1959

Casework with wives of psychiatric patients

Palm, Jeanne C.

Boston University

http://hdl.handle.net/2144/19655

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SCHOOL OF SOCIAL WORK

CASEWORK WITH WIVES OF PSYCHIATRIC PATIENTS

A Thesis

Submitted by
Jeanne Courtney Palm
(B.A., Albright College, 1957)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1959

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CHAPTER I
INTRODUCTION

Purpose

Casework services are offered to many of the wives or husbands of patients treated at the Psychosomatic Clinic at Massachusetts Memorial Hospital. Frequently the referral of the spouse to social service is made by the intake committee or treating psychiatrist in order to gain a better understanding of the patient's home situation and to provide the spouse with help in adjustment. The purpose of this study is to investigate the problems brought to casework interviews by the wives of patients treated on an outpatient basis. Special attention is given to the patterns of family interaction as they are affected by the patient's illness and treatment. The study is directed toward answering the following questions:

1. What are the problems and concerns of the wives as revealed in casework?

2. What are the effects of the patient's illness and treatment on family relationships as these are revealed in casework?

Generally it is accepted that there is a dynamic interaction between the individual, his primary group and his environment. Mental health must be evaluated in terms
of the individual's intra-psychic structure, his patterns of social interaction and the social process of the environment as these influence each other and contribute to the individual's well-being. The primary group or closest social environment is the nuclear family group which is considered here to consist of husband, wife and unmarried children. There seems to be within the family group a characteristic equilibrium which is maintained by the interaction of its members. When one member does not function as usual it is expected that the symptomatic behavior will affect the other family members and the total family equilibrium. In the case of the male psychiatric patient there are special demands made of the wife in terms of her interaction with her husband and her responsibility shared with him for maintaining the family unit. Changes in the behavior of the patient treated primarily on an out-patient basis while living at home have an immediate and direct effect upon the family members. Also the family relationships have a direct effect upon the patient so that there is a reciprocal interaction. It would seem that, as the patient's behavior changes due to his illness and treatment, reciprocal changes in the roles of family members will be necessary if the family relationships are to be maintained. The demands for adjustment and the stress caused by the patient's symptomatic behavior cause for the wife and other family members
problems which are felt to be amenable to casework help. The first part of this study is an examination of these problems as the wife reveals them in the case work situation. The wife's approach to these problems will be influenced by her conception of her husband's illness and treatment as well as by her own patterns of reaction to stress. Therefore an attempt will also be made to study the wives' understanding of and attitude toward the illness and treatment.

Resulting from the adjustments necessitated by the illness and treatment of one family member are changes in the patterns of family interaction. The study also is directed toward the examination of the effect of one member's altered behavior upon the family relationships.

Review of Literature

The Family as a Unit

Traditionally, in its early history social work dealt with the family as a unit. A gradual shift of focus to the individual apart from his group resulted from its reorientation toward the examination of the intra-psychic dynamics of the individual according to psychoanalytic theory. Recently there has been a movement back to the study of the "family as a unit." More and more persons concerned with mental health are recognizing the importance of understanding the current interaction of the psychiatric
patient and his family group. There is evolving a conscious examination of the family unit in both the diagnosis and treatment of mental illness.

Nathan Ackerman has been especially active in studying the family group and has developed some methods of family diagnosis. In an article written with Marjorie Behrens he defines family diagnosis as "a classification of emotional functioning and mental health of family groups."¹ In their report on an on-going study of the interaction of the emotionally disturbed individual with the psychosocial structure of the family, they state the following principles making the family diagnostic approach important.

(1) Mental health, in a large part, is an expression of social process. (2) The mental health of the family group bears a direct relationship to the functioning of a family member. (3) The personality structure of the individual, while a central factor in his mental functioning, is not the sole determinant; the quality of his emotional integration into his family or other substitute group may intensify or mitigate the negative expression of his personality.²

The importance of the family milieu upon the mental health of the individual is apparent. How he sees others and interprets their responses to him influences his

²Ibid.
self-image and his patterns of interaction. Through his membership in the family group he gains his sense of identity. Through the medium of the family he learns the mores and values of his cultural environment. His responses to society are inhibited or facilitated by the emotional climate of his family relationships. The extent to which he can adjust to the social roles assigned him is governed by his internal organization and his patterns of interaction in his primary group. The individual's social functioning and perception of social reality are measures of his mental health.

Correspondingly, the group as an entity is influenced by the actions of each of its members. Ackerman and Behrens emphasize this in their conceptual frame of reference for family diagnosis:

Personality, family, social structure and culture patterns are not regarded as separate independent entities, but as interrelated and interacting parts of a unified whole which change and shift over time, each part in dynamic equilibrium with every other.3

This equilibrium has been described by the presently popular term "homeostasis." Ackerman adapts the more or less biological definition as he describes homeostasis as "the changing capacity for maintaining effective coordinated

3Ibid., p. 68.
functioning under constantly changing conditions of life.\textsuperscript{4}

In family psychodynamics the adaptation of the personality to different roles and the integration of the family roles must be maintained.

Henry B. Richardson in his book \textit{Patients Have Families} also applies the term "homeostasis" to the family group. He states that homeostasis is that phenomenon by which living organisms maintain a balance between the internal and external environment and that it defines to some extent the equilibrium of the family group. He states:

\begin{quote}
The strength or weakness of a family is to be judged not so much by the character of the individual members or even by the interpersonal relationships which I have described under the heading reciprocity systems, as by the equilibrium as a whole.\textsuperscript{5}
\end{quote}

The role each family member assumes influences the family equilibrium. It has been suggested that the family group may be studied through role interaction. John Spiegel in his article, "The Resolution of Role Conflict Within the Family," states:

\begin{quote}
Thus the basic concept of analyzing the family as a system consists in describing the behavior of any one member in terms of his role in transaction with a role partner or partners. A role is defined as
\end{quote}

\textsuperscript{4}Nathan Ackerman, \textit{The Psychodynamics of the Family}, pp. 68-69.

\textsuperscript{5}Henry B. Richardson, \textit{Patients Have Families}, p. 128.
a goal-directed pattern or sequence of acts tailored by the cultural process for the transactions a person may carry out in a social group or situation.6

Each role within the family presupposes that the individual has gone through a process of adaptation in order to fulfill it. This adaptation is determined by the inner potentialities of the individual and the demands upon him by his social environment. How well he adapts influences the efficiency of the functioning of the family unit.

In times of stress there tends to be a shift in the roles within the family. Earl L. Koos reports a study done on the effect of trouble on the family life of sixty-two lower economic urban families. He found that the major effect of stress upon the family was change in the dominance pattern or in the relative authority exercised by each family member.7 The mental disturbance of one member and the inefficiency of his role functioning affected those in reciprocal roles with him and the total family equilibrium.

Conflict arises when role functions are not efficiently fulfilled. For the family to maintain itself as a stable unit certain needs of its members must be met as well as the requirements made of it by society. There must be a


7Earl L. Koos, Families in Trouble, pp. 1-22, 33-55.
degree of complementarity in role interaction. The term "complementarity" refers to the "specific pattern of family role relations that provides satisfactions, avenues of solution of conflict, support for a needed self-image, and buttressing of crucial forms of defenses against anxiety." Complementarity may offer a mutual fulfillment of needs, a positive emotional growth, or merely a neutralization of the destructive effect of conflict and anxiety preventing further disintegration.

In dealing with the concept of complementarity and complementation, Zygmunt A. Piotrowski and Stephanie Z. Dudek describe the latter:

It implies that two people are attracted to each other on the basis of their healthy or neurotic needs for the purpose of maintaining and developing their habitual needs and goals.

A relationship may be complementary and satisfactory without either participant being emotionally mature. How satisfactory or unsatisfactory it is may be measured by the areas of cooperation or conflict reported by any of its members. A relationship continues to operate satisfactorily as long as the persons involved find goal satisfaction and need

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8 Ackerman, op. cit., p. 86.

gratification. When the behavior of either or both members is altered in such a way that the complementation or balance is destroyed the relationship is no longer satisfying.

How well the needs of each member are met is correlated with the degree of integration of the family. A family is integrated and functional in a number of ways. One satisfactory pattern of interaction does not mean that all patterns will be satisfactory. A man and woman may function well in the roles of husband and wife, but poorly as father and mother. How an individual responds to any given set of interactions depends upon his own strivings, his perception of his role and of himself and his perception of those in reciprocal roles. Important, too, are the devices he uses to control specific family relationships and his success in gratifying his own needs.10

Implications for Treatment

The anxiety produced over one family member's illness may have varying effects upon the family depending upon the former functioning of that member in the family. It may induce increasing instability, constant role shift or a rigidity in adaptive capacity.11

How the wife of a psychiatric patient understands the

10 Ackerman and Behrens, op. cit., pp. 68-78.
11 Ackerman, op. cit., p. 23.
patient's illness and treatment will influence the adjustments she makes in her own behavior. The ways in which a wife may see her husband's disturbed behavior are indicated in a study done at Saint Elizabeth's Hospital on the impact of mental illness on the family. One of the questions posed was: "How does the wife attempt to understand the meaning of illness and how does she deal with its manifestations?"

Her understanding and expectations were found to govern her reactions toward her husband and toward those treating him. The time perspective of the illness, the wife's image of her husband and her anticipation of the post-treatment situation were found to influence her attitude. The authors of one of the reports stated that behavior on the part of the husband prior to his admittance to the mental hospital was not readily recognized by the wife as symptomatic if it was unfamiliar and unlikely in terms of her expectations and needs. Threatening stimuli were frequently misconceived or perceived with delay.\textsuperscript{12}

Because marriage is an elective union in this culture, the choice of a mate is greatly influenced by the individual's own personality structure and needs. The degree to which the wife can accept change in her husband's

behavior patterns is influenced by the importance of these to her own need gratification. Her emotional needs set limits to the kind of behavior she can tolerate. If, for instance, she has a need to dominate, she may block treatment which makes her husband less passive as his passivity brought her satisfactions which are difficult to give up. Further her husband's therapy in itself may be threatening to the wife as the patient-therapist relationship may arouse conflict over former relationships in her life. For instance, she may, because of her own emotional frame of reference, feel in competition with the therapist for the husband or wish for a relationship for herself.13

The needs of the wife must be dealt with if therapy is to be effective. The question is raised as to where emphasis should be laid on the continuum of therapy focused on the family as a primary unit of treatment at one extreme to therapy focused on the individual in isolation at the other. The kind of family involved will influence the kind of treatment, the degree to which family members can be used as therapeutic resources and also the amount of treatment which should be offered to those family members not labeled mentally ill.14

14Milton Greenblatt, et al., The Patient and the Mental Hospital, pp. 535-545.
The values and needs of each family member must be recognized and each member must be helped to find some gratifications for himself if he is to adjust to demands upon him and aid in maintaining the family equilibrium.

Method

The sample of eleven wives was chosen from the wives seen in the social service department of the Psychosomatic Clinic of Massachusetts Memorial Hospital during the five year period from January, 1953, to January, 1959. This represents the total number of records known to the present social service staff that met the specifications of the study. The criteria for the choice of subjects was that the wives be seen for six or more interviews and that casework be concurrent with the psychiatric treatment of the patients on an out-patient basis.

Data were obtained through the use of casework records and of supplementary material from the psychiatrist's recording of work with the husband and of staff evaluations. A schedule was used to compile the data from the records. The schedule is included in the appendix. It is divided into three sections according to the nature of the material involved. The first section, entitled Personal and Social Background, includes typical face-sheet information, as name, occupation, age, religion and school level of the patient, wife and family members. This material was readily
available and offered clearcut categories for analysis. The second section, Clinical Diagnostic Material, dealt with information concerning the referrals of patient and wife, then diagnosis and treatment. It was relatively accessible through careful study of diagnostic summaries and case content. The third section, Case Material, was based upon the content of the casework recordings and was less consistently available and more difficult to analyze since it dealt with more abstract concepts such as personality traits and attitudes. Impressions were not systematically given by the workers or recorded with clarity so that there is an unevenness in both quantity and quality of material. The problems of concern to the wife were divided into areas of concern: financial, occupational, social, sexual, and parental responsibility. The recordings did reveal pertinent information in these areas. Material on the wife's attitudes and understanding of illness and treatment were less clearly spelled out. More interpretation of data was necessary in the use of this last section of the schedule than in the use of the first two.

Limitations

The study is limited in at least three ways. A study based on case records is limited in that the frame of reference of the research person differs from that of the
caseworker. In this situation the worker was in a helping position, receptive to the problems as the client saw them. The situation was client-focused rather than family-focused as is this study. This means that the biases of the client and of the worker will influence the kind of material recorded. Material was recorded from a different orientation than that of the present research and some areas were over- or under-emphasized. It was necessary to make an interpretation to fit the research frame of reference. With any interpretation some threat to the validity of the data is involved.

Secondly, much of the casework with the wives was done by students. The recording and interpretation, as well as the focus of the interviews, was influenced by the learning position of the student. The student lacks certain skills in diagnosis and treatment of the more seasoned worker. On the other hand the student records in more detail for use of records in supervision so that material is more readily available.

Third, the results are limited by the size of the sample. Eleven cases were used and this is too small a number on which to generalize. Each case involved distinct problems for both husband and wife and distinct patterns of family interaction so that specific tendencies of the entire sample group were few. The material is qualitative and is
not clear-cut as it deals with many intangibles so that much of the analysis must be descriptive and specific.

Interpretation of the records was necessary both in evaluating the importance of recorded material in relation to the total context of treatment and in perceiving attitudes and emotional tones which were implied in the recording but not explicitly stated. The diagnostic skill of the research person is involved in the interpretation of such material, and this affects the validity of the material both in data collection and in data analysis.

Setting

The Psychosomatic Clinic is an out-patient service of Massachusetts Memorial Hospital. Massachusetts Memorial Hospital is a non-sectarian, voluntary, non-profit hospital which is used as a central teaching unit of Boston University School of Medicine. It can accommodate approximately three hundred and sixty patients, both adults and children and forty infants. A separate unit, the Haynes Department of Infectious Diseases, located in Brighton, serves one hundred and twenty poliomyelitis and tuberculosis patients.

The Psychosomatic Clinic also serves as both a treatment center and a training center. Residents in psychiatry, fourth year medical students, graduate students in their second year of social work training and third or fourth
year psychology students receive training there. The clinic was originally divided into three sections: the Seizure Clinic, the Adult Psychiatric Clinic and the Children's Psychiatric Clinic. At the present it treats only adult patients. Its diagnostic and treatment facilities are available for ambulatory psychosomatic, psychoneurotic and mildly psychotic patients. The course of treatment for each patient is carefully planned in conferences for intake, evaluation and discharge.

The clinic is operated in conjunction with the psychiatric ward. When hospitalization is felt necessary for patients in treatment in the Psychosomatic Clinic they may be hospitalized on the psychiatric ward of the hospital. Likewise, patients discharged from the ward are frequently followed on an out-patient basis in the Psychosomatic Clinic. The psychiatric ward can accommodate fifteen patients. It is an open ward with no locked doors separating it from the adjacent medical floor. Admission to the ward is voluntary and the usual hospital treatment is short term. The ward was opened November 7, 1956. Its purposes then and now are to provide a teaching facility for residents and medical students, to give service to the hospital and to provide service to the community, social agencies and physicians in crisis situations. Because of the size of the ward intensive psychotherapy is possible and inclusive planning is done for
each patient. Treatment is offered adult patients and adolescents over age fifteen. The patients are those with psychosomatic, psychoneurotic or mildly psychotic symptoms.

The psychiatric social service department coordinates its services with the psychiatric ward and the Psychosomatic Clinic. Social workers are responsible for intake in the clinic. They see applicants for the initial application interview. They also handle inquiries from social agencies in the community in relation to prospective clinic applicants.

Casework with relatives of patients in psychiatric treatment in the clinic or on the ward is also a service provided by the social service department. It is this group of persons upon whom this research has been focused. A relative may be seen to gain further social history as well as to provide continued casework treatment. The decision that a significant relative be seen by a caseworker is frequently made in the initial discussion of the patient's situation at the time of intake. It may also be made later in the treatment process by the patient's doctor as the home situation proves significant in the patient's progress.

Casework is also provided for patients in treatment with a psychiatrist where co-therapy is advisable to facilitate rehabilitation. Another group of patients seen by caseworkers are those who have terminated with the doctor
and who continue treatment solely with the caseworker.
CHAPTER II
DESCRIPTION OF CASES
Clinical Aspects of Cases

Sources of Referral

The study group consists of eleven wives seen in social service at the Psychosomatic Clinic of Massachusetts Memorial Hospital while their husbands were concurrently in psychiatric treatment on an outpatient basis. Whether on the ward or in the clinic, each patient is presented at the time of intake to the staff to decide whether the patient should be accepted for treatment and to formulate a treatment plan. At this time consideration is given to the advisability of the relative being seen by social service to gain more information for diagnostic purposes or to help the relative with stresses prevalent in the home situation. Of the wives referred at time of intake, four were referred as a decision of the Clinic Intake Conference, four from Ward Rounds and the other two by the husband's psychiatrist upon the commencement of treatment. The other two wives were referred by the husband's doctor later in the treatment process. One was referred ten months after her husband started treatment for help with her depression during pregnancy. The other was referred four years after the patient's
initial contact with the clinic for help with prenatal care and plans for marriage to the patient by whom she was illegitimately pregnant. In only one known instance did the wife request treatment and this was in accord with her referral to social service from Ward Rounds.

The sources of referral of the patients to the clinic are represented in Table 1.

**TABLE 1**

**SOURCE OF REFERRAL OF PATIENTS**

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Number of Patients</th>
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<tr>
<td>Social Agency</td>
<td>4</td>
</tr>
<tr>
<td>Private physician</td>
<td>3</td>
</tr>
<tr>
<td>Other M.M.H. clinic</td>
<td>2</td>
</tr>
<tr>
<td>B.U. Counselling Service</td>
<td>1</td>
</tr>
<tr>
<td>Self-referral</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

In the category of social agency referrals are included referrals from such agencies as Family Service and from mental health centers, such as the Massachusetts Mental Health Association. The B.U. Counselling Service might have been included in this category as it has much the same function of counselling or referral in dealing with problems of mental health. However, since Boston University is closely affiliated with the hospital, in that the clinic itself is a Boston University training unit, there is perhaps a more
direct line of communication in referral. Two of the referrals from private physicians came from specialists affiliated with the hospital so that these referrals, as well as those from other clinics in the hospital, are the result also of intra-institutional lines of communication. As stated above some of these patients were admitted to the ward at the time of referral and then referred to the outpatient department.

Reasons for Referral

Patients. The symptomatic behavior which led to referral of the husband will be incorporated in a discussion of the personality components of the husbands and the effects of the illness upon the family. The needs of the wife in terms of the reason for her referral to social service will also be elaborated upon later. The table below does present a synoptic view of the respective reasons for referral. Because each patient and wife presented a distinctive picture each is listed separately according to the code letter assigned them.
### TABLE 2

**REASON FOR REFERRAL OF PATIENTS AND WIVES**

<table>
<thead>
<tr>
<th>Family</th>
<th>Reason for Patient's Referral to Clinic</th>
<th>Reason for Wife's Referral to Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Severe phobic condition, depression, somatic complaints</td>
<td>Help with pregnancy and with plans to marry patient</td>
</tr>
<tr>
<td>B</td>
<td>Severe depression, somatic complaints, diabetes</td>
<td>Better understanding of patient; aid in supporting patient</td>
</tr>
<tr>
<td>C</td>
<td>Obsession with wife's premarital sexual relations</td>
<td>Help with anxiety over patient's symptoms; aid in supporting patient</td>
</tr>
<tr>
<td>D</td>
<td>Anxiety attacks, sexual disinterest in wife</td>
<td>Help with depression during pregnancy</td>
</tr>
<tr>
<td>E</td>
<td>Depression, somatic complaints</td>
<td>Help with own anxiety and reaction to mother's death</td>
</tr>
<tr>
<td>F</td>
<td>Chronic gambling, suicidal threats</td>
<td>Better understanding of patient; help with marital problems</td>
</tr>
<tr>
<td>G</td>
<td>Psychosomatic illness, emotionally distressed</td>
<td>Better understanding of patient; help with anxiety over patient</td>
</tr>
<tr>
<td>H</td>
<td>Paranoid reaction and hostility toward wife</td>
<td>Help with anxiety over patient</td>
</tr>
<tr>
<td>I</td>
<td>Anxiety attacks, depression</td>
<td>Wife's request for treatment; evaluate reaction to patient's hospitalization</td>
</tr>
<tr>
<td>J</td>
<td>Anxiety attacks</td>
<td>Help with depression during pregnancy; better understanding of marital situation</td>
</tr>
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TABLE 2 (continued)

REASON FOR REFERRAL OF PATIENTS AND WIVES

<table>
<thead>
<tr>
<th>Family</th>
<th>Reason for Patient’s Referral to Clinic</th>
<th>Reason for Wife’s Referral to Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>Anxiety attacks, depression</td>
<td>Better understanding of patient; aid in supporting patient</td>
</tr>
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</table>

Since the clinic deals with patients with psychosomatic or psychoneurotic complaints or with mild psychotic symptoms, it is not surprising to find a large clustering of symptoms of depression, anxiety or somatic complaints, the grosser symptoms of the psychotic patient are absent.

Diagnostic classification for most of the patients in psychiatric treatment has been made. The clinical focus is upon the individual, his needs and his distinctive symptoms rather than upon a diagnostic category. Diagnostic classification is kept flexible and loses meaning out of the context of the discussion of the individual.

Experience in staff conferences indicates that while some classifications may be clear cut others may not be so readily agreed upon and may remain ambiguous. To some extent anxiety and depression were included in all of the illnesses. These terms were involved in the diagnostic impression of five of the patients. Of these one was termed "anxiety neurosis" or "anxiety reaction." Two patients had
no diagnostic classification which could be found in the records, but were described as anxious and depressed. One of these displayed characteristics of a "schizophrenic reaction, paranoid type," but no definite classification was made. One patient was diagnosed as "chronically depressed" and another as "obsessive compulsive with strong depressive features." Both were considered seriously ill and in danger of a psychotic break at the time of referral. One patient who was later hospitalized at a state mental hospital was diagnosed as "manic-depressive psychosis with an agitated depression." Another, a chronic gambler, was labeled "character disorder" and displayed some depression.

Wives. Of the wives referred to social service, three were referred mainly for help with their pregnancies. The wife's need for help at this time was related to her husband's sickness and the husband's symptoms were influenced by the pregnancy so that there was an interrelationship of the need of both parties for help. Although in the stated reason for referral, the wife was referred to social service in the majority of the situations as a means of evaluating further the patient's environmental situation or to enable the wife to be more supportive, the actual casework focus was upon the wife and her problems in all of the cases. In four of the cases the wife's anxiety over the patient's illness merited referral.
Treatment

Patients. The length of treatment for the patients ranged from six months to seven years. In seven out of eleven cases treatment was ongoing at the time of the study; therefore, in these cases it was not possible to judge the total length of therapy. Three patients and wives began treatment in the fall of 1958, the year in which the research was begun. In these three cases treatment continued. Three more continuing in treatment began one year prior to the research and therefore were in treatment approximately one and a half years at the time of this writing. One patient, continuing with his therapist at another hospital, began treatment as did his wife one and a half years before the study was begun. Of the four cases terminated, two were in treatment two years. One of these, Mr. J, terminated of his own accord, while the other, Mr. C terminated in mutual agreement with the therapist as it was decided that since he was better and the doctor was leaving it would not be necessary for him to transfer to a new doctor. A third patient, Mr. G, was seen for about a year and then transferred to inpatient care at a state hospital. The fourth, Mr. A, who was in treatment seven years, was transferred to a special project for hard-to-reach families. One reason for this was his inability to come to the clinic for treatment because of his severe phobic symptoms.
During the time of treatment five of the patients were hospitalized for some period of time on the ward. The psychiatric ward and the clinic are not separate units but operate in cooperation with one another so that a continuity of treatment was maintained. All the patients were seen on an out-patient basis during part of their treatment. Four patients were seen exclusively as out-patients. Another patient, seen only as an out-patient was seen for approximately one year in social service while he continued in treatment with the psychiatrist. The focus of social service was upon vocational planning. One patient was hospitalized in a private mental hospital after his evaluation in the clinic. He was released after two months and treated as an out-patient for eight months until he was hospitalized in a state mental hospital and treatment was terminated. With the exception of one patient who was seen by fourth year medical students, all the patients were treated by resident psychiatrists. All therapy was under close supervision by senior staff members.

The frequency of the patient's treatment varied with the severity of his illness. Patients hospitalized on the ward are usually seen five times a week; out-patients are usually seen once a week. The variation in frequency of treatment can be seen in the example of the ward patient who is well enough to return home. He may be seen in the clinic
at first three times a week with a gradual tapering to twice a week and then to once a week.

Wives. In all the situations the wives were seen concurrently as the husbands were treated. In one case the husband's therapist moved to another hospital and continued treatment of the patient so that social service with the wife continued technically when the husband was no longer a patient of the clinic. In all the cases in which there was termination the wives terminated with social service at about the time when the patient terminated his treatment. This is not a policy of the clinic that she should do so, but in these cases was out of her desire. Generally the wife was seen in social service on a once a week basis.

Personal and Social Background

Age

The ages of the subjects studied were taken at the time of the wife's referral to social service. The following table shows age distribution of the patients and wives.

---

1See Master Table, Appendix B, showing the ages of patients and wives in relation to other personal and social characteristics and the wife's areas of concern.
TABLE 3

AGE OF PATIENTS AND WIVES

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Patients</th>
<th>Wives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20 to 29</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>30 to 39</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40 to 49</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>50 to 59</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

The age range was eighteen to fifty-three for the patients and seventeen to forty-eight for the wives. All of the wives were younger than their husbands and the age difference for all the couples but one was within ten years. In one instance the wife was fourteen years younger than the husband. The husband was thirty-six when he married and there was evidence in the content of the interviews of feeling on the wife's part over marrying a man so much her senior because of her concern that his age might influence his recuperation after sickness and because of her resentment over his dependency upon his mother and upon her.

It is noted that three of the patients and four of the wives were in the twenty to thirty age range. All three of the patients were students at the time of referral and
therapy was focused upon their student status as in two cases it was a source of anxiety and in the third a source of strength. Four of the wives (A,D,I,J) under age thirty were pregnant at some time during treatment and casework focus was upon the problems around pregnancy and management of children. Six of the patients and five of the wives were over forty. Therefore they were in the age range where the threat of middle age and of the menopausal syndrome may affect the emotional stability especially in face of stress. In one situation the wife's menopausal symptoms were important in the patient's illness. His symptomatology included paranoid accusations of the wife's infidelity and only after several interviews with the wife was it discovered that she was beginning menopause and that her own feelings over this altered her relationship with her husband. Although no generalizations can be made from this isolated incident or from the age distributions in so small a group, a recognition of problems inherent in the different stages of life adds light to the understanding of the individual's problems and of the pattern of interaction with marital partners.

There is a bimodal distribution of a group of younger patients and wives under age thirty and of a group of patients and wives over age forty. This means that the cases studied fall into two groups characterized by age. Five of the wives were under thirty and five were over
forty. The eleventh was thirty-nine. Problems were typified by problems usual during these times of life. For instance, the younger women were concerned over early adjustments in marriage, child-bearing and the management of pre-school children. The older women were concerned about the management of adolescent children or relationships with married children and with their declining physiological well-being.

Race and Religion

Ten of the couples were white and one was Negro. The religions of the couples are represented in the table below.

TABLE 4

RELIGIOUS BACKGROUND OF PATIENTS AND WIVES

<table>
<thead>
<tr>
<th>Religious Background</th>
<th>Number of Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Protestant</td>
<td>2</td>
</tr>
<tr>
<td>Both Catholic</td>
<td>1</td>
</tr>
<tr>
<td>Both Jewish</td>
<td>2</td>
</tr>
<tr>
<td>Catholic-Protestant</td>
<td>5</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Five out of the eleven marriages are of mixed religious faith. In two of these the husband is Catholic, but inactive, and the family is functionally Protestant.
One Catholic patient turned Protestant and at time of treatment was considering the Protestant ministry although this vocational indecision may have been part of his symptomatology. In another of the mixed marriages the wife turned Catholic during treatment. It is doubted that this decision was a result of treatment since it was considered long before treatment began. Little is known about the effect of the differences in faith in the other mixed marriage. It would be expected that while the differences in religious backgrounds of the marital partners might not be presented as problematic, the lack of strength available through meaningful unity in this area might be a hindrance in coping with problems.

With the exception of one couple little emphasis was placed upon religious faith by any of the other persons in interviews so that at least in the treatment situation this remained a neutral area. In the one instance in which religion was dealt with directly, the patient was involved in church activities, and the onset of anxiety symptoms came around the time he was planning to assume greater responsibility. Treatment both for the patient and wife focused a great deal on the feelings of inadequacy both had in their respective social roles in the church.

Education

The educational level of both husband and wife can
be thought of as an index of achievement, and in this light it is interesting to note the differences in school levels of the patients as compared to the wives both in terms of the two groups and in terms of marital partners.\(^2\) The following table shows the educational level according to the grouping of patients and wives.

### TABLE 5

**EDUCATIONAL LEVEL OF PATIENTS AND WIVES**

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Patients</th>
<th>Wives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 9-12</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Completed High School</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Advanced training - no degree received</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Graduated from college</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Graduate training</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Educational level unknown</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>11</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

In five out of the seven cases in which the wife's educational level was known the wife had more education than her husband. Three of the husbands in this group had not completed high school, and it is known in two of these

\(^2\)See Master Table, Appendix B, showing the educational levels of patients and wives in relation to other personal and social background and the wife's areas of concern.
situations from the interviews both with the patient and wife that the husband's lack of education had been a problem in that the husband felt inadequate compared to the wife. The other two husbands in this group were attending college and graduate school and their wives already had advanced degrees. In both situations there was evidenced some competition between husband and wife over academic achievement. In the two marriages in which the husband exceeded the wife in academic achievement, the husbands again were attending college or had graduate training while the respective wives had completed high school and college. Although in both cases the husband's occupational choice was presented as a problem by the wife and was discussed by the patient, the focus was not particularly upon academic achievement as such.

Occupation

The occupational analyses of the patients and wives are given in the tables below.3

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3See Master Table, Appendix B, for occupations of patients and wives in relation to other personal and social characteristics and the wife's areas of concern.
TABLE 6
OCCUPATION OF PATIENTS

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional person</td>
<td>1</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
</tr>
<tr>
<td>Office worker</td>
<td>1</td>
</tr>
<tr>
<td>Salesman</td>
<td>1</td>
</tr>
<tr>
<td>Actor</td>
<td>1</td>
</tr>
<tr>
<td>Manual laborer</td>
<td>2</td>
</tr>
<tr>
<td>Not working</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

TABLE 7
OCCUPATION OF WIVES

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>2</td>
</tr>
<tr>
<td>Practical nurse</td>
<td>1</td>
</tr>
<tr>
<td>Secretary</td>
<td>1</td>
</tr>
<tr>
<td>Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Factory worker</td>
<td>1</td>
</tr>
<tr>
<td>Not working</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

The three patients who were not working were unable to work as part of the symptomatology of their illnesses. In two cases the patients were too phobic and anxious to hold jobs. In the third the patient was hospitalized eventually. Those patients who were working had periods of inability to work because of their illnesses.
Occupational planning and financial problems were discussed extensively with most of the wives. However, in only one situation in which the wife was not working at time of referral did the wife begin to work because of her husband's inability to work. There were at least two working wives whose work was necessary to maintain the family and in this sense the husband's illness gave special emphasis to the wife's occupational status.

Family Constellation

Part of the motivation for this study has been the hope for a better understanding of the effect of one family member's illness and treatment upon the family unit. Therefore, a picture of the family constellations is important. All of the families studied were living as independent units. In one known instance the wife's mother was living with the family. In another case the husband and wife separated for a time after treatment with the wife was terminated.

The family constellations are given below. The term "family constellation" here deals with the number of children in the marriage. Since married children in the cases cited continued to hold important roles in the family interaction of the cases studied they are listed as such.

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4See Master Table, Appendix B, showing family constellations in relation to other personal and social characteristics of patients and wives and to the wife's areas of concern.
The inclusion of husband and wife in the family constellation is assumed.

**TABLE 8**

**FAMILY CONSTELLATION**

<table>
<thead>
<tr>
<th>Family</th>
<th>Number of Unmarried Children</th>
<th>Number of Married Children</th>
<th>Total Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>According to Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-5</td>
<td>6-11</td>
<td>12-17</td>
</tr>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>I</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>J</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>K</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

| Totals | 4   | 2   | 6    | 2   | 4 | 17  |

That the greatest number of children fall in the twelve to eighteen age group seems appropriate to the fact that the majority of the mothers were around forty years old. The number of children in the family was taken at the time of the wife's referral to social service. In four of the cases the wife was pregnant while in treatment so that during the time of treatment families A, D, I, and J each had one child under one year of age. In the case of family A a child was born each year for a period of four years while the family was followed either directly or indirectly by the
clinic. Both Mrs. D and Mrs. J, who were referred for help with their pregnancies, had children under school age.

Duration of Marriage

The duration of the marriage at the time of the wife's referral is presented in the table below.

TABLE 9
DURATION OF MARRIAGE

<table>
<thead>
<tr>
<th>Number of years</th>
<th>Number of Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>2</td>
</tr>
<tr>
<td>1 to 4 years</td>
<td>3</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>0</td>
</tr>
<tr>
<td>10 to 19 years</td>
<td>1</td>
</tr>
<tr>
<td>20 to 29 years</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

In one case the husband began treatment four years before his marriage and the wife was referred to social service two months before the marriage. The duration of the marriages shows a bimodal distribution in that five of the marriages were under five years duration and five were over twenty years in duration. Problems clustered around areas typically problematic to the marital adjustments in marriages newly formed or long-established.
CHAPTER III
AREAS OF CONCERN AS EXPRESSED BY WIFE

It was assumed that the wife would use casework interviews to discuss those matters of greatest concern to her and that, since casework contact originated through the patient's treatment, these matters would involve the patient's illness. Also since the wife represented the family and shared with the patient the responsibility for maintaining the family, it was expected that her concerns would reflect the problems of family interaction, especially as they related to the patient and his illness. These areas of family concern were focused upon in the research and are reported below.¹

Finances and Occupation

Finances and occupation are interrelated areas of family living. Financial distress was found to be the outcome of the occupational inefficiency of the patient. In families where the husband was unable to continue in his capacity as the family's main means-of-support there was a shift in roles which was more defined in this area of

¹See Master Table, Appendix B, showing the wife's area of concern for each family in relation to the personal and social characteristics of patients and wives.
finance-occupation than in any other area of family interaction. With this shift in role functioning came a shift in the dominance pattern. As the wife took over the family's financial responsibility there arose some conflict over the dependency-independency interaction of husband and wife.

**Financial Concern**

Financial distress was great enough in four of the cases to become a main emphasis in casework. The worker helped Mrs. A and Mrs. B, whose husbands were unable to work because of their severe phobic conditions, to get financial assistance. Occupational counseling was offered Mr. A directly and social service was active in interpreting to the welfare worker Mr. A's inability to work. Mr. and Mrs. B were referred for occupational counseling and for sheltered workshop therapy. Mrs. B and Mrs. G also presented problems of severe financial distress. Work was done with both to help them apply for assistance, but both were too ambivalent over accepting financial aid to go through with the applications. Mrs. G was given vocational counseling and help in getting a job. Mrs. B pressured her husband into returning to work. In all four cases the wives expressed a great deal of resentment over having to take over the financial responsibilities and over their husband's dependency upon them in this.

With Mrs. F financial distress was a direct result.
of her husband's pathology as it was caused by his chronic gambling rather than his inability to work. His pattern of building up huge bills through gambling and presenting these to Mrs. F expressed a hostile dependency. Her need to control which encouraged a neurotic interaction over finances and her resentment over the dependency expressed in this interaction were important casework concerns.

In the remaining six cases finances were not considered problematic in themselves. There was some mention of them by Mrs. I as she expressed her concern over not having an insured income with her husband in the acting profession and by Mrs. K who talked of their associates as being wealthier than they, but these discussions were not finance-focused.

Occupational Concern

Occupational concerns of the wives fell into two categories. As already suggested social service was helpful to the wife in assuming financial responsibility either through obtaining public assistance or through working in the four cases of financial distress (A,B,E,G). In only one case of the eleven, (Mrs. H) was there no expressed problem in the recording in the area of occupation. In five situations, (C,D,I,J,K) the husband's occupation was presented as a problem by the wife as an expression of more
subtle problems of interaction. With Mr. and Mrs. C there was competition scholastically and occupationally as Mr. C verbalized his need to have the same number of academic degrees as his wife. Each had problems of feeling inadequate and of needing to prove themselves and this was expressed by their need to compete in the area of occupations. Mrs. D expressed resentment over her husband's intense concentration on his job to the exclusion of his family. Again the patient's feeling of inadequacy and need to succeed on the job was symptomatic of his illness. Mrs. I resented her husband's vocation as an actor as she was threatened by his professional relationships with other women. Mrs. J opposed her husband's aspirations to become a minister as she rejected the role of minister's wife. Both of these husbands' selections of occupations were symptomatic and changed with treatment. Mrs. K had difficulty with her role as the wife of a professional person and stressed her own and her husband's feelings of inadequacy in meeting the social expectations of the roles.

Two of the wives used casework to discuss their needs to work and the problems working presented. Mrs. J was in conflict over her need to work, as a means of satisfaction to her and of an escape from facing her husband's illness, as over against her responsibility as a mother and wife. Mrs. F recognized both her need to work to pay the
bills and the effect of her work upon her relationship with her husband as the night work took her out of the home when he was home and enabled her to take over family management even more than when she did not work.

Social Relationships

All the wives but one reported difficulty with social relations outside the home as a result of the husbands' illness. Five wives were inhibited in their social contacts. Mrs. B, Mrs. F, and Mrs. G told of limiting their social contacts because of their guilt and shame over their husbands' illnesses and because of their increased working hours which made them too tired to socialize extensively. Mrs. J cut off social contacts out of her fear that they upset her husband. Mrs. A, an adolescent at time of treatment, resented her exclusion from the usual adolescent activities because of her marriage and pregnancies and because of her husband's inability to share her attentions. In all five cases the husbands withdrew from social contact as a result of the illness, thus making social relations more difficult for the wives. This was true to some extent for all the husbands. Mrs. C and Mrs. K used casework interviews to discuss their own feelings of inadequacy in social relationships. Mrs. D complained of her loneliness because of lack of social contacts when she moved from her home to her husband's home city and because of her responsibilities for her three small
children. Mrs. B complained of having to do things alone as did Mrs. F. Mrs. I felt left out of her husband's social relationships. Because of the husband's illness the problems of social relationships increased for these wives. This was true because of the husband's inability to share social interests and to give to the wife the concern and attention she needed so that she had a greater need to turn to others.

**Sexual Adjustment**

The sexual adjustment of these couples was an important emphasis in casework. The sexual difficulties were often symptomatic of the illness itself or of the neurotic interaction. All of the patients had some feelings of inadequacy and some difficulty in their masculine roles.

In three cases (B, G, and K) sexual adjustment as such was not discussed. All three wives were menopausal and two of the husbands were seriously disturbed to the point of psychosis so that focus was on the crisis situation of the illness itself rather than on the manifestations. In the other eight cases the patient's sexual adjustment represented a core problem in the illness. In the case of Mrs. D, Mrs. B and Mrs. I the husband's lack of sexual interest in them caused them a great deal of anxiety since it tended to mean to them a loss of love. Also they were concerned over the reversal of roles in their becoming the sexual aggressors. Mrs. A and Mrs. I used casework to
deal with their guilt over premarital relations with their husbands and pregnancy before marriage. Mrs. C focused on her guilt over premarital relationships with other men as one of Mr. C's presenting symptoms was his obsession over this. Mrs. A was helped with her fears over sexual relations in marriage and Mrs. D expressed her fears over becoming pregnant. Mrs. F could not express directly her fears, but the content of the interviews revealed her concern over her husband's lack of sexual interest in her and her fear of losing his love. Mrs. H's menopausal symptoms and her husband's paranoid accusations of her infidelity and incestuous relationship with their son accompanied by threats of physical harm caused maladjustment in their sexual relationship and were both cause and effect of the difficulties.

Parental Responsibility

Five of the wives used help in the management of their children. Mrs. A, Mrs. D, Mrs. I and Mrs. J were seen while pregnant and effort was made to help them accept their pregnancies and the added responsibility for the care of the new baby along with their other children. Mrs. F discussed her concern over her two adolescent children as they were affected by her work and by Mr. F's sickness and as she had difficulty in understanding them at this phase of development. Mrs. J discussed her conflict over working versus caring for her children.
Because of their illnesses, the patients generally were less able to assume their parental responsibilities. Their attentions were turned inwardly and they were less sensitive to the needs of their children. Perhaps in accord with cultural expectations, the wives assumed the dominant parental role with little difficulty. There was some conflict over the management of the children. Mrs. E felt her husband undermined her authority with her teenage daughter while Mrs. F felt her husband did not participate enough with the children. Mrs. A had problems in giving to her children and to her husband, as Mr. A competed with the children for her attention. Mr. H had paranoid ideas about his wife's taking the children's love from him and about her incestuous relationship with his son. Mr. G's separation from his son was a precipitating factor in his illness as it revived conflict over past father-son relationships. His parental responsibility was split, as was Mrs. G's, since both leaned heavily on one son while carefully protecting the younger son from any ill effects of the disturbed relationships.

Wife's Understanding of Patient's Illness

It was found in this study, as in the previously referred to study at St. Elizabeth's hospital on the impact of mental illness on the family, that the wife was slow to perceive unusual or threatening behavior on the part of the
husband. In all the cases there was some difficulty for the wife to understand the patient's behavior as symptomatic of his illness. There was a tendency to attribute the behavior to some concrete circumstance and to search for well-defined explanations of the illness.

Some misunderstanding of the nature of the illness was expressed in the often repeated accusation that the husband could feel better and function more efficiently if he had the will to. Six of the wives offered incidents in which they felt their husbands could do better if they wanted to. Mrs. A felt her husband could work and that he used his agoraphobia as an excuse. Mrs. B and Mrs. F were anxious that their husbands return to work after a period of illness as they feared that they might get used to not working and not return at all. Mrs. B and Mrs. G both thought their husbands were not as sick as they said they were and could better control their behavior. Mrs. C did not see her husband's suicidal threats as symptomatic of his illness.

Another indication of the wives' inability to understand the illness is evidenced in their search for an explanation of the breakdown. Five of the wives (D, E, F, I and J) ascribed the illness to the patient's childhood family background. An example of this is Mrs. J who described her husband's family as cold and unfriendly compared to hers. Mr. J's father was hospitalized off and on throughout Mr. J's
lifetime as a chronic schizophrenic, and Mrs. J recognized some of her husband's identification with his father. She feared that her own child might be showing signs of mental illness and that her unborn child might inherit the illness. The anxiety the illness provoked in her was indicated by her need to pin the illness to a concrete cause, and in the first interview she listed several factors she thought were causative. Mrs. I blamed the patient's relationship with his mother, saying that the mother was always "overprotective and over-solicitous, never letting him forget how much she cared for him." Four of the wives (B, D, G, and I) felt that the stress over the patient's job was the causative factor. Three (B, G, and H) pointed out specific physical factors, two of which (H and G) included "change of life" for the husband, as a cause in the breakdown.

Several of the wives did not actively seek explanations of the illness in the casework interviews. Mrs. A had a mentally ill mother and grandmother, both of whom were institutionalized and it was felt that she had a need to have her husband sick. She married him knowing of his sickness and related better to him when he was dependent upon her. Mrs. C had a masochistic need to feel guilty which made her play into her husband's neurosis. Both of these wives derived some need fulfillment in the illnesses and this may have influenced their reaction. Mrs. B also did not actively
seek an explanation of the illness. She suffered the recent loss of her mother and her energies were directed toward handling her own conflicts.

In all of the situations the wife showed some negative reaction to the patient's illness. With the exception of Mrs. C all the wives expressed strongly their resentment over the symptomatic behavior. There was some resentment over the patient's dependency and over the increased demands made on the wife. Mrs. B presents an example of this:

Mrs. B has spoken of him hanging to her physically in the morning to keep her from going to work and to keep the day from starting, constantly asking her when she'll be home or calling her at work. This is extremely upsetting to her. She has felt it selfish on his part, tells him that he must hate her or he wouldn't do this to her. When exasperated with him she has told him that she is not coming back to him at night or that he will turn out to be exactly like his mother who was mentally and emotionally ill at the end of her illness.

This was perhaps the most extreme reaction on the part of both husband and wife in the cases studied, but it does represent the general tone of reaction. Three of the wives (B, G, and E) expressed in their ambivalence over having their husbands hospitalized the burden to them of having their husbands at home where they would have to deal constantly with the symptomatic behavior.

Some resentment was expressed over the husband's inability to function as usual in his family roles. Nine of
the wives (A, B, D, E, F, G, H, I and J) complained about frustration of their own needs because of the patient's inability to give to them emotionally. The supportive casework relationship was valuable in filling some of these needs. Mrs. A expressed some of the demands made on her and the frustration of her own needs:

Sometimes she gets upset about finances and cries and he is no comfort to her. Despite this she is happy with him. She understands that he is sick and doesn't mean to behave as he does but she does not want to have to contend with his behavior. He becomes furious and hits her if she doesn't do what he wants immediately.

All the wives suffered some depression over the husband's illness. This was expressed in the discouragement over the patient's progress and in the doubt that recovery was possible. There was a general parallel of mood on the part of the wife with that of the husband. The husband's illness represented a threat to the marital relationship to seven of the wives (A, C, D, F, J, I and H) who at one time or another verbalized their doubt that the marriage could continue or that the relationship could improve. Included in this group were all the wives married under five years. Two of the wives (B and H) were fearful of bodily harm from their husbands. In each of the eleven situations the wife showed a desire to help the husband. Generally the wives saw the casework interviews as one way of helping their husbands either by giving the worker a report on the husband's behavior or by their
involvement in the problem-solving process.

There was a great deal of apprehension on the part of the wives as to the effect of their behavior upon the patient. Some of this concern may have been a reaction to feelings of guilt over the illness. Mrs. C, for instance, who had a great deal of guilt over her husband's illness could not express any anger toward him, nor little resentment over his behavior. Mrs. D expressed her concern:

She never tells her husband her worries because she feels he'll worry more. She can't share her problems with him because he doesn't understand. He is so worried about doing well on his job that he doesn't see her problems at home and she does not want to burden him with them.

Mrs. E talks of her feelings over her husband's coming discharge from the ward:

She brought up her concern over her husband's discharge. She wonders if she's going to be able to stand having him home. She will have to cater to him and be so careful when she is nervous and upset herself. Would she and her daughter have to give in in everything? Does she have rights too?

This apprehension over the effects of behavior and fear of expressing emotions is part of the general lack of understanding of cause and effect of mental illness.

The wife's reaction to her husband's illness was influenced by her past experience with mental illness. Mental illness severe enough to merit institutional care was reported in the families of three of the husbands (J, H, and K) and of three of the wives (A, B, and I). Severe pathology
such as alcoholism or family disintegration was known to be present in five of the families of the patients (A,C,D,F and I) and in one wife's family (Mrs. D). In these situations the wives tended to place the blame for the illness upon the pathology of the patient's family background. Experience in their own family background with emotional illness made the wives' present experiences more threatening. This was evidenced in the wife's tendency to bring in her feelings about the pathology of family members in discussing her feelings about the patient's illness. There seemed to be a reactivation of past conflicts over illness.

**Wife's Understanding of Patient's Treatment**

With all of the wives there was encouragement for the patient to receive treatment. Their willingness to accept casework help themselves was closely allied with this desire. At the same time there was some ambivalence over the husband's therapy. This was expressed in complaints over the slowness of therapy and question about its effectiveness. The doubt that therapy would be effective was expressed directly by six of the wives (B,D,E,F,G and K). There was some push for concrete signs of improvement and for more tangible means of treatment. For instance, Mrs. B and Mrs. E wanted their husbands to return to work as they felt that this would be a sign of improvement to the husband and proof that he could actually do more than he felt he could. Mrs. H
wanted her husband to have some medication along with the therapy, and Mrs. G suggested that electric shock treatment might be helpful.

The wife's own needs entered into her attitude toward treatment. Mrs. D, Mrs. B, and Mrs. I saw improvement in certain areas but complained about the lack of improvement in the area most important to them, that of the patient's sexual inadequacy and lack of interest in the family.

The husband's relationship with the doctor aroused some resentment which was verbalized by three of the wives (B, G and J) in their criticism of the therapist and of their husband's dependency upon him. There was some desire to be included in the therapy and this was expressed in their wish to know what went on in the interviews. Mrs. B, Mrs. E, Mrs. F, and Mrs. I stressed their need for a relationship with the worker themselves. They indicated that their therapy was important for them and not merely a complement to their husband's therapy.
CHAPTER IV
FAMILY RELATIONSHIPS

Personality Patterns and the Marital Relationship

The personality patterns of the patient and wife were revealed in the recordings of the psychiatrist and social worker, both in the content of the interviews and in the diagnostic statements. The personalities were presented in the records at various levels from a general descriptive statement to a psychoanalytically orientated evaluation. For the purposes of this study an attempt was made to understand the basic personality composition of each individual as it would represent his usual pattern of interaction with others. It was originally planned to include the children of the families in this type of analysis but a clear picture of the personalities of the children was not consistently given. The children were discussed only as the wife brought them in. This was usually related to the conflict in husband-wife interaction and the reports were colored by the wife's own projected feelings. Therefore, the children will be discussed here only as they were indicated by the wife to be important in family interaction.
Patients

In general the outstanding problem in the marital interaction revolved around the passive-dependency of the patients. Problems over passive-dependency were present with each of the patients. There was a universal lack of self-esteem and feelings of inadequacy. The dependency was stated as a "hostile-dependency" in the description of four of the patients (A, B, F and G). In all of the cases some hostility in the dependency was expressed in the demands the patients made upon their wives. Two patients (B and D) were described as "sadistic" in their relationships with their wives. There was a great deal of conflict over masculine identity which was expressed through sexual passivity. Castration anxiety was stated in the evaluation of three of the patients (A, F and K). Two patients were said to be in conflict over their latent homosexuality (C and G). There was a great deal of anxiety in all of the patients. Most of them had hostile and aggressive feelings which were strenuously defended against. All had some difficulty in their relationships with women as expressed in their passive-dependent relationships with their wives.

An example of some of these traits in the patients is given in the quotation from the consulting psychiatrist's evaluation of Mr. E while Mr. E was hospitalized on the medical ward:
This very intelligent man with some insight into his condition presents evidence of a fairly specific neurotic pattern - a kind of need to try very hard to succeed and yet an unconscious fear of succeeding too well. He has a need to be taken care of, etc. (of which he is not aware) and has been in a situation recently with his wife's preoccupation with her own troubles that prevents this.

The dependency balance of Mr. and Mrs. B was upset when Mrs. B's mother died and her own dependency needs increased. Mr. B's feelings over his own parents' deaths were reactivated and his needs were not met as usual by his wife. His sexual inadequacy and his inability to succeed indicated long-standing psychosexual conflicts. He expressed his hostile dependency upon his wife both by verbal degradation and by somatic complaints which necessitated several hospitalizations. His sickness placed a financial burden on her and forced her to sacrifice some of her own need fulfillment for his.

Another example of the hostile-dependency personality pattern is given in the pathology of Mr. B. Mr. B was a diabetic who for some years before the discovery of insulin literally depended upon his mother for life as his illness was controlled by diet. He felt himself incomplete and dependent upon an outside source of supply for life. This dependency was displaced from his mother onto his wife, his doctor, the hospital and any other "source of supply." His mother's death precipitated his illness. He unconsciously
was immobilized with fears of his own death when he lost the symbolic source of supply of life in his mother and all his energy went into rigid defense against this overwhelming anxiety. He became unable to work and had to depend upon his wife to take a job and assume financial responsibility. He became very demanding with the doctor in his irrational dependency upon him for the supply of insulin.

A third example of these personality traits is given by Mr. K. Mr. K was described as an "extremely passive person who needs to maintain impossible standards and fears failure. . . . He has an insatiable need for approval. . . . He cannot express aggression. . . . He needs to be freed from guilt over advancing further than his father." Mr. K was described by his wife as feeling very inadequate in his position as a professional person. She complained of his dependency upon her and of his lack of leadership qualities. His illness seemed to be precipitated by a change to a position of greater responsibility.

Wives

The personality patterns of the wives had less in common than did those of the husbands. The diagnostic material was not spelled out as clearly since the wives did not receive routine staff evaluations as did the husbands. There was evidenced some neurotic interaction which when upset by the husband's illness, laid stress upon the wives.
Three of the wives whose husbands were described as "hostile-dependent" were said to have a "need to control" (B, F and G). All the wives complained to some degree about their husband's dependency, but also there was evidenced some satisfactions for the wife who had a need to dominate in this dependent relationship. Mrs. F, a very controlling woman, expressed anger over her husband's dependency upon her in presenting her with his bills from gambling. At the same time she showed some pride in managing the finances as well as resentment for having to do so. She also said that she liked to work rather than stay home just as a housewife. She spoke of Mr. F's dependency in the following excerpt from the record:

Mrs. F said she does not believe her husband loves her. The doctor said he did, that Mrs. F was very important to her husband. She knows he depends upon her for everything - that he almost couldn't dress himself if she did not tell him what to wear. She does not like to make all the decisions and handle all the finances, but knows nothing will be done if she doesn't.

Five of the wives (A, B, D, E and G) had apparent dependency needs of their own. They used casework extensively to discuss their own feelings of inadequacy and to gain support. Their own dependency needs were threatened by the husband's illness. Three (C, I and K) spoke extensively of feelings of inadequacy.

In at least three situations the neurotic patterns
of the wives seemed to mesh with those of the husbands to form a certain stability in the neurotic interaction. Mrs. A, an adolescent whose mother was mentally ill and whose father was an alcoholic and had left home early in her life, became pregnant by the patient while he was in treatment. She married him with much ambivalence, knowing his severe neurotic pattern. She expressed fear that she might become mentally ill from his treatment of her, just as her mother had become ill from her father's treatment. Her need to repeat the traumatic experience she had with her mentally ill mother and her seeming compulsion to be pregnant were met in her marriage to the patient. The marriage was described as "turbulent throughout with frequent separations." There were three children and another pregnancy in three and a half years of marriage. One psychiatrist stated his opinion that the marriage was the most important event in Mr. A's life. Of Mrs. A it was stated:

Mrs. A is a very immature, insecure person with an infantile hysterical personality. She has been very accepting and supportive to Mr. A while he could be her dependent little boy. Now that he is maturing she has greater trouble accepting him.

Mrs. C and Mrs. E displayed some masochistic needs met in the husband-wife relationship. Mrs. C's masochism expressed itself in her need to feel guilty and her encouragement of her husband's obsessive questioning of her premarital
sexual affairs. This guiltiness had a genesis in her relationship with her parents, particularly her father and was described as part of "a well-developed intricate neurosis that meshes well with her marriage and her masochism makes her less sick." Both Mr. and Mrs. B were described as dependent persons. However, Mrs. B's masochism and need to give brought her some satisfaction in Mr. B's demands. When her own dependency needs increased and Mr. B's needs were not met, the balance was upset.

The equilibrium of the intra-family interaction is maintained by a mutual fulfillment of needs. In some situations studied there did not exist a satisfying complementarity as the needs of the persons involved did not dovetail. When this happened there was a good deal of marital disharmony. Mr. and Mrs. I are an example of this. Both were extremely narcissistic. The following is a quotation from the psychiatrist's evaluation:

Mr. I is a patient who has perhaps little ego, and is an extremely narcissistic man who relates everything to himself. He has a great deal of underlying aggression toward women. To help these two patients one would have to concentrate on their own feelings and let them make up their minds how they are going to work this out in terms of an adjustment to each other.

The need in each for self-gratification was too great for them to meet the other's needs except as a secondary result in meeting their own.
Generally the complementarity in the husband-wife interaction was weakened by the patient's illness, but the ego strengths of the wife were great enough to compensate for the husband's lack of strength or there remained enough need fulfillment for both that the marriage continued. In only one case, that of Mrs. J, was there a lasting separation of the couple and this was after therapy was broken by both husband and wife.

Family Interaction as Affected by Illness and Treatment

The interpersonal relationships within the families were distinctive of the personalities involved. Therefore, it is difficult to generalize on findings. Originally it was planned to categorize relationships according to behavior "Before Illness," "Due to Illness," and "During Treatment." It was found, however, that this differentiation was artificial as there was an interplay of factors with no actual time division. There was a dynamic interaction of the relationships, the symptomatic behavior and the treatment.

Change in the patient's behavior because of his illness and due to treatment threatened the family role balance and necessitated adjustment by family members in complementary roles. Examples of shifts in roles brought about through the patient's sickness have been given in the discussion of financial-occupational responsibilities assumed by Mrs. B and Mrs. G. The necessary shift in roles to maintain the family
unit aroused a negative reaction on the part of the wives.

An example of the shifts in roles is given by the following quotations from Mrs. B over a period of time. Early in treatment Mrs. B described Mr. B's behavior before his illness:

Mrs. B described how close she and Mr. B had been before his illness. He had been a responsible and successful person. They had shared hobbies and played the violin together.

Later in treatment she again expressed her feelings over Mr. B and their relationship:

Mrs. B expressed ambivalence over her husband. There is a lot of underlying hostility and guilt over his need to depend on her. She says he has been less affectionate these past few years. He uses affection to delay the day. They used to be affectionate, but she feels she has become "hard."

Mrs. B describes the father-daughter relationship during the patient's illness.

L resents her father, particularly around his authoritarianism. Mr. B is jealous of L and her closeness. L has lost respect for her father. Both she and L are embarrassed by him.

It can be seen that a change in the intra-family relationships resulted from the patient's illness and the consequent shift of roles.

In some of the families there was a reversal of the usual culturally defined roles which seemed to evolve as a result of the personality patterns of the people involved.
rather than as a direct effect of the illness. For example, the function of financial responsibility seemed congruent with the personality of Mrs. F in contrast to the negative reaction this responsibility aroused in Mrs. B. The frustration accompanying the neurotic interaction made the relationship unsatisfactory enough that change was acceptable and necessary.

Examples of a neurotic balance that was both gratifying and frustrating to those involved are given by Mrs. C, Mrs. E, and Mrs. I. With the precipitation of the illness the precarious balance was threatened. In the marital interaction of Mr. and Mrs. C there was a repetition of childhood conflicts as Mr. C acted out the parental rejection he suffered with his father and Mrs. C acted out her hostility toward her father with her husband. She defended herself against expressing this hostility through her passivity and encouraged his accusations against her for her premarital affair out of her masochistic need for degradation. His accusations were a result of the threat he felt from his latent homosexuality. Concurrent therapy helped Mr. C feel more adequate and have less need for the obsessive accusations and Mrs. C have less need for the guiltiness. The unhealthy interaction was alleviated without destroying the marital balance as each member's neurotic patterns were dealt with.

With Mr. and Mrs. B there was a more healthy balance
of needs. Mr. E's dependency needs were met by his wife who had a need to give before she could receive. The balance was upset when Mrs. E's dependency needs increased and she was no longer able to give as much after her mother's death. Both suffered from the disequilibrium and needed psychiatric help. While the pattern of interaction before the illness was not completely satisfactory to either, it served to meet their needs.

The narcissistic needs of both Mr. and Mrs. I made the marital interaction unstable. The children of the marriage represented the parents' own need fulfillment. The caseworker reports Mrs. I's feelings toward her eighteen months old daughter:

Mr. I thinks of J as herself. She wants her to be perfect. She doesn't want her to be whiny. She wants her to be independent and not dependent as she is.

Mrs. I was depressed over her second pregnancy as she felt ugly and thought her husband would feel her burdensome if she had another child. She feared losing him. Mr. I was described as taking more of an interest in his daughter as she grew older and could respond to him more. He had a need to have his wife pregnant as proof of his male adequacy. Thus, the neurotic needs of each tempered the family interaction.

There was a fairly stable balance in the H family befor
Mr. H's illness. Mrs. H accepted the financial responsibilities of the household and accepted her husband's alcoholism with little complaint. She leaned on her oldest son to help her in management of the family and looked to her children for affection and emotional support. Mr. H's operation for lung cancer followed by Mrs. H's menopausal symptoms threatened his precariously maintained feelings of adequacy and he reacted with paranoid accusations and threats. This made Mrs. H withdraw out of fear and turn even more to her children. Mr. H's insecurity and jealousy impaired all the family relationships. Although Mrs. H had talked of the marriage as never being "very good, with Mr. H always suspicious, quiet and drinking a lot," there was what appeared to be a fairly stable adjustment until change was brought about by the patient's illness.

With treatment there was a shift in the role functioning of the patient. This was particularly true in the cases in which the patient's inadequacy and lack of sexual interest in his wife was a presenting problem. This had been defined as a problem in the marital interaction of five of the couples. The shift in roles was evidenced in the following quotations from the record of Mrs. D

When they were first married, he was not interested in her sexually. She would show him affection and he would brush her off. At first she thought something was wrong with her, but gradually she decided it was not right for a husband to be so disinterested in his wife.
Later in treatment Mrs. D reported:

Now Mr. D shows her more attention sexually. He is less passive generally and shows anger more readily. Before she was spoiled by his passivity and she is not sure how to take his show of anger. She still does not feel free in showing him affection since she was hurt so often and is afraid of being hurt again. She feels more secure when he is the one who makes the advances. She is very much afraid of becoming pregnant as she has had three children in four years of marriage.

Mrs. D was not sure how to react to her husband's changed behavior as it necessitated some adjustment in her reaction to him and reevaluation of her own needs and wishes.

In all the situations communication between family members was impaired by the patient's illness. Generally there was some fear on the part of the wives over the effect of their freely expressed emotions on the sick member. There was especially an inhibition of the expression of anger or resentment. This lack of freeness of expression added to whatever difficulty had been present previously in the marriage in communication. Inability to communicate was a problem in the relationship of Mr. and Mrs. F. Neither felt the other would listen, or at the most any attempt to talk things over would cause an argument. Consequently, neither made any attempt to discuss differences, but acted on the assumption of the other's ill feeling. Mrs. F stated to her worker:

I feel we are not communicating. I don't know what to talk about with him and I want to avoid disagreeableness. I told my mother
I just don't have "rapport" with Mr. F. I cannot be spontaneous and any talk is forced.

The difficulty over discussing problems such as the management of finances which was symbolic of the pattern of their interaction carried over to block any free flow of sharing.

Mrs. K was also unable to communicate satisfactorily with her husband. The lack of communication carried with it a less hostile tone than that of the F family. Mrs. K's comments early in casework are reported by the worker:

She talked of the marriage not having been too happy. She felt she never was able to be close to her husband, that he seemed to shut himself up in his own world and was so intent on maintaining a facade of whatever he felt should be that he never was able to let go with anyone. She felt consequently he had few friends although many acquaintances. When she mentioned this to him on several occasions during the past years, that he had no time for the family, and she thought it was just as important as his work, he would say that he is doing all he can and that he is pulled in all directions.

After several months of therapy, Mrs. K said:

She said her husband was talking back now when things bothered him. Before he was silent and walked away. She denied any feeling over his talking back. He was expressing more anger and criticized her more. She felt guilty over showing anger to him and described an incident when he expressed anger, but she could not.

Therapy in both of these examples did help the husband and wife become more communicative about their feelings, and there resulted an improvement in the relationship.
In some situations the children were important in the maintenance of the family balance. There was an increased dependency upon the older children in the family with Mrs. K, Mrs. H, and Mrs. B as they gained less support from their husbands. A change in the family composition caused an increase in the symptomatic behavior for Mr. A, Mr. G and Mr. J. Mr. A and Mr. J became sicker with their wives' pregnancies as they were threatened in having to compete with the child to have their own dependency needs met. Mr. G became sick when his oldest son left for the service and his wife and youngest son were away on vacation. This, and a recent loss of an important relationship with his boss as he was displaced in the business by his boss's son, reactivated past conflicts over his own father-son relationship. Both Mr. and Mrs. B became dependent upon the oldest son to the extent of calling him home on an emergency leave from the service. The son and parents carefully protected the youngest son from the effects of the illness and family disequilibrium by encouraging him to stay away from home.

In all the cases the casework relationship was important in providing the wife the support she needed to maintain the family equilibrium. The wife's own dependency needs had to be recognized along with the tax upon her in taking on added responsibility because of her husband's incapacity. She needed help in understanding and accepting the illness
and changes in behavior. Because these women all had their own problems of adjustment each needed help with her personal problems before she could respond in a more harmonious way in the family relationships.
CHAPTER V
SUMMARY AND CONCLUSIONS

The purpose of this study was to investigate the problems and concerns brought to the casework interview by the wives of patients in psychiatric treatment on an out-patient basis. The study was focused upon the patterns of family interaction as they are affected by the patient's illness and treatment. The following questions were formulated. What are the problems and concerns of wives of psychiatric patients as revealed in casework? What are the effects of the patient's illness and treatment on family relationships as these are revealed in casework? An attempt was made to evaluate the wife's concept of illness and treatment as her attitudes and understanding of each was thought to be important factors in her reactions.

A study was made of the case records of eleven wives seen in social service while their husbands were seen concurrently by psychiatrists on an out-patient basis. Supplementary data were obtained through the use of psychiatric records and evaluations on the work with the husbands. Nine of the wives were referred to social service at the outset of treatment by Intake Conference, Ward Rounds or the patient's psychiatrist. The other two were referred later in treatment.
by the patient's doctor for help with depression during pregnancy. Casework with all of the wives was focused upon the problems the wives brought to the interviews. The wife was considered the primary client and not merely a subsidiary to the patient's treatment, although many of the referrals were made as part of an evaluation of the patient's environment or to help the wife be more supportive to the patient.

All the patients were treated on an out-patient basis. Five were hospitalized at some time during therapy on the ward and one patient was referred to a state hospital after some months of treatment. Of the five treated solely on an out-patient basis, one was seen also by the social service department of the clinic. The patients were referred from the following sources: four from social agencies, three from physicians, two from M.M.H. clinics, one from Boston University Counseling service, and one was self-referred. The clinic's affiliation with Boston University and the position of two of the doctors with the hospital made most of the referrals intra-institutional ones. Symptoms of depression, anxiety and somatic complaints were characteristic of the study group. This is in accord with the type of patients for which the clinic is established. Only one of the patients at the time of the study was institutionalized in a state mental hospital. The rest were ambulatory or had received temporary hospitalization on the open ward of the hospital.
Treatment of the wife was concurrent with that of the husband. The length of treatment for the patients was from six months to seven years. Seven of the eleven cases were ongoing at the time of the study so that the length of treatment could not be ascertained. Four had terminated. Two of these were referred elsewhere, one terminated in mutual agreement with the doctor and one broke treatment.

The personal and social background material indicated several interesting trends. The patients ranged in age from eighteen to fifty-three years and the wives from seventeen to forty-eight. All the wives were younger than their husbands. Five of the wives were under thirty and four of these brought conflicts over pregnancy and management of children to casework. Five of the wives were over forty and four of these used casework to discuss concerns over menopausal symptoms. Three of the patients were in the twenty to thirty age range and all were students. Six of the patients were over forty. The stresses typical to the time of life of the patients and wives were important factors in the illnesses and in the problems of family interaction.

Of the eleven cases, one was Negro and ten were white. There were five mixed marriages, two Protestant, two Jewish, one Catholic and one of unknown faith. Race and religion were discussed in many of the situations, but in none were they issues of concern in and of themselves.
In only seven families were the educational levels of both patient and wife known. In five of these the wife exceeded the husband in educational achievement. This disadvantage in educational status seemed to increase feelings of inadequacy for the patient and was a source of marital conflict in that competition seemed to center around educational achievement.

The same principle was true in the occupational status of patients and wives. Gainful occupation seemed symbolic of adequacy in the culturally defined role of the male's support of the family. Incapacity in occupation on the part of the patient forced him to be dependent upon the wife for the financial support of the family. This demand upon her and dependency was a source of family conflict. Three of the patients were unable to work because of the illness. Two patients were students and the rest continued to work with only minor interruptions because of illness. Five of the wives did not work at all outside the home. Two worked out of necessity to support the family, one increased work to pay bills arising from the patient's symptomatic gambling and one supported the family through A.D.C.

All the families existed as independent units. All but one had children. Nine of the eleven had children living at home. Four families had new babies while in treatment. Four had children under age six, two had children in the six
to twelve age group and four had children in the twelve to eighteen age group. The most problems in management were brought in by the pregnant mothers and by mothers of adolescent children. Three of the families with children over eighteen or married leaned heavily upon the children for psychological support in time of sickness. The length of the marriages at time of the woman's referral to social service ranged from zero months to twenty-eight years. Five of the couples were married over twenty years, one from twenty to thirty years, three from one to five years and two under one year.

The areas of family interaction were studied in terms of five concerns typical to the casework situation in work with the wife. They were finances, occupation, social relationships, sexual adjustment and parental responsibility.

Four of the families were under severe financial distress due to the patient's incapacity to work. In two of these families the wives were helped to get financial assistance, in one the wife went to work and in the other the husband returned to work. The wife of a chronic gambler was faced with high debts as a result of her husband's illness. Financial distress caused friction in the marital interaction as there was conflict over the reversal of roles. Occupational status was closely related to financial status as it was the patient's inability to work which caused financial
distress. Five of the families which were not particularly in financial distress used the occupation of the patient as a point of conflict. The patient's occupational choice had important meaning to the wife and the patient's feelings of adequacy were related to success on the job. Therefore much emphasis was laid on the patient's occupation and the effect of this upon the family relationships was important.

There was some inhibition in social relationships outside the home for both husband and wife. The patient, because of his illness, tended to withdraw from social relationships. The wives generally limited themselves in social life. Five stated that they decreased their social contacts because of the husband's illness, giving as reasons their embarrassment over the patient's behavior and over the fact of his illness and a concern that social contacts involving the patient would have a bad effect upon him. The patient's withdrawal from social relations was limiting to the wife in that it forced her to socialize alone. Two of the wives complained of having to do things alone while one felt left out of her husband's social group. Two discussed their own feelings of inadequacy in social relationships.

The sexual adjustment for these couples was perhaps the most outstanding problem. Eight of the wives emphasized the sexual adjustment as a core problem in the marriage. Three complained of the husband's lack of interest in them
sexually and three discussed their own feelings over their premarital sexual relations. For two of the patients, the presenting symptoms were obsessive ideas about their wives' infidelity. The preponderance of poor sexual adjustment in marriage is correlated with the fact that most of the patients had some problems in their masculine identification and over feelings of inadequacy.

Generally the major parental responsibility for management of the children was accepted by the wife. In five of the cases there were some problems over management. Four of the wives were helped with their pregnancies and four used casework help to discuss the management of children as it became a point of conflict in the husband-wife relationship.

The wife's understanding of the illness influenced her responses to the patient and the degree to which she could adjust to the demands made of her. There was a general tendency to seek a concrete explanation of the illness. Five of the wives sought this in the family history of the patient. Their past experience with mental illness, either in their own families or in the families of their husbands, influenced their understanding of and attitude toward the illness. The wives tended not to perceive symptomatic behavior as part of the illness. Seven of them felt their husbands could do better if they wanted to. There was a general inability to accept dysfunctional behavior which affected the wife directly.
Nine of the wives complained of their own frustrated needs. There was freely expressed resentment over the patient's behavior in all but one situation and in all cases there was depression over the illness. In three cases there was a good deal of ambivalence over possible hospitalization with the wish to be freed from the responsibility and burden of caring for the husband at home. All the wives evidenced some sympathy for the patient and a desire to help him. All expressed some apprehension over the effects of their behavior upon the husband and a fear that the expression of negative feelings would make him worse.

As there was difficulty in understanding the illness, there was similar difficulty in understanding treatment. There was a tendency to seek concrete methods of treatment and a mistrust over the ambiguous psychotherapy. There was a push for improvement which led the wives to seek some concrete sign of improvement. The slowness of change was difficult to accept especially where it was in an area of importance to the wife in her need gratification. All the wives expressed a desire for their husbands to receive treatment although there was evidenced some ambivalence over the patient's relationship with the therapist.

The personality patterns of the patients reflected passive dependency involving some hostility and feelings of inadequacy. Four of the patients were clinically diagnosed
as "hostile-dependent," two evidenced sadistic tendencies, three had some castration anxieties and two were in conflict over latent homosexuality. The wives presented a more heterogeneous group. There was some complementarity in the needs of husbands and wives which provided some satisfactions in the neurotic interactions. Three of the wives with dependent husbands were described as having a need to control. With the precipitation of illness, the neurotic balance in these marriages was threatened. However in only one case did the couple actually separate and this was after treatment was terminated.

With five of the couples there was a fairly well-defined neurotic interaction with gratification of the neurotic needs of both. There was some shift in role functioning due to the illness and treatment in all of the cases. The shifts in patterns of family interaction were most apparent in the areas of financial responsibility and of sexual adjustment. The financial responsibility was taken over in four cases by the wives. Two of these wives found some gratification in this position of financial dominance, but all expressed some negative feelings. In five cases in which the patient had conflict over his masculine adequacy he was helped through treatment to be less passive. This change in behavior resulted in some need for adjustment on the part of the wife.
Communication within the family was impaired as a result of the patient's illness. The wives generally were inhibited in freely expressing themselves. The patients were less able to share in the marital relationship because of their preoccupation with their symptoms and because of their withdrawal from a sharing relationship. The lack of communication increased marital discord.

The children of the families were discussed as they were important in the interaction of husband and wife, as they represented special concerns to the wife or as they were persons upon whom patient and wife looked for psychological support. In three cases there was a great deal of dependency by the wife on older children. A change in family composition due to the birth of children was of particular importance both to the patients and wives. In two cases the patient's symptoms increased with the wife's pregnancy and in one the pregnancy was an important indication of the patient's masculinity. For all of the wives the pregnancy brought on depression as their increased dependency needs were not met by their husbands.

The casework relationship was important in all of the situations. For some of the wives this was the only source of psychological support in dealing with the added stresses of the illness. The fact that all the wives had some difficulty in understanding and accepting the illness indicates a
need for help. The shift in family responsibility in role function was a source of conflict within the family and for the wife. She needed help in this and the help she received aided her in maintaining the family equilibrium.

Although the results of this study are limited by the size of the sample and the nature of the case records, some understanding of the effects of the illness of one family member upon the other members of the family unit has been derived. As was suggested by the Koos study, one effect of the stress of illness upon the family was a shift in the dominance patterns. There was a shift in the responsibilities of financial management and support as the patients could not function as efficiently in their roles of financial mainstay. This shift in financial responsibility and occupational status emphasized the patient's dependency and the wife's position of dominance. Another problem area in which a shift in the usual role patterns aroused anxiety was that of sexual adjustment.

The importance of complementarity in role interaction with the satisfactory need fulfillment of both parties was substantiated by the study. The wives used the casework interviews to air their complaints against their husbands and their own frustrations, in that demands were made of them and their needs were not met. When the wife was met with stress within herself, as during pregnancy or menopause, this
imbalance became critical. She used the casework relationship to gain some support and gratification. Casework support enabled her to give more in the husband-wife relationship.

The impact of illness threatened the precariously maintained family equilibrium, especially in the case of severe neurotic interaction. A diagnostic understanding of the wife's gratification was important if progress was to be made and the family equilibrium maintained as concurrent change was brought about in both partners.

An outstanding finding was the wife's inability to perceive the patient's behavior as symptomatic of his illness. This is in accord with the findings of the St. Elizabeth's study in which it was found that the wives were slow to perceive threatening behavior or misinterpreted it. Each of the wives showed a great deal of anxiety over the patient's sickness. This was evidenced in their search for concrete reasons for the illness or its causation in the patient's childhood history. Also many of the wives pushed for signs of improvement and tended to feel that the husband could be better if he wanted to be. Most of the wives feared the effect of their behavior upon the patient and inhibited themselves. These apprehensions in themselves are indications for systematic casework services for family members.

The time perspective of the illness affected the wife's reaction to the husband's behavior. Again the degree of
threat carried with the symptomatic behavior influenced the amount of anxiety and the wife's response. If the illness occurred during a time of stress for her, as after the loss of a love object, during sickness, pregnancy, or menopause, she seemed less able to accept it and needed more help. Also her past experiences with mental illness and what these experiences meant to her affected her understanding of the illness and reaction to it.

Systematic casework with family members is indicated by this study for several reasons. It provides a means for the fuller understanding of the patient's environment and family relationships. It offers the family members the necessary support to deal with the patient in a therapeutic way. The wife's anxiety and depression make her needful of casework help to dispell some of her apprehensions and to gain a more realistic understanding of illness and treatment. She needs help to focus more on the positives of the situation and to find gratification for her own needs. Practical services as vocational counseling are important as they alleviate some of the stress by helping the wife take some concrete action on her problems. In some cases the wife herself was in need of treatment and change in her neurotic patterns both so that she might be more comfortable and so that her neurotic needs would not complicate the patient's progress. Casework services can be thought of as both a curative and
preventive measure when offered the relatives of psychiatric patients.
APPENDIX A: SCHEDULE

<table>
<thead>
<tr>
<th>Case Number</th>
<th>O.P.D. Number</th>
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</table>

I. Personal and Social Background
   A. Patient - Name
      Occupation
      Age
      Religion
      School Level
   B. Wife - Name
      Occupation
      Age
      Religion
      School Level
   C. Children
      Age
      School Level or
      Occupation

II. Clinical Diagnostic Material
   A. Patient's Referral for Psychiatric Treatment
      Date of Referral
      Source
      Reason for Referral
      Diagnosis
      Treatment
      By
      Frequency
      Length
      Termination
      Date
      Reason
   B. Wife's Referral to Social Service
      Date
      Source
      Reason for Referral
      Treatment
      By
      Frequency
      Length
      Termination
      Date
      Reason

III. Case Material
   A. Impressions of Personalities of Family Members
      1. Husband
      2. Wife
      3. Children
   B. Problem Areas Discussed
      1. Financial
      2. Occupational
      3. Social
      4. Sexual
      5. Parental Responsibility
      6. Other
   C. The Patient's Illness
      1. Wife's Attitude Toward and Understanding of
         Patient's Behavior
      2. Wife's Attitude Toward and Understanding of
         Treatment
D. Family Relationships
1. Husband-Wife
   Before Illness
   Due to Illness
   During Treatment
2. Mother-Child
   Before Illness
   Due to Illness
   During Treatment
3. Father-Child
   Before Illness
   Due to Illness
   During Treatment
4. Child-Child
   Before Illness
   Due to Illness
   During Treatment

E. Other Uses of Casework
# APPENDIX B

## TABLE 10

<table>
<thead>
<tr>
<th>Family</th>
<th>Age</th>
<th>Educational Level</th>
<th>Occupation</th>
<th>Ages of Children</th>
<th>Areas of Concern</th>
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<tbody>
<tr>
<td>Patient A</td>
<td>18</td>
<td>grade 9-12</td>
<td>unemployed</td>
<td>none **</td>
<td>*finances, *occupation, *sex, social, *parental responsibility</td>
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<tr>
<td>Wife</td>
<td>17</td>
<td>grade 9-12</td>
<td>unemployed</td>
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<td>Patient B</td>
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<td>14 yrs.</td>
<td>*finances, *occupation, social</td>
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<td>47</td>
<td>unknown clerk</td>
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<td></td>
<td></td>
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<tr>
<td>Patient C</td>
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<td>college, no degree</td>
<td>student</td>
<td>none</td>
<td>occupation, social, *sexual</td>
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<tr>
<td>Wife</td>
<td>24</td>
<td>graduate training</td>
<td>teacher</td>
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<td></td>
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<tr>
<td>Patient D</td>
<td>30+</td>
<td>grade 9-12</td>
<td>office worker</td>
<td>3 and 2 yrs.**</td>
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<tr>
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<td>23</td>
<td>completed H.S.</td>
<td>unemployed</td>
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<td>unknown salesman</td>
<td>salesman</td>
<td>10 yrs.</td>
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<td>unknown</td>
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<td>Wife</td>
<td>39</td>
<td>advanced, no degree</td>
<td>practical nurse</td>
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<td></td>
</tr>
<tr>
<td>Family</td>
<td>Age</td>
<td>Educational level</td>
<td>Occupation</td>
<td>Ages of Children</td>
<td>Areas of Concern</td>
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<td>------------------</td>
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<tr>
<td>Patient G</td>
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<td>unemployed</td>
<td>21 and 18 yrs.</td>
<td>*finances, *occupation, *social, parental responsibility</td>
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<td>unknown</td>
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<td>Patient H</td>
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<td>unknown</td>
<td>manual labor</td>
<td>12, 16 yrs, 3 yrs, 3 over 18</td>
<td>*sexual, parental responsibility</td>
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<td>Wife</td>
<td>47</td>
<td>unknown</td>
<td>factory work</td>
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<td>Patient I</td>
<td>26</td>
<td>graduate training</td>
<td>actor</td>
<td>18 mos.</td>
<td>*occupation, social, *sexual, parental responsibility</td>
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<tr>
<td>Wife</td>
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<td>graduate training</td>
<td>teacher</td>
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<td></td>
</tr>
<tr>
<td>Patient J</td>
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<td>college, no degree</td>
<td>student</td>
<td>3 yrs.**</td>
<td>occupation, social, sexual, *parental responsibility</td>
</tr>
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<td>completed h.s.</td>
<td>secretary</td>
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<tr>
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<td>professional over 18 yrs.</td>
<td>occupation, *social</td>
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<td>college graduate</td>
<td>unemployed</td>
<td></td>
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</tr>
</tbody>
</table>

* Areas of Major concern to the wife

**Child born during treatment
BIBLIOGRAPHY

Books:


Articles:


