Dimensional Diagram of Maternal Attitudes

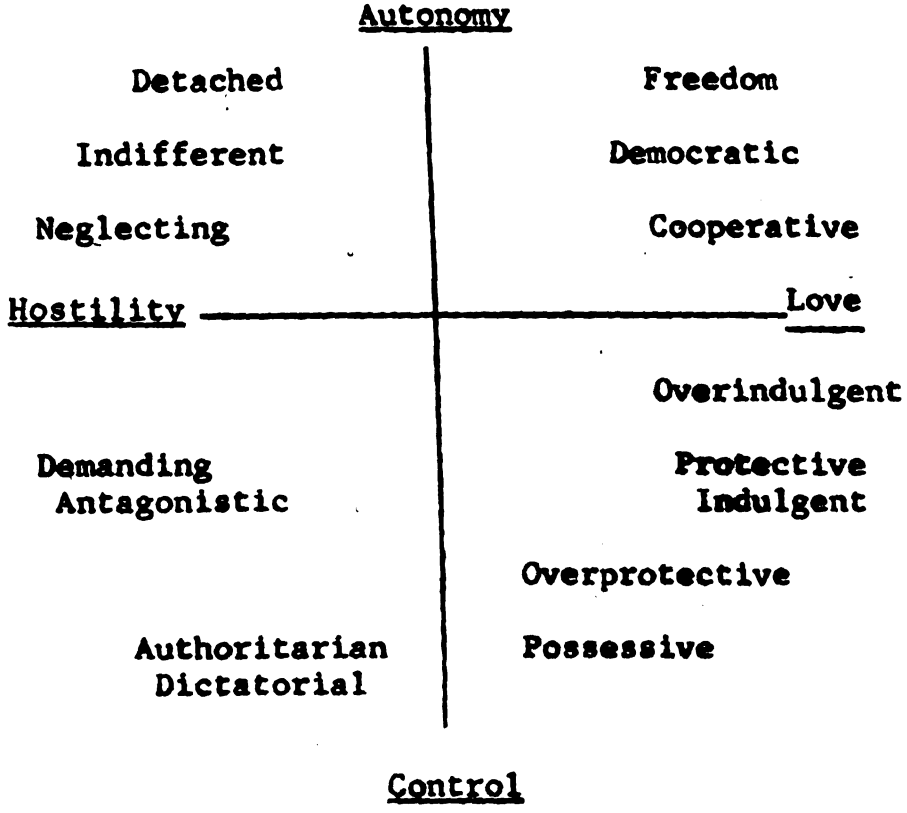


The completion of the universe of maternal attitudes and of the circumplex model[2] can now be attained by ordering other maternal behavior concepts. A hypothetical ordering of such concepts is shown in Figure 4.

Thus, from the combination of the two scales a single maternal attitude can be derived, which shows a relationship between two neighboring, polar positions.

Figure 4

Hypothetical Circumplex Order of Maternal Behavior



[2]L. Guttman, "A New Approach to Factor Analysis: The Radex." In P. E. Lazarsfeld (Ed.), Mathematical Thinking in the Social Sciences, (Glencoe, Ill. Free Press, 1954.

> "Freedom is placed on the Autonomy Vs. Control dimension with its polar opposite, possessiveness; democratic behavior and cooperative behavior are placed in the quadrant which indicated both loving acceptance and autonomy. Acceptance and its polar opposite rejection, are placed on the Love Vs. Hostility dimension. Excessive love, overindulgence, protective indulgence, and overprotectiveness are placed in a quadrant that indicates both love for the child and an inability to treat the child as a differentiated individual who has his own activities and interests apart from the parent. The variables of authoritarian dictatorial treatment and demanding, antagonistic behavior are placed in the quadrant that indicated both a hostile relationship to the child and control; while neglect, indifference and detachment are placed in the quadrant that indicates varying combinations of hostility and autonomy for the child. This organization seems to satisfy both a law of neighboring and a law of polar opposites."[3]

Measures Taken To Eliminate Bias

A pretesting of the schedule was done to determine the clarity and common interpretation of the items. Five cases of fatherless children were selected at random from the Lansing Child Guidance Clinic. Each of the writers and the administrative assistant of the Lansing Clinic independently rated these five cases. There was unanimous agreement on all of the factual items of the schedule. On the

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[3]Earl S. Schaefer, "A Circumplex Model for Maternal Behavior", Journal of Abnormal and Social Psychology (Vol. LIX, No. 2, Sept. 1959) p. 232.

ratings of the maternal attitude scales there was a difference on one of the thirty scales rated; i.e., perfect agreement by three reviewers on the fifteen ratings of the rejecting-accepting scale, and agreement on fourteen of the fifteen ratings on the controlling-autonomous scale.

Later in the course of the study, the writers felt that further evidence was necessary to demonstrate the reliability of judgments on the maternal attitude scales. Having a vested interest in the study, the writers might be accused of bias in rating maternal attitudes. To demonstrate reliability of judgments, other clinic workers, who had no vested interest in the study or knowledge of the hypothesis, were asked to rate a sample of the cases.

In the Lansing Clinic, nine cases were rated by one social worker, and five of these nine were again rated by a psychologist. The nine cases represent fourteen percent of the cases studied at the Lansing Clinic. The raters were asked to rate these cases as to predominance of rejection or acceptance shown by the mother, and as to the predominance of control or autonomy shown by the mother. There was some disagreement with the writers' choices of attitudes.

When the choices on these two scales were combined into an attitude--controlling-rejecting, rejecting-autonomous, accepting-controlling, or autonomous-accepting--it was found that the resultant choices differed with the writers' ratings in four out of the fourteen cases. The percentage agreement, then, would be seventy-one percent.

In the Kalamazoo Clinic, a social worker and psychologist each rated seven cases in the manner described above. These seven cases represented eleven percent of the cases studied in Kalamazoo. Since one of the raters did not rate one scale, this case was eliminated and the total number of ratings was thirteen instead of fourteen. There was disagreement with the writers' ratings on four of the thirteen cases. The percentage of agreement then was sixty-nine percent.

It might appear at first glance that the percentage of agreement (seventy-one percent and sixty-nine percent) with the test raters was somewhat low; however, it was felt that this much agreement was very encouraging in view of the fact that the combination of the two scale ratings into one attitude meant a possibility of four choices per case and a compounding of error found on any one scale. Thus, with four possible results in the combination of the two scales, there were 108

possibilities on the twenty-seven cases rated in both clinics. In view of this, the percentage of agreement appeared to the writers to be very high.

Many research studies employing rating scales have achieved acceptable reliability through training of the raters. No attempt was made to train the raters in this study. It seemed reasonable to conclude that any bias was minimal and training of the test raters might have increased the amount of agreement with the writers.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The fatherless families comprised the study group; the physically intact families, the control group. Since the sample in the study group was larger than the sample in the control group, percentages were used wherever appropriate.

After all of the data had been collected at the Lansing and Kalamazoo Child Guidance Clinics, it was discovered that the findings were nearly identical. This made it possible to combine the findings of the two clinics into single tables. The comparability is illustrated in the following tables which pertain to the total sample:

TABLE 1

SEX DIFFERENCES OF CHILDREN IN TOTAL SAMPLE

	Study Group				Control Group			
	Lansing		Kalamazoo		Lansing		Kalamazoo	
Sex	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Male	28	62	31	70	15	75	13	65
Female	17	38	15	30	5	25	7	35
Total	45	100	46	100	20	100	20	100

This clearly shows that there is a like distribution of males and females in each clinic.

Further evidence of comparability of the findings of the two clinics is seen in the mean age of the children and mothers.

TABLE 2

MEAN AGE OF CHILDREN AND MOTHERS IN TOTAL SAMPLE

	Study Group		Control Group	
Mean Age	Lansing	Kalamazoo	Lansing	Kalamazoo
Child . .	10.9	10.8	9.2	9.7
Mother . .	37.2	37.9	35.6	35.5

It can be seen from Table 2 that the children in the study group are slightly more than a year older than the children in the control group. This is consistent in each clinic. Furthermore, the mothers in the study group are also older than the mothers in the control group; this difference is also reflected in the data of each clinic.

This comparability of data from clinic to clinic was found in virtually every aspect of the study. For this reason, all ensuing tables will combine the findings

of both clinics into one study group of ninety-one cases and one control group of forty cases.

In addition to the comparability in clinic findings, it is both desirable and necessary to establish comparability between the study group and control group. Comparability in terms of sex of child and median age of child and mother is evident in Tables 1 and 2.

In order to test the differences between the two groups, the following table concerns the religious affiliations of the children:

TABLE 3

RELIGION OF CHILD

Religion	Study Group		Control Group	
	Number	Percentage	Number	Percentage
Catholic . .	15	17	7	17.5
Protestant .	63	69	29	72.5
Jewish . . .	1	1	. . .	. . .
Other . . .	. . .	. . .	. . .	. . .
Not Recorded	12	13	4	10.0
Total . .	91	100	40	100.0

This table shows that both groups are highly comparable in religious affiliation. There is no reason to believe that a child's religion is in any way associated with any differences which may later be found to exist between the study group and the control group.

The next table tests the ordinal position of the child in order to assess whether or not there is a difference in trend of ordinal position in either group:

TABLE 4

ORDINAL POSITION OF CHILD

Ordinal Position	Study Group		Control Group	
	Number	Percentage	Number	Percentage
Oldest . . .	25	27	18	45
Youngest . .	25	27	10	25
Intermediate	26	29	11	27.5
Only	15	17	1	2.5
Total . .	91	100	40	100.0

A marked difference appears in the percentage of oldest and only children in the two groups. However, the higher percentage of only children should be anticipated in a comparison of fatherless families and physically

intact families. Especially is this true when "fatherless" families are limited by definition to those families in which there is no father or step-father in the home. It is,then, noteworthy that a combination of the "only" and oldest child percentages in the study group yields a percentage comparable to that of the combined percentages of the control group.

Therefore, ordinal position of the child in the family does not appear to offer any real difference between the study and control groups.

Table 5 presents a comparative age distribution of the study and control groups.

TABLE 5

PERCENTAGE OF AGE DISTRIBUTION OF CHILDREN ACCORDING TO SEX

Age	Study Group		Control Group	
	Male	Female	Male	Female
2-4	3	6	7	17
5-7	12	6	18	42
8-10	46	22	43	8
11-13	12	22	14	. . .
14-16	25	41	18	33
17-19	2	3	. . .	. . .
Total Percent	100	100	100	100

This table clearly shows that the majority of the male population are referred to the clinics within the eight to ten year range. There is little difference between the study group and the control group in terms of the age ranges of the boys. There is a trend for most of the children to be referred to the clinics after the age of eight. Especially is this true of the male population of both groups and the female population of the study group. However, the females comprising the control group appear to represent a trend in the opposite direction, and the percentage of the females falling between two years and seven years is not representative of the total population of females seen at the clinics. In conjunction with this, the females in the control group only number twelve. Therefore, no definite conclusions can be drawn.

A further indication of the comparability of the two groups studied is seen in the following table showing the distribution of the intelligence of the children. Although there is an apparent difference in this table, it is not statistically significant. From a comparison of the data on Table 6, it is evident that any differences that may later be found in the behavior of fatherless children is not associated with a difference in level of intelligence.

TABLE 6

INTELLIGENCE OF CHILDREN

Intelligence	Study Group		Control Group	
	No.	Percent	No.	Percent
Very Superior. .	. .	. .	2	5.0
Superior	2	2	1	2.5
Bright Normal. .	11	12	4	10.0
Average.	56	62	17	42.5
Dull Normal. . .	13	14	7	17.5
Borderline . . .	6	7	6	15.0
Mentally Defective	3	3	3	7.5
Total	91	100	40	100.0

It might well be said that differences in maternal attitudes vary in accord with the education of the mother. In attempting to investigate whether or not a particular maternal attitude, i.e., rejection, predominated in fatherless families, it should be tested whether or not this attitude is associated with any other factor, such as the educational background of the mother. The following table presents a comparison of the study group and the control groups as to the educational background of the mother.

TABLE 7

EDUCATION OF MOTHERS

Education	Study Group		Control Group	
	Number	Percent	Number	Percent
8th grade or less	15	16	2	5
Some high school .	23	25	10	25
High School. . . .	16	18	17	42.5
Some college . . .	11	12	4	10
College.	5	6	4	10
Not recorded . . .	21	23	3	7.5
Total	91	100	40	100.0

The two groups appear to be comparable but conclusive evidence is lacking because of the great percentage of mothers whose education was not recorded.

In all of the variables considered to this point, the data has shown little difference between the study and the control groups. When the maternal attitudes of the study and control groups were compared, significant differences were found. Table 8 clearly illustrates that the mothers without husbands (study group) tend to reflect a rejecting attitude toward their children.

TABLE 8

PREDOMINANT MATERNAL ATTITUDES

Predominant Attitude	Study Group		Control Group	
	Number	Percent	Number	Percent
Control-Rejection	49	54	9	24.5
Rejection-Autonomy	27	30	5	12.5
Autonomy-Acceptance	2	2	5	12.5
Acceptance-Control	12	13	20	50.0
Inconsistency	1	1	1	2.5
Total	91	100	40	100.0

By far, the majority of the mothers in the study group tend to be both controlling and rejecting in their attitudes toward their children. This is compared to the predominance of the accepting and controlling attitudes of the mothers in the control group. Although some rejection is found in over three-fourths of the mothers in the study group and over one-third of the mothers in the control group, it is to be remembered that all the children were emotionally disturbed which, as generally accepted, tends to be highly associated with inadequate patterns of mothering.

The findings included in the above table are the first indication that there is a difference between the two groups other than the fact that the mothers in the study group have no husbands. Therefore, it may be concluded that the rejecting attitude which predominates in the study group is related to the lack of a husband and father in the home.

If the maternal attitude varies so much between the two groups of mothers, and if the third hypothesis is true that aggressive behavior results from a rejecting maternal attitude, then a greater percentage of conduct disorders should be demonstrable in the study group.

TABLE 9

COMPARISON OF TYPE PROBLEM*

Type Problem	Study Group		Control Group	
	Number	Percent	Number	Percent
Conduct	49	53.8	13	32.5
Habit	3	3.3	. . .	. . .
Personality	22	24.2	20	50.0
Learning and Developmental. .	13	14.3	7	17.5
Functional	3	3.3	. . .	. . .
Other	1	1.1	. . .	. . .
Total	91	100.0	40	100.0

*See appendix B for detailed list of problems.

The third hypothesis is supported by the data in the above table. The "conduct disorder" classification includes a disproportionate number of sex offenses and stealing in the study group. A complete list of presenting problems is contained in the appendix.

The relationship between a rejecting maternal attitude and aggressive behavior of the child would further strengthen the hypotheses. Table 10 attempts such a correlation between the maternal attitudes and the problems presented by the children.

The table clearly demonstrates a high correlation between a rejecting maternal attitude and conduct disorder and/or aggressive behavior. This relationship is noted in the control group as well as in the study group. Such hostile and aggressive behavior has been noted by several authors already cited in the review of the literature. English and Pearson[1] also pointed out that the child who experiences a rejecting parental attitude, rebuffed in his attempts to please his parents, ultimately resorts to rebelliousness, hostility and defiance.

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[1] O. Spurgeon English and Gerald H. Pearson, Emotional Problems of Living (New York: W. W. Norton & Co., 1955) pp. 115-118.

TABLE 10

PREDOMINANT MATERNAL ATTITUDE AND TYPE PROBLEM ON PERCENTAGE BASIS

PREDOMINANT MATERNAL ATTITUDE	Study Group							Control Group						
	Conduct	Habit	Personality	Learning and Developmental	Functional	Other	Total Percentage	Conduct	Habit	Personality	Learning and Developmental	Functional	Other	Total Percentage
Control-Rejection	55	04	25	12	04	..	100	56	..	44	..	..	..	100
Rejection-Autonomy	67	04	11	14	..	04	100	80	..	..	20	..	..	100
Freedom-Acceptance	..	..	100	..	..	..	100	20	..	40	40	..	..	100
Acceptance-Control	25	..	42	25	08	..	100	15	..	70	15	..	..	100
Inconsistent	100	..	..	..	..	..	100	..	..	..	100	..	..	100

The question then arises as to which of the various types of difficulties predominate at any particular age. Table 11 shows that in the study group, conduct disorders predominate at almost every age range, whereas in the control group, the personality disorders more often predominate. The table also shows that aggressive behavior increases in proportion to the age of the child. Thus conduct disorders predominate at ages fourteen to sixteen and personality disorders are common at ages eight to ten.

Table 12 presents the incidence of conduct disorders in relation to the sex of the child. An inspection of the table reveals that there is little difference between the sexes and the occurrence of conduct disorders in either the study or the control group. However, these figures are percentages and do not deny the greater incidence of problems among boys than among girls.

A comparison has now been made between the study and the control groups and it has been determined that mothers without husbands frequently present a rejecting attitude. Also a correlation has been found between a rejecting maternal attitude and the incidence of aggressive behavior on the part of the child. At this point, the focus is turned to the reality and factual

TABLE 11

PERCENTAGE DISTRIBUTION OF PROBLEMS ACCORDING TO AGE GROUP

Ages	Study Group							Control Group						
	Conduct	Habit	Personality	Learning and Developmental	Functional	Other	Total Percentage	Conduct	Habit	Personality	Learning and Developmental	Functional	Other	Total Percentage
2-4	50	..	....	25.0	..	25	100	50	..	..	50	..	..	100
5-7	45	..	33.0	22.0	..	..	100	22	..	78	..	..	..	100
8-10	38	03	41.0	15.0	03	..	100	21	..	50	29	..	..	100
11-13	58	07	14.0	14.0	07	..	100	25	..	75	..	..	..	100
14-16	71	04	10.5	10.5	04	..	100	56	..	33	11	..	..	100
17-19	100	..	....	....	..	..	100	..	..	..	..	..	..	...

TABLE 12

PERCENTAGE OF CONDUCT DISORDERS ACCORDING TO SEX

Sex	Study Group	Control Group
	Percentage	Percentage
Male	53	31
Female	56	27

material of the father-separated family.

First, the father's absence from the family was explored and is represented in the following table:

TABLE 13

ABSENCE OF FATHERS

Cause	Number	Percentage
Death	20	22
Divorce	38	42
Desertion	2	2
Separation	15	16
Prison.	6	7
Mental Hospital . .	5	5.5
Unwed Mother. . . .	5	5.5
Other	0	0
Total	91	100

Although this table presents a wide range of reasons as to the cause of father separation, divorce is the

predominant reason. When divorce is combined with desertion and separation, it is noted that this group comprises sixty percent of the total.

By definition, the writers identified the study group as comprised of only those children who had no father or male figure in the home with whom they could identify. Therefore, it was necessary to determine the frequency of father contact with the family in order to strengthen the definition of the fatherless family.

TABLE 14

FATHER'S CONTACT WITH CHILD

Father's Contact	Number	Percentage
Frequent.	3	3
Some.	12	13
None.	70	77
Unknown	6	7
Total	91	100

Table 14 shows that in almost eighty percent of the cases, no contact with the child following separation was maintained.

The age of the child at the time the father left the home was explored next. The minor hypothesis requires an investigation as to whether or not the majority of the children whose fathers left the home prior to the child's

six

in

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sixth birthday, would manifest some type of a conduct disorder.

Table 15 gives an over-all view of the number of children in the study group who experienced father-separation at various age levels.

TABLE 15

AGE OF CHILD AT TIME OF FATHER-SEPARATION

Age at Separation	Number	Percent
Under 5	46	50.5
6-8.	23	25.3
9-11.	15	16.5
12-14.	6	6.6
Not recorded	1	1.1
Total	91	100.0

This table shows that in slightly over half of the children referred to the clinics, the father had left the home before the sixth birthday. In seventy-five percent of the cases, the father had left the home before the child was nine years old. Since the majority of the children have virtually never known a father figure, it is reasonable to assume that these children may present a different kind of problem than the children who have known a father.

Therefore, is there any significant difference between the percentage of conduct disorders presented by the children of various ages at the time of father-separation?

This question logically follows if the minor hypothesis is to be supported or disproved. The following table will give the answer.

TABLE 16

AGE OF CHILD AT FATHER-SEPARATION AND TYPE OF PROBLEM

Age at Separation	Conduct	Habit	Personality	Learning and Developmental	Functional	Other	Total
Under 5.	25	1	13	5	1	1	46
6-8	12	1	5	4	1	..	23
9-11	6	..	4	4	1	..	15
12-14	5	1	..	..	..	..	6
Not recorded	1	..	..	..	..	..	1
Total	49	3	22	13	3	1	91

Table 16 supports the hypothesis that the study group children, having virtually never known a father, present a predominance of conduct disorders. However, it cannot be said that the predominance of conduct disorders is attributable to the absence of the father at any given age. This conclusion is reached since a predominance of conduct disorders occurs at every age level. There is only a two percent differential in the conduct disorders presented by children whose father left the home prior to their

sixth birthday, and those whose fathers left prior to their ninth birthday. In the older age groups, the conduct disorders also predominate.

In the study by Wylie and Delgado, cited in the review of the literature, the conclusion was reached that the relationship between mother and son became highly sexualized after father-separation. An effort was made to test this inference in the present study by examining the child's sleeping arrangements. Less than one-third of the records contained this information and therefore no definite conclusions could be drawn. Among the cases in which the sleeping arrangements were noted, there were several instances where the son either slept with the mother or shared the same bedroom. However, no definite trend could be established.

The time which elapsed between father-separation and the age of the child at the time of referral was also explored. Can any prediction be made as to the average period of time it will take an emotionally disturbed fatherless child to manifest his disturbance necessitating psychiatric help? A prediction is not possible on the basis of such a small number of emotionally disturbed fatherless children comprising this study group. However, table 17 shows the average lapse of time before the

children of the study group were referred to the clinics.

TABLE 17

TIME INTERVAL BETWEEN FATHER-SEPARATION AND REFERRAL TO CLINIC

Age at time of Father-separation	Mean lapse of time before referral	Mean age at referral
0-5 years	6.9 years	9.9 years
6-8 years	2.8 years	9.8 years
9-11 years	3.5 years	13.5 years
12-14 years	1.2 years	14.2 years

This table does not lend itself toward the establishment of definite conclusions. Since a referral to the clinic is limited to children within a given age range, it is expected that there would be a decrease in the lapse of time before referral as the child grows older. With this in mind, it is interesting to note that the mean lapse of time before referral is sooner for children whose fathers separated when the children were within the 6-8 year age group. The loss of the father may have a greater psychological impact on children of this age group than any other age group. The child of this age may be either seeking masculine identification or resolving the family romance conflict. When the father leaves the home, the child's psychic processes may be

disrupted and this may account for a more immediate recognition of the child's emotional disturbance.

In retrospect, although the hypotheses relating to maternal attitudes and types of problems have been supported by the data, there are some reality factors operating that may add another dimension to the mothers' attitudes and the children's problems. These are the very real burdens placed upon a mother by the loss of her husband and breadwinner. How does a mother left alone provide financial support for herself and family?

It has been pointed out by Maccoby[2] that the employment of the mother outside the home is not in itself inherently in conflict with the needs of family unity and child rearing. However, the attitude of the mother toward her employment, or toward her need to be employed, may well affect family unity and child rearing. Also the arrangements made by the mother for the supervision of her children while she works may have certain effects on the development of the child.

Table 18 presents the number of mothers in the study group who work full time and those who supplement some other source of income with part time employment.

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[2]Eleanor Maccoby, "Children and Working Mothers", Children, May-June, 1958. pp. 53-57.

TABLE 18

SOURCE OF INCOME FOR MOTHERS

IN THE STUDY GROUP

Source of income	Number	Percentage
Employment only . . .	43	47
ADC only.	14	16
ADC and employment. .	8	9
Employment and other.	8	9
ADC and other	7	7
Other only.	11	12
Total	91	100

All of the forty-three mothers whose sole means of support was their employment were working full time. Combining these mothers with those who worked in addition to receiving Aid to Dependent Children or some other income, it was found that sixty-five percent of the mothers were employed. Virtually all experienced difficulty in supporting their families adequately. ADC provides adequate subsistence by minimal standards, and most working mothers had jobs which provided minimum security at best. Other sources of income were Old

Age and Survivor's Insurance benefits, Workmen's Compensation benefits and Veterans' benefits. These, too, provide only partial or minimal support for the fatherless family.

Twenty-seven percent of the mothers of the control group were employed full time. A combination of full time and part time employment of mothers in the control group increases the figure to thirty-seven percent. Therefore, the percentage of mothers in the control group who are employed is considerably less than what was found in the study group. This might indicate that many of the mothers in the study group may be reacting to reality pressures.

It may be concluded that mothers left alone tend to have a difficult time supporting their family. This difficulty, with its accompanying anxiety and pressures, may well influence a mother's attitude toward her children and partially account for the negative attitudes found in the mothers in the study group. This would tend to support the first hypothesis that mothers left alone are deprived of the physical and emotional support which normally allows them to adequately fulfill their maternal roles.

Further, there may be a relationship between the financial burden on the mother of the one-parent family and the nature of the problem that the child develops.

Since most mothers must work, they may present themselves to their children as tired, cross, and disagreeable. The children may react to their mothers by aggressive and acting out behavior. Also the mothers must often be gone from the home necessitating less supervision for their children and greater opportunity for them to become involved in delinquent behavior.

On the basis of the data presented in table 18, sixteen percent of the ninety-one mothers are solely dependent upon ADC. This may suggest that most mothers prefer employment to ADC. Some of the mothers, however, combined partial ADC with some other form of income.

Another factor which might add to the reality pressures of the study group mother is the total number of children whom she has to support. The child referred to the clinic for emotional difficulty is not the only child for whom the mother must provide care and support. Table 19 presents the number of children in the families of the study group as compared with the families of the control group.

Table 19 shows no significant difference between the incidence of other children between the two groups. Mothers left alone have as heavy a family load as physically intact families and she must provide for them

by herself. This mother, then, frequently has other children adding to her burden, taxing her energies, making demands upon her time and resources.

TABLE 19

NUMBER OF CHILDREN IN FAMILY

Number of Children	Study Group		Control Group	
	Number	Percentage	Number	Percentage
1-3	58	63.7	28	70
4-6	28	30.8	10	25
7-8	5	5.5	2	5
Total	91	100.0	40	100

Table 20 explores the referral source for children in the study and control groups. It has been noted in Table 18 that the majority of the mothers have employment outside the home. This may well result in a lack of supervision, and consequently, it might be expected that many of the fatherless children would be referred to the clinic by public resources. It has also been pointed out that in the study group the primary problem at referral was in the conduct disorder classification. Therefore, it might be expected that in the study group there will

be more referrals to the clinics from an authoritarian agency, such as the juvenile court.

TABLE 20

REFERRAL SOURCE OF CHILD

Referral Source	Study Group		Control Group	
	Number	Percent	Number	Percent
Physician	8	9	11	27.5
Parent.	15	16	6	15.0
Relative.	..	..	..	....
Self.	1	1	..	....
School.	21	23	15	37.5
Juvenile Court. . .	18	20	3	7.5
Public Agency . . .	21	23	5	12.5
Private Agency. . .	6	7	..	....
Police Department .	1	1	..	....
Total	91	100	40	100.0

This table clearly shows that twenty percent of the fatherless children are referred to the clinics by the juvenile court; whereas only seven percent of the control group are referred from this source. School referrals are consistently high in both groups. However, the number of referrals from physicians in the control group is atypically high when compared with total clinic referrals.

Table 21 compares the psychiatric classification of children in the fatherless and physically intact families.

The table is regarded as particularly important since the psychiatric diagnosis represents the joint thinking of the three disciplines involved in the diagnostic process.

TABLE 21

PSYCHIATRIC DIAGNOSTIC CLASSIFICATION OF CHILDREN

Diagnostic Classification	Study Group		Control Group	
	Number	Percent	Number	Percent
Brain syndrome with convulsive disorder	2	2	..	..
All other brain syndromes	2	2	6	15
Mental deficiency	3	3	2	5
Psychotic disorders	1	1	2	5
Psychosomatic complaints	3	3	..	..
Psychoneurotic disorders	24	28	11	27
Personality (character) disorders	31	34	6	15
Situational personality disorders	21	23	12	30
Essentially healthy	..	..	..	..
Undiagnosed	4	4	1	3
Total	91	100	40	100

Table 21 shows that a greater percentage of personality (character) disorders are found among the fatherless children as compared with the children of the control group. This is indicative that the emotional disturbances of fatherless children tend to be more deep-seated than the problems of children from physically intact families. Because it was hypothesized that children from fatherless families show a predominance of conduct disorders and a disproportionately high percentage of conduct disorders as compared with children from physically intact families, it is assumed that the greater percentage of the conduct disorders in the study group will fall within the personality (character) disorder diagnostic classification. It should be remembered that the presenting problems in Table 9 represent the primary symptoms for which the children were referred to the clinics. Table 21, however, reflects a professional and interdisciplinary assessment of the total personality of the child.

Table 22 illustrates the major psychiatric classifications within which the conduct disorders of both groups fall. It can be noted that eighty-five percent of all conduct disorders within each group fall within three of the psychiatric diagnostic classifications. There is a radical difference between the two groups in terms

of the distribution of conduct disorders. The high percentage of conduct disorders in the study group, falling within the personality (character) disorder classification, is indicative of a greater amount of psychopathology; whereas in the control group, the problems fall largely within the situational personality disorder classification, which is indicative of less personality disorganization or an adjustment reaction to some environmental situation.

TABLE 22

PERCENTAGE DISTRIBUTION OF CONDUCT DISORDERS ACCORDING TO PSYCHIATRIC DIAGNOSES

Diagnostic classification	Study Group	Control Group
Psychoneurotic disorder	19	15
Personality (character) disorder	47	8
Situational personality disorder	19	62

Table 23 explores the clinic recommendations for the children in both groups. Since the psychiatric diagnostic classification revealed the study group children to be the more emotionally disturbed, the clinic recommendations may show a higher percentage of recommended referrals to other agencies for fatherless children.

TABLE 23

CLINIC RECOMMENDATION FOR CHILDREN

Recommendation	Study Group		Control Group	
	Number	Percent	Number	Percent
Treatment	39	42.9	15	37.5
Referral to other agency	36	39.6	15	37.5
Interpretation only	16	17.5	10	25.0
Total	91	100.0	40	100.0

Although the difference between the two groups is not highly significant, a greater trend is shown in the study group toward recommended treatment or referral to other agencies. Further analysis of the data reveals that the recommendations in the study group for treatment or referral show a higher percentage than the control group because the child was in many instances too disturbed or else the mother and child were considered to be less apt to benefit from an interpretation interview only. This is also essentially true of the control group, although in these cases, more families were thought to be capable of benefiting from an interpretation only.

CHAPTER V

IMPLICATIONS OF THE ONE-PARENT FAMILY

The comparison of fatherless with physically intact families has revealed few real differences between the two groups. However, a description of the circumstances of some of the fatherless families may more clearly illustrate the difficulties that these families encounter; such an approach may also suggest areas of further study to others interested in this whole problem of the father's role in the family. The discussion which follows is a presentation of circumstances which were frequently found in the fatherless families reviewed.

It has already been noted that sixty-five percent of the mothers in the fatherless families were working. The remaining mothers, with two exceptions, were dependent upon meager allowances. In the majority of cases the employed mother held a manual type job requiring long hours of work, frequently during the evening hours; pay was almost invariably low. A good percentage of these mothers were employed as waitresses, housekeepers or charwomen. Employment such as this placed financial,

as well as tiring physical burdens upon these mothers; in some instances the mothers found it necessary to work in the evening when their children were most likely to be in need of supervision. Many of these mothers expressed bitterness and resentment toward society over the burdens they carried.

Added to and complicating a mother's financial burdens were the number of children a mother had to care for. Table 19 indicated that the total number of children in a family was as high in the one-parent families. This meant the physical burden upon the mother, as well as the financial burden, were comparable to that of the mother who had a husband providing support, both financial and emotional.

In Table 15 it was shown that in more than seventy-five percent of the cases the father was gone from the home before the child was nine years old. This meant that the mothers were left to support their children for a considerable length of time. Also the father, once separated from his children, rarely maintained contact with them. Table 14 pointed out that seventy-seven percent of the fathers had no contact with their children, and only three percent had frequent or regular contact with their families.

Mothers left alone with their children were often critical of themselves; they blamed themselves for their children's difficulties; they were confused and afraid of their responsibilities. These factors may explain the fact that the median age of the study group children was more than a year higher than that of the control group children (Table 2). Mothers may have felt guilty and been reluctant to seek help for their children.

Some of the records indicated that the child with difficulty reminded the mother of her husband toward whom she felt bitterness and resentment. This may explain why it was this particular one of her children who presented the difficulty. In a few instances a child was a reminder to his mother of her own failure as a wife and she feared failure as a mother as well.

On the other hand some mothers made their child the focus of their attention, excluding all other outside interests after the loss of the husband. This often resulted in a restrictive, debilitating control of the child by the mother. In some instances mothers developed a highly sexualized relationship with a son. In several cases mothers shared a room with a son and there was no privacy exercised in dressing, bathing, etc.

In the case of Jimmie, age 11, for example, mother

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was employed as a waitress, working from 2 P.M. until 10 or 11 P.M. Jimmie was in the fourth grade and was referred by the school for stealing. In interviews with Mrs. B., Jimmie's mother, it was found that she was divorced when Jimmie was two years old. Each worker who saw Mrs. B. was impressed by the fact that she was more anxious to discuss her bitter feelings toward her husband and the wrongs he did unto her, than she was to consider Jimmie's problem. She talked bitterly about her low wages and her difficulty in keeping baby sitters to stay with Jim; at the time of the referral she often left him alone until she returned from work.

Mrs. B. also had a boy friend, but Jimmie and the friend did not get along very well. Mother resented Jim's inability to accept this man, and she likened her boy's behavior to that of her husband who had also kept her from being happy. Mother frequently spanked Jimmie to control him and often resorted to use of a strap.

CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

A group of ninety-one children from families deprived of a father or father-figure were compared with a group of forty children from families in which both mother and father were present in the home. All of the children had been seen for diagnostic study at either the Lansing or Kalamazoo Child Guidance Clinics in the three year period of 1956 to 1958.

It was determined, in an assessment of maternal attitudes that eighty-four percent of the mothers living alone with their children, showed a predominantly rejecting attitude toward the child referred to the clinic, while thirty-seven percent of the mothers in the control group showed such an attitude. Analysis of the two groups according to a number of variables indicated that they differ only in the fact that there is no husband-father in the home.

The problems of the children in the two groups showed a greater incidence of conduct or aggressive, acting out type disorders in the study group. A high correlation

was also found in both groups between a rejecting maternal attitude and the occurence of conduct disorders. This is in accord with the findings and theoretical postulates cited in the review of the literature.

This occurence of aggressive type behavior was noted more often in the older age child, especially among the girls; however, no significant trends were found in correlation of the child's age at which the father left the family and the type of problem developed by the child. It was noted that a greater percentage of the aggressive problems of the study group of children were diagnosed by the psychiatrists as personality (character) disorders; this indicates a more serious developmental disorder.

Although no attempt was made to correlate the maternal attitude or type of problem behavior of the child with employment of the mother, it was found that sixty-five percent of the study group mothers were employed, as opposed to thirty-seven percent of the control group mothers. The fact of employment was held to be of less importance in affecting the maternal attitude toward the child than the attitude of the mother toward her employment; this was not measurable, however, and the influence of employment upon the rejecting attitudes found in both groups was undetermined.

Rejection was more often found in the study group mothers. It is speculated that this attitude is related to the fact of fatherlessness. The exploration of the nature of this relationship might be undertaken in another study.

Certain limitations of the study are suggested. It is recognized by the investigators that case recorded material is probably a less reliable measure of attitudes than might be attained through use of a parental attitude questionnaire. The Parental Attitude Research Instrument developed by Schaefer and Bell[3] would provide a much more objective and quantifiable measure of attitudes.

Another means of attaining more objectivity in rating attitudes would be to have three raters rate each case and take the judgements only in those instances where there was agreement among at least two judges.

In view of the correspondence found between maternal attitude and type of behavior presented by the child, it is recommended that careful consideration be given to the mother's attitude. In the event of a rejecting attitude on the part of the mother, more serious developmental disorders might be anticipated in the child.

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[3]Schaefer and Bell, op. cit., pp. 339-61.

The data strongly suggests that such disorders would most likely be expressed through aggressive, asocial behavior.

In general the records of the clinics were complete and helpful. However, it was frequently not possible to determine the sleeping arrangements of children. In view of the sexualized relationships found between mother and son in this study and in others, it would be well to be alert in fatherless cases for unusual sleeping arrangements which would be a further source of difficulty for the boy.

Finally, it is recommended that all children's services need to evaluate their assessments of maternal attitudes and the reliability of these assessments. In view of the relationships between the parental attitude and the development of the child, the assessment of attitudes becomes very important. Pre-intake questionnaires may well offer the most objective and reliable means to accomplish this measure.

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APPENDIX

SCHEDULE

I GENERAL INFORMATION (face sheet data)

MOTHER

_____Age _____Education _____Religion

CHILD

_____Age _____Sex _____Religion

_____Number of Children in Home

Ordinal Position:
_____Oldest _____Youngest _____Intermediate _____ Only

Source of Referral:
____Parent ____Physician ____Police Department
____Self ____Private Agency ____Juvenile Court
____School ____Public Agency ____Other

Presenting Problem at Referral:
_____First recorded problem
_____Second recorded problem

II RECORDED CASE MATERIAL

Mother's Source of Income
____Employment only ____Employment and other
____A. D. C. only ____A. D. C. and other
____A. D. C. and employment ____Other only

Reason for Father-Separation:
____Death ____Prison
____Divorce ____Mental Hospital
____Desertion ____Unwed Mother
____Separation ____Other

Father's Contact with Family:
____Frequent ____Some ____None

Age of Child at Time of Father-Separation:
____Prenatal to 5 years ____12-14 years
____6-8 years ____Not recorded
____9-11 years

Child's Intelligence:
____Very superior (130 and above)
____Superior (120-129)
____Bright normal (110-119)
____Average (90-109)
____Dull normal (80-89)
____Borderline (70-79)
____Mentally defective (69 and below)

Child's Sleeping Arrangements:
____Own bedroom
____Shares bed or bedroom with siblings
____Shares bedroom with mother
____Shares bed with mother
____Not recorded

Predominant Maternal Attitude:
Controlling-Rejecting:
____Predominately controlling ____Inconsistent
____Predominately rejecting
Rejecting-Autonomous:
____Predominately rejecting ____Inconsistent
____Predominately autonomous
Autonomous-Accepting:
____Predominately autonomous ____Inconsistent
____Predominately accepting
Accepting-Controlling:
____Predominately accepting ____Inconsistent
____Predominately controlling
Undetermined____

III CLINIC ASSESSMENT (Closing Sheet Data)

DIAGNOSIS:
____Brain syndrome with convulsive disorder
____All other brain syndromes
____Mental deficiency
____Psychotic disorder
____Psychosomatic disorder

____Psychoneurotic disorder
____Personality disorder
____Situational personality disorder
____Essentially healthy
____Undiagnosed

RECOMMENDATION:
____Treatment
____Referral to other agency
____Interpretation only

APPENDIX B

PRESENTING PROBLEMS OF CHILDREN

	Study Group		Control Group	
CONDUCT	Number	Percent	Number	Percent
Defiance	10	20	4	30
Destructiveness	2	4	1	8
Firesetting	3	6	..	..
Overaggressiveness	2	4	1	8
Running away from home	..	..	1	8
Sex offenses	10	20	..	..
Stabbing	1	2	..	..
Stealing	18	38	3	23
Temper tantrums	2	4	3	23
Truancy	1	2	..	..
Total	49	100	13	100
HABIT				
Enuresis	2	67	..	..
Masturbation	1	33	..	..
Total	3	100	..	..
PERSONALITY				
Chronic unhappiness	1	4	1	5
Depression	1	4	..	..
Excessive daydreaming	3	14	4	20
Fears and nightmares	3	14	1	5
Feelings of inadequacy	2	9	1	5

PRESENTING PROBLEMS OF CHILDREN (continued)

	Study Group		Control Group	
	Number	Percent	Number	Percent
PERSONALITY (continued)				
Feminine interests	1	4	..	..
Nervousness-restlessness .	3	14	6	30
Overdependency on mother .	..	..	2	10
Pre-psychotic symptoms . .	..	..	1	5
School phobia.	..	..	1	5
Stuttering	..	..	1	5
Withdrawal	8	37	2	10
Total.	22	100	20	100
LEARNING AND DEVELOPMENTAL				
Learning difficulties . .	13	100	7	100
FUNCTIONAL				
Psychosomatic complaints.	3	100	..	..
OTHER				
Convulsions	1	100	..	..

APPENDIX C

ANALYSIS OF PREDOMINANT MATERNAL ATTITUDES OF FATHERLESS FAMILIES AS COMPARED WITH PHYSICALLY INTACT FAMILIES

Predominant Attitude	Study Group		Control Group	
	No.	Percent	No.	Percent
Possessive-rejecting				
Predominantly possessive	9	18	2	22
Predominantly rejecting	16	33	..	..
Intermediate	24	49	7	78
Total	49	100	9	100
Rejecting-autonomous				
Predominantly rejecting	11	41	2	40
Predominantly autonomous	2	7	1	20
Intermediate	14	52	2	40
Total	27	100	5	100
Autonomous-accepting				
Predominantly autonomous	..	..	..	..
Predominantly accepting	..	..	3	60
Intermediate	2	100	2	40
Total	2	100	5	100
Accepting-possessive				
Predominantly accepting	2	17	5	25
Predominantly possessive	5	41.5	10	50
Intermediate	5	41.5	5	25
Total	12	100.0	20	100
Inconsistent				
Diffuse attitude	1	100	1	100