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ABSTRACT

Present research questions the traditional unidimensional model in childhood psychopathology. Not only do parents influence the development of their offspring, they, in turn, are influenced by them. The infant is an active agent, affected by and affecting those around him. The infant emerges as a primary source of influence--often in the direction of the malevolent distortion of the caregiver's attention. This study further suggests that the family has the properties of a dynamic social unit wherein reciprocal interaction effects appear to be intrinsically related to sources of control or command over others. For example, fathers of children in psychotherapy were consistently and significantly more controlling than the normative group. Fathers of hyperkinetic children tended to have extreme scores, high or low, on a measure of hierarchical control. More systematic exploration of family life along the dimensions of power, influence, and susceptibility to influence is needed to increase the understanding of why and how specific individuals within a family succumb to pathology. (Author/SJL)

Family Psychopathology in Parent-Child Relationships

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For three decades the underlying theoretical rationale in childhood psychopathology posited the notion of primary influence from parent to child, that is, parents were regarded as causal agents in the child's illness. This unidimensional view of pathology stemmed largely from the writings of socialization researchers such as Harry Stack Sullivan, John Bowlby, and Margaret Mahler who placed great emphasis on the power of the mother to strongly influence the development of her child and to play an especially crucial role in fostering the emergence of mental illness. These theorists conceptualized the growth of the infant as singularly dependent on the quality of the attachment bonds to the mother. Where the mother was good and accepting, individuation proceeded normally. But where the mother was bad and rejecting, the child inevitably presented developmental anomalies. In this model the infant was viewed as a passive receiver of stimulation, a nonentity at birth to be molded by the quality of the ministrations of its caretaker.

Recently, a group of investigators have taken issue with this view of the child as a passive organism, consistently acted upon, but having no effect, consistently being modified, but changing no one. They regard the one-way paradigm of development as patently illogical since the infant, by its very presence, has both a real and potential impact on others in its surround. They view the child as a specific stimulus with identifiable characteristics capable of eliciting certain parental behavior and attitudes. In support of their position they call attention to evidence showing significant differences in children from the moment of birth in such traits as activity level, rhythmicity, adaptability, intensity of reaction, quality of mood, distractibility, attention span and

persistence, threshold of responsiveness, approach and withdrawal behavior (Thomas et al, 1963), as well as in sleeping and feeding patterns (Escalona, 1953), social responsiveness (Gesell & Ames, 1937), drive endowment (Alpert et al, 1956), autonomic response patterns (Bridger & Reiser, 1959; Lipton et al, 1961), biochemical individuality (Williams, 1956), motility (Fries & Woolf, 1953), and in electroencaphalographic patterns (Walter, 1953). They argue that these initial differences can be expected to exert variable effects on caretakers, depending on how they are perceived and the response repertoire of the parents.

Indeed, recent studies of variations in parental behavior with different children appear to support a child-effect model. Schaefer (1963) illustrated variations in modes of discipline on the part of the mother of schizophrenic quadruplets, with affective behavior differing from child to child. Yarrow (1963) described differences on the part of one foster mother with several infants assigned to her at different times. Characteristics of these infants appeared to evoke specific responses in the mother as well as in other members of the family. Levy (1958) found inconsistent maternal greeting behavior depending on the infant's state of arousal. These newer studies argue for modification of the model of the child as a passive organism molded by the parent in a one-way acculturation process toward that of an active agent involved in an ongoing unique human interchange.

It is now becoming increasingly clear that not only is the organism effected by its caretakers, it effects and alters them in turn. Each acts upon the other in constellations of behaviors

which are mutually elicited and maintained. In this way an interactive dynamic unit is activated in which influences flow in both directions, from mother to child, and from child to mother.

Present research explores the interactionist nature of the parent-child relationship and attempts to capture the dynamic elements of this ongoing dyad. It examines the reciprocal patterns among two groups of families in which a child shows behavioral abberations. It assesses the nature of the role of the different participants showing how the mutually elicited behavior of one member in turn influences the behavior of the other. It offers hypotheses regarding the manner and direction of these effects and suggests how they can be measured.

The hyperkinetic child:

It is axiomatic that every mother needs to feel successful in her care of the infant. She derives these feelings essentially from the way the baby responds to her ministrations. When the baby is happy and contented, and acts pleased with the mother's attention, he assures her that she is a good mother. Thus the mother depends on her child to confirm her as a satisfactory and dependable nurturer. In this way the mother develops positive attitudes about herself as a caretaker which serve to enhance the attachment bonds between mother and child.

However, where the child fails to respond positively to the mother's care, where he is difficult to satisfy, the mother begins to question her capabilities as a caretaker. In these instances the mother feels that she has failed and loses confidence in her ability to satisfactorily care for her child.

Hyperkinetic children show a preponderance of crying, fussing, and fretful behaviors from earliest infancy which resist parental efforts at altering these states. These behaviors, in turn, elicit strong feelings of inadequacy and frustration from the mother who begins to resent the hyperkinetic child's insatiable demands on her. Eventually, the mother resorts to hitting, spanking, and physical restraint to discipline and control her child.

Thus the hyperkinetic infant's initial patterns of reactivity to mothering appear to influence parental attitudes and reinforce specific punitive and restrictive practices in the care of the child.

Eight mothers of ten children diagnosed as hyperkinetic were interviewed for a total of 26 hours, or an average of 3.3 hours each regarding the earliest behaviors of the child. Two mothers had two hyperkinetic children in the family. They were asked to describe the child's earliest functioning, noting especially eating and sleeping patterns, activity level, quality of mood, responsiveness, and general health. With the mother's consent, these interviews were tape recorded and then analyzed.

In addition, these ten hyperkinetic children, ranging in age from 20 months to 13 years were observed in a variety of settings in interaction with peers and other family members in the course of their regular daily activities for a total of 154 hours, or an average of 15.4 hours of observation of each child. All observations were done by one of the authors and a trained assistant who made notes on family interaction following the observations, noting especially

transactions between the mother and the hyperkinetic children.

All families were white and lived in an East coast suburban community. Nine families were middle-class and were intact, that is, the father lived in the home. One family was lower-class; the parents were separated and the child lived with his mother.

Based on the mother's reports, behavioral difficulties were manifested in nine of the children from the earliest weeks of life. They vomited frequently, were restless and colicy, slept poorly, cried incessantly, often had diarrhea, and were generally in poor health with colds, viruses, allergies, digestive disturbances, etc.

In all cases, the mother reported strong feelings of inadequacy regarding her ability to satisfy her child's needs. "It made me feel guilty ... that there was something wrong with the way I was bringing Ronald up ... I had in some way failed." "I was at an end where I didn't seem to know what to do anymore." "They made me feel like I must be doing something wrong. You try this, try that, nothing works." "I had the feeling maybe it was my fault. It was like a zoo, like a zoo ... I couldn't handle it." "It was always in my head that something was terribly wrong, that there was something you could be doing that you weren't and this was making the children the way they were."

As toddlers, all the children were reported to show a preponderance of intractable and defiant behaviors so that they were confined to playpens, cribs, or "jumpers" for long periods of time. None of the children crawled. Some were restrained because their mothers feared they might "tear the house apart." All the mothers perceived their hyperkinetic children as "bad" and all

used physical punishment as the major form of discipline.

"Richard (12 years old) began to have severe temper tantrums at 6 months of age. He would fall down, hold his breath, turn blue. I was concerned; I had to get him out of it. I was only afraid that he would really convulse one day and then I wouldn't be able to get him out. I was told to slap him hard across the face. I was told to put his head under water. All of these things which, you know, I did try."

Ellen (8 years old) is frequently hit by both her mother and her father "who often loses his temper." Once, in a rage, her father picked her up and tossed her into the family pool with all her clothes on.

Barbara (20 months old) is hit hard on her bottom when she engages in exploratory activities such as playing with the water spigot or exploring a mound of peat moss in the backyard. Her mother seeks a baby sitter who "will be ready to spank her cause that's what she needs."

Fathers were viewed as generally unsupportive and only peripherally involved with the child. They, as well as other members of the family, were often critical of the mother's caretaking.

Clinic children:

In contrast to the hyperactive children, the clinic patients were generally good infants who were relatively easy to care for during their early years. Parents reported that they ate and slept well, and appeared to be contented, responding positively to parental caretaking. In addition, they were in satisfactory

health during the first year of life with no indication of early childhood trauma of any kind. None of the clinic parents reported any feelings of frustration or inadequacy in meeting their child's needs during these early years.

These children, 18 youngsters from 15 families ranging in age from five to 16 years, were brought to a clinic in an East coast suburban community for a variety of emotional and behavioral problems. While the onset of difficulties varied from child to child, all were manifested after age four and before age 16. Presenting problems reflected a variety of clinical anomalies such as depression, inability to adjust to adolescent social life, chronic constipation, disruptive school behavior, stealing, marked underachievement, etc. There was an absence of identifiable physical or neurological impairment and IQ's ranged from average to genius.

Parental backgrounds of the clinic children varied across religion, income, education, psychological sophistication, and previous contact with a psychotherapist. Eight marriages were intact; one father had remarried subsequent to his wife's death, while six sets of parents were no longer living together.

Based on analyses of the content of approximately 1200 hours of contact with the clinic families, fathers of the clinic sample showed a strong commonality across cases in particular attitudes and practices. All were excessively controlling, maintained considerable emotional distance, and showed a propensity for negative evaluative reactions toward their child.

The father's need to exert excessive control over the clinic child is exemplified by one father's preoccupation with policing not only his own child's activities, but others on the block. He

frequently ran out of the house to correct neighborhood children who were engaging in street activities he considered wrong. One father spent many hours designing and constructing a costume to guarantee that his son won the Halloween contest. Another father consistently woke his daughter up two hours earlier in the morning than she wished, even though she required less than half that time to get ready for school. One father insisted that his child return a Christmas present from his therapist, while another forced his son to give up a job which would provide money for a minibike.

Emotional distance was maintained by all of the fathers through both overt and covert means. For example, many of them spent long hours in basement and garage workshops; others were described as sleeping or reading excessively. One traveled extensively in his work; another spent many hours with girlfriends. All fathers strongly resisted participating in the therapy process, disclaiming personal involvement or responsibility in its outcome.

In addition, negative evaluative attitudes prevailed among all fathers and varied in form from physical abuse, excessive punishment, demeaning criticism, and the setting of unattainable standards. In one instance, a father beat his son with a strap because he walked through the garage where the family car was stored. One father demanded that his child return his Christmas presents because he had not completed all his homework. Another father demeans his son's attempts to repair appliances around the house. One father, watching his son doing push-ups always demanded five more. When the boy was unable to perform the extra five, the

father said, "See, I knew you couldn't do it !"

Thus there are unifying attitudes and behaviors among the fathers of this sample of children which seemed to be operative in eliciting and maintaining the pathological conditions which eventually brought the child to the clinic seeking treatment.

The Hierarchical Control Scale:

In both the hyperactive and the clinic families, one family member consistently brought a special constellation of characteristics and modes of action which appeared to influence other family members. We hypothesized, therefore, that there were subtle power arrangements within these families which made certain members susceptible to the influence of others. We sought to ascertain whether these influences which were suggested by observations and recordings could be measured psychometrically. Since family power initially resides in the hands of the parents, we sought to investigate power preferences among the parents of these two groups of children. Specifically, we wanted to know whether power preferences differed among parents of clinic and hyperactive children, and whether the power preferences among these two groups differed from those of parents of normal children.

The Hierarchical Control Scale (HC), a recently developed instrument measuring attitudes about authority, distinguishes preferences for authority based on power or well established precedent from preferences for situations where decisions rest with the person most effected, regardless of status (Cochran, Note 1). Said differently, HC identifies control which is "filtered down"

through a pyramid-like social structure and compares it to control patterns that are "flattened", minimizing the potency of social distance and specialization.

The 34 item HC Scale samples attitudes toward authority in the most general sense, asking about a broad range of moral, legal, and interpersonal situations. For example, responsees indicate whether they believe college instructors have the right to require students to attend all classes, if religion should be taught, if all adults should be required to serve on juries, and if the death penalty is an effective deterent of serious crimes. Child care items appear within this broad context. One item asks whether allowances should be used to reward good performance while another asks whether parents have the right to prohibit teen-agers from continuing some friendships.

Previous research indicates that HC is not significantly related to Dogmatism, Rokeach's (1956) scale measuring "closed mindedness" and "qualified tolerance" toward outgroups. However, scores are associated with a willingness to make absolute judgements. People with high HC scores are likely to think that there are always "right" and "wrong" answers to the scale items, whereas low scoring subjects are inclined to resist the forced-choice format of the questionnaire saying, "It depends." (Cochran, Note 2).

Table 1 gives the HC scores of mothers and fathers of the clinic children and hyperactive children discussed in this paper, along with comparison scores of mothers and fathers who were not identified as having problem children. The normative sample was collected from adult community college students who lived in the same geographic region as the families of the clinic and hyperactive

children. As can be seen, the average scores of clinic mother (16.53) and hyperactive mothers (16.33) were not different from each other or from the average scores of mothers from the normative group (mean = 15.39). Also, the scores of hyperactive fathers were not different from the scores of normative fathers, 16.80 and 16.19 respectively. However, fathers of the clinic children had HC scores that were higher than fathers of hyperactive children and fathers in the standardization group. The mean of 19.57 for clinic fathers differred from a hypthetical normative sample of comparable size, t (26) = 1.91 p .10. If the mean of the clinic sample had been the same for 17 subjects rather than 14, the difference would have been statistically significant, t (32) = 2.10, $p < .05$.

INSERT TABLE I

The concept of hierarchial control does not necessarily imply force or coercion, as controls may originate from any of several different sources including superior strength, prestige, experience knowledge, tradition or precedent. For any such "legitimate" source of authority, the discriminating dimension is the amount of social distance between the mechanism of control and the person effected by the control. However, high HC scores do suggest relatively less reciprocal communication about the appropriateness of existing controls. HC scores of clinic fathers

are consistent with the clinic picture of these men who have been described as excessively controlling, emotionally distant, and having a propensity for negative evaluative reactions.

In addition to comparing the means, differences in the standard deviations of the four groups suggested trends consistent with expectations. While the clinic mothers (standard deviation = 4.89) are no more or less variable than normative mothers (standard deviation = 4.99), fathers of clinic children tend to be more similar to one another than normative fathers (standard deviations = 4.14 and 5.17, respectively). The relatively small standard deviation of clinic fathers supported the observation that these fathers are highly similar and bring some special qualities to the family which may influence the development of the family constellation.

On the other hand, the magnitude of the standard deviations tentatively suggested that parents of hyperactive children are highly variable. Standard deviations of 6.02 for the mothers and 7.16 for the fathers indicated that the variability is especially characteristic of the fathers. One explanation for this variability, consistent with observations presented here, is that hyperactive children influence the family constellation, causing these parents to be more inconsistent in their control preferences than parents of normal children.

In summary, even though the sample sizes were small, the objective data presented here tend to support the observational data, suggesting that there is a relationship between the presence of a difficult child in the family and [illegible] control

preferences of the parents.

Summary and implications:

Present research supports the growing body of evidence suggesting that the traditional unidimensional model in childhood psychopathology represents a half-truth. Not only do parents influence the development of their offspring, they, in turn, are influenced by them. The infant is more than a passive organism shaped essentially by the quality of the ministrations of his caregiver; he is an active agent, effected by, and effecting those around him. Indeed, the infant emerges as a primary source of influence himself, often in the direction of the malevolent distortion of the caregiver's attention.

This study further suggests that the family has the properties of a dynamic social unit wherein members exert power over particular behaviors and attitudes of other members. While we lack sufficient information to specify the characteristics of power and influence and how these operate within the family, reciprocal interaction effects appear to be intrinsically related to sources of control or command over others. Unquestionably, more systematic exploration of family life along the dimensions of power, influence, and susceptibility to influence would help us understand why and how specific individuals within a family succumb to pathology.

Although the widest parameters of the family as an interactive social unit have yet to be explored, it is becoming increasingly clear that paternal influence is stronger than previously suspected. Articles describing the effect of certain maternal behaviors on infant function abound in the literature, but little has been done

to study paternal effects on child development. Previous emphasis on the mother as central in caregiving activities, and, therefore, singularly responsible for the course of the child's growth have served expeditious, if not egalitarian ends.

Finally, our paper points to the need for basic research investigating why organisms behave the way they do within the family. We need to know more about the specific characteristics of parents and individual infants and how and why these characteristics influence others in the family. We need to know other salient characteristics of both infants and caregivers and which sets of characteristics are complimentary and which are antagonistic. Knowing the properties of the salient features of each might enable us to ascertain what constitutes a "good fit" between two parents and their children. In this way we might eventually incorporate these characteristics within a theoretical interactional framework designed to distribute power more equitably. Or, we might take steps to assure that power in the hands of one member does not work against the best interests of other family members.

Table I

HC Scores of Mothers & Fathers of Clinic, Hyperactive & "Normal" Children

	N	$\bar{X}$	SD
Mothers			
Clinic children	17	16.53	4.89
Hyperactive children	6	16.33	6.02
Normal children	345	15.39	4.99
Fathers			
Clinic children	14	19.57	4.14
Hyperactive children	5	16.80	7.16
Normal children	203	16.19	5.17

Reference Notes

1. *Cochran, N. Measuring preferences for hierarchical control: An attitude scale for contemporary times. Manuscript submitted for publication, 1974.**

2. *Cochran, N. Authority orientations of police officers. Manuscript submitted for publication, 1974.**

**Available from the author at 33 Boylston Street, Garden City, New York 11530.*

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