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THE HEARING MOTHER OF A DEAF CHILD: TOWARDS UNDERSTANDING HER EXPERIENCE OF MOTHERING

City University of New York PH.D. 1984

THE HEARING MOTHER OF A DEAF CHILD:

TOWARDS UNDERSTANDING HER EXPERIENCE OF MOTHERING

by

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Abstract

THE HEARING MOTHER OF A DEAF CHILD:

TOWARDS UNDERSTANDING HER EXPERIENCE OF MOTHERING

by

Sarah Stemp

Adviser: I. H. Paul

This study is an exploration of the experience of mothering for twelve hearing mothers of young deaf children. It suggests that many hearing mothers of deaf children may feel deprived of being able to fully "feed" their child since they are unable to give of themselves through use of voice--in words, sound and song--with the assurance that their communication is received and understood. The proposition is advanced that in response to this frustration many of these mothers are likely to experience a pull towards developing compensatory behavior with their child around the actual feeding of food.

Through evaluating the data from a small sample of hearing mothers who for the most part did not use sign language, and whose children had already been identified by an independent source as having serious eating problems, the study constitutes a preliminary step towards investigating the possibility of a relationship between a mother's need to talk and the development of a feeding disturbance with her deaf child. Discussion is organized around the hypothesis that eating-disordered

deaf children (of hearing parents) have mothers for whom talking is a central need. For the twelve mothers evaluated, degree of need to talk was assessed through three measures: teacher-ratings of mothers' talkativeness over time, clinician-ratings of mother-interviews, and the mothers' own self-report.

Results show the study mothers as a group to have a significantly higher need to talk than other mothers of deaf children who had no feeding disturbance. Interview material which reflected associations between feeding and restoration of the deaf child's hearing and speech is discussed. Evidence is cited which illustrates ways in which the mothers' preoccupation with feeding appeared to be an attempt to substitute for the missing and longed-for verbal aspect of mothering. Various other issues such as the contribution of a maternal eating-problem history and the impact of time of diagnosis of the child's deafness upon subsequent symptom formation are considered. Some final comments regarding contrasting models of mothering, in general, and of mothering a child who is "different," in particular, are included.

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Throughout the duration of this project, staff at the Lexington School for the Deaf have been enormously supportive. To Joan Gottschalk for her wisdom about mothers and children, her warmth, and her generous assistance at various stages of the study; to the Preschool and Infant Center teachers for their time, interest, and desire to help; to Alan Lerman for his assistance with the research design; to Arnold Rothstein

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Finally, I am deeply grateful to the twelve mothers who spoke freely of the love for their children, their frustrations, their despair, and their hope.

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Chapter I

INTRODUCTION AND LITERATURE REVIEW

The impetus for this study grew out of my work with hearing mothers and their very young deaf children at the Lexington School for the Deaf. In thinking about the experience of mothering a deaf child, I have become especially interested in how mothering behavior may be affected by the particular frustrations imposed upon these mothers by the nature of their child's handicap.

The experience of leading a weekly mothers' group at Lexington has led me to consider the question of whether, in particular, one aspect of mothering--that of feeding, may typically become disturbed in response to specific deprivations experienced by many mothers of deaf children. The examples of 5-year-old Billy for whom eating had "always been a problem" and who now eats almost nothing but peanut butter despite his mother's strapping him into his chair during meals to "force" him to stay at the table and eat, 3-year-old Danny whose mother in an attempt to figure out why he eats so little wants to see inside of him to make sure his stomach is not too small, and 6-year-old Michelle who has "always been a very fussy eater" came up for review and discussion by the group members over and over again.† As further evidence from other cases of deaf preschool children with eating disorders came to my attention, I began to wonder whether the difficulties around feeding

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†These are not the actual names or eating behaviors of the group members' children.

experienced by the six mothers in the mothers' group represented more than a problem specific to them and their children. The alternative speculation--that these feeding disturbances reflected a response to a problem shared by many hearing mother-deaf child couples--came to be the central hypothesis which the present study seeks to explore.

A primary frustration often experienced by the mother of a deaf child is that of not being able to speak, sing, or coo to her child with the assurance that her communication is fully received and understood. Although it has not been traditionally regarded as such, I suggest that a mother's giving of herself to her child through these verbal (voiced) means be viewed as an aspect of normal maternal feeding behavior. This proposed expansion of the notion of orality to include the mother's feeding of her sounds, words, and songs, and in turn, being fed by her infant's sound productions, suggests then that the hearing mother of a deaf child (especially one who chooses not to use a manual communication system) would be likely to experience significant frustration in this sphere.† Holding, touching, gazing, gesturing--all the nonverbal pathways of dialogue and mutual nurturance--are, of course, fully available to her, as is the elemental give-and-take of the feeding process itself. Nonetheless, I suggest that she may feel herself to be deprived of being able to fully "feed" her child, since she is unable to give through her voice.

I therefore hypothesize that the "average-devoted" hearing mother of a deaf child, in response to this frustration, is likely to be inclined towards developing compensatory behavior around the actual feeding

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†The issue of choice of communication mode will be discussed at various points later in this chapter and in Chapter IV.

of food. This feeding disturbance could take the form of overfeeding, underfeeding, neglect and irresponsibility with respect to feeding, or the development of elaborate inflexible rituals around feeding--to name a few possibilities. By arguing that an important arena of compensation will be the feeding process itself, I do not mean to imply that it alone would become the sole arena of increased or changed activity on the mother's part. Rather, I assume compensation will take place along all pathways of nonverbal† dialogue (physical contact, facial expressiveness, use of gesture), as well as, in some cases, through attempts to teach speech and/or sign language to the child. I simply have chosen for this study to focus upon whether significant compensatory behavior would tend to emerge as well, through a less readily acknowledged vehicle--that of the feeding process.

I will turn now to a review of each of the several assumptions upon which the above formulation has been built.

In order to highlight the experience of oral frustration I believe is undergone by many hearing mothers of deaf children, I will first review the literature which concerns itself with defining and describing the contrasting picture of optimally orally gratifying mothering. I will then examine the role of audition in early development and the possible effects of its absence on the deaf child-hearing mother dyad in an attempt to elucidate the ways in which, as a result of this lack, the mother may experience significant oral frustration over the course of her child's development. After then turning to a brief discussion of the particular trauma for a mother of diagnosis of her child's deafness, I will conclude the introduction with an exploration of the

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†Throughout I will be using "nonverbal" in the strict sense, to mean "without words." That is, both speech and sign are considered to be "verbal" communication.

meaning of the feeding process for mother and child, followed by a final section which presents the rationale for the proposal that a likely response of a hearing mother of a deaf child to the various levels of deprivation discussed in prior sections would be to develop some form of feeding disturbance with her child.

Reciprocal Orality in Early Mother-Child Interaction

In turning to the work of those psychoanalytic authors who have focused particularly on the mutuality and reciprocity of the mother-infant dialogue, I was surprised to find relatively little exploration of the needs and conditions for gratification required by the mother from this exchange. Winnicott (1956, 1960), in his evocative portrayals of the earliest attunement of mother to child, discusses this heightened sensitivity as a product of the natural processes of identification and projective-identification with the infant which develop during pregnancy. Spitz similarly attributes the "maternal urge to provide for the gratification of the child's anaclitic needs" to the mother's "greatly increased capacity to perceive [those needs] both consciously and unconsciously" (1965b, p. 174). This view of early mothering behavior as primarily responsive to and determined by the infant's needs continues in the work of Erik Erikson. He depicts a mother who "meets the infant's inborn more or less coordinated ability to take in by mouth with her more or less coordinated ability and intention to feed him and to welcome him" (1968, p. 97). This ability and intention of the mother is again seen as a built-in quality with which she comes to her child in

Sullivan's discussion of the mother's "need to give tenderness" (1953) and in Balint's analysis of what she calls "instinctive maternity" (1949).

None of the above authors approach mothering with the intent to explore in depth the ways in which the mother's own needs are gratified through her caretaking. Benedek, in her work on pregnancy and parenthood (1956, 1970), sets this exploration as her task. In characterizing the "emotional household of pregnancy," Benedek notes the manifestations of primary narcissism (those stressed by some of the above authors), but she proceeds to primarily focus upon the centrality of receptive and retentive feelings and fantasies in the psyche of the mother-to-be. She sees the process of identification with the baby during pregnancy and lactation as permitting the mother to regress and satisfy unconsciously her own oral wishes. Examples of emotionally healthy mothers who feel "emptiness" when they leave their child alone or who view reunion after separation as "eating up" or "putting back" the child serve for Benedek to illustrate her central thesis that "the postpartum symbiosis is oral, alimentary for both infant and mother" (1956, p. 398). In this light, the active, giving, succoring attitudes of motherliness are viewed as a screen for the more deep-seated unconscious oral needs which are rooted in the early alimentary symbiotic relationship which the mother experienced with her own mother, and she proceeds to trace how the dominant tendency of childhood--the need to be fed--becomes transformed into the adult woman's aspiration to feed, to succor, to be a mother.

Following Benedek's lead in understanding mothering behavior as largely fueled by oral needs on the mother's part, I will attempt in the following sections to, first, delineate the ways in which the hearing mother of a deaf child is likely to sustain significant oral frustration over the course of her child's development, and, second, to discuss the possible effects of such frustration on mothering behavior and present a case for the emergence of compensatory behavior in the realm of feeding.

Audition in Early Development: Considerations Regarding Its Role in the Mother-Child Relationship

In this section I will explore the role of audition in early development, attending at each step of the way to the possible effects of its absence on the deaf child-hearing mother dyad.†

I will look first at the early regulative processes operative in the dialogue between mother and hearing infant in the earliest months. To start, a brief review of the auditory capacity with which the infant enters into relation with the mother. At birth, the infant can perceive sound and orient towards auditory stimuli (Pratt, 1954; Wolff, 1959) and can also differentiate among sounds on the basis of variables such as duration, frequency, and interstimulus interval (Eisenberg, 1970). Studies of speech perception have shown that infants as young as 1 month are not only able to make fine phonemic discriminations but also perceive speech sounds in the same way adults do--by sorting acoustic variations of adult phonemes into categories (Eimas,

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†This section owes much to Meshover's (1980) comprehensive review of the literature on the role of audition and its absence in the development of hearing and deaf children.

Siqueland, Jusezyk, & Vigorito, 1973). This sound discrimination capacity has ramifications for development of self-object differentiation and the ability to differentiate mother from other. Brazelton (1974) suggests that the infant may first recognize his mother as a specific object by her voice rather than by her face. Wolff (1967) reports a selective smile to the sound of the mother's voice at 4 weeks, which precedes the smile response at 6 weeks to the sight of her face. By 4 weeks as well, there is evidence in blind children of the capacity to distinguish between mother and other on the basis of the sound of the respective voices (Fraiberg, 1969). By 12 weeks an infant is able to tell whether or not s/he is the object of mother's vocalizations (Lewis & Freedle, 1973).

From the start, the deaf infant clearly will neither simply respond nor differentially react to the segment of the environment consisting of auditory stimuli in the way a hearing infant would. Although the manifestations of the perceptual deficit are quite subtle (since other senses are intact), and thus may hardly be noticed by a mother who has no cause to expect her infant to be handicapped, I nevertheless submit that from very early on this mother will in some ways not be provided with the same gratification she might otherwise have experienced, both with respect to her child's unfolding "competence" and with respect to knowing of her specialness through seeing the infant differentiate mother from all others--just by the sound of her voice from afar.

Recent research has demonstrated not only the extent of the infant's receptivity to environmental stimuli but also the ability to seek stimulation and initiate social interaction (Meshover, 1980).

In this regard, particularly the infant's capacity for vis-à-vis orientation and sustained visual regard has been considered central (Beebe & Stern, 1977; Robson, 1967; Walters & Parke, 1965). The work of Stern (1974, 1976) and his colleagues (Beebe & Stern, 1977; Perry & Stern, 1975) delineates the mutual touching, moving, gazing, and non-linguistic vocalizing which constitute early mother-infant dialogue. In this dance made up of complex sequences of mother "chasing" and infant "dodging," and vice-versa, each has the capacity to initiate and control the amount of contact. Stern (1974) stresses that the infant's ability to control gaze allows her/him to regulate the amount of social contact through vision and to reduce or increase state of arousal. In thinking about the impact of deafness on gaze behaviors it seems reasonable to assume that in relying significantly upon vision for contact, the deaf baby is not as free to "dodge" the mother and thereby reduce stimulation for her/himself since that would leave the infant with no distal contact (normally, through hearing) at all. Thus, the infant may choose to remain visually "glued" to mother's face, or to "dodge" and completely cut off contact with mother--creating in either case a very different balance of distance and closeness than that which might have been offered to the same mother by the same baby with hearing.† Stern (1974) has demonstrated, as well, that capacity to provide the mother with response to her gaze is also affected by the infant's ability to hear. Since he found the ability of the mother's gaze to elicit and to hold her infant's gaze to be

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†Of course, the channel of kinesthetic contact with the mother is completely available to the deaf infant and affords her/him an additional way by which to regulate degree of closeness.

greatest when accompanied by vocalizations, it stands to reason that the deaf baby may not allow the mother's gaze to "hold" her/him in the same way a hearing baby would (Meshover, 1980).

Lewis and Freedle (1973), in their discussion of the complex "communication network" between mother and hearing infant from birth, emphasize the centrality of vocalization production and response:

> The interaction of the infant and its mother reflects what we believe to be a rather finely tuned and potentially meaning-laden system wherein each allows the other to act. Nowhere is this more readily seen than in the vocalization interaction of these two dyadic members. If we forget that the infant at twelve weeks of age is totally without any formal language system, observation of his vocal interactions strikes one as having a "conversational quality." Mother vocalizes, infant listens; infant vocalizes, mother listens--the chain of vocalizations varying in length. The resulting phenomenon might very well be said to resemble that of two adult language-users carrying out a conversation. (pp. 128-129)

Condon and Sander (1974a, 1974b) have demonstrated the effect of the caretaker's vocalizations upon the infant's movements. Through the method of frame-by-frame analysis of sound film taken (as early as 20 minutes after birth) of the awake-active neonate exposed to human speech, they have identified change points in the infant's movements and shown them to be exactly synchronized with the occurrence of onsets of words and of phonemic boundaries analyzed from the film's soundtrack.

In sum, the deaf infant is not stimulated by mother's voice and is therefore not responsive to her in certain subtle but basic ways. In turn, the hearing vocalizing mother is provided neither with the normally synchronous body movement feedback, nor as fully with reciprocal gaze, nor with responsive vocalization by her baby. Thus, in some deaf infant-hearing mother couples, both partners may be partially out of tune with one another with respect to the mutually

stimulating and potentially gratifying exchanges which constitute the fabric of their relationship (Meshover, 1980).

By the time the deaf infant reaches 6 months, Mindel and Vernon (1971) contend, there have been enough cumulative instances of unresponsiveness to sound that the parents have developed a definite, if unspoken, conviction that their child is deaf. At 6 months a hearing infant can move the whole body in response to sound, as contrasted to earlier behavior when first random head movements and then, at 16 weeks, controlled head movements were the reaction. By 6 months, as well, a hearing infant will have been soothed and calmed countless times by mother's sounds and songs--a response which dates from immediately after birth when repetitive rhythmic auditory stimulation such as tape-recorded heartbeats or lullabies have been shown to produce profound alterations in the infant's state including induction of sleep (Terhune, 1979). These responses of the infant are tremendously gratifying to the mother. The infant's purposeful movement to localize the sound of her approach and cessation of crying or relaxing into sleep in response to the rhythmic use of her voice serve to build and reinforce the mother's sense that she is a meaningful person to her baby and a good mother. The mother of a deaf infant is deprived of these particular kinds of reinforcement.

With respect to sound production, it is around 8 months that the deaf infant's voice patterns begin to noticeably differ. When the hearing baby is forming intonational voice patterns, the deaf baby, since no speech has been heard, will make the same nonspeech sounds regardless of what s/he desires to communicate. At 9 months there is

true imitation of speech in the hearing infant who is busy repeating sounds of her/his own repertory and some from the environment. In contrast, at 1 year, babbling in the deaf infant (which at 6 months was on par with that of the hearing child) largely stops. Without sound input, speech does not naturally develop, and the vocalization process dependent upon internal biological programming falls off (Mindel & Vernon, 1971).

A specific subclass of infant vocalization noteworthy for its special significance to the mother is her baby's crying. Initially there may be no difference between a deaf infant's cry and that of a hearing baby. However, within the first few weeks the normal neonate's cry quickly differentiates into cries signalling various physiological states (pain, hunger, distress) as well as an attention-getting "fake" cry (Wolff, 1969). In the case of the deaf infant who is deprived of the process by which s/he would hear the cry and experience its effectiveness in differentially altering the external environment, it is improbable that proprioceptive muscle feedback alone would enable the baby to produce a number of different reliably identifiable cries. The mother of the deaf child therefore receives different information as to the exact nature of her child's inner state. Thus, paralleling the difference in the deaf infant's subjective experience of the omnipotent cry that "magically" summons an omniscient mother, the mother of a deaf child may feel herself to be relied upon less or differently than does the mother of a hearing child.

I want to pause here to note that in speculating thus far about a mother's likely experience of the deprivations imposed upon her by

her child's deafness, I have been referring to the fictional "average-expectable" mother and child who live only in our imaginations. The actual expereince of a given mother with her particular deaf child will of course depend on the interaction of such characteristics of the mother's as her temperament and perceptual stimulation sensitivity thresholds with those of her child's (Escalona, 1968). It will also depend upon the interplay between mother's and child's "preferred modality" of contact (Mahler, Pine, & Bergman, 1975). For example, one mother may be more comfortable than another with the much greater degree of nonverbal expressiveness and frequency of proximal contact necessitated by the inability to connect with her child through words and over distance via sound. By the same token there is variation among infants with respect to such attributes as degrees of "strength of looking interest"† or "cuddliness," both of which would have differential effects upon communication development between hearing mother and deaf child.

Before continuing on to follow the deaf infant-hearing mother couple through the subsequent phases of separation-individuation, I want to briefly mention how already in the earliest months the absence of the auditory modality may make more difficult the achievement of libidinal object constancy and the development of differentiated affects--both of which are areas in which deficits may impact significantly upon the mother's experience of her child. To start, it seems reasonable to assume with Meshover (1980) that, since for the

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†For elaboration upon the implications of "strength of looking interest" for the mother-child relationship see Riess's treatment of this issue in "The Mother's Eye--For Better and for Worse" (1978).

hearing baby the rudiments are present during the symbiotic phase for the later awareness that the need-satisfying mother exists even when out of sight, therefore "the absence of the early object-defining and anxiety-reducing qualities of the mother's voice may affect the deaf infant's reality by making it more ambiguous, more discontinuous and less reliable" (p. 116).

Affect differentiation, suggests Stern (1978), normally grows out of the mother's use of the "music" of her voice to modulate and regulate her infant's states of excitation. Without being able to make use of the modulating effect of mother's sounds in the task of transmuting impulses into discrete affects, the deaf child may face more difficulty in the achievement of stable, complex, and deep affective experience.

Viewed from a wider perspective, both the object-defining and affect-modulating functions of the mother's voice can be seen as aspects of the "holding" environment she creates for her infant (Winnicot, 1960). Brazelton, Kislowski, and Main (1974) emphasize an additional aspect of what constitutes "active" holding: mother's voice used together with gaze and facial movements serves to organize her infant and bring her/him into a state of alert attention which leads to the infant's being able to control motor responses and attend for increasingly longer periods of time--in other words, to organize her/himself. This achievement frees the infant to attend more and more to the external world and marks growth beyond the symbiotic orbit into the world "out there."

The infant's growing interest in the other-than-mother world brings with it a shift to distance perception which enables her/him to explore the environment and to perceive and enjoy mother from a greater distance (Mahler et al., 1975). Shopper (1978) stresses the importance of sound in connecting mother and child over distance:

> Hearing has certain advantages for the developing child not possessed by vision, advantages crucial in the handling of certain developmental problems: Hearing can take place in total darkness; hearing can go around corners (i.e., from room to room); hearing is the sensory modality for the back of the body, i.e., when the face is turned away from the object or the child is moving away from the mother. Further, hearing is the sensory modality of sleep, there being no organ analogous to the eyelids to markedly reduce auditory registration. As the growing child is able to separate itself more and more from mother, and both initiates and tolerates the separation, hearing and vision for both mother and child become the modalities of sustained contact, but it is only audition that allows contact despite the barriers of curved distance, darkness, and the turning of one's back. (pp. 283-284)

Shopper emphasizes the crucial role of sound especially during the second year (Mahler's practicing subphase) because it allows the now locomoting child to move away from and stay in contact with mother simultaneously and, furthermore, allows her/him to be connected to mother while attending to other things. The mother uses her voice both to provide an "auditory presence" and to catch her toddler's attention and warn of any possibilities of physical danger. The mother of a deaf child, however, may not be able to fully enjoy either this "distance contact" (Pine & Furer, 1963) or the new image of her child as becoming autonomous and independent. If her toddler is not looking at her or is out of her immediate range of vision she has only two choices: to tolerate the anxiety of not knowing whether she will be able to get to her child in time if there should be danger, or to

demand that the toddler stay in constant eye contact--a situation which would deprive both mother and child of freedom and force them to relinquish something of their separate selves. Thus, for both partners in the deaf child-hearing mother dyad, the process of separating from each other may be less gradual and may entail experiences of either uncomfortable (that is, developmentally inappropriate for both partners) overcloseness or equally uncomfortable isolation in which they feel themselves to be thrust into premature separateness from each other (Bergman, 1979).

During the last half of the second year, with mother's having become psychologically and physically more distant, spoken language becomes increasingly necessary for the hearing toddler as a means of both retaining a connection to mother and expressing the increased complexity of now more differentiated needs. Clearly, acquisition of a rich manual language system would afford the deaf toddler these same opportunities. However, since this study focuses primarily upon the experience of hearing mothers and deaf children who do not learn sign language, the remaining discussion of separation-individuation in this chapter will speak only to experience of the nonsigning dyad. Assuming, then, that the deaf child does not learn sign by the end of the second year, her/his failure to significantly develop speech or language except for a very limited gestural system (a situation which depending on a number of variables to be discussed later on may or may not change appreciably in the coming years) profoundly exacerbates the frustration and sense of deprivation experienced by the mother. The fact that she is unable to inhabit with her child the world of shared

meaning created by words frustrates her on two counts--first, in terms of her desire to mother and give to her child and, second, in terms of her own need to be understood and validated as a person by her child.

Gregory (1976) cites a number of poignant examples from her interviews with hearing mothers of deaf children in Britain of the feeling of being "cut off" from one's child due to lack of a communication system:

> I used to feel that when a child is two, and he can talk to you, you're like companions, and you're at home all day with a child and you can sort of say "Let's have a drink now" or "Let's do this," like I can with Pauline, but with Derek I can't. I used to say it to him but I used to think --well he is in a world of his own and I am. (p. 212)

> They're not able to ask questions are they? I mean we're going out in the car and Susan will say "What's that tractor doing in the field?" Well I often wonder what he thinks when he sees a tractor. I mean obviously he doesn't ask. I wonder if he works it out for himself or what. I mean Susan at this age used to ask questions all along, but he doesn't. I wonder if he thinks about things and wonders. (p. 215)

In addition to feeling unable to satisfactorily answer questions, label affects, and generally communicate basic information to assist her toddler in learning about an increasingly large and complex world, the mother of a deaf child may feel helpless each time her child becomes frustrated or hurt and can communicate only as much as squeals and tears and gestures can convey. She may feel she is further depriving her child when she peremptorily forbids behavior without explaining why or that it will be permitted later (both of which are often too complicated to convey without words):

> I mean you can't say like when Janet [his sister] gets older, we'll say "Now you won't touch the fire because it will burn.

> Nasty. Hurts." But all you can say to Stephan is "No" and that's it. You just can't explain why. It's horrible. (Gregory, 1976, p. 20)

The frustration at not feeling able to give enough may be heightened by a mother's sense that her deaf child depends largely on her (since she usually is the one who has come to understand her/him best) for explaining and "listening" to her/his communications--both of which a hearing child can receive from other family members and people outside the family. The mother is burdened also with a function the hearing child automatically serves for her/himself--that of being an audience to one's own speech. Klein (1965), in his paper "On Hearing One's Own Voice," contends that the auditory return of one's own speech has great significance for the development of control of behavior and secondary process thinking as well as for the maintenance of a sense of self. Lacking adequate ability to put thoughts and feelings into words for her/himself, the deaf child turns to the mother to lend a sense of reality and concrete existence to her/his internal experience. Audition assists, as well, in the verbalization necessary for the child's progressive mastery of affects and impulses (Katan, 1961), and in the transformation of external parental prohibitions into the "voice of conscience" (Isakower, 1939). The mother of the deaf child is likely to feel called upon to somehow "do" these developmental tasks for her child--that is, to provide the psychological "nutriment" which is missing. Similarly, she may also feel a pressure to, in some way, make up for the external stimulation including the constant accompaniment of background sound (overheard voices, the music of nature, radio and television, traffic noises--to name but a few) from which her child is shut out

(Pine, 1981).

It is not only the child who is deprived by her/his lack of language--the mother is as well. Optimally, a child can provide parents with some affirmation of their worth as parents and people, together with an opportunity to rework and resolve some of their own childhood conflicts as they accompany the child through negotiation of developmental phases (Benedek, 1970b). These processes presume the child's capacity to truly enter into relation and connect with parents at a number of different psychological levels. The mother of a deaf child is deprived, to some extent, of experiencing such "caretaking" from her child. Her differentiated affects, her complex thoughts--much of her entire inner experience in which language participates so deeply --is out of the range of her child's understanding.† Thus, the deaf child may provide for her/his mother many experiences of a less-integrated kind of communication in which regressive or primary process phenomena may perhaps occur more readily. A vignette from Anthony's treatment of an electively mute boy illustrates an extreme form of this kind of communication:

> The little amorphous thing [a piece of clay] was put in my hand. I looked at it with the eye of my understanding and thought: What may this be? And the answer came to me from somewhere within me: It is all that this particular child can make of me, of himself, of our relationship and of the world.... It was not a gift but rather something created by us and between us. (Anthony, 1977, p. 310)

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†This is not to say the deaf child lacks the capacity to understand. The difficulty lies, rather, in acquiring the basic tool for understanding--language. Problems inherent, for the deaf child, in oral language learning (the route chosen by most hearing parents [see Stuckless & Birch, 1966]) will be considered in the following sections.

Whereas a child analyst expects these kinds of communications, feels comfortable digesting them, and does not fear loss of her/his differentiated sense of self and of reality, a mother may feel less at home being communicated to by her 3 or 4-year-old largely in this way. The extent to which she is able to take in what is given to her by her deaf child is dependent upon many factors, among which is likely to be her comfort with and nondefensive mastery over her own primitive impulses and affects. It seems to me that one factor which would interfere with a mother's allowing herself to be "fed" by her deaf child's less-defined communications is the fear of being flooded by frighteningly intense affect--that is, to paraphrase George Eliot in Middlemarch, the fear of "dying from the roar of [her child's] silence."

Escalona, in the Sixth Josiah Macy Jr. Foundation Conference (1952), discusses a related concept in her attempt to understand why particular mothers are comfortable and skilled at transmitting feeling states to their infants (for example, conveying a sense of calmness to a crying baby) through a process which she calls "contagion," while others are not. She extends this distinction as well to mothers' skill at reading behavioral information transmitted by their babies. Especially relevant for our purposes here is the suggestion offered by Sylvester in discussion of Escalona's paper, that contagion may be a developmentally early mode of communication which is never completely relinquished and which remains the medium through which mimicry and gesture are transmitted and understood. Escalona characterized those mothers who were observed to possess a high degree of contagion-reception and transmission skill as "not tending to intellectualize,

not seeming anxious or preoccupied, not seeming overly distressed when the baby cried, and having no rigid notions or anticipations about what should be done to the baby when" (p. 36). In other words, these mothers appeared to be spontaneous and immediate in their acts of mothering; their responses to the baby were somehow more on the level of "sense and muscle" than that of conscious intellectual awareness. They were able, however, to view the baby as an individual in her/his own right, in contrast to mothers with less skill in this area who seemed to either view their child simply as "the baby" without distinct preferences or characteristics, or to see the infant as a little adult with unrealistic powers of thought and observation. Escalona generally characterized these "less skilled" mothers as having "overly intense expectations and emotions toward the baby, of a kind other than is compatible with the maternal role" (p. 39). In addition, she speculated that a mother whose energies are heavily engaged in holding at bay anxiety aroused by unconscious conflict would find it more difficult to direct herself wholly toward the baby, as seems to be necessary when contagion is used deliberately.

In this section I have explored the possible effects of the absence of audition on the deaf child-hearing mother couple and particularly to elucidate the ways in which, as a result of this lack, the mother may experience significant deprivation over the course of her child's early development. The final section of this introduction will concern itself with understanding the possible impact of these feelings of deprivation upon mothering behavior, especially in the realm of feeding. Before turning to that task, however, I would like

to take a step back to define more precisely what I have meant thus far by "deafness," and to briefly review the parents' experience of the process of diagnosis including the mourning which may follow.

Parental Response to the Diagnosis of Deafness

The deaf children with whom this study is concerned are those whose hearing loss is sensorineural, "profound" (over 90 decibels), and "prelingual"--that is, who do not receive speech sounds clearly enough through their residual hearing to develop language, even though they may be aware of loud or random noises. Since a damaged inner ear transmits distorted or poor quality impulses to the brain, these children's ability to interpret sound information is severely compromised. Therefore, high-powered amplification through hearing aids can only create sensitivity to some aspects of sound; it cannot increase the capacity to discriminate sounds within a particular frequency and intensity range, nor can it restore hearing in the high-frequency ranges (those typically lost to deaf children) which carry most speech information. Thus, for those deaf children born to hearing parents there is typically no system for communication in early childhood other than primitive home-made gestures and other nonverbal communication.† Even after the child enters a school for the deaf, receptive and expressive oral skills are usually slow to develop and only rarely develop adequately enough to support meaningful communication with

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†Of all profoundly deaf children in the U.S. (numbering 200,000 in 1975), 90% have hearing parents (Liben, 1978b). In the most recent survey conducted, only 11% of these parents reported using manual communication with their deaf children (Stuckless & Birch, 1966).

those who have not learned some form of sign language (Liben, 1978).

The possible causes of early profound deafness may occur prior to birth, during the perinatal period, or in early childhood. Suspicion that a child might be born deaf may arise during pregnancy if inherited deafness or maternal rubella is involved. However, in both cases there is often no prior reason for the parents to assume the child will be deaf; 90% of genetic deafness is carried by a recessive gene and thus frequently appears where there is no known deafness in the immediate family, and in the case of rubella the illness may not come to actual clinical definition so that the mother may be unaware she has contracted it (Mindel & Vernon, 1971). The two prominent causes of deafness related to the perinatal period are prematurity and blood-type incompatibility between mother and child (especially where the mother is Rh negative and the fetus Rh positive). Again, in these cases, there is no cause for parents to necessarily expect deafness since most doctors would choose not to alarm parents by informing them of the small risk. Finally, postnatal causes of deafness such as meningitis and encephalitis may also occur prelingually--that is, before a child is old enough to have learned language through hearing it. Parents of children who contract these infections probably will have been alerted by their physican to watch for possible effects of whatever brain damage has occurred, including the possibility of deafness (Mindel & Vernon, 1971).

Because in many congenital and perinatal cases parents have no reason to expect deafness at the start, generally 1 to 3 years go by before the hearing loss is diagnosed. Part of the reason for this

delay may be that most deaf infants do respond to some gross low-frequency sounds such as airplanes overhead or banging pots and pans. However, the ubiquity of parents' recollections that they knew something was "just not right" from very early on suggests that the delay of full awareness is an early manifestation of processes of denial of the deafness. For example, during the phase of not-wanting-to-know, a mother may interpret her child's turning towards her when she approaches while speaking as a response to her voice. Or upon noticing that the child's eyes shifted after a door has been closed, she lets herself attribute this to the child's supposed hearing of the sound rather than to the feeling of vibrations through the floor, or to the fact that the light in the hallway became blocked out. She may also rationalize that her child hears but is unresponsive to her due to stubborness or negativism.

When the realization finally becomes inescapable that their child is both not speaking more than three or four words and not discerning what is spoken, parents usually bring her/him to the family physician. Since the problem of differential diagnosis between aphasia, autism, mental retardation, normal but unusually slow development, and deafness is quite complex, and because deafness is a medically unexpected event, many parents go through numerous and often contradictory consultations during this phase. One-third of the parents in Meadow's (1968) study of parental response to the medical ambiguities of congenital deafness, reported that the first doctor consulted said there was nothing wrong with their child and implied they were overanxious and "neurotic" parents. Mindel and Vernon (1971) claim that one-third of all cases

of early deafness are originally misdiagnosed.

Finally, the child's deafness is determined beyond any doubt, and the real sorrow begins. Although there may be some initial relief at knowing what was previously unknown, or at discovering that the child is not retarded or autistic and does not have some other problem thought to be worse than deafness, the predominant experience following the diagnosis is most often shock and disbelief. The discovery of deafness confronts parents with an experience of profound loss--the loss of the longed-for healthy perfect baby. Although the trauma may be equally intense for both parents, it is likely that each experiences it somewhat differently. Since in this study my interest is primarily the experience of the mother, I will focus mostly upon her reactions and the meanings her child's impairment may assume for her.

From an early time of first thoughts and dreams of having a child, through pregnancy, delivery, and the slow letting-go and letting-become of mutual individuation, a mother's psychological reality is intimately bound up with the meanings, for her, of the fact of her child and the fact of her motherhood. These meanings, at the start, usually include the promise of gratification of some sort which the as-yet-unborn baby will provide its mother. To this end, the psychological preparation for the new child during pregnancy normally involves the wish for a perfect child and fear of a damaged child. If the baby is discovered to be "damaged," the sudden loss of the expected child and the substitution of a feared, threatening child constitute a uniquely traumatic event for the mother (Solnit & Stark, 1961). Since during pregnancy the child was seen as an integral part

of the self, the impaired child is likely to be experienced by the mother as a narcissistic blow. Feelings of devaluation and worthlessness often ensue. The mother may now recall fears she experienced during pregnancy about the health and safety of the baby-to-be (which are normally experienced by most expectant mothers and subsequently repressed with the birth of a normal child), and she may see the "damaged" baby as a confirmation of what she had expected would happen all along. She is likely to wonder: What is wrong with me that I produced a defective child? Why has it happened to me? What have I done?

Lax (1972) suggests that the meaning of these questions relates to the rekindling of dormant unconscious conflicts (particularly around wished-for compensation for lack of a penis and acceptance of feminity) set in motion by the birth of the impaired child. This is due to the fact, Lax continues, that the child impaired in reality represents to the mother's unconscious her infantile damaged self:

> Whereas the birth of a healthy vigorous baby could have compensated for mother's unconscious sense of impairment and could have served to fulfill in a psychodynamically acceptable way mother's unconscious childhood longings, the birth of an impaired child evokes in the mother a hopeless sense of failure. The mother feels as if she created what she always, unconciously, felt she is rather than what she hoped for. (p. 340)

Thus, Lax understands a mother's symbiosis with her felt-to-be-defective child as a "relationship bound by the mortar of ... self hatred projected onto an object unconsciously perceived as an externalized defective self" (p. 342). She views the extent to which negative feelings towards the self predominate in the mother's character and the extent to which the symbiotic involvement with her own mother has been dissolved, among other factors, as determining the strength of the symbiotic links which bind

mother and impaired child. Only with the mother's gradual realistic achievement of self-fulfillment by attaining goals aligned with her ego ideal aims in other areas of her life, will she be able to begin to view herself and her child as separate. With this replenishment of the self-esteem (or narcissistic libido) which had been depleted following the discovery of the child's impairment, the mother's earlier depression can turn into a feeling of sadness for her child whose handicap she can now view realistically since she sees the child as a person apart from herself (Lax, 1972).

Whereas Lax's formulation focuses upon the mother's projective identification with her impaired child, other authors emphasize different aspects of the mother's reaction--such as guilt that somehow she has caused the handicap to occur as a punishment to her for ambivalent feelings about parenthood or for angry fantasies she harbored toward the unborn child who gave her discomfort during pregnancy (Mindel & Vernon, 1971). However, all the attempts in the literature to understand the relationship of mother and handicapped child uniformly stress the necessity of mourning, or, as Lax puts it, "dissolving of the symbiotic glue"--if a positive realistic adaptation is to be achieved. Solnit and Stark (1961) describe this mourning process as follows:

> The disappointmted highly charged longings for the normal child may be recalled, intensely felt, and gradually discharged in order to reduce the impact of the loss of the expected loved child. This process, which requires time and repetition, can liberate the mother's feelings and interests for a more realistic adaptation. The mourning process makes it possible to progress from the initial phase of numbness and disbelief; to the dawning awareness of the disappointment and feeling of loss with the accompanying affective and physical symptoms; to the last phase of the grief reaction in which intense re-experiencing of the memories and expectations

> gradually reduce the hypercathexis of the wish for the idealized child. (p. 526)

The mother who is able to undergo this painful process of letting go of the child who embodied her profoundest hopes and in whose potential she saw the extension of herself into the future--is rare. Often after a short period of incomplete mourning, a mother will adopt a stance toward her handicapped child characterized by particular defensive modes. The choice of defensive constellation depends upon the mother's life-long mode of coping with crisis and stress as well as upon the specific meaning, for her, of having a child who is impaired in a particular way (Ross, 1964).

For the mother of a deaf child, the task of mourning entails nothing less than her acceptance that "the lovely healthy hearing child has died [and that she must now] give birth to a lovely healthy deaf child" (Furth, 1973). Many mothers of deaf children never achieve this acceptance. In their hearts they keep a ghost child alive, persisting in the hope that their child will grow out of being deaf or at least behave and appear to others like a normal hearing speaking person (Benderly, 1980). Chronic denial of the implications of deafness is abetted by the child's many visible similarities to his hearing peers. Often parents encounter professionals who reinforce their denial by overly optimistic statements about the values of hearing aids and the effectiveness of lipreading (Vernon, 1974). Seldom told to parents are the facts that a proficient deaf lipreader is likely to be able to lipread at best 30% of what is spoken to him (Shopper, 1980) and that, on the average, 30% of deaf children leaving deaf schools at age 16+

are functionally illiterate and that only 5% attain 10th-grade level (McClure, 1966). I do not mean to imply that adhering to the oral philosophy which recommends that deaf children be exposed only to oral communication if they are to learn speech necessarily signifies rejecting the reality of a child's hearing loss. I do mean to capture the sense of frantic hoping for a miracle to commute the sentence of deafness which often characterizes the stance of mothers of young deaf children who have failed to develop oral language. Success of the purely oral system with a given child depends not only upon the child having sufficient residual hearing and ego endowment and upon the availability of sufficiently expert training as early as possible, but also upon intensive efforts at home, especially by the mother to constantly provide oral stimulation. For many mothers who choose this route, assuming the role of teacher is experienced as a tremendous burden:

> Colin and I always seem to be together once Colin's here (at the swimming baths) purely because I have always been working with him.... And I think if I am perfectly honest with you, I don't think I could say enjoying [playing with him] comes into it anymore, because you seem to be conscious all the time whether I am pumping enough into him with what we are doing now. I mean I am happy with him, don't get me wrong, but as regards saying do I enjoy that, I enjoy taking him to the swimming baths, I enjoy that, but it's a real strain.... It's sometimes difficult when you're playing with them not to concentrate on teaching them things--you know. Always trying to pack in as much as you possibly can. You have to be careful not to try and cram too much in, and let them enjoy playing whatever it is. (Gregory, 1976, p. 122)

Whereas the purely oral path is fraught with difficulties, there are drawbacks to casting one's die with the other side of the oral-manual controversy as well. A mother who adopts the position of "total communication," which entails using sign language along with speech,

faces the enormous task of learning a new language herself. The decision to attempt to integrate a foreign language into one's being for the sake of the relationship with one's child squarely confronts a mother with the fact of her child's differentness; and she may struggle with feeling that her own flesh and blood is a stranger to her. Choosing sign also means making an invisible condition visible to everyone including strangers in restaurants and supermarkets; it means letting the whole world see that something about one's child and thus one's self is "different."

Parents are often confronted with this centuries-old manual-versus-oral-communications war immediately following diagnosis of the deafness. So in their time of greatest distress, with confused minds and aching hearts, they must make an urgent and difficult choice of utmost gravity in an area in which, as yet, there is no conclusive empirical evidence substantiating the claims of either side.† And they must make it quickly, since both camps agree on the urgency of beginning systematic steps to develop language given the increasingly persuasive case for a critical period for first-language acquisition (Benderly, 1980).

This section concludes our exploration of the various levels of deprivation likely to be sustained by the mother of a deaf child. In it I have attempted to clarify the ways in which the mother's sense of

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†In fact, the conclusion warranted by the research to date is that level of language functioning attained by deaf children depends more upon the degree of emotional availability of the mother than on the particular language education method employed (Greenstein, Greenstein, McConville, & Stellini, 1975). This simply begs the question, however, of whether "emotional availability" may be facilitated by use of sign language. This issue will be further addressed in the Discussion section.

profound loss during the period following diagnosis lends an added dimension to the deprivation she is likely to experience daily from the fact of the hearing deficit itself.

I will turn now to a discussion of the rationale for the argument I proposed at the start of this chapter--that a likely response of a mother to depriving and being deprived by her deaf child may be to develop some form of compensatory behavior with the child in the realm of feeding. I will approach presenting the case for this position by considering two questions. First, what does feeding one's child provide for a mother in terms of gratification of her own needs? And, second, how does this meaning of the feeding process make it for the mother of a deaf child a likely vehicle through which to enact feelings engendered by her child's deafness?

The Giving of Food: Its Meaning between Mother and Child

After birth, the reciprocal nature of the mother-infant bond is reestablished largely through the feeding process which affords the mother gratification and at the same time supplies the infant with physical and emotional necessities for growth. The biologic substrate of this reciprocity is illustrated by the process of satisfactory breast-feeding in which the nursing infant satisfies its hunger while sumultaneously pleasurably stimulating the mother's breasts and relieving tension caused by accumulated milk. Both mother and infant may experience sexual excitement during nursing. For the mother, nipple erection, uterine contractions, and even orgasm may occur. In older infants,

rhythmic motions of hands, feet, fingers, and toes often accompany the rhythm of sucking. Erections during nursing are common in male babies (Kaufman, 1970).

The mutual gratification afforded by the feeding process is, of course, emotional as well. While many psychoanalytic authors discuss at length the ways in which, for the infant, repeated satisfactory feeding experiences contribute towards a psychological state of oral gratification and emotional security, usually little more than brief mention is made of parallel developments in the mother. Benedek's work stands as the exception to this generalization and as such is uniquely relevant to the concerns of the present study.

Benedek (1956) sees repeated successful feeding experiences as offering a mother ongoing proof that her infant is thriving and thus "good." This validation in turn establishes, in the mother, confidence in her motherliness and trust that her own self is "good." In addition to offering an opportunity for affirming her identity as a mother, the process of feeding allows the mother to gratify her infant-self through identification with her child.† Benedek sees this identification as being stimulated by the reawakening of the mother's yearnings for nurturance from her own mother due to the intensification of receptive needs in reaction to separation from her child at the time of birth. Through identification with her child, the mother can care both for her child and for her infant-self as well--in the way she wished to

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†The universal tendency of mothers to open their own mouths while feeding appears to be a concrete manifestation of this identification (Kris, 1952).

be loved and cared for by her own mother. Thus, just as once her own mother was the only person who could alleviate her frustration and feelings of deprivation, now her infant alone, through its thriving, can fulfill the mother's oral-receptive needs. In other words, the child becomes the "good" or "bad" mother who alone has the power to restore mother's emotional security through becoming satiated by her.

Before continuing on with Benedek's argument, I want to clarify an assumption which she takes for granted and thus does not spell out. "Food" for Benedek is shorthand for the package of food-plus-love. In the beginning, for the infant, mother and the food she gives are felt to be one. For the mother, as well, feeding her child constitutes the primary early demonstration of her desire to give of herself to foster her baby's growth. For Benedek, then, if the child is able to take in and be gratified by the food-plus-love mother gives, then mother experiences her giving as "fed-back" to her by her child. In Benedek's words:

> What she once received from her mother in the form of food and love, now as a mother she gives back to her child consciously in the form of food and love. As she enables the child to produce libido, her own libidinal state is enhanced through the emotional exchange with her child. Thus the mother takes from the child in a transformed state, as libido, that which she once received from her mother in the form of food and love. (1956, p. 421)

In this excerpt, Benedek alludes to a link between the development of a mother's "emotional exchange" with her child and the feeding process. I would like to further explore how the two are related. Whereas in the early months of the infant's life emotional exchange takes place through the giving and taking of food, through mother holding and infant allowing her/himself to be held, and through eye contact and facial

expressiveness, with time, the sounds of both partners come to play an increasingly larger role in their communication with each other. By the time the infant turns 2, much of what happens between mother and child is mediated through words; the gratifications surrounding feeding and being fed have largely given way to the gratifications of differentiated verbal expression through language and of being understood in terms of one's differentiated thoughts and feelings. Greenson, in his paper "The Mother Tongue and the Mother" (1950), discusses this evolution of verbal communication out of the early feeding experience from the point of view of the child:

> The child who suckled at the breast, now replaces this by introjecting the "new milk" of mother--her sounds. Speaking represents an opportunity for the child to repeat actively this old passive gratification. Passivity and mother attachment is replaced by activity and mother identification. (p. 22)

I propose that Greenson's understanding of this transformation holds true for the mother as well. She gradually replaces the giving of her milk with the giving of spoken words and songs--a process which serves to further developmentally appropriate separation from her child while still enabling her to retain the connection (or "emotional exchange") which now has become less libidinized.

Other psychoanalytic authors have noted the relation between feeding through the mouth (giving milk) and feeding through the ear (giving words). Wormhoudt (1949) illustrates what he views to be the unconscious identification "words-milk" by the following quotations from the Bible and other literary works:

> My words shall drop as rain, my speech shall distill as the dew, as the small rain upon the tender herb, and as the showers upon the grass. (Deuteronomy 32:3)

> Desire the sincere milk of the word as new born babies, that ye may grow thereby. (The First Epistele of Peter)
>
> Man shall not live by bread alone but by every word which proceedeth out of the mouth of God. (Deuteronomy 8:3)
>
> My ears have not yet drunk a hundred words of that tongue's uttering yet I know the sound. (Shakespeare--Romeo and Juliet)

Knapp (1953) discusses the ear as a receptive organ which can be either passive or active. The phrase "to receive an earful" illustrates the ear's operation as a funnel through which one is fed. The ear may also become a mouth to "drink in sound" and in this way function actively as a probe or antenna to grip important invisible data from the environment. Jones (1951) elaborates an unusual variation on the view of the ear as a passive-receptive organ in his analysis of the transcultural legend that mothers of saviors--such as Mary, mother of Jesus, and Maya, mother of the Mongolian Savior--became impregnated through the ear.

I have cited the work of Wormhoudt, Knapp, and Jones together with that of Benedek and Greenson in order to lay the foundation for the principal argument of this study. Given the view that the gratification which a mother originally derives from giving food and receiving the feedback that her child is thriving evolves into the gratification she derives from giving words and receiving her child's verbal communications, I propose that if gratification mediated through the verbal channel is unavailable to the mother she will experience a pull to enact her need-to-give through the original channel, that of the feeding process. I further hypothesize that this is what happens in the case of many mothers of deaf children. Deprived of being able to give of herself to her child through verbally sharing her thought and feeling,

the hearing mother of a deaf child may develop exaggerated concern (which could manifest itself in many different ways) around feeding--a giving-process which is available to her since it is concrete and tangible. Deprived as well of the experience of being stimulated by and trusted with her child's communication of her/his internal world, she may behave in some extreme fashion in relation to procuring from her child the visible feedback that s/he is well-nourished and thriving.

To lend support to this argument, I now want to go back to Benedek's (1956) presentation of what a mother, consciously and unconsciously, hopes to get out of the "emotional exchange" with her child, focusing this time on her discussion of consequences when the mother's oral needs are frustrated. Benedek contends that if the child, because of congenital or acquired disability, cannot take in mother's "food" (in which I include her sounds), the child remains frustrated and in turn frustrates the mother. In Benedek's words, the experience of frustration

> induces a regression in the mother which intensifies the aggressive components of her receptive needs.... The regression stirs up in the mother the preverbal memories of the oral dependent phase of her own development. If the recathexis of the infantile relationship with her own mother activates in the mother confidence and hope, she will overcome the actual disappointment and frustration, secure in her wish to love the child and to take care of him as she herself was loved and cared for. (p. 405)

In the case of the frustration imposed upon a mother by her child's deafness, it is unlikely that even the most positive experience at the hands of her own mother could protect the mother from feeling painfully deprived. Nevertheless, I do submit that the more emotionally healthy a mother is, the greater the chance that she will psychologically

tolerate her affective responses to her child's deafness and choose ways to actively build communication channels. Such a mother would probably experience less pull to enact her feelings through developing a feeding disturbance.

However, most mothers--and therefore even "average-devoted" mothers of deaf children--have not had superior mothering themselves and thus are likely to experience significant anxiety related to oral-dependent conflicts as part of their character. The emotional processes induced in this kind of mother by her frustrating child are formulated by Benedek as follows:

> If the regression induced in the mother involves the reactivation of preverbal memories of frustration and the "incorporation of bad mother," the mother's security in her own motherliness is shaken.... Since the mother identifies with both her own mother and with her infant, this means in terms of herself, that she becomes the "bad, frustrating mother" of her child as well as the "bad frustrating infant" of her mother again. In terms of the infant it means that the "bad frustrating infant" becomes the irreconcilable "hated self" and at the same time, as once her mother was, her infant now becomes the needed and feared object. Just as she could regain emotional equilibrium as a child by satiation through her mother, her emotional balance can now be re-established only through "reconciliation" through the thriving of her child. (p. 405)

Following Benedek's lead, I am suggesting that a likely response for the mother of a deaf child who typically, I believe, is prone to experience her child's inability to be fed verbally by her as a kind of failure to thrive, may be to frantically anxiously try to supply the child with food for growth. At some level the mother may even harbor the fantasy that her loving feeding might restore to life her child's hearing. An alternative response to the same experience of deprivation by a deaf child may be a decrease in the mother's ability or desire to give.

As Benedek puts it: "Without the ability to receive from the child the mother's ability to give to the child declines. She then comes to that state of frustration, disorganization, which makes her unable to give" (1956, p. 421).

Possible configurations for the feeding disturbance which I am proposing is likely to occur in some form for many mothers of deaf children are numerous. A particular mother's characterological make-up and her own present and past relationship to food are clearly variables which, in addition to her specific response to her child's deafness, will affect the shape and severity of any feeding disorder she develops with her child. In order to highlight the significance of these other variables, I will very briefly review some of the literature which addresses how a mother's conflicts around feeding may contribute to her child's developing a functional eating disorder.

Maternal Factors in the Development of Childhood Feeding Disturbances

Anna Freud (1946) characterizes the optimal attitude towards feeding as one which would enable a mother to "give her child direct access to food as early as possible, and to trust the self-regulatory powers of its appetite with sensible limits until such time as she would be able to increasingly withdraw from the feeding situation as the child learns to handle food independently" (p. 125).

The experiments of Davis (1928) are often quoted by modern pediatricians to give a mother faith in the wisdom of her baby's appetite (Spock, 1963). Davis presented 15 infants between 8 and 10

months old with a variety of foods at meals, allowing each baby to freely choose what to eat and how much. In spite of great individual differences in their selections, all the infants gradually chose a well-balanced nutritionally sound diet and developed no feeding problems (1928). This advice of "leave it to the baby" is hard to follow for most mothers. It is almost impossible if the mother is anxious, particularly if she was herself a problem eater. She may clearly remember from her own childhood that her mother's urging and forcing did not work. Nevertheless, she finds herself helplessly repeating her mother's pattern--all the while feeling guilty, anxious, and irritated with herself, her mother, and her baby (Kessler, 1966).

Some authors classify feeding disturbances on the basis of symptom; that is, a child may eat too little (in its extreme form, anorexia nervosa), too much (obesity), or the wrong things (for example, pica) (Kessler, 1966). A particularly useful method, from the point of view of this study, is Anna Freud's (1946) classification by the nature of the conflict which disturbs the normal function of eating. The first source of conflict she discusses is organic. In this category are included those feeding disturbances attributable to a change or defect in the physical state of a child which interferes with his drive to survive or need for nourishment. Her second category is "non-organic disturbances of the instinctive process itself" where eating has ceased to be a pleasure due to the mother's interference with the instinctive desires of the child through, for example, commitment to rigid schedules or only certain types of food. The child's preferences for sweets, soft or hard foods, using hands rather than implements, and so

on are disregarded. In these cases, mealtime becomes the scene of intense struggle--with the child dawdling, becoming distracted, and resisting new foods while the mother coaxes, bribes, threatens, gives in, and may even spoon-feed a grown child. Children with such feeding problems eat well at school or camp where there is no overinvestment in their food intake (Kessler, 1966). Anna Freud's third category, "neurotic feeding disturbances," constitutes a further development of the second category in that these cases have internalized the pairing of mother and food so that even in mother's absence eating is an anxiety-ridden highly charged process. While originally a child feels "love" only for the food itself which gives pleasure, once s/he can conceive that there exists a person through whom s/he is fed, this love is transferred to the mother. When this capacity is attained, the child's conflicted feelings towards mother may be displaced onto food which, in the unconscious, is identified with mother. For example, ambivalence toward mother may be expressed in alternation between overeating and undereating; resentment of her may be displayed in a stubborn dislike of food; jealous need for her attention may be expressed in greediness, and so on. Anna Freud concludes her discussion of the third category by listing other neurotic conflicts, not directly involving the mother, which may also interfere with eating--such as a child's fears around aggression, anal concerns, and fantasies of oral conception.

In those cases of feeding disturbances reflecting the child's association between food and mother (occurring in categories two and three above), Anna Freud suggests it is highly likely that

the mother has reinforced such association by offering food as if it were part of herself. Some such mothers "are pleased and affectionate when the child accepts the food, and offended when food is rejected as if their love for the child had suffered a rebuff; they beg a badly eating child to 'eat for their sake'" (1946, p. 126). Bruch (1970) cites somewhat similar dynamics in mothers of both obese and anorexic children who would feed when they themselves felt it was the correct time or when they felt hungry--disregarding their child's needs. There are other mothers, however, who foster the association between themselves and food by withholding food or neglecting to feed. While such a mother (just as the mother with a compulsion to feed) may also feel that her child's eating represents an ingestion of her very self, this fantasy produces intense anxiety rather than gratification. Burlingham (1972), in her discussion of a case in which a mother almost starved her son, traces how the mother's unconscious rage at being deprived by her own mother became displaced and projected onto her infant resulting in fears that, by taking her milk, he would suck her dry and empty her out. Similarly, Middlemore, in her monograph The Nursing Couple (1941), stresses the role played by unconscious oral-sadistic fantasies in maternal feeding behavior. Lehman, in the course of reviewing feeding problems of psychogenic origin, points out that a mother's rejection of her child need not necessarily be expressed directly through withholding of food. Excessive guilt and anxiety about the nourishment of an unwanted child may lead to excessive attention to feeding procedures. As a result the child may ultimately become anorexic, and in this way the mother will have indirectly expressed her unconscious death wishes

towards the child (Lehman, 1949).

It should be clear from this brief review of the feeding-disturbance literature that any given configuration of maternal feeding behavior can have a host of different meanings depending on the dynamics of each particular case. That is, excessive concern over feeding can be a function of defense against hostility or it can represent a genuine desire to give, albeit without adequately taking into account the needs of the child. Likewise, a mother's withholding of food can take on a number of meanings, such as rejection of the child or rejection of her own "good" self for not feeling herself able to be a competent mother.

All of the above meanings are likely to have some relevance in cases of a feeding disturbance developed by a hearing mother with her deaf child. In contrast to the cases reviewed above, however, I am suggesting that the feeding disturbance of such a mother arises not necessarily as much out of her own psychopathology, but rather may represent a relatively typical response to the particular deprivations imposed by a child's deafness. Based upon formulations advanced in the preceding pages, one might expect the mother of a deaf child to experience both a pull to give more to her child in compensation for her not feeling able to give enough--which could manifest itself as overfeeding, as well as rage at being deprived by her child--which might lead her to withhold food. One might also expect such a mother to be tempted to use food to appease nonnutritional needs of her child, since without her child's use or comprehension of language, she often can neither understand nor verbally satisfy many of these needs. It is the extent

to which a mother experiences each of the above responses, together with other variables relating to her personality and to the child's constitution and personality, which determines the form the feeding disturbance will take.

In searching the literature on feeding disturbances, I have come across only one paper which discusses psychological factors in feeding disorders specifically in the population of handicapped children and only one study of feeding disorders among deaf children. In his comprehensive treatment of feeding disorders in handicapped children, Weir (1979) traces how psychological responses to the birth of a handicapped child may affect the feeding relationship. He contrasts the guilty-oversolicitous response where there is often an accompanying tendency to overfeed and the related problems of vomiting, diarrhea, and food refusal, with those cases where the reaction is overt rejection or severe depression often accompanied by a tendency to underfeed and understimulate so that the child may show failure to thrive. Weir also argues that the particular differences which occur in the emotional development of a child who is mentally or multiply handicapped can cause added difficulties in the feeding relationship. In line with studies which show that mentally handicapped children (Webster, 1970) and children with perceptual handicaps (Wills, 1970) often develop a characteristic self-isolating and self-stimulating personality, he suggests that such children, who refuse any kind of change, are likely to resist variety in their diet or advancing to more developmentally appropriate foods.

The single study I found (Freeman, Malkin, & Hastings, 1975) which investigated feeding disorders among deaf children was concerned only with determining the incidence of these problems. Attention to feeding disturbances was paid as part of a larger effort to delineate the distribution of a number of psychosocial problems of 120 deaf children, ages 5 through 15, and their families in the Vancouver region of Canada. No attempt was made to explore the dynamics of the disturbances nor to differentiate among syndromes. Nevertheless, it is worth noting the findings of this study here to lend at least some support to my hypothesis that the hearing mother of a deaf child is likely to experience a pull toward developing a feeding disturbance with her child. Freeman et al. found that 5% of their population had feeding problems in early infancy only, 3% had problems which lasted through the preschool years, and 12% reported feeding to be a persistent problem. However, since in the published report of this study there is no mention of criteria for defining "feeding problem," it is not possible to assess the meaning of these figures or to compare them with figures on incidence of feeding disturbances in a comparable hearing population. Also, the figures in this study do not truly reflect the incidence of feeding problems (in whatever way they were defined) among hearing mothers of deaf children, since a small percentage of deaf mothers were included in the sample.

Chapter II

HYPOTHESES AND RESEARCH DESIGN

In thinking about how to design a study which would test the validity of the proposition put forth in the previous pages--that many hearing mothers of a deaf child are likely to develop feeding disturbances with their child--I faced a number of choices. Had I a research team and the resources to carry out a comprehensive large-scale investigation, I could assess the incidence of feeding disturbances among a very large sample of hearing mother-deaf child couples and compare it to the incidence of feeding problems among a number of control populations. Optimally, I would run at least the following two control groups: first, a comparable sample of hearing mothers with nonhandicapped hearing children--to determine whether the incidence of feeding problems among the mothers of deaf children is significantly greater than that among the mothers of hearing children; second, one of hearing mothers with hearing children who have a severe handicap other than deafness--to address the question of whether the feeding problems in the hearing mother-deaf child group constitute a response to the specific deprivations imposed upon a mother by her child's deafness, or whether they should be understood as a reaction to the experience of deprivation likely to be sustained by mothers of children with any severe handicap.

In the absence of the resources necessary to systematically run each of the above studies, I have chosen at this time to simply take

a first step towards investigating the possibility of a relationship between a hearing mother's need to "feed" words and the development of a feeding disturbance with her deaf child. In other words, I see the present study carried out for purposes of this dissertation not as a demonstration of the validity of my original hypothesis but rather as a preliminary piece in a series of investigations which I envision as a program for future research in this area.

For this first study, then, rather than attempting any sort of incidence investigation with all the methodological complications that would entail, I decided to limit myself to an exploration of a corollary of the more ambitious proposal argued in the introductory chapter. Since it was methodologically feasible to collect a sample of hearing mothers whose deaf children had already been identified by an objective independent source as having serious eating problems, I decided to then attempt to ascertain whether these mothers, as a group, were people who had a significantly high need to talk. Thus, the more limited hypothesis of the present study came to be that deaf children (of hearing parents) with feeding disturbances† have mothers for whom talking is an important and highly pleasurable activity.

Even with this more limited focus, however, it was clear to me from the outset that any positive findings would still require further examination through subsequent studies to make them more meaningful. For example, at least the following issues would need to be followed-up.

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†The terms "feeding disturbance" and "eating disturbance" are used interchangeably here as they are throughout the relevant literature. See the final section of Chapter I for further elaboration of this point.

First, for those families in which the eating-disturbed child had hearing siblings the question of whether the siblings also had eating problems would need to be addressed. Second, a comparable group of hearing mothers of deaf children without feeding problems would need to be studied to see whether these mothers as well came out as highly talkative. If they did, the two groups of mothers would then need to be compared to determine if the no-feeding-problem mothers were differentiated by a higher degree of comfort with nonverbal communication or were emotionally healthier in some way than the feeding-problem group and thus may have experienced less pull to enact their feelings through disturbed feeding behavior.

To summarize, my intent in the present study was to determine whether the data from a small sample suggested the existence of a relationship between a mother's development of a feeding disturbance with her deaf child and a high need on her part to talk. Whereas the design of the study clearly does not warrant concluding any causal link between these variables, I felt that if its findings proved to be strong, a reasonable case would then be arguable for regarding the verbal frustration experienced by the hearing mother of a deaf child as a significant factor in understanding the etiology of feeding disturbances in deaf children of hearing parents. The question of the degree of its significance relative to other factors viewed as contributing towards the development of a feeding disorder in any particular case remains to be addressed by future research.

Subjects

Subjects were hearing mothers of young profoundly deaf children with serious eating disturbances who were enrolled in the Infant Center or Preschool of the Lexington School for the Deaf. Although originally I had hoped to work with a larger sample, it turned out that only 12 mother-child pairs (out of a combined Infant Center and Preschool population of approximately 70) met the sets of both child and mother criteria required for the mother to become a candidate for the study.

Child criteria consisted of the following specifications as to hearing status, pattern of eating behavior, and age.

1. Hearing status. The child had to have a prelingual hearing loss diagnosed as "profound."† This typically means that prior to being provided with hearing aids and to embarking upon the process of auditory training the child would have shown little or no response to most sounds and no response to the human voice. Ideally, it would also have been desirable for all the children of the sample mothers to have shared a common level and range of aided hearing as well as, for that matter, a common level of speech and language development. However, due to the difficulty involved in finding a sample of deaf children who share similar audiograms, both unaided and aided, and who also match each other with respect to levels of receptive and expressive language, taken together with other constraints of the subject selection procedure discussed below, it was not possible to control for the

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†See pages 21-30, above, for further elaboration of the meaning of prelingual profound deafness.

above factors. Data on these variables were nevertheless obtained for each child so that any apparent effects of the variability among these factors could be addressed in the analysis of the study's findings.

2. Pattern of eating behavior. The children were drawn from a group identified by Lexington teachers as having a serious eating problem for the last 2 years. The teachers were used as raters of eating behavior since I assumed them to be less biased than mothers but still familiar enough with students' eating habits over time and various contexts to render a valid judgment.† Although my interest was in finding deaf children who had eating problems which reflected feeding disturbances with their mothers, I felt that an eating problem which showed up in school over time as "severe" would almost certainly indicate the presence of a significant degree of feeding disturbance at home. Of the 70 Infant Center and Preschool children, 6 were determined by the teachers to have a "severe" eating problem, and 17 others were rated as having a "moderately high" degree of eating disturbance. At first it seemed that by combining these two categories I would have a subject pool of adequate size from which to draw my sample mothers. However, after ruling out a few children who had other severe handicaps (physical, intellectual, or emotional) in addition to their deafness, only seven mothers of the remaining children satisfied the mother-criteria described below. I therefore decided to include also mothers of children who had recently graduated from the Preschool and were considered

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†Since the school day is a long one (8:30 to 2:30), over the course of a year the Preschool teachers typically grow to know their students' daily habits quite well. Infant Center teachers experience their students' eating behavior three mornings a week during lengthy sessions with mother and child together. In addition, they often make home visits.

by their teachers to have a moderately high or severe eating problem. Five more children were added in this way to the subject pool, three of whose mothers qualified for inclusion in the study sample, thus bringing the sample total to 12.

3. Age. Optimally I would have liked for the children to be approximately the same age. Since this was not possible given the methodological difficulties described above, I decided that at least they had to be young enough so that eating behavior would still be fertile ground for the manifestation of a jointly developed disturbance between mother and child, yet old enough for relatively stable (in age-appropriate terms) eating patterns to have become established. These conditions were satisfied by the sample children, although ages ranged from 2 to 7 years old. In all cases enough time (at least 1 year) had elapsed after diagnosis of the deafness to insure that the feeding disturbance was not an acute transient reaction to that event.

To the three categories listed above I originally wanted to add a number of other child criteria which would have to be met before the child's mother could be considered for the sample. These intended additions were as follows. First, I would have liked for the target child to have been the most recent-born so that the mother's early memories of herself with this child would be uncontaminated by memories associated with later-born children. Second, I would have liked to include no first-born children since there is typically greater anxiety associated with the birth of a first child which in and of itself might make for greater likelihood of developing a feeding disturbance. Third, I wanted the target child to be the mother's first experience with

deafness. However, since these last three conditions could not be satisfied within the constraints of the population which was available to me, I settled upon a sample where other mother and child criteria were fulfilled but in which three of the children were not most recent born, seven were first-borns, and two had older deaf siblings.

There were two additional variables as well--etiology of deafness and age at diagnosis--for which I would have preferred to control in the process of sample selection but was unable to do so. In the final sample of 12, 2 of the children had a hearing loss which was clearly genetic, 3 were born deaf due to rubella contracted during their mothers' pregnancies, 1 sustained progressive hearing losses resulting from a high fever followed by recurring severe ear infections from 6 months on, and for the remaining 6 children cause of deafness was given as unknown. Age at diagnosis also varied widely, ranging from immediately after birth to 3½ years old.

Although the study design did not control for the variability among all these factors, implications for particular sample mothers of the specific values of some of the above variables will be addressed in the discussion of study results. The data for all child-variables for the 12 children are summarized in Table 1.

Once the group of eligible children was identified, their mothers were considered for inclusion in the final sample only if English was their first language or at least a language in which they felt thoroughly comfortable and in which they usually communicated with their child. A number of mothers who primarily spoke only Spanish or Greek had to be ruled out since the procedures (discussed below) used to determine

Table 1

Summary of Child-Variables

	Current age	Birth order and hearing status of siblings	Eating problem (teacher's rating)	Language level relative to age (teacher's rating)	Etiology of deafness	Age at diagnosis	Other major illnesses or separations
Adam	5 1/2	2nd w/hearing sibling	moderately severe	low	progressive loss due to ear infections	18 months	pneumonia with frequent hospitalizations at 6 months
Carlos	3	only	moderately severe	low	unknown	12 months	-
Catherine	6	only	moderately severe	low	rubella	15 months	-
Christi	7	1st w/hearing siblings	moderately severe	advanced	genetic	6 months	-
Daniel	4 1/2	only	moderately severe	low	unknown	3 1/2 years	-
Elizabeth	7	3rd w/hearing siblings	moderately severe	advanced	rubella	27 months	early operations on kidney and heart
Gerard	2	2nd w/deaf sibling	moderately severe	moderately advanced	genetic	immediately after birth	-

[cont'd]

Table 1 [cont'd]

	Current age	Birth order and hearing status of siblings	Eating problem (teacher's rating)	Language level relative to age (teacher's rating)	Etiology of deafness	Age at diagnosis	Other major illnesses or separations
Jessica	3	only	moderately severe	moderately low	unknown	20 months	-
Joseph	6	1st w/hearing sibling	moderately severe	advanced	unknown	14 months	-
Samuel	4	2nd w/hearing sibling	moderately severe	advanced	unknown	12 months	-
Sandra	3	3rd oldest sibling hearing, next sibling deaf	severe	low	unknown	24 months	pneumonia and high fever with hospitalization for few weeks at 10 months
Tracy	5	1st w/hearing sibling	moderately severe	moderately advanced	rubella	11 months	-

degree of need to talk were to be administered by people who were conversant only in English. In addition, obviously, no mother who was herself deaf could be included in the sample since I assumed she would not experience the same kind of differentness from her deaf child as I believed would be felt by a hearing mother.

Mothers were recruited by means of a letter sent to their homes which asked for their participation in a study whose purpose was to "look at the relationship between hearing mothers and their deaf children and what may be some common problems that come up in relation to this issue."† All 12 mothers to whom letters were sent agreed to participate.

Data obtained from the mothers about age, marital status, and educational level and occupation for themselves and their husbands were distributed as follows. Ages ranged from 26 to 31 at the time of birth of the target child. Ten of the mothers were married, 1 was separated, and 1 lived with her child's father without marriage. As measured by Hamburger's (1957) Occupational Scale for Rating Socioeconomic Class (where Level 1 represents the highest level of socioeconomic status and Level 7 the lowest), one of the sample families was rated as Level 1, one as Level 2, two as Level 3, four as Level 4, and four as Level 6. As far as the occupations of the mothers themselves, out of the five who held full-time jobs outside the home, one was a professional, one was a semiprofessional, and three were clerical or manual workers. In terms of education, the sample broke down into

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†See Appendix I for the complete text of this letter.

two who had some graduate school, one who graduated college, three who had begun college but not graduated, three who had completed high school, and two who had not finished high school. Ethnic backgrounds of the mothers included Caribbean black, Hispanic, Italian, Jewish, Indian, and Pakistani.

Again, where any of these factors were judged to be significant for understanding the findings on particular study mothers, they will be discussed in Chapter IV. In particular, the question of relationship between both socioeconomic level and cultural background and degree of need to talk will be explored.

Procedure

The steps taken to identify eligible children and assess the need to talk of the study mothers were carried out in the following order. First, the teachers were asked to rate with respect to degree of talkativeness all the mothers whom they knew well out of the entire Infant Center and Preschool. Second, they were asked to rate the children in their class this year and last year with respect to severity of eating problems. Third, the group of 12 mothers whose children had been identified by the teachers as having serious eating problems and who themselves met the mother-criteria listed above were interviewed by me. I then assessed these mothers based on my interview experience of them for degree of need to talk as well as for other traits I considered relevant. Transcripts of the interviews were then rated for degree of need to talk by two independent clinicians. Finally, I went back to

the teachers and asked them to share with me the thinking behind their choice of rating for each of the 12 study mothers.

I will now review in detail the procedure and rationale for each of the above steps.

Teacher-Ratings of Mothers' Need to Talk

Since Lexington's Preschool and Infant Center programs involve a great deal of parent participation, teachers typically grow to know many of the mothers quite well. Teachers may have some of the same children in their class for 2 years in a row, and often even after a child moves up a year her/his mother still maintains contact with the previous year's teacher. It therefore seemed reasonable to use teachers' judgments as an index of a mother's verbal behavior over time and in various contexts. I decided to ask the teachers to rate all the 57 English-speaking mothers in the department so that I could, in effect, collect data on a group of "control" mothers as well. This then enabled me, in the data analysis, to compare teacher ratings of the 45 control mothers of children with no eating disorder (non-E-D mothers) with those of the 12 mothers of eating-disordered children (E-D mothers) to see whether as a group the E-D mothers showed a significantly higher need to talk than the non-E-D mothers.

Instructions to the teachers were as follows. They were first told that I was doing a study investigating various aspects of the relationship between young deaf children and their mothers and that I would need their ratings on a number of child and mother variables. They were then asked to rate all the mothers whom they knew out of a

list of 57 names (among which the 12 E-D names were distributed) with respect to the mother's degree of need to talk. The ratings were to be done on a 5-point scale with "1" being the lowest score and "5" the highest. I defined someone with a strong need to talk as a person to whom talking was a highly pleasurable activity for its own sake. As illustrations of talking done not for its own sake but rather for another ulterior purpose, I gave the examples of someone who asks many questions in order to obtain information or reassurance and of someone who keeps talking in order to please an audience who s/he feels would disapprove were s/he to stop.

Before going on to a description of the next step in the procedure, I want to discuss a number of methodological complications involved in the use of nine different teachers, each of whom knew only some of the 57 mothers and knew them, for the most part, only at a particular point in time--that is, only during the year(s) their child was in the particular teacher's class. Clearly, assessment of the ratings would have been quite straightforward had there been one teacher who knew all the mothers well over time. At Lexington this is not the case. Even the Infant Center teachers, who one might think would have had experience with all the mothers at the start of their child's career at Lexington, did not know a few of the mothers whose children entered Lexington at a later age. Moreover, the Infant Center teachers work with a mother during the period immediately following the diagnosis of deafness--a moment in time when she is likely to be depressed, withdrawn, and probably less likely to enjoy talking than would normally be characteristic for her. I decided to consider both these problems--of ratings

based on limited knowledge of a mother during a given time period and of teachers' not all having rated the same group of mothers--as aspects of "teacher-bias." Another factor which I also subsumed under "teacher-bias" was the possibility of a given teacher's tendency to rate exceptionally high or low. In performing the statistical analysis, this bias factor was taken into account through a procedure reviewed in Chapter III.

A second way in which I attempted to offset the difficulty presented by using teachers who each rated a different segment of the mothers was to include the ratings of the department supervisor, who knew almost all 57 mothers over time. However, her ratings were also biased in that they were based, in many cases, on less frequent and less intensive experience of the mothers than the teachers' experience over a shorter time period. Because of this drawback, I decided in the analysis not to weigh the supervisor's ratings any more heavily than those of the teachers and to adjust for the bias built in by her particular vantage point through the same procedure I used for the teachers.

Teacher-Ratings of Children's Eating Behavior

So as to minimize possible contamination from the mother-ratings, I waited 2 weeks before returning to the teachers to elicit the child-ratings. Each teacher was told to rate the eating behavior of all children in her class this year and last year on a scale of 1 to 5, with "1" being no eating problem and "5" a severe eating problem. I specified that "eating behavior" meant any kind of behavior around

eating which the teacher herself observed over the course of her relationship with the child. Each teacher was further told that the ratings should be based on her experience with children of her particular age group over the years and thus should be made relative to some baseline, in her own mind, of "normal" eating behavior for the age with which she had grown familiar.

During the same session in which they were asked to rate eating behavior, teachers were also asked to evaluate on a 5-point scale each child in their class this year for level of speech and language development. This was requested for two reasons. First, I thought it would enrich the data by providing some independent picture of the verbal communication of each E-D child. Second, when I would later return once more to the teachers to ask them to elaborate specifically upon their ratings of the E-D mothers and upon the eating behaviors of their children, I wanted them to be able to provide these elaborations without being overly burdened by clear memories of other ratings they had assigned to a particular mother or child. To this end, I asked the teachers to think about the child's speech and language to take some of their focus away from the other areas they had been asked to evaluate.

Mother Interviews

The final phase of this study consisted of interviewing the 12 study mothers and then rating the interviews for strength of need to talk.

Few social-psychological studies on interactional behavior have taken as their main focus an interest in the quantitative, noncontent

aspects of vocal activity (Mortensen, Arntson, & Lustig, 1977). Those researchers who have incorporated within their studies an assessment of subjects' vocal productivity per se typically have used an interview or a discussion between two subjects as the vehicle for production of word flow. A transcript of this word flow was then analyzed in terms of such variables as frequency and amount of speaking (Jaffe & Feldstein, 1970; Matarazzo, Hess, & Saslow, 1962; Mortensen et al., 1977), number of interruptions (Weins, Saslow, & Matarazzo, 1966), and frequency and functions of pauses and hesitations (Pope, Siegman, & Blass, 1970; Rochester, 1973).

For the present study, as well, an interview was used as the vehicle for promoting a texture of word flow which would reflect values of the above variables characteristic for each mother. To this end, the interview began with a single open-ended question, and only later, when it seemed clear that the mother had exhausted the flow of speech she was motivated to produce, did I question further, probe, or introduce topics. This further questioning was done both to obtain additional speech samples (albeit less spontaneous ones) as well as to enrich the picture of each mother's personality, relationship to talking per se, and relationship to her deaf child, which emerged from the content of the interview.

The interviews were conducted in settings chosen by the mothers. Four mothers chose to be interviewed at home, seven in my office at Lexington, and one at her office. Mothers were asked to schedule the interview at a time when they could be available and undisturbed for "an hour or so," though no constraints were placed on the length of

the actual interviews. Most interviews lasted approximately an hour, although some continued for almost 2 hours. Some of the mothers who were interviewed at home interrupted the session a few times to attend to children or answer phone calls.

The procedure adhered to for the session with each mother was as follows. I began by reiterating the purpose of the study as an exploration of the relationship between a deaf child and her/his mother. I then made a comment encouraging the mother to ignore the tape recorder, followed by a statement emphasizing confidentiality. At this point most mothers simply nodded their understanding, although a few immediately asked if I would ask them questions, and one launched into three pages of talk about her relationship with her child without any prompting from me at all. Except for the case of the mother who began by herself, I opened the interview with the question, "What has it been like for you to have a deaf child?" I then said nothing until the mother seemed to have finished whatever she wanted to say. Unless she had gone on at very considerable length, which would have already provided me with enough preliminary evidence of an apparently strong need to talk, I then allowed approximately 30 seconds of silence to elapse before saying simply, "Go on," to see whether with this one prompt the mother would produce further word flow. When it became clear that she had clearly exhausted her response to the opening question (usually signified by her saying something like "that's about it"), I asked, "What would you say are some of the problems X [her child] has?" This question was aimed mostly to elicit the mother's feelings about her child's eating behavior and its meanings for her--without alerting her

to my specific interest in eating problems per se. If in her answer she did not mention a problem with eating or if she insisted her child had no problems, I added the further statement that "Often children of X's age have some problems with daily routine sorts of things such as sleeping, eating, or toilet training, so it would be no surprise were X to have some problems with any such things." If the mother answered that her child did have a problem with eating, I then asked whether X's eating habits were similar to her own (at present and as a child) or those of anyone else in the family. By this point in the interview I had gathered enough uncontaminated speech samples to free me to follow up or refer back to anything mentioned by the mother which I felt merited further elaboration. In addition to pursuing lines of thought initiated by any given mother, the one remaining area about which I asked each mother, usually in the context of her speaking about her child's language development, was to tell me about herself and talking--that is, did she consider herself to be a person to whom talking was not so important or very important. This was followed up with a question about the role of talk during her childhood. It should be clear that although I did occasionally (after the early part of the interview) make requests for elaboration as well as direct the mothers to answer the few questions I asked outright, my stance as interviewer was primarily that of an interested passive listener who did nothing to interfere with a mother's flow of associations. At the end of the interview, a few minutes were taken to have the mother tell me the following information: etiology of her child's deafness (if it had not already been brought up), whether there had been major illnesses or separations

from mother, languages spoken at home, composition of the household, and her and her husband's ages, occupations, and levels of education. At this point a number of the mothers chose to spontaneously talk further about themselves or ask me questions about myself. After this last flow of conversation ran its course, I closed the interview by offering to contact them, if they wished, to discuss the results of the study.

Interview transcripts were then assessed by me in terms of both form and content. Form-ratings reflected the intensity and amount of word flow as measured by such variables as characteristic length and density of speech bouts, number of times a mother interrupted me, number of examples and degree of detail provided to illustrate a particular point, and any other evidence of an inner pressure (or lack of it) to speak. Based on these form-ratings, along with my general clinical impression from the interview, I gave each mother an overall score (on a scale of 1 to 5) for degree of need to talk. Content assessment consisted of a clinical evaluation of the interview material in terms of a number of themes related to the theoretical underpinnings of this study. Specifically, each interview was studied for evidence of the following: (a) the particular kind of need-gratification provided for this mother by her deaf child, (b) the meaning which talking had for this mother as demonstrated by her behavior with me and by her statements about the importance of talking for her at present and during her childhood, (c) the meaning which eating had carried for the mother herself throughout her life, and (d) the psychological significance which feeding her deaf child had for her in terms of wishes of various sorts.

Each interview transcript was also rated by two independent clinicians who had experience interviewing a broad range of people over the years. These raters were instructed to score the transcripts on a scale of 1 to 5 for degree of the subject's need to talk. They were told to think of someone with a high need to talk as someone to whom talking was a highly pleasurable activity for its own sake. The raters, of course, had no prior knowledge of the goals of the study.

Chapter III

RESULTS

In order to determine whether the study mothers emerged as people with a significantly high need to talk, the following measures were used: teacher-ratings of mothers' talkativeness over time, judges' ratings of the interviews, and self-report of degree of need to talk given by each mother herself as part of the interview. All ratings employed a scale of 1 to 5, with 1 representing the lowest need to talk and 5 the highest. These measures provided findings for the E-D mothers (mothers of eating-disordered children) both as a group and as individuals.

Teacher-Ratings

Teacher-ratings were used in computing two kinds of results. First, when compared with teacher-ratings of the non-E-D mothers, they provided a measure of the degree of need to talk for the E-D mothers as a group. Second, they served as one of the three scores which together comprised a composite rating of talkativeness for each individual E-D mother.

I will turn first to the findings for the E-D mothers as a group, after briefly reviewing the complications involved in group data analysis. At Lexington there was no one teacher who knew all 57 E-D and non-E-D mothers. There were, however, 10 raters (9 teachers and their

supervisor), each of whom knew a different set of the total group at different points along the children's career in Lexington's Infant Center and Preschool. For example, Ms. P, an Infant Center teacher, knew 28 of the 57 mothers. Of these 28, she was currently involved with only 12. She had worked with 5 others 2 years ago and with the remaining 11 mothers 3, 4, or 5 years ago. In the latter cases, despite the time which had elapsed since active involvement, regular contact was maintained through chatting in the halls. It is clear that Ms. P's scores were biased in that her current involvement with the mothers of the older children was rather limited, her knowledge of these mothers was neither as intense nor recent as her knowledge of the mothers of younger children, and also in that she happened to be the first teacher encountered by mothers after diagnosis of their child's deafness--an event which may have temporarily lowered a mother's degree of talkativeness for some time (as would seem to be borne out by Ms. P's lower mean ratings shown in Table 2).

The illustration of Ms. P serves to highlight several of the methodological problems dealt with through use of a procedure which adjusted all the ratings to take into account the following teacher-bias factors: limited knowledge of a mother during a given time period, a given teacher's disposition to rate everyone high or low, each teacher not having rated the same group of mothers, and each teacher having a different proportion of E-D mothers in the total group she rated. Although teachers' nonadjusted scores were not used in the data analysis, the means of these ratings are presented in the middle section of Table 2 to enable comparison between adjusted and non-

Table 2

Teacher-Means for Eating-Disorder and Non-Eating-Disorder Groups

	E-D group (n = 12)		Non-E-D group (n = 45)		Total (N = 57)		
Teacher	No. mothers rated	Teacher-mean	No. mothers rated	Teacher-mean	No. mothers rated	Teacher-mean	SD
1	5	4.20	13	2.77	18	3.17	1.29
2	5	4.20	10	3.60	15	3.80	1.08
3	2	3.50	7	4.14	9	4.00	0.87
4	7	4.14	18	2.61	25	3.04	1.34
5	3	4.33	8	3.25	11	3.55	1.57
6	7	4.14	18	2.67	25	3.08	1.32
7	4	4.00	13	3.08	17	3.29	1.21
8	5	4.20	12	3.42	17	3.65	1.17
9†	8	3.75	20	2.05	28	2.54	1.48
10‡	12	3.83	42	3.17	54	3.32	1.10
	Grand $\overline{X}$ 4.03		Grand $\overline{X}$ 3.01		Grand $\overline{X}$ 3.24		Grand SD 1.28

†Ms. P.

‡Supervisor.

adjusted results.

I assumed a fair representation of a teacher's composite bias to be the difference between her mean rating for all the mothers whom she rated (teacher's mean) and the mean of the teachers' means (grand mean). These means are shown in the next-to-last column of Table 2. To take this bias into account, I then adjusted all her scores by the amount of this difference. This procedure enabled me to preserve all teacher-ratings for every mother; that is, I did not have to collapse data which otherwise would have been lost if I had simply calculated a mean of all teachers' scores for each of the 57 mothers. Many more data points were therefore generated--58 adjusted ratings for the E-D group and 161 adjusted ratings for the non-E-D group. That is, the number of ratings distributed among the 12 E-D mothers by the 10 raters (each of whom knew a different proportion of the group) totaled 58, and the number of ratings given to the 45 non-E-D mothers totaled 161. I have spelled out this breakdown among teachers and mothers for the E-D group at the bottom of Table 3.

To facilitate statistical analysis comparing the two groups, the amount by which each adjusted score deviated from the grand mean (of the entire group of 57) was used in place of the adjusted score itself. Table 4 summarizes the results of t-test analysis comparing the mean of the adjusted deviation scores for the E-D group (.78) with the mean of the adjusted deviation scores for the non-E-D group (-.28). The E-D mean has a positive value indicating that these mothers rate as more talkative than the average of all the teachers' scores for all the mothers. The non-E-D mean has a negative value, showing that this

Table 3

Teachers' Ratings of Eating-Disorder Mothers

Mother of	Teachers										Average score
	1	2	3	4	5	6	7	8	9†	10‡	
Adam	4	3						4		2	3.25
Carlos									2	4	3.00
Catherine				3	3	3				4	3.25
Christi		5		5		5		5	5	5	5.00
Daniel			3					3		2	2.66
Elizabeth		4		3		3			2	4	3.20
Gerard		4		4	5	4			3	4	4.00
Jessica	5						4		4	4	4.25
Joseph	5	5		5	5	5	5	5	5	5	5.00
Samuel				5		5		5		5	5.00
Sandra	3						3			3	3.00
Tracy	4		4	4		4	4	4	4	4	4.00

†Ms. P. ‡Supervisor.

Computation of *N* (number of independent ratings generated by the teachers) for the E-D group:

No. of E-D mothers		rated by	No. of teachers	No. of independent ratings generated
1		X	2	2
2		X	3	6
4		X	4	16
1		X	5	5
2		X	6	12
1		X	8	8
1		X	9	9
			total *N* =	58

Table 4

T-Test on Teacher Mean-Adjusted Ratings
Comparing Eating-Disorder Group with
Non-Eating-Disorder Group

Group	n†	Mean of deviation scores	SD	SE
E-D	58	.78	.98	.13
Non-E-D	161	-.28	1.19	.09

$t = 6.66$; $p < .0001$.

†n represents the number of teacher-ratings distributed among the 12 mothers in the E-D group and among the 45 mothers in the non-E-D group.

group scored as less talkative than the teachers' overall average. The obtained t value is 6.66, which is significant at the .0001 level. In sum, as measured by teacher-ratings, the E-D mothers as a group emerged as having a significantly higher need to talk than the non-E-D mothers.

In addition to generating the data for comparison of E-D and non-E-D groups, the teacher-ratings also served as one of the measures which contributed toward a composite talkativeness score for each individual E-D mother. Distribution of teacher-ratings for each E-D mother is presented in Table 3. In computing mean scores for each mother, teacher-ratings were not adjusted for bias (as they were for purposes of group comparison), since it was felt that such a complicated procedure was unnecessary with this small a sample where the raw data could be easily inspected. Moreover, the cumulative bias factor is smaller for the E-D group alone than for the entire group of 57 mothers since the issue of different teachers rating different proportions of E-D versus non-E-D mothers was eliminated. The final column of Table 3 shows one mother with an average score of less than 3, five who scored between 3 and 4, and six who scored 4 or more. I will return to this breakdown later to compare it with the pattern of results for the other two measures of talkativeness for individual E-D mothers.

Judges' Ratings of the Interviews

A second measure of degree of need to talk was provided by clinician-ratings of my interviews with the E-D mothers. The distribution of scores given by the three judges (E, V, and myself, S) is

presented in Table 5. Interrater reliability was assessed through use of kappa--a statistic which measures the proportion of agreements observed in excess of the proportion expected by chance given independence of raters and the distribution of scores for each rater (Cohen, 1960). Kappa is computed by the following formula:

$$\kappa = \frac{P_o - P_c}{1 - P_c},$$

where P_o is the observed proportion of agreements and P_c is the proportion of agreements expected by chance. It varies from +1 for perfect agreement, through 0 for chance agreement, to negative values for less-than-chance agreement. As shown in Table 6, the obtained kappas of .37 for agreement between E and V, and of .47 for agreement both between E and S, and between V and S, all exceed the respective critical values of kappa at the .025 level of significance for a one-tailed test. Significance would be even greater had partial credit been given for near-misses (i.e., one-step discrepancies) in agreement (Everitt, 1968).

A less powerful measure of interrater reliability was obtained through simply computing the proportion of agreement among the three raters without taking into account the degree of agreement expected by chance. As shown in Table 5, there was perfect agreement on the ratings of 7 of the 12 mothers. In the cases of three of the remaining five mothers, two raters agreed, with the third rater's score differing only by one point. In two cases, the raters gave three different scores, with two points comprising the largest difference between any two scores. To summarize in terms of percentage, there was either perfect agreement or agreement with a single-step discrepancy for 84% of the mothers.

Table 5

Judges' Ratings of Eating-Disorder Mothers' Interviews

Mother of	E	V	S	Weighted average (E + V + S + S)
Adam	5	5	5	5.00
Carlos	2	2	2	2.00
Catherine	5	5	4	4.50
Christi	5	5	5	5.00
Daniel	5	4	3	3.75
Elizabeth	2	3	4	3.25
Gerard	5	5	5	5.00
Jessica	5	5	5	5.00
Joseph	4	5	4	4.25
Samuel	5	5	5	5.00
Sandra	2	1	1	1.25
Tracy	5	5	5	5.00

Table 6

Kappa Statistics for Agreement between Pairs of Interview-Raters for Eating-Disorder Mothers

Pairs of interview-raters	κ	SE	Critical value	p
E with V	.37	.18	.34	< .025
S with E	.47	.18	.32	< .025
S with V	.47	.20	.32	< .025

The judges' interview-ratings generated both group and individual results. To evaluate whether the E-D group contained a significantly high proportion of highly verbal† mothers, a chi-square test was done for each of the sets of ratings provided by the three judges. Since the point of this test was to determine the likelihood that the obtained proportion of high-verbal ratings would occur by chance alone, it was necessary first to decide which scores to assign to the high category. I decided to run the test twice--once with only the 5 ratings in the high cell and the second time with both 4 and 5 ratings included. The results of both test runs for each of the three raters are presented in Table 7. In the first run, the expected frequency by chance of a 5 score was considered to be 20%. For all three raters the computed chi-squares exceeded the critical chi-square value of 6.6 for one degree of freedom at the .01 level. In the second run, with both 4 and 5 scores considered high, the expected frequency of a high score increased to 40%. Under this division of the ratings, the computed chi-square values for all three raters, although smaller than in the first run, were still significantly larger than a critical chi-square value of 3.8 at $p < .05$ but not at $p < .01$.

Composite interview-ratings for each of the E-D mothers are listed in the second column of Table 8. These scores were derived by taking a weighted average of the three clinicians' scores for each mother. S's scores were given double the weight of those of E and V

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†Although the phrase "highly verbal" is often taken to mean highly intelligent or articulate, in this study it will be used solely to describe the pattern of word flow. That is, a high-verbal subject will be taken to mean one who shows a high need to talk regardless of the content or manner of speaking.

Table 7

Chi-Square Statistics for Proportion of High-Verbal Ratings for Each Interview-Rater of Eating-Disorder Mothers

	E	V	S
		First run[†]	
Sample $\chi^2_{(1)}$	16.33	16.33	6.75
		Second run[‡]	
Sample $\chi^2_{(1)}$	6.13	6.13	6.13

[†]A high rating includes only scores of 5; $\chi^2_{(1,.01)} = 6.6$.

[‡]A high rating includes scores of 4 and 5; $\chi^2_{(1,.05)} = 3.8$.

Table 8

Summary of Results of Individual Assessment of Eating-Disorder Mothers

Mother of	1 Teacher-rating (average)	2 Interview-rating (weighted average)	3 Self-report (as rated by S)	Composite score (weighted average cols 1+2+2+3)	
Adam	3.25	5.00	4	4.31	H
Carlos	3.00	2.00	1	2.00	L
Catherine	3.25	4.50	4	4.06	H
Christi	5.00	5.00	5	5.00	H
Daniel	2.66	3.75	3	3.29	M
Elizabeth	3.20	3.25	3	3.17	M
Gerard	4.00	5.00	5	4.75	H
Jessica	4.25	5.00	5	4.81	H
Joseph	5.00	4.25	4	4.38	H
Samuel	5.00	5.00	5	5.00	H
Sandra	3.00	1.25	3	2.13	L
Tracy	4.00	5.00	5	4.75	H

since S's experience was live while E and V based their ratings on only transcript data. It is important to note that relative weights were assigned to the interview-ratings only after it was ascertained that interrater reliability among the three clinicians was high. That is, in order to weigh the scores of E and V equally, a high degree of agreement between the two of them and between each of them and S was required. In addition, this high coefficient of agreement suggested that the validity of S's scoring was not significantly affected by the fact that she knew the purpose of the study and was invested in its outcome. As shown in Table 8, the distribution of the derived interview scores was as follows: the mothers of Carlos and Sandra were rated as 2.0 or below; the mothers of Daniel and Elizabeth were rated between 3.0 and 3.75; and the remaining eight were scored between 4.25 and 5.0.

Self-Report

The final measure of degree of need to talk consisted of each E-D mother's self-evaluation elicited during the interview. Mothers' reports of how much of a talker each considered herself to be were extracted from the interview protocols and rated by me on a scale of 1 through 5. These ratings are presented in column 3 of Table 8. The same four mothers who were given the lowest interview ratings of the group were those who reported themselves to be the least talkative of the group. Of these four, the one (Carlos's mother) who scored the lowest self-report rating (1) said of herself, "I talk when I have to.

Otherwise, I'm just quiet. I like being home by myself." The other three in this group were rated as moderate on self-report based on the following characterizations of themselves:

> I'm not too much of a friendly person, but I'm not quiet. In the beginning I'm quiet, but if I get used to you I'm very open. Once I get on the phone with close friends, I'll talk. (Sandra's mother)

> I'm the quiet type. I don't tell everyone what I did every day. I don't even tell my husband. We talk, but I feel he's not interested.... [laugh] I do gab. I spend two hours on the telephone, but I don't tell my personal life. (Elizabeth's mother)

> I'm okay. We're a small family. Not many people to talk to.... I would just say hello to strangers and not go on to a conversation. I don't mind talking a lot. No, I do ... no, I can talk. I talk. I talk with people I know ... That's how Daniel started ... I ask my husband questions. He's the quiet one. (Daniel's mother)

Out of the remaining eight mothers, three considered themselves moderately high talkers, while five saw themselves as high talkers. These mothers all spoke of a strong need to talk and/or the pleasure which talking afforded them, as illustrated by the following examples:

> I like having conversations. I like talking a lot, yeah, about a lot of things. (Christi's mother)

> When I was young, a lot of emphasis was put on talking to one another and communication. I couldn't wait to get home to my mother to talk and tell her everything ... like visiting your friend. (Jessica's mother)

> I'm usually a talker. I usually prefer to sit and talk with people about certain areas.... I'm overly honest and not ashamed to talk about anything in my life. I've thought to write my autobiography.... I'm sure it would be published if I were willing to tell all about my whole total self. (Samuel's mother)

> I feel much better if I talk about something.... I like to talk. (Tracy's mother)

> I talk a lot. I normally talk a lot. I've always enjoyed talking, socializing, being with people. (Gerard's mother)

In sum, teacher-ratings and interview-ratings--the two measures which generated group results--showed the E-D mothers to appear highly verbal when viewed as a group. However, when viewed as individuals noteworthy variability among them is apparent, as shown in Table 8. Composite results of individual assessment of each mother as determined collectively by the three measures of teacher-rating, interview-rating, and self-report show the mothers of Carlos and Sandra to have a clearly low need to talk, the mothers of Daniel and Elizabeth to be moderately verbal, and the remaining eight mothers to be moderately high or high talkers. Although all three measures did not agree across the board for each mother, they did agree with respect to designating the four lowest scoring mothers. That is, the mothers of Carlos, Sandra, Elizabeth, and Daniel, who scored lowest in the interview and self-report ratings, were also assessed by the teachers to have a low or moderate need to talk.

The composite scores in the last column of Table 8 were computed by taking a weighted average of the three measures used, in which the interview score was counted twice as heavily as the self-report and teacher-rating. Although the latter two ratings constitute an assessment over time while the interview score reflects behavior at only one moment in time, the interview was judged to provide a more accurate assessment of a subject's need to talk in that it is a more objective measure than self-report and comes closer to the actual verbal behavior itself (preserved in transcript form) than the rating provided by a teacher who attempts to remember a mother with whom she may even not have had much contact in the first place.

Chapter IV

DISCUSSION

The significantly positive findings for the study mothers as a group provide strong evidence for the hypothesis that deaf children (of hearing parents) with feeding disturbances have mothers who have a high need to talk. Moreover, although these results clearly do not warrant concluding any causal link between these variables, they are strong enough to warrant further more rigorous investigation of the possibility of a relationship between a hearing mother's need to talk and the development of a feeding disturbance with her deaf child. Suggestions for future research will be discussed at the end of this section.

These results, however, do not reflect a group of uniformly high-scoring mothers. Individual results show only eight of the mothers to have had a high or moderately high need to talk, while the other four emerge as moderate or low talkers. To understand this variability I will look at the interview protocols of the four lowest scorers in an attempt to determine other major factors to which each child's feeding problem can be related. I am assuming in these four cases that the factor of the mother's frustration around lack of verbal give-and-take is not central in the etiology of her child's feeding problem--since these mothers were shown to have low needs to talk and would therefore, ostensibly, experience less frustration in

this sphere. This is not to say that the low-scoring group did not complain of frustration at not being able to communicate with their children. Rather, I am suggesting that for this group the evidence is less compelling for the hypothesis of this study--that verbal frustration is a significant factor in the development of the feeding problem --and that therefore alternative explanations must be considered.

Sandra's and Carlos's mothers, the two lowest talkers, emerge from the interview data as the women who were least connected to their children. They experienced themselves as having failed to understand and please their deaf child and therefore viewed themselves and their child as profoundly unsatisfactory. They both conveyed a strong sense of hopelessness and having given up:

> If you have a child that's deaf, nothing you can do about it --right? Not something gonna change.... Sandra has a way of ignoring you completely ... I can't get her to do nothing, absolutely nothing. I don't know what she's really up to. (Sandra's mother)

> He be screaming, throwing himself on the floor, and I don't want to see him like that so I take him next door.... When I was alone with him for a month he got on my nerves. I wanted to bang him. Sometimes I want to kill him. I felt hurt. I felt bad that he doesn't spend time with me. Sometimes he doesn't care about me.... I'm not happy, but I just do what he wants. It's not hard. What can I do? (Carlos's mother)

What markedly differentiates the records of Carlos's and Sandra's mothers from the others is a much lower level of symbiosis or basic attachment and commitment to their child. Whereas many of the other mothers emerge as overly enmeshed and overidentified with their children, that is, involved in what can be loosely called a negative symbiosis,†

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†Examples of this negative symbiosis will be discussed later in this section.

Sandra's and Carlos's mothers present as inadequately bonded to their children.

Both mothers felt particularly incompetent, enraged, and rejected by their children around the issue of feeding:

> Sandra don't eat. Only cereal from a bottle, juice, yogurt, nothing more. Not plain milk either. Have to be in cereal. ... There is nothing I can do to get her to eat. Nothing. I try everything. The doctor told me, "Let her stay without and she would eat." Not true. I don't care how hungry she gets. She's not gonna eat what you give her. What can I do? I can't starve her because of that! When I's give her even baby food she'd wipe her mouth like crazy! (Sandra's mother)

> He eats nothing for a couple of days. I guess Nestle's Quick satisfies him. I don't know. I give him vitamins. I guess that keeps him up.... I don't do nothing. What can I do? I'm not gonna force it down his throat! (Carlos's mother)

For these two mothers, given the larger context of insufficient symbiosis, the above feeding disturbances cannot be viewed as compensatory attempts to enact (around the giving of food) maternal longings which have been frustrated by virtue of the child's deafness. Rather, the disturbances seem to be more of a primary expression of rage, rejection, and having given up on the child. In other words, I am suggesting that Sandra's and Carlos's feeding problems be understood as expressions of inadequate mothering rather than as compensatory manifestations of maternal desire to give.

Although one may speculate from the interview data as to reasons for the less-than-adequate maternal bonding with Sandra and Carlos, it is important to bear in mind that the psychological factors and reality considerations which appear to have contributed toward this end can be found in the records of other mothers as well. Given the caution

that no substantial causal inference about the role of any variable may be made from the kind of interview data employed in this study, it is nevertheless worth noting these factors--first as they appear in the protocols of these two mothers and later on in this section as they show up in various permutations in the records of other mothers. In the cases of Sandra's and Carlos's mothers, one can base speculation as to primary reasons for the insufficient symbiosis upon brief allusions in the material of both women to unsatisfactory mothering at the hands of their own mothers and to a sense of themselves has having been "bad" ungratifying children. For example, Carlos's mother, in addition to recounting how she failed her own mother by being a stubborn tantrummy child, stressed how she saw her badness as a sin for which she was punished through having a "defective" baby. This understanding of the precursors of inadequate mothering presumes a high degree of maternal deprivation sustained by the mother in her own childhood, followed by identification with her unsatisfying mother and projection of her rage at the disappointing mother of childhood onto her own child. Other considerations which probably contributed towards the despair and withdrawal of these two mothers are as follows. They both gave birth to handicapped children within life-contexts which were already particularly overly stressful. Specifically, Sandra's mother already had one deaf child whom she had left to stay with relatives in another country and about whom she felt intensely disappointed and guilty. Carlos's mother felt she was not yet ready to have a child at the time Carlos was born and blamed her withdrawn emotionally unavailable husband for the pregnancy. In addition, both Carlos and Sandra as babies had attributes which

may have made them less appealing to their mothers. In the case of Carlos, it is likely that the fact of his sex predisposed his mother towards rejecting him in that the intense disappointment she felt in her father and in her husband was generalized onto her son. Sandra's high fevers, throat and ear infections, and pneumonia for which she was hospitalized for a few weeks may have made her mother feel she was too much of a burden to bear.

All of the above factors--that is, variables relating to the mother's relationship to her own mother, aspects of the life-situation into which the deaf child was born, attributes of the child her/himself --combined in the cases of Sandra's and Carlos's mothers to create a less-than-adequate attachment to their child, one symptom of which has been a feeding disturbance. I will now turn to a discussion of two other configurations of these factors and the feeding disturbances to which they contributed, as they appear in the records of the two moderately low-verbal mothers in the study.

The mothers of Elizabeth and Daniel seem to have fundamentally accepted and bonded to their children. Their children's deafness, however, appears to have evoked unmastered childhood conflict around unmet needs for nurturance from their own mothers together with the corresponding images of themselves as defective, unsatisfying children. The resulting present-day mother-child relationship in both cases can be described as one of negative symbiosis where the child is mostly "used" by the mother to revive, reenact, and attempt to repair aspects of her childhood experience, rather than regarded by her as a separate human being with her/his own needs who is worthy of care on her/his

own terms.

Elizabeth's mother's record clearly delineates important aspects of the steps in this process. She began by describing how the fact of her child's being handicapped had evoked longings for her own mother:

> It's very difficult for me [having a deaf child]. I don't have anyone that I can really talk to on how I really feel. I keep it all bottled up inside. If I had my mother I would be able to talk to her how I feel and she'd be able to help me cope. I think that's mainly it, that from the beginning I didn't have my mother to tell her how I really felt.... I feel I would have been able to handle it differently if I had an older guidance to tell me to do it this way or try, you know, I had to try things on my own. I never, you know, I'm not that old. I don't know if I'm doing it right or wrong.

She then went on to illustrate ways in which through identification and projection she had recreated the childhood paradigm with her mother in her present relationship with Elizabeth--in an attempt to keep her mother alive inside of herself. From the perspective in which Elizabeth was regarded by her mother as a "twin" (a word which is also used in reference to mother's own mother) and the one who "listens to me and understands me more than anyone else," she (Elizabeth) represented the good nurturant mother of her mother's childhood. Regarded from a different vantage point as the "nagging" depleting child who gives her mother "no reprieve" and who "has to know every little thing," Elizabeth came to be identified with her mother's bad self as a child. In her mother's words, "She's got a lot of me in her--her temper, her expressions, her eating." The way in which this last equation of Elizabeth with herself as a child served to internally keep her own mother alive is graphically illustrated in the realm of feeding:

> I am worried because I see that night after night she don't eat. And that becomes frustrating, and I guess that becomes

> frustrating to her because I'm yelling at her to eat and she's going "I don't want it; I don't like it," without even tasting it or trying it, you know.... When I was a child I was the same as Elizabeth. I ate nothing. I think I ate less than Elizabeth. But I can remember my mother yelling at me to eat, eat, eat, you know, and taking me to the doctor to get a tonic to make me eat. I mean I was very very skinny. And she [Elizabeth] is probably taking after me--"I'm going to be just like my mother and I'm not going to eat." She reminds me of me, and I can, I hear myself when I yell at her to eat, I can hear my mother yelling at me in my head. I can remember what she used to say, and I sound the same thing.

In tracking the multiple identifications and repetitions played out in this feeding disturbance, an additional vector to consider is Elizabeth's mother's projection of her rage at a coercive mother onto her daughter, expressed, for example, in frequent episodes of tying her to a chair in an attempt to force her to eat. Of course, in projecting this anger onto her daughter, Elizabeth's mother is at the same time enacting an identification with the mother at whom she is enraged.

In the case of Daniel's mother as well, although the data to support this proposition is less rich, I suggest that the feeding disturbance be viewed as symptomatic of a relationship in which there is inadequate separation between mother and child. As with Elizabeth, Daniel is overly identified for his mother with herself as a child:

> When I was small I was like Daniel. I didn't like to eat either, just snacks. I was really skinny until I finished high school and left home when there was no Mommy to give you what you wanted. Then if you missed lunch you missed it. That's how I started eating proper. That's the problem with Daniel. He sees Mommy and that's it. He knows Mommy is going to do everything for him, you know. He knows he is going to get his way. If he doesn't like something, you make something else for him. But I let him do it. He'll grow up, I know I did.

In this case the lack of limits and expectations around feeding seems to repeat and thus revive the kind of mothering Daniel's mother received

from her own mother, whom she seems to have perceived as nurturant but infantilizing.

Feeding also figures prominently in other elaborations of this mother's symbiotic tie to her son: fantasies around both the cause and cure for Daniel's deafness center upon her power to influence his physical being through her feeding. She attributes his deafness, at least in part, to "not eating right" during her pregnancy and implicitly offers to her son the hope of restored hearing through becoming like her if he eats. Her repeated threat that "If you don't eat you won't become big and grow like Mommy; you will remain slow and small" has led Daniel to join his mother in her preoccupation with his physical growth, through constantly showing her the size of his muscles and hands to prove he was growing. Though feeding, then, for Daniel's mother seems to represent an effort to get under her son's skin and make the two of them more alike, there are indications in the record that, to begin with, she had little appreciation for the real differences between them. Her difficulty in seeing herself as different from her son is particularly underscored in examples of her lack of attunement to the current limits (due both to his young age and his deafness) of Daniel's cognitive and verbal capacities.

I want to now turn back to the larger group of eight high-scoring mothers for whom it does make sense to posit a strong connection between their high need to talk and the feeding disturbance they have developed with their deaf child. In reviewing these interviews for both manifest and more disguised expressions of this connection, it proved useful to organize this material around themes dictated by

the theoretical propositions outlined in Chapter I. First and foremost, I considered as supportive to the basic hypothesis of this study any statements suggesting a clear conceptual link among processes of a mother's feeding food and speaking words to her child and the child's ingestion and excretion of food and speaking of words back to mother. Second, I deemed important any other evidence which stressed the importance of a verbal component in creating a satisfying experience of mutuality between mother and child.

To begin with, a number of the mothers spoke of speech as a concrete something which after being put into the child becomes located within the child's body until it gets put (or taken) back out. What may partly underlie this connection in fantasy between food and speech is the (usually unconscious) wish that if only they could feed their child well enough then the child would be able to produce (i.e., excrete) language. Tracy's mother spoke of the decrease in physical tension in her daughter when she acquired the ability to relieve herself of the language inside of her:

> I want to put the words in her mouth.... All that, you know, I don't know, all that pent up inside of her she couldn't express [before she learned sign language]. Without sign, it was like a closed door.

Gerard's mother seemed to experience her child's verbal productions as gifts to her from the inside of his body:

> It's a lot of work to get all that speech out.... [Deaf children] will talk to you in spurts but you have to pull a little. He'll give me chopped up little words here and there, and you gotta kind of put the rest together yourself.

Catherine's mother also expressed frustration at not knowing what was going on inside her child's body:

> I'm just wanting to know--what does she want, what does she have in her mind, what does she want to say? And I just can't get anything out.... I want her to speak it out. I try to get it out of her.

Although this last example is anal-extractive in tone, the way in which "speak it out" reminds one of "spit it out" illustrates the close connection between anal and oral modes apparent in all these excerpts. Clearly, incorporative, retentive, and expulsive/productive aspects of both modes appear as interconnected with each other in this material as well.

Other examples suggesting an interrelationship between eating/feeding and speaking include the following. Joseph's mother conceptually crossed the two domains and came up with, "Sometimes he goes on a 'binge' where he talks a lot. He doesn't know when to put a zipper on his mouth." Adam's mother described how her son's language learning was integrally bound up with the experience of eating:

> I try to teach him informally in the kitchen where he shows interest. I capture that moment to teach him something. Where he wants to do something like make his own milk, chocolate milk, or make his own eggs. That's the opportunity I use to say, "Well, you've gotta say this, what do you want?"

The mothers of Catherine and Jessica both spoke animatedly of some of the most affectively charged rituals of their childhoods as being characterized by the twin processes of talking and eating:

> We always--with our family--what we used to do, you know, when we would get together is sit around the table, talk and eat. And that was typical of my family. Talk and eat--that was it. I mean it's like, my sister, my parents are coming tomorrow, so the first thing you say on the phone is "Well, let's see, we'll have pizza one night and then we'll go out and we'll get rolls for breakfast." [laugh] So already it's sitting around--cheese and crackers, talking, talking until the middle of the night. This is what we do. So that's the type of family we are. (Jessica's mother)

> When I got home from school, the first thing would be to eat. Fruit. My mother would sit there and peel it up for me and all that stuff [laugh]. And we'd talk. By the time I got home I was really hungry. I could eat just anybody.... I remember my mother feeding me even when I was in college. I would get home very late. It was very hot. My mother would say you have to eat. I would tell her all that happened that day and she'd sit and feed me and I'd gobble quite a lot. (Catherine's mother)

Without relating it in any way to feeding per se, many of the mothers stressed the centrality of verbal communication in discussing their conceptions of what a good mother does for her child and what she hopes for in return. Christi's mother spoke of her wish for a verbally mediated exquisitely mutual relationship with her daughter:

> I think our relationship is good.... I wish it could be better where she could understand me more. Like Betsy [Christi's friend] has a lot of conversations with me.... Uhmmm, conversations with Christi. I'd like Christi to basically, you know, like I'd like to go within her and her to go within me. You know, like feel parts of me and I'll feel parts of her. I'd basically like for her to grow up to know me as, like her mother and like as her friend, too.

For Gerard's mother an essential aspect of giving to her son was providing him with words:

> I clue in and give him the language for what he wants. You really have to be clued in to see if they're grasping it or not.

Adam's mother, as well, saw her teaching of words as a kind of mother's milk she wanted to give to her son:

> To put Adam at a table to teach him about something, he refuses. And if I force the issue, he just wipes it off the table. He just takes his hand and sweeps it right off as if to say, "I will have none of this." And that is difficult, because I feel like I can give him something and he's refusing it from me.

A number of the mothers spoke of how in order for them to be gratified through their mothering they needed to be given words by their children:

> I needed somebody to need me. I was dying to hear someone say, "Mommy." ... I remember the first sign I taught her was "bird," and the first time she looked and saw a bird and she looked at me and said "bird"--I mean, we were communicating for the first time--I can't explain the feeling. And it wasn't anything--I mean, she didn't tell me, "I love you very much" or anything. It was just to know that we had something that we could communicate and, you know, it's hard to describe. You know? (Tracy's mother)

> It's so quiet with a deaf child. I'd go and try to make conversation for my sake also. I'm expecting, you know, sounds. It's lonely.... Like I never had the relationship with my mother where I could go and really talk to her about certain things. I missed that myself, so I always wanted to have that with my own children. (Gerard's mother)

While the evidence strongly suggests, then, that for the eight high-verbal mothers preoccupation around feeding seems to be an attempt to substitute for the missing and longed-for verbal aspect of mothering, this of course does not preclude the feeding problem from having other meanings as well. For example, almost all the mothers expressed considerable worry that the poor eating would severely affect their child's growth. It seems likely to me that the concern about growth predated the eating problem and developed originally in response to the child's hearing loss. I suggest that feeding, then, may have constituted an attempt by these mothers to heal what they knew (or sensed even before diagnosis) to be physically wrong with their child. That is, if only food could facilitate enough growth the lost hearing might grow back as well. Tracy's mother, for instance, in order to get her daughter to eat vegetables told her that if she does she will grow the breasts she so badly wants. There is some indication from the record that mother may also have intimated to Tracy (who was quite disturbed at not being a boy) that if she ate she might also grow a penis. The unspoken promise to

both herself and her daughter was that if she ate enough ultimately she would even acquire the capacity to hear. It is important to note that in the record of Tracy's mother (as well as others) anxiety about growth and concern lest the child die of starvation may have also reflected the opposite desire--to be rid of the defective baby who had caused mother so much emotional pain. That is, a mother might have had both feelings --of hope for her child's restoration and of wishing the child dead-- and both of these may have been expressed in the feeding symptom.

Another prominent theme recurring throughout these interviews is depiction of the feeding disturbance as the vehicle by which mother's longings towards her own mother were expressed--a dynamic we have already encountered in a number of low-verbal mothers. The following three cases illustrate efforts through relation with a child at repairing the disappointing relationship with mother's own mother through the medium which symbolizes the original damage--food.

Christi's mother, after beginning to describe her daughter's eating problem, interrupted herself to take a piece of gum from her purse, "since you get dry talking"--a first hint at the empathic bond with her daughter around this issue. She then proceeded to discuss her own relationship with food:

> We had to eat everything that was on our dish. If we didn't eat, we went to bed. My parents were very strict. And as you can see, because we had to eat everything that's why I'm like this. I can never lose weight. I'm always fighting the battle of the bulge. But basically I won't do that to my daughter. I don't want her to eat a large quantity of food, because I don't want her to be overweight, to go through what I've gone through. I don't want that at all.

Expanding further on her attempt with Christi to redo her own past, she

went on to insist that what happened between her and her mother would never happen with her daughter:

> I don't think we would ever, like, fall away from each other or stop thinking of each other or things like that. I think Christi knows that, like, I'm always there for her and that she could count on me.

In this case, a factor which most probably contributed towards the positive closeness between Christi and her mother was mother's own history of painful ear infections and operations resulting in a slight hearing loss. As she spoke with sadness of her own impairment during the interview, she looked down at her daughter's coat in her lap and said with anxious concern, "My daugther's coat--look how dirty it got. Gotta wash it." A few seconds later she commented, "My hands are so badly chapped. I didn't know it was that bad. They're hurting." Clearly, in this dyad projective identification around feelings of vulnerability and hurt had facilitated a deep empathy between mother and daughter without promoting a boundaryless negative symbiosis.

Samuel's mother as well wanted to save her son the pain inflicted on her by her parents and thus, I believe, reparent herself through identification with her son:

> We'd go into a candy store, and Samuel would want a pack of Bazooka, and [I'd say], "You don't need that. Want a banana, an apple? No? Okay, then you have nothing. So you either settle for what I want to give you that I think is good because that's bad." I show him I hardly have any teeth in mouth because at a young age my parents gave me sweets to pacify my crying. "Here's a quarter," and in those days a quarter would buy you ten strips of candy buttons. Little did they realize that by the time I'm fifteen I'm not going to have any teeth in my mouth. I realize that now, and I don't want my son to be without teeth.... I don't take him. "Let's go to the candy store and Mommy'll buy you a bag of candy." Only because I've experienced that as a child. My parents didn't realize the

> damage they were doing. I realize it because I experienced it. I can prevent it.

Jessica's mother again illustrated this theme:

> I mean, Jessica's so skinny. You look at her and say, "Oh God." But then I was like that, too. I never ate. And my parents used to force me to eat and doctors used to tell my mother, "Don't force her to eat. When she's hungry her body will crave something and she'll eat." But I see [Jessica] is eating almost nothing now. I mean, now it's down to the bare minimum.... I remember taking this horrible medicine that I used to have to take. It was supposed to give you an appetite.... Then I think I acquired such a taste for food from food being pushed at me that it's been a battle ever since. So I always tell my mother, "You overdosed me on that medicine," because now I can't stop eating.... I probably would have forced Jessica if it hadn't been that I'd been through that myself before. But one thing I did learn as a kid is to eat a lot of good things as opposed to junk. And that's what I'd like to see for her. If she's not going to eat a lot, I'd just like to see her eat things that are good for her.

On the strength of these last few segments, one might be tempted to argue that a maternal history of particularly affectively charged relation to food is, in fact, the most important contributory factor in a mother's developing disturbed feeding patterns with her child. Further support for this position is provided by the fact that evidence of maternal childhood eating problems is apparent across the board--for 10 out of the 12 mothers regardless of whether they are high or low talkers. However, this argument, while certainly relevant, misses the point of the study. It was my intent in assessing these mothers to simply determine whether one specific factor--frustration of a mother's need to talk--turned out to be significant enough to merit more rigorous further consideration. The study results have shown this to be so.[†] In assessing

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[†]It is, of course, impossible to know from this study design whether the high-verbal mothers would have developed a feeding disturbance with their children had there not also been a maternal history of eating problems.

the interviews, however, other maternal and child factors have also emerged as clearly important if one is to attempt a full understanding of the meaning of a feeding disturbance between hearing mother and deaf child. In addition to a mother's own history vis-à-vis food, these factores include: the degree to which her husband or significant others are supportive to her and/or involved with the child; prior familial experience with deafness or other handicaps; mother's life-context at the time of the child's birth; the child's birth-order, sex, and temperament as they interact with mother's wishes and degree of psychological adaptibility; mother's overall degree of psychological health; etiology and extent of the child's hearing loss; degree and rate of speech and language acquisition; and whether or not mother and child have learned sign language. Clearly, future research attempts to parcel out the differential significance of any one of these variables must control for the multiplicity of other factors involved--either through establishing numerous control groups (as discussed at the start of Chapter II) and/or by randomization of effects through use of very large samples. In thinking about future studies, however, a cautionary note is in order. Even the most sophisticated research designs could not fully address all relevant questions since in clinically oriented research it is so difficult to tease out the contributory elements in the development of a symptom (here, the feeding disturbance). In other words, given that character and behavior are multidetermined by variables in so many different realms, it is almost impossible to plan a study (or even a series of studies) which would yield definite causal or predictive statements.

Turning back now to the process of assessing the present study's findings, I want to address whether there appears to be any noteworthy relationship between other characteristics of mother or child and the extent of a mother's need to talk. For most of the factors listed above there is no apparent difference between the high- and low-verbal groups. That is, both groups contain children with varying degrees of speech development and a range of hearing loss patterns due to several different causes diagnosed both early and late. Both groups included first-born and later-born children of both sexes and varying temperaments. In each group, one or two of the mothers had prior experience with deafness. And for both groups, life contexts of the mothers ranged from those ostensibly providing a great deal of support to those which were said to provide very little.

At first glance, one factor which does appear to be related to the extent of a mother's need to talk is her socioeconomic status. Although one mother in the low-verbal group scored at the highest socioeconomic level on the Hamburg scale, the fact that the other three low-verbal mothers were rated at the lowest possible level certainly seems to warrant further exploration--especially given that among all the high-verbal mothers only one scored at the low end. This pattern of results seems to indicate that lower-class mothers have less of a need to talk; or, phrased differently, that talking for them is a less pleasurable, less important activity. Interestingly, a cursory review of the research on the relationship of speech and language style to socioeconomic class may, at first, appear to underscore the validity of this supposition. However, results of a more thorough

study of this literature (Bernstein, 1962a, 1962b, 1964, 1970; Schatzman & Strauss, 1955; among others) clearly does not support any such conclusion. Meltzer (1978), in his discussion of a related subject--the effect of class differences upon suitability for psychotherapy--summarizes the theory of Bernstein and others as follows:

> People in different social classes can be differentiated by the way they formulate their talk. Lower-class people employ [what Bernstein calls] the "restricted code"--a form of speech which is highly predictable and reinforces social solidarity by discouraging the production of individualized thoughts and feelings.... In this language form, the assumed intent of the speaker is standardized and taken for granted. And because of the kinds of abbreviated grammar, short sentences and inattention to tense that are characteristic of restricted codes, the content of speech is usually "concrete, descriptive, and narrative rather than analytical and abstract" (Bernstein, 1962a, p. 33).... The "elaborated code" of middle-class people is a more structurally complex idiom which facilitates individualized explicit communication. Speakers of elaborated codes must select from a large number of possible structures and words those which closely fit their specific intentions and shades of meaning. Since a greater choice is involved, the encoding process is more complex and the speaker is called upon to plan his utterance in a more comprehensive way.... [In sum,] whereas the restricted code transmits symbols held in common, elaborated codes transmit the "elaboration of the individual experience" (Bernstein, 1962a, p. 33).† (1978, pp. 365-366)

This formulation offers no reason to assume that the verbal productivity of a restricted code user need be any less than that of one who speaks an elaborated code. As Bernstein himself says,

> This does not mean that [such a person's] speech output is relatively reduced. Rather, the verbal planning of the speech, relative to an elaborated code, involves a relatively low order and a rigidity of syntactic organization. (1970, pp. 36-37)

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†It is important to note, along with Meltzer (1978), that although the ultimate validity of Bernstein's distinctions has yet to be determined, his notions of class-related semiotic structures are, at the least, "heuristically useful exploratory constructs" (p. 363).

In short, from the literature one would expect the low SES mothers in this study to speak differently, rather than less. The finding, then, that three out of the four low-verbal mothers happen to be of low socio-economic status should be viewed as a sampling artifact rather than as an indication of the effect of class on degree of need to talk.

The difference in lower-class speech suggested by Bernstein was found to clearly hold for only two of the lower-class mothers in the sample--the two who also showed the lowest need to talk and who seemed least attached to their children. These two--the mothers of Carlos and Sandra--spoke comparatively little about their own or their child's feelings, expressed relatively few thoughts about causes for their child's behavior, and elaborated almost no fantasies of the experience of deafness. In short, they emerged as less psychologically minded than all the rest of the mothers. Why this finding did not hold true for the other two low-SES mothers, as would be expected from the literature, may also reflect a sampling artifact due to the small number of subjects.

The fact that two of the low-verbal mothers in addition to all eight high-talkers emerged as moderately or highly psychologically minded led me to consider the possibility that the development of a feeding disturbance between hearing mother and deaf child might usefully be understood in relation to some maternal quality associated with psychological-mindedness--a somewhat different hypothesis than the one put forth in these pages thus far. In reviewing the interviews, the characteristic shared by these 10 mothers which seemed to fit this description was a strong desire, on the mother's part, to give to

her child[†] and to understand his or her experience.[‡] This alternate formulation, then, would subsume a mother's need to talk to her child under the larger need to give and would thus suggest a somewhat different range for the types of mothers who would be expected to develop a feeding disturbance with their deaf child. Whereas our original hypothesis predicts simply that mothers with a high need to talk would be more likely to create feeding problems, this alternate hypothesis in stressing urgency and press of need to give predicts that both low and high talkers would be equally vulnerable to developing the symptom and suggests that, instead, the variable to pay attention to is degree of developmentally appropriate separation between mother and child. Thus, the feeding disturbances of the 10 moderate- or high-need-to-give study mothers would be understood as a function of the fact that these mothers all seemed to have attachments to their children which were more or less overly symbiotic with respect to the child's developmental needs. The only mothers, then, who would be expected to escape the pull to develop a feeding symptom would be those who either expressed their

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[†]Parenthetically, although this characteristic often goes hand in hand with psychological-mindedness, the two are not strictly isomorphic qualities, since it is conceivably possible that a psychologically minded mother would not choose or be able to nurture her child well. In other words, psychologically minded does not at all necessarily mean psychologically healthy.

[‡]An additional characteristic shared by only these 10 mothers which can easily be seen as an expression of this desire to give is that of functioning as speech teachers to their children. Whereas these mothers all gave numerous examples of their commitment to practice and enrich their children's language, the other two mothers did not.

attachment-disturbance in some other way, or those who were particularly psychologically healthy, particularly comfortable with nonverbal communication, and particularly well able to adapt to the unexpectedly extreme psychological demands of having a deaf child, or those who were blessed with children who were, in Benedek's words, "endowed with such ability to love and with such strength in pursuing their individuation that they 'cure' their mothers" (1970a, p. 164).

Although this new formulation, then, does at first seem to better account for this study's findings (that is, it explains 10 out of the 12 feeding disturbances rather than only 8), I submit that the apparent gain it offers in explanatory power is small. Since the extent to which a hearing mother can attune to her deaf child within a frame of optimal respect for the child's individuation needs is obviously related to how she metabolizes the experience of her child's deafness, one is brought right back to consideration of the particular nature of the deprivation imposed upon a hearing mother by having a deaf child--which is precisely the issue addressed by our original hypothesis. In other words, the alternate formulation should be viewed as elaborating upon the original hypothesis rather than as, in any way, detracting from its import. For the balance of these pages, then, I will continue to focus upon the hypothesis as it was originally proposed.

Before leaving the consideration of this third factor with which both degree of need to talk and the development of a feeding disturbance appear to be correlated, it is worth noting one particular way in which the above formulation contributes to a deeper understanding

of the relation proposed in the original hypothesis. Along the way to defining this relation, it at some point becomes necessary to ask the question--were the eight high-verbal mothers in this study to be "psychoanalyzed out of" their high need to talk, would the feeding disturbance be "cured" as well? If one thinks of need-to-talk as a subset of need-to-give, and of the feeding symptom as an expression of disturbed maternal giving, as elaborated above, then it becomes clear that curing a high need to talk could not be achieved without concomitant change in the disturbed giving between mother and child--which would of course mean resolution of the feeding problem as well.

I want now to turn to a discussion of several remaining methodological and theoretical issues. These include various questions around use of the interview as an instrument by which to measure strength of need to talk, cultural and class considerations relating to the interview context, and additional factors to be explored in future research.

With respect to suitability of an interview to assess need to talk, there are at least three separate questions. I will address first the issue of whether a mother's behavior during the interview with me can be taken to reflect her characteristic degree of talkativeness in some "average-expectable" context. One might at first expect that out of anxiety related to the emotionally difficult themes of the interview as well as to the situation of being questioned by someone in authority, mothers would tend to respond with skewed, nontypical behavior such as agitated nonstop talk in attempt to please the interviewer or with long silences. There is some

evidence to support this expectation from research studying the relationship between anxiety arousal and interviewee verbal behavior. Mahl and Schulze (1964) found anxiety to be associated with flustered speech --that is, increased frequency of speech disturbances and increased number of long silences. Pope, Siegman, and Blass (1970) concurred with Mahl and Schulze that anxiety tends to disrupt the flow of speech; however, they found that at the same time it functions as an activator of speech through increasing verbal productivity and rate of speech. There is further evidence to support the suggestion that with anxiety resulting from the content and/or context of the interview with me would alter a mother's typical speech pattern from studies comparing the speech of lower- and middle-class patients during an initial psychiatric interview. White, Fichtenbaum, and Dollard (1964), in explaining their finding that lower-class patients were silent for a greater percentage of an interview, suggest that such patients may sometimes be suppressing (not repressing) verbalization because of the stress of interview procedures which they do not understand. Other studies with lower-class patients further elaborate such factors as inhibiting awe of the therapist, increased anxiety due to experience of the therapist's silence as disinterest, and hesitation to break a silence due to an assumption that the doctor should take the initiative (Overall & Aronson, 1963).

Although all of the above considerations are not without relevance for the present study, their significance in this case is mitigated by the following factors. First, this was not a psychiatric interview. Even in the first phase of the session where I said almost

nothing so as not to contaminate the measure of word flow, I was non-verbally encouraging and responsive--that is, far from affectively neutral. Moreover, if in my clinical judgment a mother needed me to provide increased verbal feedback in order to keep her anxiety level within the bounds of comfort, I did so after the initial question was handled in the standard manner. Of course, in assessing each interview, the effects of any such input from me was taken into account. Second, it was assumed that whatever emotional factors might be impinging upon a mother's characteristic motivation to talk would be apparent to the evaluating clinicians. For this reason, clinical assessment of interviews, although less rigorous in some ways, provides significant advantages over the more mechanical methods (such as computing percentages of intervals of silence) employed in the studies mentioned above. Third, this interview was by no means the mothers' first experience discussing the issues under consideration with Lexington personnel. Thus, it did not carry the meaning of traumatic self-exposure which an initial interview about these matters might. Furthermore, the context of Lexington had come to symbolize (at least in large measure) acceptance and comfort to these mothers, as many of them--across cultural and class lines--remarked spontaneously and sincerely during the interview.

Moreover, additional credibility is lent to the validity of the interview by the convergence of results among all three measures of verbal productivity used in this study. In other words, though each measure may have had some drawbacks, the fact that similar inferences were drawn from the interviews, the self-reports, and the

teacher-ratings, strengthens faith in the data supplied by any one of them. Further respect for the validity of the interview as a measure of need to talk is provided by Mortensen et al.'s (1977) research on the measurement of predisposition towards verbal behavior. In their study, in which they employed three instruments very similar to those used here--the PVB (Predisposition toward Verbal Behavior) Scale, which is a variant of self-report; an interview in which number of words and mean duration of talk were measured; and teacher-ratings of graduate-student subjects for talkativeness over an entire semester--they also found high correspondence between self-perception about communicative tendencies and measured level of verbalization.

Another consideration to address with regards to the interview's validity is whether it offers an index of verbal productivity that would hold across other contexts and especially whether it would hold for the specific situation of interaction between mother and child. Throughout the literature on the quantitative aspects of talk, researchers have noted the "stable individual differences in the patterning of verbal behavior" and the "consistency of overall frequency and amount of speaking over situation, task, and participants" (Mortensen et al., 1977). Whether these findings would apply as well to the determination of a mother's disposition to talk to her child remains a question. With respect to the present study, however, this consideration may present little difficulty for the following reason--given that clinical analysis of these interviews has shown a mother's need to talk to her child to be intimately related to wishes around talking to her own mother, I suggest that the need vis-à-vis her own mother may be

quite well measured through an assessment of her need to talk with me--a relatively nurturant woman authority-figure. Of course, in attempting any definitive answer to this issue one must take into account the particular meaning which the child has to a particular mother. For example, it remains for a future study to explore whether a mother who is frightened in even the most nonthreatening interview situation might respond very differently in interaction with her child.

Since, throughout these pages, many terms have been used interchangeably to mean "strength of need to talk," before concluding this section on the interview as instrument I want to address what may appear to be lack of clarity around use of this phrase. The key variable of interest here, as determined by the theoretical underpinnings of this study, is the centrality of a mother's need to give of herself through words to her child. Defining the quality in this way highlights the question of meaning; that is, it tells us to attend not only to volume of speech or to verbal productivity per se but to the motivation for speaking as well. In other words, it distinguishes between a mother who "talks with intensity"--that is, who enjoys talking for its own sake, and a mother who speaks in order to be reassured or advised--that is, in order to get feedback. The former in her manner of talking shows that it is necessary and important for her to speak; the latter shows a need to be spoken to. Clearly, for the purposes of this study it would be the first mother who would score high on the need-to-talk scale. Interestingly, however, in relation to this study's hypothesis, a mother who manifests a high need to be spoken to would probably be just as likely to develop a feeding disturbance

with her deaf child as the mother who shows a high need to talk. Differential ramifications of each of the two speech profiles remain to be explored in future research.

A further reason to distinguish between strength of need to talk and amount of speech output is in order to respect the relativity inherent in the concept of "need." It is conceivable, for example, that a person may speak very little as a function of socialization and upbringing but still have a high need to talk relative to her/his own culturally determined standard. Although none of the low-verbal mothers in this study reported themselves to have a high need to talk, the potential for this "mixed picture" theoretically exists.

Besides serving as a measure of the degree of a mother's need to talk, the interview also functioned in this study as the vehicle by which to elicit from the mother information about herself and her relationship with her child. Therefore, in addition to the questions considered above, it is also worth noting here doubts that have been raised in the child-development literature as to the value of using an interview for obtaining accurate information about a mother's observations, actions, and feelings. Wenar, in a thorough review of this issue entitled "The Reliability of Mothers' Histories" (1961, pp. 491-500), divides these doubts into those concerning the validity of mother-as-observer and those concerning the reliability of mother-as-rememberer. He cites research demonstrating that by her very involvement a mother is the person most vulnerable to her perceptions being distorted by the tricks affect plays on cognition--that is, that she cannot be relied upon to be an accurate reporter of

events. With respect to a mother's capacity for recall, he argues that how a mother reconstructs a given event will be determined by the nature of subsequent events (the "interpolated material"), as well as by her particular combination of intellectual and personality characteristics.

Wenar goes on to argue that even if a mother has perceived accurately and remembers faithfully, she may report distorted information as a function of the interpersonal aspects of the interview itself. He stresses that mother-as-interviewee must be viewed as someone who has her own concern about the picture of herself and her child which she presents to the interviewer, as well as her own reactions to her/his personality and external characteristics such as class, race, and sex. Yarrow (1963) further elaborates ways in which a mother's values about parental and child behaviors and the childrearing mores attached to her class identification would both tend to influence what she chose to report in an interview.

Although these criticisms of the interview as research instrument certainly raise some doubt as to the truth of the material reported by mothers in this study, again it is my contention that clinical evaluation of interview content and process for each mother served to reveal many of her areas of distortion, the degree to which her report expressed her true feelings, and how much it was a defense against underlying attitudes. Moreover, for the purposes of this study it is mostly a mother's perception of reality, rather than reality itself, which is of interest. Thus, for example, if a mother said, "As a baby my child was always crying," what is important is the mother's evaluation of the infant as a constant crier and the attitudes of exasperation or

desperation which accompany such a perception, rather than whether or not the child actually did cry all the time.

At this point I would like to collect several "loose-end" issues, including some which have come up in passing but were not actually addressed earlier.

First, I want to consider the effects, if any, of using as subjects mothers who chose to send their children to an "oral" school for the deaf. Though one might think that this would be a group to whom talking was particularly important, teacher-ratings of talkativeness for all Preschool and Infant Center mothers did not show the group as a whole to be significantly highly verbal. Parenthetically, the study mothers' choice of oral education for their children not unexpectedly appears to be correlated for them as a group with a predominantly negative attitude towards sign language. Only three mothers spoke positively during the interview about the use of sign. Of the other nine, one merely mentioned it neutrally, five did not mention it at all, and three spoke against its use.

Second, I want to reiterate a striking finding of this study that 10 out of the 12 mothers who developed feeding disturbances with their children had eating problems themselves. Of these 10, 5 spoke of problems with overweight and lack of control over eating in the present as well as heightened concern about food during their childhood, and the other 5 had eating disorders only when they were children. In order to evaluate the significance of this finding, data are needed on the incidence of comparable eating problems at present and in the remembered past among the general population of mothers and specifically among

mothers of children with no feeding disturbance. Whether or not this study's finding is significant in relation to other populations, further investigation is needed to determine how large a role was played by the present mothers' eating disorder histories in the determination of symptom choice with their children.

I will now turn to the question of whether the study provided evidence to suggest that hearing mothers of deaf children heighten or change their activity in spheres other than feeding. Although not directly elicited during the interview, many illustrations were given of ways in which mothers were overprotective, had great difficulty setting limits, and greatly increased the amount of physical contact with their deaf child through sleeping together, physical fighting, massage, etc. Interestingly, these other realms of activity which featured prominently in the material but were not addressed in the analysis of study results bring to mind psychosexual issues (autonomy, control, phallic initiative) other than the oral conflicts with which this study has been mostly concerned. This observation suggests that the emphasis in this study upon the oral aspects of maternal feeding, giving, and taking may have been too singleminded. A more complex way of thinking about a particular mother's need to be given to by her 2-year-old child, for example, might be to see it as an orally colored issue of autonomy and separation rather than as simply oral. Another illustration of the layering of psychosexual themes in this material is seen in the desires expressed by so many of the study mothers to force-feed their child both food and words and to then extract speech.

Consideration of the intertwining of themes from different developmental epochs leads me to wonder about a related issue--the impact of time of diagnosis of the deafness upon subsequent symptom formation. The extreme case to be made with respect to this study would be as follows. At age 1½ (when deafness is typically diagnosed) mother is switching her infant from milk to solids which entails her becoming more active in the feeding. Therefore, her reaction to the trauma is likely to be expressed through acting out around the developmentally salient event occuring at that time in her child's life. Hence, the development of a feeding disturbance. In other words, the argument goes, mother would experience a pull to develop the symptom in whichever area of mothering-activity she is most effortfully and actively engaged at the moment of trauma. It seems to me that although this construction highlights a factor which probably plays some role in determination of symptom choice, it does not adequately account for the continuation of the disturbance over several years (as was the case with all the children of the study mothers) and for the fact that later-diagnosed cases in this study seem to have developed the feeding symptom later as well.† Moreover, it assumes an oversimplified theory of fixation to explain human reaction to trauma. It also assumes that in the case of diagnosis of deafness one can pinpoint a moment of trauma.

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†Unfortunately, the question of when the feeding problem began was not routinely asked during the interview. No mother spoke of gross feeding difficulties within the first few weeks, but some did make statements like "He has always been a poor eater." It might at first seem that such evidence of early feeding problems preceding diagnosis would challenge this study's hypothesis. However, I do not believe this is necessarily the case given the consideration raised below that a mother is likely to sense something is "off" in her communication with her child long before the moment of diagnosis.

Whereas confirmation of the diagnosis does clearly constitute a discrete moment, I believe it is probable that a mother comes to know her child is deaf through gradually accruing a sense of something missing in the relationship over time. I suggest, therefore, that it is likely the feeding disturbance would develop gradually over time as well.

I will close this discussion on a final theoretical note. The central argument of this thesis has been an elaboration of Benedek's notion that a mother, by definition, has significant oral needs which in the act of mothering become directed towards her child. Or, in other words, the effort to satisfy her child's orality activates a mother's own oral needs (1956). Thus, the attempt here to understand the meaning of a feeding disturbance developed by a mother with her deaf child became, in essence, an attempt to understand the specific ways in which a deaf child would be likely to frustrate precisely those oral needs which a mother intends (consciously or unconsciously) to gratify through her mothering. Benedek's formulation seems to assume a view of the average-expectable child as satisfier of mother's needs and as such appears to be predicated upon a model of mother-child relationship which seems to me to be less than optimal. That is, it describes a mother who sees herself predominantly as a poorly mothered child and who attempts to repair her own sense of deprivation through feeding her child ideally. It essentially depicts a mother who sees feeding as her principal mothering function and who may thus be vulnerable in even average-expectable life situations to developing a feeding disturbance with her child. In contrast to this view, it seems likely to me that the average-expectable mother may be a healthier mother who,

operating out of more positive identification with her own mother, would generally adopt a more separate stance in relation to her child. For this mother, principal mothering functions would include affirmation, attunement, and anticipation of her child's developmental needs, with her own emotional needs largely directed for satisfaction elsewhere towards significant adults in her life.

It may be, however, that severe narcissistic injury such as that represented by the trauma of giving birth to a deaf child may predispose even a relatively healthy mother to experience significant oral regression. That is, in the face of her extreme disappointment, accompanied by lowered self-esteem, even this mother is likely to be less able to sustain an optimal degree of separateness from her child in that "her [radically] increased self-hatred becomes projected onto the [deaf] child whom she unconsciously perceives as an externalized defective self" (Lax, 1972, p. 342). Thus, a mother who in other situations may have been perfectly adequate, under the pressure of this increased symbiosis may act out with her child wishes and conflicts around orality which otherwise would not have been stimulated. Within this formulation, then, development of a feeding disturbance can be understood both as an expression of this oral regression and as an effort on the mother's part to heal her narcissistic wound by attempting to restore her child's hearing through "perfect" feeding. Interestingly, these two possibilities are precisely those which emerged from the study interviews when analyzed earlier from the perspective of Benedek's position. The narcissistic-injury perspective and oral-frustration perspective appear to converge, then, in terms of their approaches to understanding

development of symptoms and disturbance--that is, if one is interested in attuning to the pull-to-pathology experienced by the hearing mother of a deaf child. If, however, one chooses to focus upon the adaptational potential for the dyad, the two perspectives suggest somewhat different directions. Benedek's position stresses the importance of maximizing mutual gratification between mother and child through any course which would enable the mother to feel better understood and less deprived by her child. The narcissistic-injury position argues that the more a mother can view her deaf child as separate from herself and see her/him as being different rather than deficient, and the more she can affirm the child in this difference rather than focus upon ways in which she feels deprived, the more joy she will experience in her mothering and the more healthy her child will be.

In exploring the disappointment and the wishes of the hearing mother of a deaf child, this study has focused primarily on experiences of deprivation and frustration. It is my hope that future theoretical and experimental work will further attempt to understand the nature of successful styles of mothering in the face of a child's difference and will specifically consider determinants of maternal capacity to optimally affirm in the face of difference in communication mode.

Appendix I

The Research Department of the
LEXINGTON SCHOOL FOR THE DEAF
30th Avenue & 75th Street
Jackson Heights, NY 11370

December 1982

Dear Parents:

You are being asked to participate in a study. The study will look at the relationship between hearing mothers and their deaf children and what may be some common problems that come up in relation to this issue. Ms. Sarah Stemp, who is in charge of the study, will ask you to meet with her once at Lexington where she will talk with you for approximately 45 minutes which will be tape-recorded. The information you provide will help us to better understand young deaf children.

Your participation in this study is completely voluntary. At no time will your name or that of your child be used in any part of the study. The tapes will be used only by Ms. Stemp.

If you would like to have the results of the completed study, we will make arrangements for you to receive this information.

If you would be interested in participating in this study please sign and return the form in the enclosed envelope.

If you have any questions about Ms. Stemp's study, please contact me at the Lexington School: 899-8800 (ext. 213).

Sincerely,

Alan Lerman, Ph.D.
Director of Research

BIBLIOGRAPHY

Altshuler, K.Z. Studies of the deaf: Relevance to psychiatric theory. American Journal of Psychiatry, 1971, 127, 221-226.

Altshuler, K.Z. The social and psychological development of the deaf child: Problems and treatment. In P.J. Fine (Ed.), Deafness in infancy and early childhood. New York: Medcom Press, 1974.

Ames, L.B. Child care and development. New York: J.B. Lippincott, 1970.

Anthony, E.J. Nonverbal and verbal systems of communication: A study in complementarity. The Psychoanalytic Study of the Child, 1977, 32, 307-325.

Anthony, E.J., & Benedek, T. (Eds.). Parenthood: Psychology and psychopathology. New York: Little, Brown & Co., 1970.

Arlow, J.A. Communication and character: A clinical study of a man raised by deaf-mute parents. The Psychoanalytic Study of the Child, 1976, 31, 139-165.

Balint, A. Love for the mother and mother-love. International Journal of Psychoanalysis, 1949, 30, 254-259.

Balkanyi, C. On verbalization. International Journal of Psychoanalysis, 1964, 44, 64-74.

Barsch, R.H. The parent of the handicapped child. Springfield, IL: Charles C. Thomas, 1968.

Beebe, B., & Stern, D.N. Engagement-disengagement and early object experiences. In N. Freedman & S. Grand (Eds.), Communicative structures and psychic structures. New York: Plenum Press, 1977.

Benderly, B.L. Dancing without music: Deafness in America. New York: Anchor Press, 1980.

Bene, A. The influence of deaf and dumb parents on a child's development. The Psychoanalytic Study of the Child, 1977, 32, 175-195.

Benedek, T. Toward the biology of the depressive constellation. Journal of the American Psychoanalytic Association, 1956, 4, 389-427.

Benedek, T. Parenthood as a developmental phase: A contribution to libido theory. Journal of the American Psychoanalytic Association, 1959, 7, 389-417.

Benedek, T. Motherhood and nurturing. In E.J. Anthony & T. Benedek (Eds.), Parenthood. New York: Little, Brown & Co., 1970. (a)

Benedek, T. The family as a psychologic field. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 114-136). New York: Little, Brown & Co., 1970. (b)

Benedek, T. The psychobiology of pregnancy. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 143-151). New York: Little, Brown & Co., 1970. (c)

Bentovim, A. The clinical approach to feeding disorders of childhood. Journal of Psychosomatic Research, 1970, 14, 267-277.

Bergman, A. Therapeutic communication playgroups with deaf children: The unfolding of the separation-individuation process. Paper presented at The New York Freudian Society, 1979.

Bernstein, B. Linguistic codes, hesitation phenomena and intelligence. Language and Speech, 1962, 5, 31-46. (a).

Bernstein, B. Social class, linguistic codes and grammatical elements. Language and Speech, 1962, 5, 221-240. (b).

Bernstein, B. A sociolinguistic approach to socialization, with some reference to educability. In F. Williams (Ed.), Language and poverty (pp. 25-61). Chicago: Markham, 1970.

Bibring, G.L. Some considerations of the psychological processes of pregnancy. The Psychoanalytic Study of the Child, 1959, 14, 113-121.

Bibring, G.L., Dwyer, T.F., Huntington, D., & Valenstein, A.F. A study of the psychological processes in pregnancy and of the earliest mother-child relationship. The Psychoanalytic Study of the Child, 1961, 16, 9-72.

Birns, B., Blank, M., & Bridger, W.H. The effectiveness of various soothing techniques on human neonates. Psychoanalytic Medicine, 1966, 28, 316-322.

Blum, E., & Fields, B. An exploration of symbolic development in deaf infants ages one to three. Paper presented at the American Psychoanalytic Association, New York, December 18, 1981.

Bowlby, J. Attachment and loss. New York: Basic Books, 1973.

Bradford, L., & Hardy, W. (Eds.). Hearing and hearing impairment. New York: Grune & Stratton, 1979.

Brazelton, T.B., & Als, H. Four early stages in the development of mother-infant interaction. The Psychoanalytic Study of the Child, 1979, 34, 349-369.

Brazelton, T.B., Kislowski, B., & Main, M. The origins of reciprocity: The early mother-infant interaction. In M. Lewis & L.S. Rosenblum (Eds.), The effect of the infant on its caregiver (pp. 49-76). New York: Wiley, 1974.

Brinich, P.M. Application of the metapsychological profile to the assessment of deaf children. The Psychoanalytic Study of the Child, 1981, 36, 3-33.

Brody, S. Patterns of mothering. New York: International Universities Press, 1956.

Brody, S. A mother is being beaten: An instinctual derivative and infant care. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 427-447). New York: Little, Brown & Co., 1970.

Bruch, H. Family background in eating disorders. In E.J. Anthony & C. Koupernik (Eds.), The child in his family (vol. I, pp. 285-309). New York: John Wiley & Sons, 1970.

Burlingham, D. Hearing in the development of the blind. The Psychoanalytic Study of the Child, 1964, 19, 95-113.

Burlingham, D. Psychoanalytic studies of the sighted and the blind. New York: International Universities Press, 1972.

Chodoff, R., Friedman, S., & Hamburg, D. Stress, defenses, and coping behavior: Observations in parents of children with malignant disease. American Journal of Psychiatry, 1964, 120, 743-749.

Cohen, J. A coefficient of agreement for nominal scales. Educational and Psychological Measurement, 1960, 20, 37-46.

Coleman, R., Kris, E., & Provence, S. The study of variations of early parental attitudes. The Psychoanalytic Study of the Child, 1953, 8, 20-48.

Condon, W.S., & Sander, L.W. Neonate movement is synchronized with adult speech: Interactional participation and language acquisition. Science, 1974, 83.

Condon, W.S., & Sander, L.W. Synchrony demonstrated between movements of the neonate and adult speech. Child Development, 1979 45, 456-462.

Coulthard, M. A discussion of restricted and elaborated codes. Educational Review, 1969, 22, 38-50.

Davis, C.M. Self-selection of diet by newly weaned infants. American Journal of Diseases of Children, 1928, 36, 651-679.

Deutsch, H. The psychology of women (Vol. II). New York: Grune & Stratton, 1945.

Edelheit, H. Speech and psychic structure. Journal of the American Psychoanalytic Association, 1969, 17, 342-381.

Eimas, P.D., Siqueland, E.R., Jusezyk, P., & Vigorito, J. Speech interpretation in infants. In L. Stone, H. Smith, & L. Murphy (Eds.), The competent infant. New York: Basic Books, 1973.

Erikson, E.H. Childhood and society. New York: Norton, 1950.

Erikson, E.H. Identity: Youth and crisis. New York: Norton, 1968.

Erting, C. Communication with children. In C. Baker & R. Battison (Eds.), Sign language and the deaf community (pp. 161-165). New York: National Association for the Deaf, 1980.

Escalona, S. Emotional development in the first year. In M.J.E. Senn (Ed.), Problems of infancy and childhood (pp. 34-92). New York: Josiah Macy Jr. Foundation, 1953.

Escalona, S. The roots of individuality. Chicago: Aldine, 1968.

Everitt, B.S. Moments of the statistics kappa and weighted kappa. British Journal of Mathematical and Statistical Psychology, 1968, 21, 97-103.

Fields, Barbara. A theoretical and practical consideration of libidinal object constancy and object permanence: Issues related to normal development and hearing impairment. Unpublished master's thesis, Sarah Lawrence College, 1979.

Forrer, G.R. The mother of a defective child. Psychoanalytic Quarterly, 1959, 28, 59-63.

Fraiberg, S. Libidinal object constancy and mental representation. The Psychoanalytic Study of the Child, 1969, 24, 9-47.

Fraiberg, S. Insights from the blind. New York: Basic Books, 1977.

Freedman, D.A. The influences of various modalities of sensory deprivation on the evolution of psychic and communicative structures. In N. Freedman & S. Grand (Eds.), Communicative structures and psychic structures. New York: Plenum Press, 1977.

Freeman, R.D., Malkin, S., & Hastings, J. Psychosocial problems of deaf children and their families: A comparative study. American Annals of the Deaf, 1975, 120, 391-405.

Freud, A. The psychoanalytic study of infantile feeding disturbances. The Psychoanalytic Study of the Child, 1946, 2, 119-133.

Freud, A. Normality and pathology in childhood. New York: International Universities Press, 1965.

Freud, S. (1917). Mourning and melancholia. Standard edition (Vol. 14, pp. 237-258). London: Hogarth Press, 1957.

Freud, W.E. Assessment of early infancy: Problems and considerations. The Psychoanalytic Study of the Child, 1967, 22, 216-238.

Freud, W.E. The well-baby profile II. The Psychoanalytic Study of the Child, 1971, 26, 180-184.

Furth, H.G. Thinking without language. New York: The Free Press, 1966.

Galenson, E., Miller, R., Kaplan, E., & Rothstein, A. Assessment of development in the deaf child. Journal of the American Academy of Child Psychiatry, 1979, 18, 128-142.

Gardner, R.A. The guilt reaction of parents of children with severe physical disease. American Journal of Psychiatry, 1969, 126, 636-644.

Gesell, A., Halverson, H., Thompson, H., Ilg, F., Castner, B., & Ames, L.B. The first five years of life. New York: Harper & Row, 1940.

Giles, H., & Powesland, P.F. Speech style and social evaluation. London: Academic Press Inc., 1975.

Greenberg, J. In this sign. New York: Avon, 1970.

Greenberg, J. And Sarah laughed. In J. Greenberg (Ed.), Rites of passage (pp. 119-132). New York: Holt, Rinehart & Winston, 1972.

Greenberg, N.H. A comparison of infant-mother interactional behavior in infants with atypical behavior and normal infants. In J. Hellmuth (Ed.), Exceptional infant (Vol. II, pp. 401-405). New York: Brunner Mazel, 1971.

Greenberg, N.H., & Hurley, J. Maternal personality inventory. In J. Hellmuth (Ed.), Exceptional infant (Vol. II, pp. 128-151). New York: Brunner Mazel, 1971.

Greenson, R. The mother tongue and the mother. International Journal of Psychoanalysis, 1950, 31, 1-6.

Greenstein, J., Greenstein, B.B., McConville, K., & Stellini, L. Mother-infant communication and language acquisition in deaf infants (Project # H 0061 SJ, Grant # OEG-0-72-5339, Office of Education, U.S. Department of Health, Education, and Welfare). Washington, DC: U.S. Government Printing Office, 1975.

Gregory, S. The deaf child in his family. New York: John Wiley & Sons, 1976.

Guntrip, H. Schizoid phenomena, object relations and the self. New York: International Universities Press, 1969.

Hall, J.A., Rosenthal, R., Archer, D., DiMatteo, M.R., & Rogers, R. Profile of nonverbal sensitivity. In P. McReynolds (Ed.), Advances in psychological assessment (Vol. 4, pp. 179-221). San Francisco: Jossey-Bass, 1975.

Hamburger, M. A revised occupational sacle for rating socio-economic class. Unpublished manuscript, Teachers College, Columbia University, 1957.

Hartmann, H. (1939). Ego psychology and the problem of adaptation. New York: International Universities Press, 1958.

Hays, W.L. Statistics for psychologists. New York: Holt, Rinehart & Winston, 1963.

Hewett, S. The family and the handicapped child. Chicago: Aldine, 1970.

Hoyt, M., Siegelman, E., & Schlesinger, H. Special issues regarding psychotherapy with the deaf. American Journal of Psychiatry, 1981, 138, 807-811.

Isakower, O. On the exceptional position of the auditory sphere. International Journal of Psychoanalysis, 1939, 20, 340-348.

Jacobs, L. Methods used in the education of mothers. The Psychoanalytic Study of the Child, 1949, 3/4, 409-422.

Jaffee, J., & Feldstein, S. Rhythms of dialogue. New York: Academic Press, 1970.

Jones, E. Conception through the ear. Essays in Applied Psychoanalysis, 1951, 2, 84-96.

Katan, A. Some thoughts about the role of verbalization in early childhood. The Psychoanalytic Study of the Child, 1961, 16, 184-188.

Kaufman, C. Biologic considerations of parenthood. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 25-35). New York: Little, Brown & Co., 1970.

Kessler, J. Psychopathology of childhood. Englewood Cliffs, NJ: Prentice-Hall, 1966.

Kestenberg, J. On the development of maternal feelings in early childhood. The Psychoanalytic Study of the Child, 1956, 11, 257-291.

Klein, G.S. On hearing one's own voice. In M. Schur (Ed.), Drives, affects and behavior (Vol. 2, pp. 87-117). New York: International Universities Press, 1965.

Knapp, P.H. The ear, listening, and hearing. Journal of the American Psychoanalytic Association, 1953, 1, 672-689.

Lax, R.F. Some aspects of the interaction between mother and impaired child: Mother's narcissistic trauma. International Journal of Psychoanalysis, 1972, 53, 339-344.

Layland, W.R. In search of a loving father. International Journal of Psychoanalysis, 1981, 62, 215-223.

Lehman, E. Feeding problems of psychogenic origin. The Psychoanalytic Study of the Child, 1949, 3/4, 461-488.

Leiken, S., & Hassakis, P. Psychological study of parents of children with cystic fibrosis. In E.J. Anthony (Ed.), The child in his family (Vol. 2, pp. 50-53. New York: John Wiley & Sons, 1973.

Levy, D.M. The concept of maternal overprotection. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 387-409). New York: Little, Brown & Co., 1970.

Lewis, M., & Freedle, R. Mother-infant dyad: The cradle of meaning. In P. Pliner, L. Krames, & T. Alloway (Eds.), Communication and affect (pp. 127-155). New York: Academic Press, 1973.

Lewis, M., & Rosenblum, L.A. The effect of the infant on its caregiver. New York: John Wiley & Sons, 1974.

Liben, L.S. Developmental perspective on the experiential deficiencies of deaf children. In L.S. Liben (Ed.), Deaf children: Developmental perspectives (pp. 195-215). New York: Academic Press, 1978. (a)

Liben, L.S. The development of deaf children: An overvivew of issues. In L.S. Liben (Ed.), Deaf children: Developmental perspectives (pp. 3-20). New York: Academic Press, 1978. (b)

Lindemann, E. Symptomatology and management of acute grief. American Journal of Psychiatry, 1944, 100, 141-148.

Lurie, O. Psychological factors associated with eating difficulties in children. American Journal of Orthopsychiatry, 1941, 11, 452-467.

Mahl, G.E., & Schulze, G. Psychological research in the extralinguistic area. In T. Sebeok, A.S. Hayes, & M.C. Bateson (Eds.), Approaches to Semiotics. The Hague: Mouton, 1964.

Mahler, M.S., Pine, F., & Bergman, A. The mother's reaction to her toddler's drive for individuation. In E.J. Anthony & T. Benedek (Eds.), Parenthood (pp. 259-274). New York: Little, Brown & Co., 1970.

Mahler, M.S., Pine, F., & Bergman, A. The psychological birth of the human infant. New York: Basic Books, 1975.

Matarazzo, J.D., Hess, H.F., & Saslow, G. Frequency and duration characteristics of speech and silence behavior during interviews. Journal of Clinical Psychology, 1962, 18, 416-426.

Meadow, K.P. Parental response to the medical ambiguities of congenital deafness. Journal of Health and Social Behavior, 1968, 9, 299-309.

Meadow, K.P. The "natural history" of a research project: An illustration of methodological issues in research with deaf children. In L.S. Liben (Ed.), Deaf children: Developmental perspectives (pp. 21-40). New York: Academic Press, 1978.

Meadow, K.P., Greenberg, M., Erting, C., & Carmichael H. Interactions of deaf mothers and deaf preschool children: Comparisons with three other groups of deaf and hearing dyads. American Annals of the Deaf, 1981, 26, 454-468.

Meltzer, J.D. A semiotic approach to suitability for psychotherapy. Psychiatry, 1978, 41, 360-376.

Meshover, P. Communication processes in early development: With special reference to the deaf. Unpublished doctoral dissertation, Ferkauf Graduate School, Yeshiva University, 1980.

Middlemore, M.P. The nursing couple. New York: Hamish Hamilton Medical Books, 1941.

Mortensen, C.D., Arnston, P., & Lustig, M. The measurement of verbal predispositions: Scale development and application. Human Communication Research, 1977, 3, 146-158.

Nagera, H. The developmental profile: Notes on some practical considerations regarding its use. The Psychoanalytic Study of the Child, 1963, 18, 511-540.

Overall, B., & Aronson, H. Expectations of psychotherapy in patients of lower socioeconomic class. American Journal of Orthopsychiatry, 1963, 33, 421-430.

Perry, J.D., & Stern, D.N. Mother-infant gazing during play, bottle-feeding and spoon-feeding. Journal of Psychology, 1975, 91(2), 207-213.

Pine, F. In the beginning: Contribution to a psychoanalytic developmental psychology. International Review of Psychoanalysis, 1981, 8, 15-33.

Pine, F., & Furer, M. Studies of the separation-individuation phase: A methodological overview. The Psychoanalytic Study of the Child, 1963, 18, 325-342.

Pope, B., Siegman, A., & Blass, T. Anxiety and speech in the initial interview. Journal of Consulting and Clinical Psychology, 1970, 35, 233-238.

Pratt, K.C. The neonate. In L. Carmichael (Ed.), Manual of child psychology. New York: Wiley & Sons, 1954.

Racker, H. Transference and countertransference. New York: International Universities Press, 1968.

Radford, P. Changing techniques in the analysis of a deaf latency boy. The Psychoanalytic Study of the Child, 1973, 28, 225-248.

Rainer, J.D. Some observations on affect induction and ego development in the deaf. The International Review of Psychoanalysis, 1976, 3, 121-128.

Rainer, J.D., Altshuler, K.Z., & Kallman, F.J. (Eds.). Family and mental health problems in a deaf population (2nd ed.). Springfield, IL: Thomas, 1969.

Rich, A. Of woman born. New York: Norton, 1976.

Riess, A. The mother's eye--for better and for worse. The Psychoanalytic Study of the Child, 1978, 33, 381-409.

Robertson, J. Mothering as an influence on early development. The Psychoanalytic Study of the Child, 1962, 17, 245-264.

Robson, K. The role of eye-to-eye contact in maternal infant attachment. Journal of Child Psychology and Psychiatry, 1967, 8, 13-25.

Rochester, S.R. The significance of pauses in spontaneous speech. Journal of Psycholingustic Research, 1973, 2, 51-81.

Rosenberg, A. Some considerations in outpatient mental health services to deaf patients. Paper presented at North Shore Hospital, Department of Child and Adolescent Psychiatry, Grand Rounds, March 1983.

Ross, A.O. The exceptional child in the family. New York: Grune & Stratton, 1964.

Sander, L.W. Issues in early mother-child interaction. In E.N. Rexford, L.W. Sander, & T. Shapiro (Eds.), Infant psychiatry: A new synthesis. New Haven: Yale University Press, 1977.

Sandler, J., & Sandler, A. On the development of object relationships and affects. International Journal of Psychoanalysis, 1978, 59, 285-296.

Schatzman, L., & Strauss, A. Social class and modes of communication. American Journal of Sociology, 1955, 60, 329-338.

Schlesinger, H., & Meadow, K.P. Sound and sign: Childhood deafness and mental health. Berkeley: University of California Press, 1972.

Sears, R.R., Maccoby, E.E., & Levin, R. Patterns of child rearing. New York: Row Peterson, 1957.

Shapiro, T. The development and distortions of empathy. Psychoanalytic Quarterly, 1974, 43, 4-25.

Shopper, M. The role of audition in early psychic development, with special reference to the use of the pull-toy in the separation-individuation phase. Journal of the American Psychoanalytic Association, 1978, 26, 283-310.

Shopper, M. Therapeutic and preventive interventions with deaf children. In Treatment of emotional disorders in children and adolescents (pp. 687-701). Philadelphia: Spectrum Publications, 1980.

Siegel, S. Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill Book Co., 1956.

Solnit, A.J., & Stark, M.H. Mourning and the birth of a defective child. The Psychoanalytic Study of the Child, 1961, 16, 523-537.

Spitz, H. The primal cavity: A contribution to the genesis of perception and its role for psychoanalytic theory. The Psychoanalytic Study of the Child, 1955, 10, 215-240.

Spitz, H. No and yes. New York: International Universities Press, 1957.

Spitz, H. The evolution of dialogue. In M. Schur (Ed.), Drives, affects and behavior (Vol. II, pp. 170-190). New York: International Universities Press, 1965. (a)

Spitz, H. The first year of life. New York: International Universities Press, 1965. (b)

Spock, B. Baby and child care (rev. ed.). New York: Pocket Books, 1963.

Stein, L.K. Counseling parents of hearing-impaired children: A psychotherapeutic model. In L.J. Bradford & W.B. Hardy (Eds.), Hearing and hearing impairment (pp. 443-450). New York: Grune & Stratton, 1979.

Stern, D.N. Mother and infant at play: The dyadic interaction involving facial, vocal, and gaze behaviors. In M. Lewis & L.S. Rosenblum (Eds.), The effect of the infant on its caregiver (pp. 187-213). New York: Wiley, 1974.

Stern, D.N. A microanalysis of mother-infant interaction. In E.M. Rexford, L.W. Sander, & T. Shapiro (Eds.), Infant psychiatry: A new synthesis. New Haven: Yale University Press, 1976.

Stern, D.N. The role of audition in the development of affect. Paper presented at the Lexington School for the Deaf, June 9, 1978.

Stuckless, E.R., & Birch, J.W. The influence of early manual communication in the linguistic development of deaf children. American Annals of the Deaf, 1966, 111, 452-460, 499-504.

Sullivan, H.S. The interpersonal theory of psychiatry. New York: W.W. Norton & Co., 1953.

Terhune, C.B. The role of hearing in early ego organization. The Psychoanalytic Study of the Child, 1979, 34, 371-381.

Thatcher, B. The imaginary companion and the sounds of mothering: The case for an auditory transitional object. Unpublished doctoral dissertation, City University of New York, 1981.

Vernon, M. Psychological aspects in diagnosing deafness in a child. In P.J. Fine (Ed.), Deafness in infancy and early childhood (pp. 87-97). New York: Medcom Press, 1974.

Vernon, M., & Miller, W.G. Language and nonverbal communication in cognitive and affective processes. Psychoanalysis and Contemporary Science, 1973, 2, 124-136.

Vernon, M., & Mindel, E. They grow in silence. Silver Springs, MD: National Association of the Deaf, 1971.

Walters, R.H., & Parke, R.D. The role of distance receptors in the development of social responsiveness. In L.P. Lipsett & C.C. Spiker (Eds.), Advances in child behavior and development (Vol. 2, pp. 59-97). New York: Academic Press, 1965.

Webster, T.G. The emotional development of mentally retarded children. In F.J. Monolaxino (Ed.), Psychiatric approaches to mental retardation. New York: Basic Books, 1970.

Weins, A.N., Saslow, G., & Matarazzo, J.D. Speech interruption behavior during interviews. Psychotherapy: Theory, Research, and Practice, 1966, 3, 153-158.

Weir, K. Psychological factors in feeding disorders occurring in mentally or multiply handicapped children. Child Care, Health and Development, 1979, 5, 285-294.

Wenar, C. The reliability of mothers' histories. Child Development, 1961, 32, 491-500.

White, A., Fichtenbaum, L., & Dollard, J. Evaluation of silence in initial interviews with psychiatric clinic patients. Journal of Nervous and Mental Disease, 1964, 139, 550-557.

Wills, D.M. The "ordinary devoted mother" and her blind baby. The Psychoanalytic Study of the Child, 1979, 34, 31-51.

Winnicott, D.W. (1956). Primary maternal preoccupation. In Through pediatrics to psychoanalysis. New York: Basic Books, 1975.

Winnicott, D.W. (1960). The theory of the parent-infant relationship. In The maturational processes and the facilitating environment. New York: International Universities Press, 1965.

Winnicott, D.W. The mother-infant experience of mutuality. In E.J. Anthony & T. Benedek (Eds.), Parenthood. New York: Little, Brown & Co., 1970.

Wolff, P.H. State and neonatal activity: Observations on newborn infants. Psychosomatic Medicine, 1959, 21, 110-118.

Wolff, P.H. Cognitive considerations for a psychoanalytic theory of language acquisition. Psychological Issues, 1967, 18/19, 299-344.

Wolff, P.H. The natural history of crying and other vocalizations in early infancy. In B. Foss (Ed.), Determinants of infant behavior. New York: Barnes & Noble, 1969.

Wormhoudt, A. The unconscious identification "words-milk." The American Imago, 1949, 6(1), 57.

Yarrow, M.R. Problems of methods in parent-child research. Child Development, 1963, 34, 215-226.