1950

A study of the paternal attitudes of veterans in treatment at the Veterans Administration Mental Hygiene Clinic, Boston, Massachusetts in 1948

King, Barbara Fullerton

Boston University

http://hdl.handle.net/2144/4748

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A STUDY OF THE PATERNAL ATTITUDES OF VETERANS IN TREATMENT AT THE VETERANS ADMINISTRATION MENTAL HYGIENE CLINIC, BOSTON, MASSACHUSETTS IN 1948.

A Thesis

Submitted by
Barbara Fullerton King
(A.B., Colby College, 1947)

In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service
1950
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CHAPTER I
INTRODUCTION

The area of paternal attitudes has until recently been neglected by the case worker. This is particularly true in family case work agencies and child guidance clinics where the focus for contribution to the child's problem has historically been upon the mother's attitude. Children are certainly influenced greatly by their mothers' attitudes toward them, but the father's role in the child's development had been rather generally minimized until this factor recently assumed increased importance.

Actually, although the father is usually out of the home a good part of the child's day, his attitude is of vital importance to the child. On the one hand, a negative attitude may impede the child's oedipal solution, while on the other hand, a positive attitude may serve as a stimulus for his growth and development. Although in a cross-section of civilian fathers there is likely to be a vast range of paternal attitudes, in a group of veterans with neuropsychiatric disabilities, a relatively large percentage of negative attitudes might be expected.

As has been widely recognized, the neurotic veteran's adjustment to civilian life has been fraught with problems. Most common among veteran patients is their feeling of alienation from civilian groups such as the community and the family. Neurotic veterans feel particularly isolated: they identify neither with
soldiers nor with civilians. They feel unappreciated, rejected, exploited, and insecure. They are bitter and many rationalize their hostility in criticism of individuals, social groups, and the government.¹

The Veterans Administration was quick to mobilize to meet the special treatment problem of the 475,397 men who were medically separated from the armed forces for psychiatric disability and the large number of men "without a military record of psychiatric difficulties who would need treatment for problems brought to light or precipitated by the stresses of readjustment to civilian life."²

In 1948, there were forty-seven mental hygiene clinics under the Medical Department of the Veterans Administration set up to serve the veterans with neuropsychiatric disorders, who constituted forty per cent of all medically discharged servicemen.³ Such facilities were established to "alleviate minor neuropsychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization."⁴ A preventive program of

this kind has far-reaching implications in the area of the patient's family relationships, for, with the focus on keeping the patient out of the hospitals, the strain on the family will be great. If the veteran was married, as so many were, shortly before or during the war, there is the problem of the wife's acceptance into her life of a stranger. Not only is he a stranger but a stranger who will require the kind of understanding she may be ill-equipped to give. Similar acceptance will be required of the mother, siblings, and children of the psychiatric casualty.

Although much has been written on the subject of the work adjustment of the disabled veteran in respect to the Veterans Administration rehabilitation program, the family adjustment has apparently been for the most part, delegated to a minor focus in psychiatric treatment. There are, however, many children with emotional disturbances resulting from separation from one or both parents during the war years. It might be said that the return of a neurotic or psychotic father would, in some cases, be even more traumatic to the child than the separation itself.

This study will attempt to show the predominant paternal attitudes of a random sample of veterans who sought treatment for their neuropsychiatric disability at the Veterans Administration Mental Hygiene Unit, Boston, Massachusetts (hence to be designated as the Clinic), during the year, 1948. It is
hoped that such a case study will emphasize the potential effect of such an illness upon the children of veterans with psychiatric problems.

Many of the neurotic patients at the Clinic are diagnosed passive-dependent or passive-aggressive in their personality structure. Therefore, it was the writer's expectation that most of the patients in this study would have an attitude toward their children expressive of their general emotional problems. This study is not concerned with the actual effects of such attitudes in terms of the child's behavior, but is intended only as an initial research in this area.

The writer recognizes the limited scope of the study in that a random sample of one year of the Clinic's operation was arbitrarily selected. Another limitation is recognized in that, in most cases, the patient's adjustment has been the major treatment focus rather than the specific problem resulting from his attitude toward his children. This accounts for the dearth of material on paternal attitudes in some of the records. The criteria for selection for this study are also a limitation in that the group is not of the Clinic as a whole but only of those cases assigned to social workers.

For the purpose of obtaining adequate material for this study it was necessary that the cases be selected from the entire listing of those seen at intake during the year, 1948, and who had since been discharged from treatment. Further
criteria for selection for this study were marital status, assignment to case workers for treatment, and the presence of children in the family. A superficial criterion was also set up so that only those cases seen for at least three interviews were included. This latter seemed essential after preliminary investigation of the cases meeting only the other criteria did not yield enough material upon which to base a significant classification.

Out of the 1021 cases which came into the Clinic in 1948 and have since been discharged, 283 cases were treated by psychiatric case workers. The small percentage of such cases is due to the fact that many of the 1021 cases were rejected at intake. Of these 283 cases, seventy-three cases were selected for this study after the criteria were applied. From these, twenty-five cases were selected by taking every third case from the list of cases meeting the requirements of the study. It was felt that a sample of somewhat in excess of one third of the whole would adequately represent the material.

To facilitate classification of the paternal attitudes of these twenty-five patients, an attitude scale was set up. This is included in the schedule which can be found in the Appendix. The statistical data pertinent to the paternal attitudes were also collected on this schedule and may be found in the tables which are a part of this text.

The data for this study were obtained from the records of
the Mental Hygiene Unit, Veterans Administration, Boston, Massachusetts. The case illustrations have been summarized and disguised in order to protect the confidentiality of the material.
CHAPTER II
DESCRIPTION OF THE MENTAL HYGIENE UNIT

The Mental Hygiene Unit of the Veterans Administration was established in Boston on March 18, 1946. This clinic, originally staffed by one psychiatrist, one psychologist, and two psychiatric social workers, has grown rapidly to include a staff of eight full-time psychiatrists, ten part-time psychiatrists, seven resident psychiatrists, six full-time psychologists, ten psychiatric social workers, and also five psychology graduate students, four medical students, and eight students in social work. There is also a branch clinic, established recently in Lowell, Massachusetts, consisting of two psychiatrists, one psychologist, and three psychiatric social workers. This vast growth is indicative of the increasing recognition of the value of and need for psychiatric treatment, even now, five years after the cessation of World War II. As of this month, almost ten thousand veterans have already been seen at the Clinic.

Treatment at the Clinic is primarily based upon the official Veterans Administration policy as stated in the Medical Director's Letter:

The purpose of the Clinic will be to assist the patient through personal interviews, supplemented by the selective use of resources within the family and the community to adapt himself to his environment and its stresses, to relieve his anxieties, and integrate conflicting feelings and tendencies.
in his personality: to improve the quality of his relationships with others and afford him an opportunity to know and understand himself better.¹

This treatment may be assigned to any one of the three disciplines represented in the Clinic team at intake: that is, to the psychiatrist or social worker for individual treatment or to the psychologist for group therapy.

The intake process has undergone, since 1946, many changes in the search for the most effective means of assignment of cases and the most efficient means of accepting and rejecting the applicant. In 1948, the year used for this study, intake was a dual process with the social worker and psychiatrist both participating. It was the social worker's function to interview the patient to obtain a brief history of the patient's illness, his motivation in seeking treatment, the source of referral, legal eligibility, and identifying data. The psychiatrist then interviewed the patient for diagnostic survey, to evaluate treatability, and to recommend a course of treatment.

Assignment to one of the three disciplines is apparently based on flexible principles. To the social worker are assigned the patients who are chronically neurotic, psychotics in remission, pre-psychotics, character disorders, and other types of patients who will require long term, supportive

¹. Charles M. Griffith, Veterans Administration Medical Director's Letter, September 17, 1945, (unpublished).
treatment. The psychiatrist treats those patients who present unconscious material which must be dealt with, those with acute conflicts, and the more emotionally disturbed patients. The psychologist uses group therapy with those patients who cannot accept individual treatment and those in individual treatment who will benefit from the group experience as a supplement. The patients, then, are assigned to a psychiatrist for psychotherapy, a social worker for case work, a psychologist for psychometric testing or group therapy, or any combination of these, either at intake or at some point during treatment.

As a training center for medical students, psychology graduate students, and social work students, the Clinic's educational facilities are wide in scope. Students of all three disciplines have regular supervision and psychiatric consultation, in addition to staff meetings and seminars.

The Clinic, then, as a model unit, is contributing valuable experience in organization, policy, research, and standards of treatment to the many public and private psychiatric clinics which are springing up all over the country.
CHAPTER III
DESCRIPTION OF THE PATIENTS AS A WHOLE

As further introduction to the findings of this study, it is indicated that some explanation be given as to the type of patient who comes to the Mental Hygiene Clinic for treatment. Valenstein states that it "is the opinion of the professional staff that most of these veterans are ill in a chronic, deep-seated manner." It has been noted that many of the patients adjusted well to the regimented service experience but found upon their discharge that the more flexible civilian existence was overpowering: it could be considered to represent the repetition of the adolescent conflict involved in the process of emancipation. The veteran finds, however, that he can no longer assume the partially dependent role of the adolescent but is considered by his family to be a man with increased responsibility. This situation often creates considerable anxiety.

The tightening of social mores, parental rejection or oversolicitude, the "battle of the sexes", the needs of dependent wives or children, and economic insecurity have flushed into the open the many compulsive type of individuals who...required no psychiatric attention while in the service.2

Under the stress of combat, or even the stress of being forcibly removed from their homes, many men whose ego strengths

were not strong enough to cope with the service experience, regressed to an infantile level. As has been reported, the combat soldier's expectations of home become more unrealistic as the "neurotic and regressive" reasons for his desire to go home increase.

Actually the return home to a "brave new world" is fantasied as a rebirth after the personal psychological death symbolized by repetitive combat missions. ³

As his desires were unrealistic, the discharged veteran is in a disturbed state of mind when he finds himself among the civilians who constitute his social and family group. Then, again, in addition to his disappointment, the veteran's conflicts are reactivated in this home setting where they originated. However well he had defended such conflicts prior to the service experience, he is likely unable to cope with them after his ego has been weakened during the stress of combat.

Since it has been mentioned that a large number of passive-dependent and passive-aggressive veterans seek treatment at the Clinic, it would be advisable to investigate this group as regards etiological factors. Such patients demonstrate that:

The need to be loved, emotionally supported and cared for creates strong drives for satisfaction which are usually frustrated because such great quantities of passive gratification are rarely attainable by an adult in real life. Hence con-

flict rages between intense desire and frustrating reality. On the other hand, portions of the patient's self-respecting ego may not permit direct or sufficient gratification of his childlike need for love and care, in which case an intrapsychic conflict is developed... We have found that the stress of combat is responsible for considerable regression in previously mature men as well as immature boys. Some were far more emotionally dependent than their chronological ages justified, to the degree that they were abnormally attached to home, mother, father, or their substitutes. It is to these boys that we may attach with justification the appellation of passive-dependent characters prior to combat, and we could have predicted that many would in some degree react adversely to the stress of combat.4

In the same way, the patient who displays passive-aggression is functioning on an infantile level where his dependent needs were met and is overcompensating for this passivity by expressing "false masculinity" in aggressive and hostile behavior.

With this brief description of personality types, the writer will now give a picture of the diagnostic groups most frequently treated at the Clinic. The majority of patients who seek treatment at the Clinic are diagnosed as psychoneurotic. Pratt discusses psychoneurotic disorders in the following statement:

It is... a loosely-used term but includes those suffering with anxiety states, either acute or chronic; those with psychosomatic disorders (functional conditions that reproduce symptoms suggestive of disease of some physical organ without that organ's actually being damaged); those with obsessive thoughts or compulsive actions; and those with nu-

It is agreed within the psychiatric profession generally that, except for the acute war neuroses, the veteran with a psychoneurotic disorder presents the same dynamic problems as does the civilian who develops a neurosis. Often, the neurosis is considered to be the patient's defense against a psychotic break. In such cases, treatment with brief psychotherapy can only attempt to alleviate the immediate discomfort and improve the patient's adjustment to his immediate situation.

Dr. Adler's study of the Clinic after three months of operation disclosed that 58 per cent of the patients were diagnosed as psychoneurotic, while 7 per cent were diagnosed as character and behavior disorders. (The other categories were negligible). As shown by Table I, sixteen, or 64 per cent of the sample used in this study had some form of psycho-neurosis. The character and behavior disorders totaled seven, or twenty-eight per cent. One patient was diagnosed under the heading of transient personality reaction to acute or special stress, and one was diagnosed under psychosis with associated organic changes in the central nervous system. Thus, this sample of patients seeking treatment at the Clinic two years after its establishment were not markedly different by diag-

5. George Pratt, Soldier to Civilian, p. 105.
Table I

Diagnoses of Patients in Study*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient personality reaction to acute or special stress</td>
<td>1</td>
</tr>
<tr>
<td>Psychoneurotic disorders</td>
<td></td>
</tr>
<tr>
<td>Anxiety reaction</td>
<td>7</td>
</tr>
<tr>
<td>Conversion reaction</td>
<td>2</td>
</tr>
<tr>
<td>Somatization reaction</td>
<td>3</td>
</tr>
<tr>
<td>Hypochondriacal reaction</td>
<td>1</td>
</tr>
<tr>
<td>Neurotic depressive reaction</td>
<td>3</td>
</tr>
<tr>
<td>Character and Behavior disorders</td>
<td></td>
</tr>
<tr>
<td>Emotional instability reaction</td>
<td>1</td>
</tr>
<tr>
<td>Passive dependency reaction</td>
<td>1</td>
</tr>
<tr>
<td>Passive aggressive reaction</td>
<td>4</td>
</tr>
<tr>
<td>Aggressive reaction</td>
<td>1</td>
</tr>
<tr>
<td>Psychosis with associated organic changes in the central nervous system</td>
<td>1</td>
</tr>
</tbody>
</table>

*For the purpose of this table, psychosis without organic etiology, epilepsy, disorders of intelligence, and pathological behavior reaction are omitted.
nosis from those seen at the Clinic during its first three months of operation. It should be noted, however, that the percentage of character and behavior disorders in this group was considerably larger than that of the first Clinic group.

Due to the variations in diagnostic classifications used by the different psychiatrists at the Clinic, it has been the writer's observation that many of the patients diagnosed under one of the psychoneurotic categories were also classified as having a disposition of passive-dependency or passive-aggression. This would indicate a reason for the fact that there was considerable overlapping between character and behavior disorders and psychoneurosis. In many cases, the psychiatrist's diagnosis was one of the neurotic reactions superimposed upon a character disorder. The increase in the applications of the more deep-seated psychiatric disorders would be expected as more of them became incapacitated by their disability.

Resistance, as in many psychiatric clinics, is one of the chief factors which, even after the patient has made the initial move toward treatment by coming to the Clinic, influences a large percentage of broken contacts. (In the Clinic, cases are usually closed after the patient has broken two appointments). A reason for the perhaps more extensive resistance on the part of veterans, as opposed to civilians, is their close contact with companions in the service who suffered from
acute neurotic or psychotic episodes: also the attitude stressed frequently by the officers in the service that such men "couldn't take it". A connotation of weakness which such a diagnosis carried in the service setting is brought by the veteran into his civilian life and constitutes a factor which, in itself, builds resistance.

In addition to the element of resistance to seeking treatment, it can be assumed that many of the veterans with weak personality structures have probably functioned on a marginal level for many years: only some crisis such as the loss of one of the important emotional supports in their lives would lead them to seek treatment. These supports are very often mothers, or wives who are mother surrogates, and any form of rejection by these figures is a most traumatic crisis in the lives of such patients. Thus such veterans may require long-term emotional support from the case worker.

With this diagnostic background, further data about the patients in this study will give a general picture of the factors other than their attitudes toward their children which will influence the children. The first of these would be the patient's marital status. It has been established that one of the causes of behavior problems in children is separation from one parent, be it through death, divorce, or separation. Table II shows that most of the patients are living with their wives despite their apparent difficulties.
TABLE II
MARITAL STATUS

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>20</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

This large percentage of patients living with their wives is significant to this study since it indicates that the majority of these patients were a direct influence on their children. A third factor which may enter the picture is that of religious affiliation, for religious beliefs do influence family life. There is a predominance of members of the Catholic faith in the group of patients studied. (see Table III).

TABLE III
RELIGIOUS AFFILIATION

<table>
<thead>
<tr>
<th>Religion</th>
<th>No. of Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>18</td>
<td>72.0</td>
</tr>
<tr>
<td>Protestant</td>
<td>6</td>
<td>24.0</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
This table shows the distribution of the patients' religious affiliations. Although there is, in the data, no indication of the reasons for the predominance of married status or Catholic religion, these factors will bias this study to a minor extent. It can be assumed that since there is a predominance of Catholics in this population area there would be a similar religious grouping among these patients. This may influence the factor of marital status for there would be less divorces in a predominantly Catholic group.

The age of the patient is also an influence upon the children. The very young veteran and the middle-aged veteran could logically be expected to have more difficulty in adjusting from a dependent role in the service to the role of the family breadwinner and father. (see Table IV).

**TABLE IV**

**AGE OF THE PATIENTS**

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>2</td>
</tr>
<tr>
<td>25-29</td>
<td>9</td>
</tr>
<tr>
<td>30-34</td>
<td>8</td>
</tr>
<tr>
<td>35-39</td>
<td>2</td>
</tr>
<tr>
<td>40-44</td>
<td>1</td>
</tr>
<tr>
<td>45-49</td>
<td>1</td>
</tr>
<tr>
<td>50-54</td>
<td>1</td>
</tr>
</tbody>
</table>
Although Table IV shows some predominance among the group from twenty-five to twenty-nine, which could be considered young if about three years are subtracted for the years spent in the service, the age factor is not of any marked significance for the study.

Dependent somewhat upon the degree of the patient's disability, is a fourth factor: that of the number of children in the family. To an inadequate father it is quite likely that each additional child as his family increases might be considered a progressively heavy burden. As one of the patients in the study stated in discussing the approaching birth of his third child, "this hellish situation will be much worse when the next one comes...those kids will have to work for what they get like I did." This statement, if atypical, is certainly an expression of the problem facing a great many patients with psychiatric diagnoses whether they be veteran or civilian. The number of children could be a definite influence in the paternal attitude of such patients. (see Table V).

|TABLE V| NUMBER OF CHILDREN |
|---|---|---|
|No. of Children | No. of Patients | Percentages |
|1 | 12 | 48.0 |
|2 | 7 | 28.0 |
|3 | 3 | 12.0 |
|4 | 2 | 8.0 |
|5 | 1 | 4.0 |
|Total | 25 | 100.0 |
This table shows that twelve, or 48 per cent of the patients studied had only one child; seven, or twenty-eight per cent of the patients had two children; three, or twelve per cent had three children; two, or eight per cent had four children; one, or four per cent had five children. The average number of children, then, for this group of patients was 1.9 which is slightly below the national average number of children per family in the country as a whole. The number of children in a particular patient's family will influence not only the patient's attitude toward the children but the actual amount of attention the individual child is able to receive.

It is well-known that an only child can be handicapped to a certain extent by the lack of the experience of a close relationship to another child rather than an all-adult orientation. The only child often develops a selfish, demanding personality and learns early the methods of playing one parent against the other to achieve his ends. This type of mechanism, of course, has dire implications for his future life unless the parents are sincerely interested in the child and handle him intelligently. Such conditions might not exist when the child has a father with a psychiatric disorder which limits the extent to which he can take a firm father role with the child. Since Table V indicates a predominance of only children, the above-described situation may apply in many cases.

It may also be true that the child who is a part of a fam-
ily of more than two children may suffer from lack of attention, particularly if his parents are immature and have negative attitudes. "Each additional child coming into the family introduces a changed psychological as well as physical situation in the family circle." For the child of a large family, the return of a neurotic or psychotic father would also be traumatic, for such a family is dependent upon the father not only for economic security but for integration of the family unit.

Along this same line, a father's attitude would be, in most cases, more positive toward the children resulting from his own marriage than if the children he is supporting are either his wife's by a previous marriage or his wife's illegitimate children. This would apply to a perhaps lesser degree in the instance where the patient's marriage was forced by his responsibility for the wife's pregnancy. In the latter case, there would probably be some feelings of guilt in connection with the child which would influence the patient's attitude toward him. The data on this factor is to be found in Table VI. As is shown by Table VI, there are two children listed as illegitimate, two children whose fathers stated that they were conceived prior to the marriage, and one adopted child. The remainder of the children of the patients included

Table VI

Parentage of Patients' Children

<table>
<thead>
<tr>
<th>Patient</th>
<th>Present Wife's Marriage</th>
<th>Forced Previous Marriage</th>
<th>Adopted Previous Marriage</th>
<th>Illegitimate Marriage</th>
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<tbody>
<tr>
<td>Pt. A</td>
<td>2</td>
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<tr>
<td>Pt. B</td>
<td>3</td>
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<tr>
<td>Pt. C</td>
<td>2</td>
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<td>Pt. D</td>
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</table>

In this study were results of the patient's present marriage. Thus this factor will not bias this study to any great extent.

Because of the limited scope of this study, the writer has not investigated thoroughly the obviously important factor of the patient's attitude toward his own parents and siblings. It is to be expected that the patient would repeat in his marriage many of the patterns established in response to his original family constellation. This is demonstrably true of
the passive-dependent patient, with a close attachment to his own mother, who, in his marriage, seeks a mother substitute and competes with his children for her affection and attention. (see case of patient P.) Where there is marked neglect in the patient's early life, often the patient rejects his own children as his dependent strivings were not met and because of this, he is not sufficiently mature to take on a giving role with his children. Sometimes such a father will be overprotective of the children out of his complete identification with them and their desires. It might be said, then, that if a man has not reached an adequate heterosexual adjustment by the time he raises his family or if a veteran has, under the stress of war, regressed to an infantile level of development, he will very likely be an inadequate father with negative attitudes toward his children.

With this general picture of the patients studied, it is appropriate that the findings in the area of the paternal attitudes be presented briefly. This will be developed in detail in Chapter IV. Here it will suffice to indicate the predominance of certain attitudes.

For the purpose of this study, the term, attitude, can be defined as "a continuing predisposition to react in a characteristic manner toward a given type of person." This definition is self-explanatory as it applies to the paternal at-
titudes of the Clinic patients.

The writer has classified the material from each patient's record into seven categories: rejection, indifference, over-protection, ambivalence, rivalry, normal parental affection, and no attitude elicited. It was felt that these categories were sufficient to give a significant indication of the most frequent attitudes as found in this group. As an aid to classification, the attitudes were designated in the following manner:

1) Rejection: father shows little or no interest in the children.
2) Indifference: father accepts the financial responsibility for the children but shows no affection for them.
3) Overprotection: father oversolicitous toward the children.
4) Ambivalence: father shows mixed feelings for the children.
5) Rivalry: father competes with the children for their mother as a sibling.
6) Normal parental attitude: father loves and takes adult responsibility for the children.
7) No attitude toward the children elicited: problem exclusive of patient's attitude toward the children or case work focus entirely on other problems.

On application of this attitude scale, it was discovered that the predominant attitude among the patients studied was that of rivalry. It is interesting to note that this one attitude was twice as great in frequency as the next largest frequency, with eleven, or forty-four per cent of the patients
showing rivalry toward their children. The next largest category, ambivalence, had five, or twenty per cent of the patients. Rejection was next in frequency with four, or sixteen per cent of the study group. Normal parental affection, the only positive attitude included, was represented by only two, or eight per cent of the group. Indifference and overprotection were least common, with one patient in each category: four per cent of the patients were indifferent and four per cent of them were overprotective of their children. There was one case in which no attitude was suggested in the case material. Each of these attitudes will be discussed fully in Chapter IV, and case illustrations will be presented for the major categories as shown by the frequencies demonstrated in Table VII.

<table>
<thead>
<tr>
<th>Attitude*</th>
<th>No. of Patients</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Rejection</td>
<td>4</td>
<td>16.0</td>
</tr>
<tr>
<td>Indifference</td>
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</tr>
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<td>Overprotection</td>
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</tr>
<tr>
<td>Ambivalence</td>
<td>5</td>
<td>20.0</td>
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<tr>
<td>Rivalry</td>
<td>11</td>
<td>44.0</td>
</tr>
<tr>
<td>Normal parental affection</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>No attitude elicited</td>
<td>1</td>
<td>4.0</td>
</tr>
</tbody>
</table>

*As used in the attitude scale of the schedule

In a relatively small number of cases it is significant that there was such a large percentage of cases in which ri-
valry was the patient's major attitude toward his children. This bears out the statement made earlier that with character and behavior disorders a major diagnostic category at the Clinic, children would probably be subjected to negative attitudes. This would, of course, also be true of psychoneurotic reactions in which a certain amount of regression would be present. When regression is present or the patient has a character disorder, the patient will in all probability relate to his spouse in a dependent role so that it would follow that the addition of children will be a threat to the satisfaction of his dependency needs. The bulk of the patients of this study group have rivalry, rejection, or ambivalence as paternal attitudes, a total of nineteen cases being so classified. Since these three classifications are the most actively negative reactions used by the writer in this study, it is interesting that the greater part of the study group entertained these attitudes. It must be noted that these negative attitudes overlap considerably and are discussed, not as the only attitude present, but as the more pronounced attitude in each paternal relationship.
CHAPTER IV
THE PATERNAL ATTITUDES
(WITH) CASE ILLUSTRATIONS

The parent-child relationship is one of the most determinitive interpersonal relationships in respect to the child's mental health. It is out of this relationship that many of the child's difficulties arise. The attitude of the parents toward the child, their way of handling, caring for and training him, their general attitude toward life and people, and the way in which the child's environment meets his instinctive and developmental needs are the many sources of his emotional experience. Early emotional security is highly essential in the personality development of the child.¹

Since ninety-two per cent of the patients in this study had a negative attitude toward their children, while only eight per cent of the patients had apparently positive, healthy attitudes, it is evident that a great many of these children will be handicapped in their personality development. To illustrate this, the parental attitude of the study will now be discussed with case illustrations.

1. Rejection

The concept that all parents love their children through instinct has been proven to be unsubstantiated in fact. There is a vast range of parental attitudes from the parent who really loves his child to the parent who really only hates his child. "Over-strict parents whose attitude to the child is one of rejection actually hate the child more than they love

¹ Arthur Noyes, Modern Clinical Psychiatry, p. 496.
This rejection by one or both parents is undoubtedly one of the trauma inherent in many parental attitudes which may cause severe character and behavior disorders. Surely during infancy and early childhood, a child needs a great deal of love, affection, and security if he is to meet the world in later life as a mature, well-adjusted adult. Catastrophically, the rejected child receives none of these in his family environment, and unfortunately, the rejected child is not an oddity in our society.

From the time he awakens in the morning until he goes to bed at night, he is nagged, scolded, and frequently slapped. His attempts at conversation are received with curt, cold silence or he is told to be quiet. If he attempts to show any demonstration of affection, he is pushed away and told not to bother his parents. He receives no praise for anything he does no matter how well he has done it. If he walks with his parents and lags a little, his arm is seized and he is yanked forward. If he falls he is yanked to his feet. He is supposed to be seen and not heard. At mealtime he is either ignored or his table manners and inconsequential food fads are criticized severely. He is made to finish whatever is on his plate....The child soon realizes that he can expect nothing but a hurt body or hurt feelings from his parents.3

This rather dramatic picture of the rejected child leaves the reader with little doubt as to the reasons for runaways or other delinquencies, for the small child feels that his parents are the prototype of all adults. Another reaction to rejection may be that the child, on being punished for his

rebellion, withdraws from any action which may incur his parents' anger. He soon learns that submission and repression are the only paths open to him. He has not found the solution to his problem by mobilizing these defenses, however, as he is then filled with terror lest his parents uncover his hostile thoughts. These, too, must be repressed. Although this is the child's only solution, it solves nothing: instead this leads to a possible source of neurosis.

In an atmosphere of complete rejection, the child may "develop anxiety, resistance to discipline, reactive aggressions, and other neurotic forms of behavior that express his hostility and his deviated search for love." He may, on the other hand, find that illness will achieve for him some of the attention and concern of which he has been deprived in health. These, then, are some of the possible effects of rejection.

More specific are the psychological effects of a father's rejection of his son. During the Oedipal situation, the boy becomes antagonistic toward his father as he works through his desire for his mother. If the father dislikes the boy, he will return this antagonism. The father, however, is stronger and the boy is forced into submission. He finds this submission gets him some attention and he gets satisfaction from this. This pattern gradually "produces a feminine orientation to his father" instead of leading the boy to identify with the fa-

4 Arthur Noyes, Modern Clinical Psychiatry, p. 495.
ther's masculine traits. There may also be repressed ideas of revenge with which the boy may react toward his son as his father did toward him.

Why does a parent reject his child? Ignorance may excuse some few acts which, to the child, represent rejection, but the majority of parents with rejection as an attitude toward their children have conflicts, conscious or unconscious, which prevent them from feeling love for the child. Very often, it is not actually "this child that the parent rejects but the child has touched off his feeling of being unloved by his own parents, his own immaturity and emotional instability."

The neuropsychiatrically disabled veteran returning from service finds a child who is a stranger to him as he has, in many cases, been away from home during months or years of the child's development. In such cases, he may feel as one patient said, "like I was interrupting the proceedings." Again, his child may have been born too soon after his return, before he has made the adjustment requisite of a loving father. An insecure father is seldom capable of mature love for his child. These factors, in addition to the conflicts inherent in the disabled veteran's illness, make rejection a common pattern.

In this study, there were four patients with attitudes of rejection toward their children. Although there may have been

a degree of rejection in more of the patients, the writer chose only those cases in which rejection was pronounced and the attitude well-established.

**Case Illustrations**

Two cases have been selected to illustrate the attitude of rejection as it has been discussed in this chapter. This selection was not made on the basis of typicalness but rather on the basis of somewhat exaggerated dynamics, in order better to demonstrate the causative factors in an attitude of rejection. All case material has been disguised to protect the confidentiality of the Clinic records.

Patient 0. came to the Clinic, self-referred, on 11-5-48, complaining of confusion, insomnia, drinking problems, and irritability. He requested hospitalization. The intake doctor diagnosed him as Character and Behavior Disorder, immature, passive-aggressive reaction, manifested by irritability, demands, unemployment with chronic job dissatisfaction, and marital separation. The patient had a thirty per cent pension for his nervous condition. Since he presented several tangible requests such as relief and hospitalization, case work therapy was recommended.

Patient 0. was a twenty-six year old white, married veteran who described himself as "lost", unable to decide what to do about a divorce from his wife. He had been hospitalized recently for drainage of his pilodial cyst and had requested psychiatric treatment. The hospital had diagnosed, emotional instability reaction.

The patient was the oldest of ten siblings. His mother died in 1943 while the patient was in service. This death was particularly traumatic as the patient and his mother were "very close". Patient's father remarried shortly after the mother's death. The stepmother tells people that the patient is shell-shocked and makes life unbearable for the
patient so he does not live at home.

Patient O. served as a private in the Army, having enlisted at the age of nineteen years, in 1942. He was discharged via medical survey in 1944. The patient spent thirteen months in combat.

This man was unemployed. He explained this on the basis that he was unable to hold jobs because of the severity of his headaches. His last employment was six months ago when he worked for a few weeks as a painter. He has applied for a cab driver's license but was turned down.

There is a history of minor delinquencies (larceny, and three assault and battery charges) from the age of seventeen but no sentence was served.

Patient O.'s wife had charged him with assault and battery. She considered patient "psycho" and "won't give him a chance". She likes to run around. At the time when the patient was seen, the wife was living in W. with her father. Patient's marriage had been forced by the wife's pregnancy. Patient is suspicious that his wife has been unfaithful to him and questions the paternity of the children. He also is suspicious of the relationship between the wife and her father. Wife's mother and sister have been in a state mental hospital for several years. Wife is diabetic.

The patient's two children, a girl thirteen months old and a boy of two years, are boarded with a public welfare agency. Patient has "no feeling" for the children. He does not visit, nor does his wife. He feels the homes are "a good place for them...maybe they will learn how to behave." These children are "supposedly" his, but he "doubts it".

This patient was seen for three interviews by a social worker. The patient then broke treatment and was discharged, unimproved. It was felt that due to the irregularity of patient's keeping appointments and the history of delinquency in addition to the nature of his character disorder, the patient was not amenable to treatment on an out-patient basis. He was later hospitalized.
This case demonstrates clearly an attitude of complete rejection. It is also clear that Patient O. is incapable of forming any relationships with either men or women and this element alone would indicate that if such a man had children they would be rejected. The patient's overattachment to his mother and her death give a picture of an unsolved Oedipal situation: this patient's wife too was not the mother substitute he needed, but rather, an ill person who had to be dependent on the patient. Unable to face this total situation, Patient O. was forced to escape into a hospital where he could be taken care of. Rejection of the children, even to refusing to accept paternity, was the patient's escape from the responsibility of a family. It may have been also his unconscious revenge upon his own parents for what he felt to be rejection.

**Patient D.**

Patient D. was referred to the Clinic by the VA rehabilitation division on 10-7-48. He complained of headaches, irritability, "blows his top". Patient had been hospitalized for malaria and kidney trouble while in the service. Diagnosis at intake was passive aggressive reaction. Patient had a ten per cent nervous disability. Case work was recommended.

This is a 28-year-old married Protestant veteran who was using a strong aggressive behavior as a defense against homosexual panic. He showed a pattern of rejection by women.

The patient states that his home was "as good as anyone else's." His mother, however, drank excessively. Patient feels parents didn't understand him. He was cared for but often they had difficulty in getting enough to eat. Patient can't remember "much about his childhood". He resents that
his father never told him about the "facts of life." The family had a history of many contacts with SPCC. At present, the patient has nothing to do with his parents, has nothing against them, but they "mean nothing to him". Patient would not even consider attending their funerals if they died.

Patient D. is the second oldest of nine siblings. He feels that these siblings gang up on him. If he tries to ask his mother for the money he thinks she stole from him while he was in service, they are against him. If he tries to give his mother money, she uses it for drink and they blame him anyway. One brother is a policeman, another is in the Navy, and a third is in high school. He has one older sister and two at home (the rest of the nine he did not account for).

The patient married shortly after the death of his fiancée when he "didn't give a damn about anything". He doesn't love his wife. She is Catholic and "dumb". He states that his wife was ignorant about sex when they were married so was frigid for the first year. Patient likes to "raise hell" whereas his wife likes to go visiting. The patient refuses to sit around and talk. If she gets mad at him, he's mad; if she doesn't get mad at him, he's mad. Sometimes he feels sorry for her with so many children. When the patient is drunk he frequently wants to kill his wife. He hits her and then is sorry and ashamed. His wife had him arrested for assault and battery. He is on probation.

The patient has two children, a girl two years old, and a boy eleven months old. Patient feels that the children tie them down, are too much trouble. He expresses fear of hurting the baby which is expected soon. "This hellish situation will be a lot worse when the next one comes." Patient believes in giving nothing to his children, "they'll have to work for what they get like I did."

This patient was seen for nineteen hours by the social worker. Treatment was focused on the expression of hostility toward authority and women. During treatment the patient was able to express aggression here and controlled it in relation to
his wife although he still worried about his aggression toward the baby. He was discharged, improved on 6-16-49.

This patient evidently had never experienced warmth, security, or affection and anticipated rejection each time he let himself become fond of anyone. Even his fiancee had rejected him by dying. He was unable, therefore, to form a satisfactory marital relationship with his wife who evidently did not plan to leave him. All of his aggressive impulses which he was unable to express during his youth, are acted out now that he has found some security in his marital relationship. This aggression he can express more securely toward the children from whom he need expect no retribution. He can give nothing to the children as he feels he received nothing in his childhood.

2. Ambivalence

As there were five cases of ambivalent attitudes toward the children which is a sizeable number in a study of twenty-five patients, this concept will now be discussed.

It is a universal experience to harbor many conflicting interests, desires, and emotions. This concept of ambivalence is one of the most fundamental to the dynamics of psychiatric case work treatment. Parents who have an ambivalent attitude toward their children, experience "an emotional state of feeling both love and hate toward a person at the same

time". A certain amount of ambivalence in the attitudes of parents toward their children is to be expected for it is true that children impose a great deal of responsibility upon their parents. Even though parents have wanted a child over a long period of time, the baby's actual arrival does create some conflicting feelings, for a child takes up a great deal of his parents' time, energy, and resources. In addition, either or both parents may have unsolved conflicts in relation to their past family relationships which will be transferred to the child in some degree. Although some ambivalence exists in all relationships, usually the negative part is repressed. The child is quick to pick up any hint of negative feelings by those on whom he must depend, however, and herein lie the dangers to normal development.

Ambivalence can be the basis for rejection when the parent's emotions are so conflicting that the negative part of the ambivalence becomes more powerful than the positive. (This attitude has already been discussed.) An element of ambivalence in a parental attitude can, in itself, create difficulties for the child. As has been widely publicized, consistency of parental management is an aid to the child's development. In families where the parents are ambivalent, there will be periods when the child is loved and periods when the child is hated; the parent will act accordingly. This causes

the child's confusion as to what he may expect as a response to his actions from his parents. Whereas on one occasion he is punished severely for imitating his father, on another occasion he may receive an affectionate response. This baffles the child so that he may not be able to distinguish between acceptable and unacceptable behavior. In other words, development of the superego would likely be hampered by such a parental attitude.

The father who has bragged about his baby to his fellow servicemen, displaying his snapshots and giving a daily account of what the baby may be doing, returns home to find that this child who has provided him with so much prestige in the service, makes him quite nervous when he cries all night. The practical aspects of being a parent, may be a cause of ambivalence, as any parent who is absent from the home and builds up fantasies around the child has mixed feelings when he returns to the real child. This will be particularly true of the veterans who developed psychiatric disabilities during the war.

Case Illustrations

The paternal attitude of ambivalence is a marked focus in the first case to be presented and a minor point in the second case.

Patient T. was referred to the Clinic by the VA Medical out-patient department on 10-22-48. He complained of headache, insomnia, irritability, and back pain. Diagnosis by the intake doctor was Pas-
Sive-Aggressive Reaction, manifested by the above-listed symptoms. He had been hospitalized in a VA hospital for two years where he had been diagnosed psychotic and suicidal. The patient had a fifty per cent disability for psychoneurosis. Psychotherapy with a psychiatrist was recommended.

This thirty-five-year-old, divorced, Catholic veteran was seen by a social worker and showed hostile, aggressive behavior. He was seclusive, lived alone, and had only a marginal social adjustment. He was resistant to treatment on the basis of his fear of hospitalization.

The patient was the oldest of eight siblings. He had never gotten along with his brothers, there being constant fights between them. The patient also expressed hostility toward his mother. Patient T. was unable to give much background information other than that he had been separated from his wife for fifteen years and divorced for eight years. He greatly resented having half his pension go to her for the support of their son as he felt she had never "given him a break." He saw no reason why he should contribute to her support now as she earns a substantial salary herself. The patient has had no direct contact with his ex-wife for several years.

The patient served for thirty-four months in the Army, some of this time being spent overseas. He was hospitalized overseas for jaundice.

He has been employed as a shipping clerk since his discharge in 1945 and since this is a rather solitary job where his employer is accepting of the patient's limitations, the patient is fairly secure in his employment situation.

Periodically on the request of his parents, the patient has moved home. Each time, however, there is so much friction that he returns to a rooming house. He knows his mother and father worry about him and goes to visit them frequently. Although the patient denied any disinterest on the part of his family, both the mother and sister refused appointments with the worker to discuss plans for the patient.
The patient has a son seventeen years old. His feeling for the boy is mainly positive and he spoke with pride of the various ways the boy had identified with him. However, during the first few interviews he spoke consistently of his resentment at having to support the boy and that "the boy only comes when he wants something."

Although this patient was discharged unimproved, after almost a year of irregular interviews with the social worker, the discharge was on the basis that treatment was creating too much anxiety for the patient to bear. He had used the worker's permission to be a father to his son, however, as he began taking an active interest in the boy. The patient attended the boy's graduation, took him to shows and seemed pleased with the new role.

This patient was hospitalized shortly after his Clinic contact and diagnosed, schizophrenic reaction.

This is a case which shows a very disturbed patient who had been unable to form any relationships but who did show some positive feelings for his son which he could not demonstrate to the boy. His attitude of ambivalence toward the son had evidently been more positive at one time, but he had transferred some of the resentment he felt toward his wife to his son. This resentment stemmed from her initial refusal to give him love, and then her demand that he contribute to her support. With the help of the worker, he was able to sort out and accept his positive feelings for the boy.

Patient S.

Patient S. was referred to the Clinic by a Red Cross worker on 1-29-48. He complained of diarrhea, irritability, and pains in the back, shoulders, and left leg. He was unemployed and had been receiving financial assistance from the Red Cross. Diagnosis at intake was psychoneurosis,
somatization reaction, with a background of passive-aggressive character disorder. The patient was receiving thirty per cent disability pension for his nervous condition. Case work was recommended.

Patient S. was a thirty-one-year-old, married, Catholic veteran who seemed to project all his difficulties on the environment and gave a history of a passive dependent personality.

The patient was the oldest of five siblings. He described his parents as being very happily married as his mother was "all for" his father. They never argued. His father demanded respect, was strict, but gave the children "everything". Patient S. stated that he got along well with his father but argued with his mother.

Patient S. described his brothers as "good" boys who studied hard and "behaved". He considered himself the only source of trouble to his parents as he was rebellious. At present, the patient's father would not speak to him as he disapproved of the patient's recent divorce.

The patient graduated from high school at the age of eighteen. He was on the honor roll. He was employed at the ship yards following this.

Patient S. spent three-and-a-half years in the Navy. He was overseas part of this time and served as an interpreter of Italian. He was discharged following a short period of hospitalization in 1946.

Patient S. was married in 1941 to a woman he describes as a "good kid, the kind one wants for a wife." She was a good housekeeper and budgeter, an inspiration to the patient to work. However, they did not get along. The patient blamed this on his mother-in-law who was opposed to the marriage and upon whom his wife was "dependent." The couple was divorced shortly before the patient came to the Clinic. There was a daughter, five years old, who lives with the mother.

The patient had been living on his pension for some time. He had refused several jobs because he did not like the work. Noise bothered him. Even before the service he had a spotty work rec-
ord. He had entered college but quit after less than a year. He had been unemployed for sixteen months before coming to the Clinic.

Patient S. expressed a desire to obtain employment out of state but was in conflict about going as it would mean he could not see his daughter. He had been supporting her and visiting once a week. He resented this as he would like to see her "all the time". However, he "probably couldn't see her anyway." The daughter lived with the wife and she was in the process of moving into her mother's home. The patient refused to visit there. He spoke with considerable affection for the daughter but at the same time speaks of his irritation with her when she misbehaves.

This patient was seen for thirteen hours by a social worker. As the interviews proceeded, he gained some insight into his passive-dependent behavior. He went out and secured employment as a painter. As soon as he began work, his symptoms began to disappear. The patient was able to speak of mistakes he had made and poor judgment he had shown in the past. He began to show parental concern for his daughter's welfare. As he requested discharge from treatment, he was discharged, improved, on 5-27-48.

This case shows the patient's ambivalence toward his entire situation. That is, he wanted to leave town but he found it difficult to actually make such a plan. He would like to see his child all the time but "probably couldn't see her anyway." He was ambivalent about his employment situation. A deep dependency conflict seemed to be at the base of his ambivalence toward his child; he has not worked out his emancipation from his mother and therefore he is in conflict in his relationship with his daughter.

3. Rivalry

There were eleven cases in this group of patients whose
attitudes toward their children were of rivalry. As this term is defined on the attitude scale (see Appendix) it applies to a competitive relationship with the child for the wife and mother.

Rivalry, of course, is commonly considered to be a potent force as it refers to the reactions between siblings. The birth of a new baby will always arouse the hostility of the older child toward what he considers an intrusion. The older child reacts often very dramatically to this change in his circumstances which will demand that he share his parents' affection with another child. This, to him, means serious deprivation and he is jealous of the newcomer. His behavior will show this as he will either attempt to injure the baby or will profess love for the baby and attack a playmate. Accompanying this reaction there will be some hostile behavior toward the parents who are, in reality, giving the new baby a great deal more attention than the older child. He may refuse to conform to his usual routines or he may use various other attention-getting devices to detract his parents' attention from the baby. The older child can also be expected to present behavior problems at school particularly in relation to his schoolmates toward whom he may be actively aggressive.

All of these problems may occur at the birth of the new baby. If, however, the home is secure and the parental attitudes favorable, the child will work out normal attitudes to-
ward sibling rivalry before he reaches adolescence. His competition will be channeled into broader areas such as sports and school marks.

Although the topic under discussion is paternal rivalry with the children, the above remarks apply to a great extent.

When a married couple become parents, a new psychological situation develops between the two members, for practically every couple carry into their marriage earlier conceptions and hopes concerning parenthood. A change in attitude of both may even date from the moment conception becomes known. The situation calls for rearrangement of affection and love...Ordinarily both parents are quite ready to relinquish a generous portion of affection in favor of the newcomer and make real sacrifices. In pathological cases where the father unconsciously still prefers to continue in a former role of son...the deprivation of a portion of the devotion is not well borne.10

The father who is rivalrous of his children, is a most immature person who can only be compared to a small child. An immature parent is as "insecure, unloved, and overcompetitive as a child, married without working through his or her problems may be in fierce competition". This sort of paternal attitude can be traumatic to the child, for instead of having a father, the child is forced to grow up with a sibling who may sometimes act like a father. As has been pointed out earlier, a child needs a secure, reasonably mature father in or-

der to develop normally. A father's function is not to compete with the child for the wife and mother, but "to impersonate for the growing infant the restrictive demands inherent in the code of every civilized society." He is depriving the child of a father and causing considerable conflict in the relationship.

Case Illustrations

Since the attitude of rivalry was represented by sixty-four per cent of the patients in the study group, three cases will be presented as illustrative of the group.

Patient P.

Patient P. was referred to the Clinic on 8-6-48 by VA Medical out-patient department. His complaints were numbness, pain in the left arm, occasional heart pain, and general nervousness. He was receiving a twenty per cent pension for a gunshot wound and "nerve pain" in his hand and arm. Diagnosis at intake was Conversion Reaction in a passive-dependent personality. Case work was recommended.

This fifty-two-year-old, World War I married veteran presented a life long pattern of being unable to express anger except in bodily symptoms.

Patient P. was an only child. His father died when the patient was one year old. The mother supported the maternal uncle and grandfather in addition to the patient on her salary of nine dollars a week. She was employed as a compositor on a newspaper. The mother is now living on an old age pension. The patient is "attached" to her and "frets about her" if he leaves town for a day. He contributes small amounts toward her support.

The patient has been married twice. He blames the first wife for his job and financial difficulties. He feels he should have broken off with her before he did but his mother "wouldn't let him."

Patient P. has been married to his present wife for three years. He describes her as a good housekeeper. She discourages him by throwing his failures up at him. She used to be suspicious of him but this is no longer a problem. She is younger than he but has "the same tastes."

The patient has a two-months-old baby. In his discussion of the child his concern is mainly centered on the hospital bill rather than the baby. He complains that since the birth of the baby his wife does not show him as much affection. She resents his overtures and takes for granted that he will bring her breakfast in bed. The patient feels his wife is completely absorbed in the care of the baby and he feels "pushed out."

Patient P. is a painter by trade. He has always worked in the north during the summer and in the south during the winter. Ordinarily he receives good pay but last winter could not go south because of his wife's pregnancy and delivery. As a result, the patient is in debt. Many problems worry him. He worked on a part time job which aggravated him and made him more nervous.

A treatment plan was carried out with this patient which included acceptance and help in ventilating his feelings in the case work situation. After a short time, the patient was able to accept clarification and saw how his behavior and suppressed hostile reactions and worries over dependency brought on physical symptoms. He was discharged, improved, after ten hours of treatment by the case worker.

This patient demonstrates the extreme rivalry which must be the paternal attitude of a man who has such deepseated personality problems. In this case the major problem is passive dependency. This patient has never experienced a rival for his mother's affection. Consequently, when his baby appears,
he is upset. He has always depended heavily upon his mother and his two successive wives and now during his middle age for the first time he must compete. This situation will doubtless be very difficult for the child for he will have a middle-aged sibling as a rival.

Patient A.

Patient A. was referred to the Clinic by the VA adjudication division on 3-15-48. He had been hospitalized for four months for his nervous condition. He was diagnosed Anxiety Reaction manifested by many dependent needs. Case work was recommended.

The patient is a twenty-five-year-old married Catholic veteran whose major problem is around his marriage and financial difficulties. He gives an indication of being constitutionally unable to accept responsibility.

Patient A. shows considerable hostility toward his mother. He was brought up by the mother after the separation of the parents when the patient was very young. He lived with her until his marriage. Patient sees his father occasionally and considers him "a good guy". He enlisted in the Navy at the age of seventeen, serving almost four years as an electrician's helper.

The patient has one sister who is younger than he. Patient is hostile to her, considers her foolish as she "runs around in cars with men she hardly knows." There are many arguments between the two siblings as the patient feels his sister considers herself superior to him.

The patient's chief complaints are in regard of his wife who insists the patient stay home but complains of patient's pallor from staying in the house. Patient A. blames his wife for getting sick. She has cancer of the ovaries according to the patient and is consequently frigid sexually. She shames him in front of company for his nail-biting, which is embarrassing to him. The patient states that he gives her everything "if
not more" and still she doesn't appreciate him. He repeatedly spoke of the responsibility being "too much for him."

The patient has two children, girls, three years and thirteen months old. Patient A. finds himself irritable with the children and often, when they bother him, he slaps them. He knows this is not right, but cannot control himself. Both children have been ill as well as the wife and the patient speaks a great deal about the many medical bills he must pay. While the children were ill the patient's wife had to spend most of her time caring for them and had no time to care for the patient. He has tried to help in the children's care but his wife doesn't appreciate anything he does for them.

This patient broke treatment after three interviews with the social worker and was discharged, unimproved.

This case shows a younger patient who was hostile toward his mother and yet married a woman who was also a dominating mother to him. The children deprived him of any satisfaction of his dependency strivings and their arrival, in addition to his wife's illness, precipitated a severe anxiety attack. Clearly, he was unable to stand up under all the responsibility which his situation demanded of him. As is true of most dependent fathers, he blamed his wife for his illness. This was probably his reaction to her rejection of him by having children to take his place.

Patient L.

Patient L. was referred to the Clinic on 4-5-48 by VA Medical out-patient department. His complaints were poor hearing and gastro-intestinal difficulties. Diagnosis at intake was somatization reaction. He was assigned to case work.
This is a twenty-two-year-old married, Catholic veteran who appeared to be a dependent person with many concerns about his marital maladjustment and financial difficulties. He had served four years in the Navy.

The patient's mother died when the patient was four years old. He and his father had to "shift for themselves". His father remarried when the patient was twelve and patient never got along with his step-mother. He describes her as bossy, not at all motherly, very strict. As a result, the patient was late to school, did poor work, etc. He was punished for this by the step-mother with extra work around the house. He lived for a short time with his grandparents where "everything was fine." Patient finally joined the CCC on his father's suggestion. He felt rejected and hostile to his father.

The patient did not present much material about his wife except to express considerable guilt that he had been cheating on her. He had caught himself "just in time". He describes her as being highstrung and says that she feels badly when the patient "doesn't feel well." He cannot understand why he began running around with a fast crowd but feels he got out before he really hurt his wife.

The patient has two children, a girl two-and-a-half years and a boy, six months. He is unable to express his resentment of them except to say that there is not enough room in their house for them and the children. As they live in a large apartment this statement was not based on fact. He also states that perhaps the reason he was running around was because his wife was busy all the time with the children and had little time for the patient.

This patient was seen for five treatment hours with the social worker. During treatment he gained enough insight into the emotional nature of his illness so that he was able to settle his situational difficulties. He was discharged, improved, on 8-17-48.

This patient's reaction to his children is very similar to that of Patient A. in that the responsibility of having a
wife and children to support was a heavy burden. This, in addition to the fact that neither patient A. nor patient L. were getting the satisfaction of their dependent needs that they had expected from their wives. The dynamics of this case differ, however, in that patient L. had never had a mother and had considered himself rejected by his father. This adds to the difficulty he would have in being a father to his children, as he no doubt felt he must compete with the children. This patient had no siblings so that this was a new experience for him. In addition to the major attitude of rivalry, this patient is also somewhat rejecting of his children, as he felt he had "no room for them" in his home. They are a threat as his wife has no time for the patient and he must seek attention from his "fast" crowd.

4. Indifference and Overprotection

Since there were so few of the patients in this group whose attitudes fell into the categories of indifference and overprotection, a description of these attitudes will suffice to complete the picture of the negative attitudes predominant among this representative group of Clinic patients.

Indifference, as designated on the schedule, refers to an attitude by which "the father accepts the children as part of the family group but shows no affection for them." This attitude is, in effect, emotional rejection of the child. (In making up the attitude scale the writer felt that a division
of rejection into complete rejection, indifference, and over-protection was indicated by the material.) Indifference, then, is acceptance of the child only insofar as financial responsibility is concerned. This attitude is perhaps less damaging to the child than complete rejection as he will at least be materially supported. However, a parent's expression of indifference toward the child indicates that the child will probably feel rejected and thus, will suffer in his personality development as does the totally rejected child. As there was only one patient in the group representing an indifferent attitude toward his children and it would be repetitious to discuss this type of rejection, it is important here merely to differentiate between indifference and complete rejection. The effect upon the children will be essentially that of rejection but the attitude itself is somewhat more mature than rejection, for the father who is indifferent does nevertheless feel responsible for the child. He also may have less conflict over his attitude toward the child as he feels he is doing his duty and is above criticism as regards his care of the child. The patient in this group who was indifferent felt that his five-year-old daughter was the one element in his family situation which kept him from running away. He apparently had no positive feelings other than a sense of responsibility toward his child.

Overprotection, as defined on the schedule, refers to
oversolicitude on the part of the father in his attitude toward his children. As has been stated, overprotection is often the result of the guilt for the unconscious hostility the parent feels toward the child. Such a parent gives in to the child's every whim, uses little or no discipline, and is constantly fearful that the child will be hurt or become ill. The patient in this group who was overprotective of his children showed a rather extreme reaction in that he was unable to leave the children with anyone other than his wife. He was meticulous in keeping the heat in his home at an even temperature fearing that the children would become ill if the heat varied as much as one degree. He refused to allow the children out during the winter time and was constantly fearful that they would contract one of the contagious diseases. This patient also was anxious and dreamed frequently that the house would burn and the children would be killed.

A child living with such a parent may become

- Selfish, demanding, undisciplined...
- anticipating constant attention, affection, and service, responding to denials of his wishes with temper outbursts or assault, is restless and completely at a loss in solitude...
- Gifted in the use of charm, wheedling, coaxing, and bullying to get his own way.\(^13\)

Such a child is thwarted in his development by the lack of mature parents. Certainly, the child with an overprotective father is greatly hampered, for, such a father would find

\(^{13}\) David Levy, *Maternal Overprotection*, p. 43.
it difficult to discipline the child in any way for fear of hurting him. The child would have a poor background upon which to base his social adjustment for his father has not represented the demands of society in imposing them on the child as preparation for social mores with which the child must comply. An overprotective father may receive recognition in his social group for being an excellent father as he never strikes the child, gives the child everything he wants, and spends much time looking out for the child's safety. In reality, he may dislike the child and be constantly fearful that his hostility will break through and he will harm the child. In such an environment, the child may have a poor chance for ego development, for his id impulses will probably be uncurbed by the parents.

5. Normal Parental Affection

As Levy states, the most "important stipulations for a wholesome parent-child relationship are emotionally mature parents who can give love freely." There must be a balance between love and discipline in the training of a child. The mature parent will be able to free the child gradually from the dependent emotional attachment to his parents, to develop his own personality. There are only two patients in this group who seemed to meet these prerequisites and who seemed to have normal affection for their children. Both of these pa-

tients were basically adequate fathers who were able to enjoy their family life and who had looked forward to raising children when they were married. Although there is no adequate definition of normal parental affection, in the cases which were classified in this category, the patients' attitudes were predominantly positive. This would indicate that these patients' love for their children outweighed their negative feelings which are present to some degree in every parent. This would mean that the children of these parents will have a chance of developing a personality which will be adequate to adjust to the crises of life.

The parent who genuinely loves his children not only gives them security, affection and a feeling of being wanted but he also has a real desire to help the child to develop into the adult who will be well-adjusted and happy. This help may often take the form of disciplinary action, but even this will be done in such a way that the child will benefit from it rather than feel abused. He will enter into activities with the child, making him feel a real part of the family. The parent who really loves his child will attempt to understand the various stages of the child's emotional life and cope with them calmly and without too much concern. This will enable the child to grow with a minimum of traumatic emotional experiences. It would be expected that the children of the two patients in this study with normal parental affection would develop without major neurotic patterns.
One brief illustration of this type of attitude will be presented.

**Patient X.**

Patient X. was a thirty-year-old married Negro veteran who was referred to the Clinic on 9-28-48. At intake, a tentative diagnosis of conversion reaction was made although there was some question of posttraumatic encephalopathy. He was referred to a case worker for help with his marital situation which was his main concern.

The patient's mother had died when the patient was two years old as a result of a condition developed during delivery of the patient. His father was a foreman on a railroad crew. He died when the patient was seven. Patient described his father as being strict and preferring the patient's brother to him.

The patient was the youngest of four children. He had a sister twenty years older than the patient who died when the patient was born. His next sister was ten years older than patient and the brother was four years older. The patient was especially fond of the sister who had "always taken care of" the patient. She had married when the patient was twelve. Patient resented her husband but grew fond of him after he had lived with them for a few years.

Patient X. has married before entering the service. Before his service experience, patient stated he was "very happily married", had a good sexual adjustment, and they "understood each other." While patient was in the service he "ran around" and his wife did also as they had agreed they would be "lonesome." Since his discharge, the wife has been unfaithful consistently. As a result of her brother's threat to kill the patient, he had left St. Louis and come East.

The patient was ambivalent about divorce although he had heard nothing from his wife in six months. She had been living with another man when patient last heard from a friend. Patient had a deep concern about his children, was asking help in decid-
ing what would be best for them and stating that he would even return to his wife if that was the only way to be with the children.

The patient had two daughters, aged five and seven. There was almost daily correspondence between the children and the patient. They expressed a desire to come to live with the patient. During treatment he decided he should get a divorce and bring the children East as he realistically felt they were not getting adequate attention with their mother. The patient stated that really their happiness was most important to him, and planned to get an apartment and "some nice woman" to care for them while he was at work.

The patient was seen for nineteen hours with the social worker and attended sixteen sessions of group therapy. As there was some organic damage of the central nervous system, treatment goals were limited. However, in the treatment situation the patient was able to set himself up in business to earn enough so that his daughters could join him. There was marked improvement in the patient's condition when the girls arrived and he requested termination of treatment. When the case was closed the patient's divorce was pending.

This patient demonstrates a predominantly normal affection for his children. He is genuinely concerned about their happiness and wants to do the best thing for them. He seems much happier when the children are living with him and although his wife's infidelity had been a serious blow to him he is able to think of what the separation would mean to his children. This patient's ego strengths are an important element in his attitude toward his children as he is handling his organic condition and employment situations most adequately.
CHAPTER V
SUMMARY AND CONCLUSIONS

The writer has attempted to determine what type of paternal attitudes are predominant among a group of twenty-five patients who were first seen at the Clinic during the year 1948. These patients were all married, all had children, and all were treated by social workers. The paternal attitudes were classified in seven categories: rejection, indifference, overprotection, ambivalence, rivalry, normal parental affection, and no attitude toward the children elicited. Factors other than the patient's attitude toward his children, which would also have significance to the development of the children or which were contributory to the paternal attitude, were also studied. These factors included the patient's diagnosis, marital status, religious affiliation, age, number of children in his family, and the parentage of the children whom the patient was supporting.

In the group included in this study, sixty-four per cent of the patients were diagnosed psychoneurotic and twenty-eight per cent were called character and behavior disorders. It was noted that these diagnostic categories overlap to a considerable extent as often there was an underlying character disorder in the patients who were diagnosed psychoneurotic. Both of these groups would show immaturity in their family relation-
ships due to the regression and fixation which may be apparent in the neurotic group and the inadequate development in the group diagnosed as character and behavior disorders. The diagnoses of the patients are an important factor in the patient's attitude toward his children since most of the group are seriously ill.

Most of the group were living with their wives at the time they sought treatment at the Clinic: only three patients were separated and two were divorced. This factor is important as an influence upon the child since the father will in most of the cases be directly reacting to the child.

Seventy-two per cent of the patients were Catholic and twenty-four per cent were Protestant, while only four per cent were Jewish. This is important only insofar as religious beliefs influence family relationships and practices around marriage.

The age factor proved to be insignificant as most of the veterans in this study were between the ages of twenty-five and thirty-five years. This age range could be considered to be neither older nor younger than the usual age for parenthood.

The next factor considered in this study was that of the number of children per patient. Fifty-eight per cent of the group had two children. The average number of children per patient was 1.9. This does not represent a pattern of large families but the significance of this factor cannot be deter-
mined, as cultural patterns and economic status would have to be considered before a statement of the greater or smaller families average to this group could be made.

Parentage of the children supported by the patient was then considered in this study. In the group of twenty-five patients, four patients were raising children who were not their own. Of these four, one had adopted a child, one was bringing up his wife's illegitimate child in addition to his own three children, one was bringing up his own child by a forced marriage and his wife's illegitimate child, and the fourth was bringing up one child who was his through a forced marriage. This factor was insignificant to the study since only four children were conceived illegitimately.

The primary focus of this study was the paternal attitudes of these veterans with psychiatric problems. The writer has demonstrated that eighty-eight per cent of the group had negative attitudes toward their children. Of these, forty-four per cent had an attitude of rivalry with their children; twenty per cent had an ambivalent attitude; sixteen per cent had rejection as an attitude; eight per cent had normal parental affection for their children; four per cent were overprotective toward their children; and in four per cent of the cases no attitude was elicited.

This high percentage of negative attitudes, particularly rivalry, ambivalence, and rejection, is an indication that the children of such veterans are likely to develop behavior prob-
lems themselves. As has been discussed, an immature, emotionally unstable father is unable to contribute constructively to the child's personality development: in such cases solution of the Oedipal situation may be blocked. Many potential problems have been cited which may arise when rivalry, ambivalence, or rejection is the paternal attitude toward the child. It has also been noted that there is considerable overlapping in the writer's application of the attitude scale among the various negative attitudes. The writer has demonstrated with case material the predominant attitude in each case although in many cases there was a combination of attitudes.

Although this study has merely indicated the paternal attitudes and implied the problems to the child implicit in such attitudes, it is hoped that a more extensive study of the other factors important to the child's development will result. It is the writer's opinion that this study alone indicates a need for more emphasis upon the family, particularly the children, of the patients who seek treatment at the Clinic. Some work is being done with the wives of patients in treatment as an adjunct to the patient's treatment. However, the writer feels that some attempt should be made by the social worker to see that the children receive treatment when it seems indicated. In the work with this group of patients, there were no referrals of children to child guidance clinics or other sources. It is the writer's opinion that, in some of the cases in this
study, further exploration by the worker in the area of the child's reactions to these negative paternal attitudes would offer to these children the type of preventive work which is being increasingly emphasized by those concerned with emotional adjustment.

Approved

Richard K. Conant
Dean
SCHEDULE

Name _______________ Branch of Service
Case Number ___ Army ___
Age ___ Navy ___
Occupation _________ Air Force ___
Religion ___________ Marines ___
Marital Status _______ Rank in Service ______
Number of Months ___
Date of Intake ______
Referral ____________
Intake Psychiatrist's Diagnosis ______
Predisposition __________
Disability __________
Psychiatrist's Recommendation ______
Date of Closing ______
Disposition at Closing __________

Family:

Parents-
Give a general picture of the patient's parents in terms of their personalities and their attitude toward the patient and their other children. Comment on the patient's feelings about his parents.

Siblings-
Give a general picture of the patient's reactions to his siblings (if any) both while the patient was at home and at the present time.
Wife-
Describe the patient's wife, his attitude toward her and her attitude toward the patient and their children.

Children-
Number of Children ____
Ages ______
Sex _______
Result of Present Marriage ____ Wife's Previous Marriage ____
Patient's Previous Marriage ____ Illegitimate ____
Forced Marriage _____ Adopted _______

Patient's Attitude Toward the Children:

A. Rejection (father shows little interest in the children)

B. Indifference (father accepts the children as part of the family group but shows no affection for them)

C. Overprotection (father over-solicitous toward the children)

D. Ambivalence (father shows mixed feelings for the children)
E. Rivalry (father competes with the children for the mother)

F. Normal Parental Affection (father loves and takes adult responsibility for the children)

G. No Attitude Toward Children Elicited (problem exclusive of patient's attitude toward his children or case work focus on other problems)

Interpretative Summary of Case:
BIBLIOGRAPHY


Mid-West Conference of Chicago Association for Child Study and
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