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A study of fifteen women at the psychosomatic clinic of the Massachusetts Memorial Hospitals referred to social service for help in finding social outlets June, 1951 to March, 1952

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF FIFTEEN WOMEN AT THE PSYCHOSOMATIC CLINIC OF THE MASSACHUSETTS MEMORIAL HOSPITALS REFERRED TO SOCIAL SERVICE FOR HELP IN FINDING SOCIAL OUTLETS

JUNE, 1951 to MARCH, 1952

A THESIS

SUBMITTED BY

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CHAPTER I.

Introduction

This thesis is a study of fifteen women under treatment in the Adult Psychosomatic Clinic at the Massachusetts Memorial Hospital in Boston, Massachusetts, who have been referred to the social service section for help in finding satisfactory social outlets. These referrals were made when either the patient expressed a desire for help in arranging for such outlets or the psychiatrict found that such outlets would ameliorate the emotional disturbance for which the patient is being treated.

The term social outlet is here used in a broad sense and covers any activity the purpose of which would be to increase the scope of the patient's interests outside of her home and/or the range of her present interpersonal relationships.

Purpose of the Study

This study will attempt to determine whether the kind of social outlet chosen was indicative of the patient's problem or whether it was an expression of another need she had.

In order to do this an attempt will be made to find answers to the following questions:

1. What social outlets did these women seek?
2. What emotional needs did these women seek to meet through these social outlets?
3. To what extent did these patients make use of these social outlets?

4. What factors contributed to the creation of these needs?

5. How did the caseworker use her awareness of these facts in making treatment plans to help the patient meet these needs?

All cases were seen by both the psychiatrist and the caseworker. Some cases were seen by both concurrently. Several are being seen by the caseworker alone in the patient's home because the patient cannot or will not come to the Clinic. The worker in these cases confers with the psychiatrist periodically. Some cases continued to be seen by the social worker after the psychiatrist terminated treatment.

Scope of the Study

This is a study of all fifteen women who were referred for social outlets and whose cases were active in the Social Service Department of the Psychosomatic Clinic between June, 1951 and March, 1952. These dates were chosen because many of the cases closed prior to June, 1951 were carried by student workers who had left the agency by the time the writer came to the clinic. The writer wished to be able to consult with the workers currently working on the cases in order to avoid as much as possible the limitations set by the methods of recording which so often do not give full play to the progress of relationship between patient and worker.

All cases selected had at least three interviews and all but two are still active. All had been in treatment with a

psychiatrist for a period ranging from one month to two years prior to being referred to the Social Service Department, and some have been carried by more than one worker and/or psychiatrist over the period of treatment.

Since the focus of this study is on the emotional needs which are presumably to be met by the patients engaging in the social outlets they seek, the success or lack of success in finding these outlets is not being used as a criterion of the casework being done.

Sources of Data

The sources from which the data for this study were gathered were the social service case records and psychosomatic charts supplemented by consultations with the workers and psychiatrists active in the cases. A survey of the literature served as background for casework theory in Chapter III, psychosomatic concepts in Chapter II, and the dynamic and cultural development of women in Chapter IV.

The writer is indebted to the members of the social service staff for their help in the selection and interpretation of cases, suggestions for background reading, information regarding the organization and policies of the Psychosomatic Clinic and their personal interest and encouragement.

Method of Procedure

A schedule was used to gather information pertinent to the study from the sources noted above.

In selecting the cases for this study, the writer considered face sheet information, supplemented by conference with the case worker active in the case. Education, social contacts and avocational interests, vocational training and employment fell into the category of social outlets. In making the selection of cases referred for employment, only those cases were chosen in which employment was considered a means to meet an emotional need. The writer excluded those cases referred for employment in which financial need was the primary consideration or in which the emotional problems were attendant upon financial need itself.

Limitations of the Study

As has been stated above, an effort has been made to avoid the limitations imposed by the nature of recording in case records by using for this study only those cases which are active and whose workers are available for consultation and discussion of process. This is especially helpful in cases which, because of the pressure of work, are recorded in summary form, or are not recorded up to date.

The casework process is continuous and flexible so that treatment methods change and overlap as the patient and the situation present various needs and different stages of growth and understanding. Therefore, although treatment techniques have been nominally classified in the schedule as environmental modification, psychological support, clarification, and insight development, the methods often overlap or are used

with varying degree of emphasis so that it is not always possible to draw a line of demarcation as to where a particular method was used, where it ended, and where another began.

Value of the Study

This study will attempt to show the dynamics in a particular kind of problem consciously presented by women patients in the Psychosomatic Clinic in an effort to help the caseworker understand the emotional needs which this kind of problem represents.

It will also attempt to show how the caseworker can collaborate with the psychiatrist in a therapeutic situation to help the patient more fully than each could do alone.

CHAPTER II

The Psychosomatic Clinic at the Massachusetts Memorial Hospitals and Discussion of Psychosomatic Medicine.

Casework is practiced within the framework of an agency whose function determines the selection of clients and the areas in which the caseworker can work with clients. A brief account, therefore, of the Psychosomatic Clinic, its purpose and its organization would serve to explain the milieu within which the caseworkers are attempting, through an interpersonal relationship, to help the patients meet certain emotional need and adjust better to their social environment.

Organized in 1946, under the dual auspices of the Massachusetts Memorial Hospitals and the Boston University School of Medicine, the Clinic is part of the School's Department of Psychiatry and Neurology and also part of the Out-patient Department of the Hospitals. It is financed by both the Hospitals and the School of Medicine. As part of the Out-patient Department, it offers treatment to patients who are emotionally disturbed; as part of the School of Medicine it affords an opportunity to fourth year medical students and to residents for learning and practicing the techniques of psychotherapy and working on a team. They learn how and when to use social service in the treatment of their patients. The staff doctors are of the personnel of the general hospital and on

teaching staff of the Medical School.

Three units comprise the Department of Psychiatry and Neurology: the Psychosomatic Clinic, the Neurology Clinic, and the In-patient work. In-patient work screens all patients on the Medical Service in the Hospitals and the residents are also consultants on the Surgical Service. In this way, patients whose illnesses appear to have a considerable emotional component come to the attention of the staff while they are still in the hospital and can receive some treatment. If further treatment is indicated upon discharge, they are referred to the Psychosomatic Clinic. Casework service is available in all three services. Psychiatric casework is provided in the Psychosomatic Clinic.

The Psychosomatic Clinic is actually three clinics: the Adult Clinic, the Children's Clinic, and the Seizure Clinic. Both Adult and Seizure Clinics refer their patients to Social Service for help with social problems; the Children's Clinic refers to Social Service the mothers (or fathers) of children being treated in the Clinic. In this study, all patients were referred by the Adult Clinic.

There are eight staff psychiatrist in the Clinic and eight psychiatric residents. Four or five fourth-year medical students at a time are assigned to the Clinic for one month to do therapy under the supervision of a staff psychiatrist. One psychologist is employed part-time and there are also two psychology students. To augment the team, there are three

psychiatric social workers and seven social work students under their supervision.

The majority of the patients treated in the Adult Clinic are those who have physical symptoms with a great degree of emotional involvement. Referrals to the Clinic come from any of the other services in the Hospitals or from sources outside the hospital. Patients who are referred from one of the hospital services get an appointment for an evaluation interview in the Clinic; referrals from other sources are made by letter through Social Service. Before being accepted for treatment, each case is presented at an intake conference at which the Director of the Clinic decides whether the case is one which can be properly and profitably treated at the Clinic and by whom (student, resident or staff psychiatrist) or whether it should be referred elsewhere. The experience this treatment will give to the therapist as well as the illness of the patient is considered.

The Adult Clinic accepts for treatment, patients who have psychosomatic or psychoneurotic symptoms as well as patients with organic ailments which create emotional problems. Alcoholics, drug addicts, psychopathic personalities, psychotics, and patients with behavior problems, are not accepted if these are the primary symptoms at the time of referral. The cases of patients already in treatment, are presented at weekly staff conferences at which all members of the team contribute their observations. The patients themselves are presented on a

voluntary basis.

The Social Service Department in the Clinic works with patients referred by psychiatrists in the Adult Clinic and in the Seizure Clinic. If in the course of therapy, the psychiatrist finds that concern over an environmental problem is impeding the progress of treatment, he will make referral to Social Service on the basis of this problem, but will continue to treat the patient in the area of psychic conflict. In such a case the social worker and the psychiatrist work together. Often the patient's symptoms are alleviated and the social problem remains; then the social worker only works with the patient. Occasionally the social worker alone continues contact with the patient, because the patient refuses to or cannot, for some reason, come to the Clinic and the worker visits the patient at home. In working with the patient, the worker may at times be called on to interview relatives and to contact other agencies.

Discussion of Psychosomatic Medicine

The trend in medicine today is to treat the person as a whole, rather than to treat a disease apart from the person. Recognition is given to the interrelatedness of physical and psychic in the concept of psychosomatic medicine.

> Every manifestation of human activity, thought and feeling is inseparable from the psyiological function of the biological organism which is man.[1]

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1 Leon J. Saul, M.D., "Psychosomatic Knowledge in Case Work", The Family, 22:220, November, 1941.

> Psychosomatic medicine deals with emotional tensions as they disturb the physiology and produce physical symptoms.[2]

Physical illness is accompanied by emotional reaction. It is a regressive experience in that it makes the invalid more dependent. It may reactivate the conflict between dependency and independence. Some may welcome the opportunity to have their dependency needs met in the socially acceptable fashion; others may rebel at being made dependent once more. The irritability, querulousness, or depression of invalids are emotional responses to physical illness. Illness that leaves a residual weakness or malformation creates emotional responses which may range from complete withdrawal to aggressive overcompensation.

Emotions use the body for expression, too. The overactivity of sebaceous glands, palpitations, rapidity of the pulse which accompany anxiety, are physical expressions of emotions. Some illnesses, such as asthma, ulcer, colitis, hypertension, have been found very often to be of emotional origin. They are symptoms of emotional conflict which the patient was unable to express openly and therefore, repressed. However, the emotional tension found expression in illness.

Persons are predisposed to the kind of bodily expression they will give to emotional stress depending upon the period of development at which the greatest emotional conflict

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2 Ibid., p. 225.

ocurred. The mechanisms of expression of conflict remain fairly constant in the adult as a result of behavior patterns set up in childhood (repetition compulsion).

> One aim of psychosomatic medicine is to learn how to determine prior to the onset of a disease, which personality is apt to choose under given stresses, which disease, which organ, or which neurosis or psychosis...[3]

It has been indicated that illness can be caused by pathogenic organisms or by emotional stress, or both, and that the physical and psychical functions of the person, influence one another.

> ...ill health may arise from long standing dissatisfactions in the business, social, or home life of the individual and that the failure of adjustment to environment is manifested by a disturbance in some part of the personality, either as bodily symptoms of various kinds, capable of mimicking almost any disease, or as affections of the spirit resulting in attacks of anxiety, obsessions, phobias, depression and other disturbances of mood... besides excluding physical disease in the one case and correctly evaluating the part it plays in another, it is of the greatest importance to know the patient's ability to adjust to certain life situations, his pattern of reacting to them, the degree of anxiety in his make-up and the nature and seriousness of his conflicts.[4]

Many people seek illness as a refuge from life situations which they cannot meet comfortably or successfully, being willing to bear the suffering because of the secondary

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3 Elise De La Fontaine, "Some Implications of Psychosomatic Medicine for Case Work", The Family, 27:128, June 1946

4 Edward Weiss, M.D. and O. Spurgeon English, M.D., Psychosomatic Medicine, p. 8.

satisfaction they gain from their chosen symptoms.

> Whether this clinging to symptoms is caused by too much affection or too little, it is a last resort for those who have never found a secure place for themselves. Men, women and children turn to pain or discomfort only because of the inadequacy of their own (or their parents' personalities). Their inability to cope with the environment in which they find themselves sets up an emotional disturbance which translates itself into a physical disorder, and the tortured system thriftily selects an ailment which may have compensating features. The sufferers lose their symptoms when their personality difficulties are remedied, that is, where they are helped to become the kind of people they have the capacity to be.
>
> Despite their appearance of welcoming illness or injury, they do not deliberately set out to become nuisances. No one really wants to be sick, but these misfits may want something else so badly that sickness is brought upon them. If it helps achieve the desired end, it is welcome for what it brings, nor for what it is. If it fails, as it so often does, it becomes a double tragedy. It should be remembered that the personality inadequacies of these patients result from parents and circumstances rather than from innate weaknesses in themselves.[5]

Since the ailing person is a troubled person, and since his recovery is in some respects dependent upon his frame of mind and reaction to the total situation, illness becomes the concern of the social worker. The worker should recognize

> ...a symptom is employed by an individual as a disguise. Through this device the individual tries to defend himself against greater emotional conflict, and his attempts to hide the conflict from himself.[6]

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5 Flanders Dunbar, M.D., Mind and Body: Psychosomatic Medicine, p. 34.

6 De La Fontaine, op. cit., p. 134.

By reducing the external and/or more conscious reactions by the client to recognized, external problems, the case worker can ease indirectly the more fundamental problem (even though not removing it or directly reducing it); and this gives a chance for the physical symptoms to be reduced.

...treatment would aim to alleviate the symptom, that is, the tension or discomfort.[7]

7 Ibid., p. 128.

CHAPTER III

Casework Aims and Techniques

Briefly stated, the aim of casework is to help the patient make a satisfactory adjustment to reality in his environment.

> ...in casework the individual is always seen in his relation to the environment to which he is attempting to adapt himself and from which he is hoping to satisfy his fundamental needs. This environment may either encourage or become a hindrance to the achievement of his physical and emotional aims. It consists both of material things, and of other people who like himself, are striving to gratify their wants. His ability to find contentment depends partly on his good fortune in finding a benign environment, partly on the skill he develops in mastering the physical world, and partly on the growth of his ability to love others and draw the love of others to himself.[1]

Casework is a fluid interpersonal process in which the worker and the patient are both active within a relationship in which the worker feels with the patient but maintains an understanding objectivity and the patient is aware of the worker's interest and understanding and response to it. Without this relationship no casework can take place.

> The same depth of understanding of the client, the same quality of concern and consideration for his request for service, the same skill in making service available through the medium of a relationship which by its very nature facilitates the client's

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1 Florence Hollis, Women in Marital Conflict, p. 11-12

> capacity to make and act on his own decisions in respect to social difficulties he is encountering . . . is required of any and all social workers practicing in any and all settings.[2]

Psychiatric social work is social work practiced in a psychiatric setting with a direct and responsible working relationship with psychiatry. The psychiatric social worker becomes a member of a team. "Teamwork is a r pprochement which permits specialists to work together and not at cross purposes."[3]

To this relationship the psychiatric social worker and the psychiatrist each brings his special knowledge and skills to bear upon the emotional problems of the patient--an attempt to make their solution more effective.

> The essential purpose of this working union is that each has within its professional equipment skill which complements that of the other and facilitates the achievement of their common objectives . . . to be of service to people in need of their help.[4]

The psychiatrist addresses himself to the intrapsychic conflicts of the patient. He deals with unconscious material. His aim is at personality change achieved by bringing unconscious material into the conscious in order to give the

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2 Ruth Smalley, "Psychiatric Social Worker or Psychotherapist?" The News-Letter, 13:107-110, Spring, 1947.

3 Elizabeth B. Bech, Psychiatric Social Work Possibilities in a Mental Hospital," Journal of Psychiatric Social Work, 18, Spring, 1949.

4 Myron John Rockmore, "Social Case Work as Therapy", Journal of Psychiatric Social Work, 18:182, Spring, 1949.

patient insight into the dynamics of his neurotic (or psychotic patterns of behavior.

The psychiatric social worker, while aware of the unconscious motivation of the patient's behavior, uses this knowledge to work with the patient's feelings around his reality problems. Her aim is adjustment to environment which may involve environmental changes as well as changes in the patient's attitude and behavior.

> The psychiatric social worker with his knowledge of dynamics as a reference for himself, uses the genetic approach to examine a phenomenon as such and the forces that brought it about. He evaluates the role relatives play, he listens behind the words he wins confidence and makes people comfortable in asking and seeking help. He operates on the basic concept of reciprocal action and continuity between worker and client. He gives specific help in using whatever inner resources patient may have to make decisions and to take action on everyday problems.[5]

The treatment plan for a patient may be carried out simultaneously by a psychiatrist and a psychiatric social worker, each working in a different area of the patient's problem, each meeting a different need, yet both consulting with and contributing to one another to give the patient the benefit of both disciplines.

> The psychiatrist treats the illness of the patient while the psychiatric social worker helps the patient use the self he is at any particular time as effectively as possible in the various social situations

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5 Bech, op. cit., p. 175.

with which he must deal.[6]

To this association a social worker brings his orientation to human needs and the knowledge of community resources which attempt to meet these needs. He brings an understanding of the philosophy and administration of social agencies and their use. He brings training and experience in interview techniques which are designed to relate the individual's needs to existing facilities. He brings a professional attitude toward helping people meet and solve problems.[7]

Social Workers who are by training and professional experience the first hand observers and gatherers of data about the effects of the social and cultural environment on personality functioning in the only way that culture can be observed accurately and concretely . . . i.e. through the lives of people.

While the individual as the patient is the proper concern of the psychiatrist, the social community as the patient is the proper concern of the psychiatric social worker . . . The task of the social worker is a difficult one since the social community cannot be comprehended apart from the individuals who make it up. This means that the psychiatric social worker's frame of reference has to be broad enough to encompass knowledge of varied and complex social forces and her knowledge of personality functioning deep enough to understand the interplay between the individual responses to environmental stimuli of the social forces.

Not only her knowledge but her activity has to be a three-dimensional quality so as to be helpful to the individual and his family, to the community, and to the psychiatrist, with the stimulus coming from individual patients.[8]

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6 Smalley, op. cit., p. 108.

7 Rockmore, op. cit., p. 185.

8 Celia S. Deschin, "How can Social Work Make a Major Contribution to Psychiatric Theory?", Journal of Psychiatric Social Work, 20:43-51, December, 1950.

Treatment methods employed by the skilled caseworker are determined by the needs of the patient and his readiness to accept help on various levels. The treatment techniques are aimed at relieving external and internal pressures. These techniques fall generally into four categories: environmental, madification, psychological support, clarification, and insight development (as described by Florence Hollis).[9]

Environmental modification refers to direct action taken by the caseworker to relieve environmental pressures, to change the environment to facilitate the patient's adjustment to it, such as contacting another agency, whose function can better meet patient's environmental needs like employment or housing, or contacting the patient's family to give them a better understanding of the patient. This is undertaken only when environmental pressures are beyond the client's control but can be modified by the worker, or where such pressures would more readily lend themselves to modification through the activity of the worker rather than through that of the patient. The effectiveness of environmental modification does not depend upon the strength of the client-worker relationship as do the other three techniques, but may help to foster such a relationship and is often part of psychological support.

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9 Hollis, op. cit.

Psychological support is used "in the sense of focusing attention on the client's present reality problems and minimizing efforts to give the patient insight into the unconscious causes of his behavior."[10] It is used by the worker to foster the ego strengths of the patient and to help him marshal these strengths in meeting the exigencies of his existence. This technique is used with individuals who are basically well-adjusted to help them over a period of severe stress caused by traumatic life experiences, or with immature individuals who need guidance, or with neurotics for limited help when psychotherapy is not available.

The caseworker fosters the relationship by creating a permissive atmosphere in which the patient is encouraged to talk freely and to express his feelings about his problem, by the worker's expressing sympathetic understanding of the client's feelings and acceptance of him, by the worker's showing confidence that a solution can be found to the patient's problem, that the patient can contribute to this solution and that he can make his own decisions; by indicating that the worker has respect for and approves of the steps the client has taken or is planning to take when this respect and approval are realistically warranted.

It is hoped that within this relationship the patient can

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10 Fritz Schmidt, "A Study of Techniques Used in Supportive Treatment," Social Casework, 32:413, December, 1951

be relieved of some of his anxiety, his guilt feeling, his feelings of inadequacy and given confidence in his own ability to handle his situation.

In this kind of relationship recognition is given to the patient's dependency needs and it becomes a sort of warm understanding parent-child relationship in which the patient-child finds strength and courage to take independent action because he feels secure in the support of the caseworker-parent.

Clarification is an intellectual interpretation of the patient to himself on a conscious level, and is aimed at helping the patient understand himself and his environment as he relates to it. The patient is encouraged to talk freely about his problems. The worker helps the patient to see external realities in better prospective and to understand his own emotions, attitudes, and behavior. This may consist of the worker's making the patient better acquainted with his environment and the people in it, by helping him evaluate the attitudes of others towards him in a more realistic manner, to understand their motives, to see the needs of others on the effects of his actions on others, of pointing out inappropriate emotional responses and inconsistencies in the patient's actions or thinking. The worker helps the patient become more aware of his own feelings, desires and attitudes which may have been vague and unformulated but close to the

conscious.

> Clarification consists of attempts to bring to the patient's attention feelings and attitudes which are vague and obscure but which still are on a conscious or preconscious level. Clarification helps the patient to gain an adequate perspective of his problems--astep in the direction of understanding himself and consequently, of handling his problems differently.[11]

The relationship between the patient and worker is mostly on a realistic basis and, therefore, the transference phenomenon is well controlled.

Like psychological support, clarification is aimed at helping the patient to function more effectively in his social environment, but with clarification, the patient is made more aware of his process of adjustment and hence may be considered as effecting this adjustment more actively and more consciously. These two methods may be used concurrently and to supplement each other.

Insight development as a treatment method is used sparingly by the worker and only if she is skilled and well-trained. While this method does not probe into deeply repressed unconscious material as does psychoanalysis, it does carry the patient's understanding of himself and his motivation to a deeper level than does clarification and involves manipulation of deeper transference.

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11 Grete L. Bibring, M.D., "Psychiatric Principles in Casework," Journal of Social Case Work, 30:230-231, June, 1949.

The purpose of insight development is to give the patient a better understanding of himself and his situation so that he can manage his life more realistically with less anxiety and hostility and with less use of defense mechanisms which absorb so much of his creative drive. The patient is helped to become aware of factors below the level of his consciousness which influence his present feelings and actions and is led to modify the projection of his inner needs and subjective responses upon his environment.

CHAPTER IV

Personality Development of Women

Dynamic Development

The Freudian concept of personality invests it with three forces: the id which is the sum total of instinctual drives; the superego which is the incorporated standards and mores of the parents and through them the culture of their environment, and the ego

> that composite of qualities through which the individual adapts himself to the outside world, securing from it the opportunity to express his fundamental drives and to meet his major needs. These qualities include the ability to perceive external realities and internal feelings, the ability to find ways of meeting internal needs through the environment in a fashion that will not only be satisfying but will bring the minimum of discomfort to others or to himself, the ability to foresee the outcome of various courses of action, to learn from experience to weigh the advantages and disadvantages of his behavior, to suppress and repress desires that cannot be safely expressed, in general to control, direct, and harmonize his activities.
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> It is through the ego that we become aware of feelings of pleasure, anger, fear, anxiety, and guilt. We feel pleasure when needs are gratified, anger when they are thwarted, fear when we are threatened by a known external danger, anxiety when we are threatened by subjective dangers from forces within our own personalities, or more general, less defined dangers from without, and guilt when we have violated, or contemplate violating the tenets of our own superego. It is the task of the ego then, to find as much pleasure as possible, to avoid the creation of anger by frustration whenever possible, to protect us from both outer and inner

> danger in order to avoid the development of fear and anxiety, and to do all this in a manner that will not arouse feelings of guilt.[1]

The normal personality is one, according to Dr. Edward Glover of London[2] which is free of symptoms, is unhampered by mental conflict, has a satisfactory working capacity, and is able to love someone other than himself. This last attribute, the ability to relinquish narcisistic satisfaction and make object relationships, is one of the criteria of maturity. In order for an individual to be able to give love, he must have received love. A child who is secure in the feeling that his parents love and want him can reach out to his parents and to others with a feeling of security and a desire to reciprocate in kind. A child who feels rejected by his parents expects rejection from others and seeks satisfaction within himself.

> . . . the clinical importance of the passive-receptive to be loved is great and warrants the differentiation. The importance lies in the fact that to be loved is the basic need of childhood. It contains elements of parasitism and dependence. This is the pwerful force behind oral demands. Only through the vissitudes described by Freud does the infant frowing to adulthood finally achieve the capacity for responsible, productive object interest for generality and mature loving . . .
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> Few adults have outgrown their childhood needs for parental love; hence the fateful force of such need in human affairs. It is of central importance in every neurosis. Regression is always largely a return to childish forms of the insatiable need to be

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1 Hollis, op. cit., p. 11.

2 Quoted in Weiss and English, op. cit., p. 27.

> loved. Self love (vanity and narcissism) partially satisfies the craving for love and adulation from the parents. Ambition, prestige and competition are often largely strivings to win from the parents, later from society, love and approval. Neuroses and much of mankind's sufferings arise not from loving, but from infantile demands from love in some form. It is this which motivates excessive jealousy and other manifestations of hate. Its great importance is as a source of hate, hostility and violence. Too strong needs to be loved, especially when colored with childhood needs for dependence, conflict with our cultural standards of self-reliant individualism and also with the biological forces of development to independence. In so doing they hurt self-esteem and can thereby generate out of these feelings of inferiority, intense and unremitting rage. Rage is engendered by failure to satisfy excessive needs to be loved which are predestined to failure because the adult cannot satisfy needs which belong to childhood.[3]

The foregoing observations on personality growth and development are applicable to people in general. This thesis is, however, concerned with the study of emotional problems in women whose growth and development at some point were hampered by various circumstances and who, as a result, developed psychosomatic or psychoneurotic symptoms in an attempt to resolve their conflicts and turned to social activities as the answer to some of their problems. It is, therefore, of interest to review the psychic development of women as distinct from that of men and to note the cultural factors which influence women's adjustment.

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3 Leon J. Saul, M.D., "The Distinction Between Loving and Being Loved," Psychoanalytic Quarterly, 19:402-3, 1950.

Both boys and girls receive the same kind of instinctual gratification during the oral and anal periods. They gradually turn from narcissistic immediate self-gratification to form relationships with others and to defer instinctual gratification to retain the love and protection of those on whom they are dependent and whom they love. They make some adjustments to social demands. They begin to learn to live by the reality principle rather than by the pleasure principle.

In spite of the fact that both sexes seem to pass through the early phases of development in the same way, some differences do appear.

> In their instinctual disposition . . . there are differences which foreshadow the later nature of the woman. The little girl is as a rule less aggressive, less defiant, and less self-sufficient; she seems to have a greater need for affection to be shown her, and therefore to be more dependent and docile.[4]

Whatever sex differentiation there has been in these two periods becomes more pronounced and reaches its height in the phallic period at which time interest in anatomical differences is intensified with increased masturbatory activity and with emotional reactions. The love for the parents which up to now has been asexual becomes sexualized and is directed with greater intensity towards the parent of the opposite sex. This presents a threatening and frustrating

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4 Sigmund Freud, M.D., L.L.D., New Introductory Lectures on Psychoanalysis, p. 159-160, 1933.

situation to the child: because of his love for the parent of the opposite sex, the parent of the same sex becomes a rival. Since the child, however, needs the love and protection of the rival parent and realizes that the parent has the power to retaliate by withdrawing his love and protection, this becomes a dangerous situation. Furthermore, the parent of the opposite sex does not respond to the child as a sexual love object and this is frustrating to the child.

Both the boy and the girl are primarily dependent upon the mother and this period creates a greater problem for the girl. Because of the seeming danger to the girl that the oedipal conflict creates, she needs more than ever the protection of a dependency relationship. However, since the source of this dependency gratification is the mother, a struggle occurs between her wish to give up the maturation process in order to be assured that her dependency needs are met and the wish to renounce her security.

This period poses another problem to the girl: she discovers that she has no penis and feels inferior to and envious of the boy. She feels cheated or castrated.

> The discovery of her castration is a turning point in the life of the girl. Three lines of development diverge from it; one leads to sexual inhibition or to neurosis, the second to modification of character in the sense of masculinity complex, and the third to normal femininity.[5]

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5 Ibid, p. 172.

The neurotic resolution of the oedipal conflict usually results in hysteria and indicates a more mature personality structure than other neuroses. The conflict centers around the oedipal triangle and evinces itself in anxiety over the collapse of defenses and the punishment that will ensue for the activity of the released impulses. The dominating component is a fear of expressing a forbidden type of love rather than hostility such as is found in the obsessive-compulsive neurosis. The hysteric has a greater capacity to love. Freud practically equates femininity with passivity.

> When the little girl gives up clitoral masturbation, she surrenders a certain amount of activity. Her passive side has now the upper hand and in turning to her father she is assisted in the main by passive instinctual impulses. You will see that a step in development such as this one, which gets rid of phallic activity, must smooth the path for femininity. If in the process not too much is lost through repression, this femininity may prove normal.[6]

In pursuing this concept of feminine passivity, Freud ascribes the masculine complex in women to a constitutional factor; the possession of a greater degree of activity so that she refuses to accept her femininity and avoids the onset of passivity. An extreme development of this masculinity complex is homosexuality.

The emotionally healthy girl eventually gives up the gratification she sought from her father and seeks a

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6 Ibid, p. 174-175

desexualized identification with her mother and develops heterosexual relationships with more acceptable love objects.

Prepuberty is the last stage of the latency period in which the sexual drives are at their weakest and ego development is most intense. This period is characterized by a "thrust of activity" which precedes the sudden increase of passivity which marks the young girl's development into womanhood. The "thrust of activity" is an increased process of adaptation to reality and mastery of the environment which the development of the ego made possible in its drive towards growth and independence. There is a loosening of the affective ties of childhood and an increased sense of responsibility and independence. Infantile fantasy life is abandoned and new object relationships are sought and new ego-ideals formed.

New identifications are formed depending upon the manner in which the child has resolved its ambivalence towards its love objects of the preceding periods. Because of the growing need for independence, there is a tendency to renounce earlier identifications. She becomes critical of her parents especially of the mother, and may seek a substitute female figure which she invests with the attributes she feels her mother lacks. This has the dual purpose of giving her a feeling of independence from her mother but of meeting her dependency need for the kind of mother she would like to have.

Excessive attachment to the mother at this period is a threat to the girl's desire to attain adulthood.

This period may be termed homosexual since object relationships are formed with members of the same sex. This is the period of "crushes" on teachers, club leaders, or other female figures. This is the period of intense friendships with other girls of the same age, interests and aspirations.

> Despite her noisy self-assurance, she is aware of her inadequacy and needs someone as insignificant as herself in order to feel stronger, doubled as it were. She wants someone who not only shares with her the pleasure and burdens of secrecy and curiosity, but who also resembles her and who, like herself, is undergoing the suffering of feeling insignificant. She can endure the burden of secrecy, the feeling that the surrounding world is hostile, and the torments of guilt, with greater ease because she endures them with another.[7]

Whatever interest in boys occurs is mostly due to curiosity rather than sexual attraction. There is a tendency to play act and to interfere in the affairs of adults while at the same time resenting any adult interference in their affairs. This defiance against discipline is directed mainly against the mother who represents her strongest tie to infantile dependency. At the same time she circuitously seeks support from the mother.

An attempt at independence from the mother at this

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7 Helene Deutsch, M.D., The Psychology of Women, Vol. I, p. 13.

period which has been frustrated or is too weak can lead to infantilism in the woman's personality. Her relationship with both sexes is one of dependency and insatiable demand for love and support. They are easily discouraged from pursuing their goals and have little confidence in themselves and are easily influenced by others.

Anxiety states and neurotic symptoms are not uncommon at this stage.

The friendship of children of the same sex may also have elements of danger: the release from guilt feelings may lead to mutual abetting in socially unacceptable acts; and the possible fixation of homsexual tendencies with its influence on the course of psychosexual development in adolescence.

In puberty the girl must face the problem of her ties with her family, free herself from too strong ties with other girls and withdraw from the bisexual triangular situation to form a relationship with a male love object. "The situation in early puberty is . . . surrounded by numerous dangers. The sexual urges are strengthened but they still lack a direct goal. As a result, all the relations are subject to the danger of sexualization."[8]

The conflicts in the home relationships become

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8 Ibid., p. 35-36

intensified, and the girl has a need to be free and belong to a group not identified with the family. This is the "joining" period; the club, the group becomes of paramount importance and claims the girl's loyalties. This can have its funtion of implementing social adjustment and facilitating the solution of the individual problems of youth by a collectivist ideology. In such groups, the girl usually tries to form personal friendships rather than to form aggressive groups against authority. Occasionally, the girl resorts to flight from home, usually if a friendship has failed or she is not accepted by a group. This flight is not usually motivated by hetersoxual eroticism. Other solutions are found in neurotic illness.

Physical maturation is completed during adolescence with the menarche which signifies that the girl has become a woman able to do her biological duty to the species. Emotional development in this period is based upon the way in which emotional conflicts of the previous periods were resolved. Psychological changes fall into two general categories: the upsurge of sexuality, conscious, verbalized and acted out in the manner accepted by the peer group, and the increased pressure from within to free oneself of infantile dependency and arrive at adult status. To facilitate this growth towards independence, the girl begins to devaluate

her parents and to renounce their standards in favor of those of her group. For purposes of identification, the girl adopts substitute figures for the parents which in turn are abandoned for an abstract age-ideal.

The resurgence of the sexual drives creates fear and invokes the use of mechanisms of defense to handle these drives. The struggle between the id and the superego is more intense. The superego, because of the very nature of its origin in the mores of the parents, sometimes is weakened when in the drive for independence, these parents and their standards are devaluated. As a result the adolescent sets up rigid standards of behavior for herself with which it is almost impossible to conform. Battered by the onslaughts of both the id and the superego, the adolescent's ego often breaks down and neurotic and psychotic illness at this period is not infrequent.

In this period narcissism acts as both a negative and a positive force.

> In the first place, it has a certain unifying force that prevents dissolution of the young girl's personality as a result of too many identifications. In the second place, by increasing her self-confidence, it contributes considerably to strengthening the youthful ego. However, it certainly also exerts a negative influence on the ego; and it is this double action that gives rise to the movement back and forth, the ebb and tide of overweening pride and contrition, in brief, the whole

> picturesque medley that is the psychologic pattern of adolescence.[9]

The excess of narcissism makes relations with others difficult. The adolescent's ego, unsure of itself, is sensitive to love frustrations, is intolerant of criticism. The realization of her own limited capacity to love leads to a feeling of solitude.

The adolescent has a great need to be loved and to love. This explains the erotic readiness to fall in love again and again, often with an idealized love object whom she hardly knows or does not know at all. In such instances, what is important is the experience of loving, not the love object himself. Very often these love objects bear a resemblance to the girl's father.

The conflicts that beset the adolescent are numerous: between her duties to herself and to her family, between her desire for the security of childhood and the advantages of adult-hood. Her adjustments to these demands fluctuate with corresponding fluctuation of moods. Fantasy life is rich where reality appears to be drab. The oedipal conflict may be reactivated.

> Thus, for instance, a girl's identification with her mother may signify that she is assuming a woman's role, or it may imply all the difficulties of the oedipal complex and thus stand in the way

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9 Ibid., p. 84

> of the realization of her feminine wishes. Her perseverence in this identification may also express her inability to develop her own personality. Another result of it may be that the girl clings to her infantile dependence on her mother, that she avoids every conflict with her, and thus leads a shadowy existence at her side. In such a case, instead of reaching a feeling of emancipation and love, the girl has a spiteful and unsuccessful attempt to detach herself from her mother, and this may result in an emotionally crippled personality. If the girl does not succeed in solving the problem of adolescence, she remains during this period and likewise later as a maturing or mature woman, the child she was during prepuberty, continually aggressive and nervously struggling against this tie with her mother, developing various symptoms in connection with her conflict, and persisting in a completely passive dependence . . . a number of conversion symptoms, particularly lack of appetite and similar disturbances, all kinds of phobias and paranoic ideas, are connected with such an inability to dissolve the old attachment to the mother.
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> Every gesture, every inner and outer experience, is put before the mother and subjected to her favorable or unfavorable criticism . . . The happiness or unhappiness of a person with such an attachment depends absolutely on the judgment of others, and she expends a great deal of energy in finding out the reactions of those around her to everything she does.[10]

Girls who have been subjected to excessively rigid morality in childhood, who have too restrictive a superego with accompanying guilt feelings around sexuality, find themselves in a reactivated conflict in adolescence and react in characteristic fashion: the urge for love and freedom are replaced by rigid moral principles. The ascetic girl with a

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10 Ibid., p. 116-117

tendency towards obsessional neurosis is a product of this kind of solution of conflict.

The opposite extreme is the girl who has not developed any inhibitions and cannot accept the mores of her social group.

Fantasies in the adolescent girl act as a safeguard against sexual wishes. Her fantasy life is a turning inward and is the root of the intutition and subjectivity which are feminine characteristics. It also leads to a prolonged and stronger tendency towards identification.

Menarche in puberty constitutes physical sexual maturity. The foundations for psychological maturity have been laid in the preceding periods. A girl's reaction to menstruation and its implications depends upon how she solved the conflicts of those periods. If she has passed through these periods without severe trauma, if her growth and development have taken place in an atmosphere of love, acceptance, and security, she can accept her femininity and is ready to assume her role as a woman, wife and mother. If her development has been accompanied by traumatic experiences at various levels, she will tend, when faced by various life situations, to regress to a period in which she formerly found satisfaction.

Cultural Influence

The incidence of the neurotic pattern of behavior in

women today in our culture is greater than it ever was before.

> . . . diametrically opposed principles of competition and cooperation are reflected in each individual as a personal conflict . . . one which he must settle for himself; and a successful solution in our present age is the exception rather than the rule. The result is an overwhelming number of emotionally unbalanced persons.[11]

The culture of the western hemisphere is largely patriarchal, and the social concept of woman is that of a being inferior to man. The feeling of inferiority is not a comfortable one, hence the acceptance of femininity, under the impact of both psychological and cultural pressures, is found to be fraught with conflict.

Woman's libidinal drives find satisfaction in her biological functioning, as mothers and wives. But in addition to this she needs to feel appreciated in this role. Prior to the Industrial Revolution, the home was the center of all economic, cultural, and biological activities. The family participated in all these activities and the woman contributed her share in the economic and cultural aspects without sacrificing her creation of the home and the bearing and rearing of children. She felt herself a complete person, indispensable and appreciated for what she was and what she did. She had a sense of achievement.

The Industrial Revolution with its separation of the

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11 Franz Alexander and Thomas French, Psychoanalytic Therapy, p. 3.

economic and eventually recreational activities from the biological, its encouragement to the division of labor and eventual commercialization of many of the woman's home activities, took from her many of her satisfactions and her sense of adequacy." . . . everything about the behavior of modern women shows they have been seeking restitution and compensation for an injured and outraged ego."[12]

Today, being a successful woman carries no social prestige. In order to find satisfactions and appreciation women look to other sources than the home for ego supportive activities.

No one can deny that the problems of women are different from those of men. The very difference in biological function creates a difference in problems, but biology in itself becomes a problem when it creates a situation which is unsatisfactory to the cultural pattern. If the fulfillment of the role of woman puts her at a disadvantage, then being a woman would be a handicap. The cultural attitude that woman is inferior with its accompanying restrictions does put a woman at a disadvantage.

> Even where a woman has become consciously convinced of her value, she still has to contend with the unconscious efforts of training, discrimination against her and traumatic experiences

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12 Ferdinand Lundberg and Mrynia F. Farnham, "Modern Woman: The Lost Sex," p. 126.

which kept alive the attitude of inferiority.[13]

Many of the psychological characteristics which Freud attributes to women may be in part due to cultural pressures, Her neurotic need to be loved, her narcissism, may be a mechanism for establishing security in a dependency relation. It may also be a device to establish security in a cultural situation producing dependency.

It is still considered more "womanly" for a woman to marry and be economically dependent on her husband. However, to a woman who has achieved success and economic dependence in business or a profession, accepting marriage with economic dependence creates a conflict. The Freudian concept of penis envy may be envy of the cultural advantage that man has to satisfy his needs for social and economic recognition without sacrificing his need to satisfy his libidinal drives. Where this envy becomes pathological, the woman thinks of man as hostile to her and the penis becomes a symbol of aggresion, a weapon used against her. She then wishes she had the destructive qualities she attributes to man so that she can use them against him.

According to Freud women solve this penis envy in three ways: by accepting their femininity, by developing neuroses,

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13 Clara Thompson, "Cultural Pressures in the Psychology of Women," A Study of Interpersonal Relations, p. 135.

by developing a "masculinity complex."

Biologically woman can find fulfillment only as a woman and be frustrated to the extent that this fulfillment is denied. However, the acceptance of femininity may have cultural implications that are far from satisfying. It may mean an expression of submission and resignation; it may mean choosing the path of least resistance; giving up ego satisfying activities for security.

Solving penis envy by neurosis is a solution by evasion. The cultural patterns in such a solution are not very different from those that invite the development of the masculinity complex.

One difference between the masculinity complex and the neurosis is that the former is in many ways more acceptable to the culture. It is not only a solution of the woman's conflicts, but it takes its pattern from the culture which invites masculinity in women.

Seeking recognition in the fields of endeavor in which man had set the standards since the Industrial Revolution, women began to ape men in order to find equality with them. In doing so, they often lost sight of their own interests as women.

Our culture now encourages woman to develop some characteristics which were once considered typically masculine, but she may also use this cultural situation to meet her neurotic

needs arising from her failure to adjust herself to being a woman. Resentment at being a woman may be due to a variety of reasons, some cultural, some developmental.

> Being a woman may mean to her being inferior, being restricted, and being in the power of someone. In short being a woman may mean negation of her feeling of self, a denial of the chance to be an independent person. Refusal to be a woman therefore could mean the opposite . . . The woman with a masculinity complex shows an exaggerated need for "freedom" and a fear of losing her identity in any intimacy.[14]

Distaste for the role of being a woman may be due to the fact that dependency presents a threat to the integrity of her personality because previous dependency, e.g. on a domineering or hostile mother, was threatening to her.

The masculinity complex paradoxically takes the form of wishing or pretending to be a man accompanied by a hatred of men.

> Two things in the situation encourage this type of character defense. First, because of the general cultural trend there is secondary gain in such an attitude. It looks like progress and gives the woman the illusion of going along in the direction of the freedom of her time. Second, it offers a means of avoiding the most important intimacy in life, that with a man. This relationship because of its frequent implication of dependency and subordination of the woman's interests especially reactivates all of the dangers of earlier dependencies. The struggle for some form of superi-

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14 Ibid., p. 144

ority to men is then an attempt to keep from being destroyed.[15]

Whether a particular neurotic pattern is the result of traumatic growth and development or of cultural pressures is difficult to determine. Psychiatric social worker, dealing with emotional problems pertaining to reality situations must be fully aware of social and cultural pressures upon their patients. In making diagnoses and setting up treating goals, they must consider the contributions of both dyname and cultural factors in working with patients to help them adjust to their environment.

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15 Ibid., p. 145.

CHAPTER V

Analysis of the Group as a Whole

Since only a portion of the cases studied will be presented in detail in the following chapter, the writer wished to give a composite picture of the fifteen women under discussion from which the basis for the summary and conclusions are to be drawn and presented in Chapter VII.

All cases were referred to Social Service by the psychiatrists who were treating the patients.

Twelve of the women are white and three are Negro. Two of the latter were born in the south and their emotional problems were aggravated by a change of environment. Four of the patients are Catholic, one is Jewish, and ten are Protestant. One of the latter was educated in parochial schools, and her religious identifications are mixed and affect her attitudes. Eight are married and of those six have poor relationships with their husbands, one has ambivalent feelings towards her husband, and one appears to have a good relationship with her husband. Four are single, one is divorced, and two are separated.

The majority of the woman studied are between twenty and forty years old, two are under twenty and three are over forty. Of those whose educational background is known, only one failed to reach high school. Three started to go to college

but dropped out before graduating. Four depend upon public funds for support and only one is of employable age and still dependent upon a parent for support. Two are self supporting and are supported by their husbands.

A survey of the patients' family backgrounds and relationships reveals the following facts: Six sets of parents were living together beyond the patients' adolescence. Of these, five mothers were domineering, four of which were also covertly rejecting and one was overprotective. The sixth mother was also overprotective. One patient reported that both parents were restrictive and rejecting. Two sets of parents were separated by divorce prior to patients' adolescence. One of these mothers divorced twice and married a third time. In three cases, the mother died when the patient was very young; in one case, the mother became ill when the patient was fourteen; in three cases the mother is known to have been employed and to have thrown the burden of the housekeeping upon the patient. Only one patient had a warm, dependent relationship with her mother, but the mother died when the patient was thirteen. Another patient whose mother died when she was eight has a warm feeling towards her. The attitude of the other thirteen patients towards their mothers is either openly hostile or dependent-passive and hostile.

The relationships to siblings were as follows: In ten cases there was sibling rivalry; in three of which patient

had a warm relationship with one sibling out of several; in one case the relationship was unknown; in two cases the relationship was ambivalent; and in two cases there were no siblings.

The relationships to the father were as follows: Five patients felt overtly rejected by the father,;one patient's father died when patient was young; six had a good relationship with their fathers; two of whom were weak and sickly; one felt rejected by her father but not as much as be her mother; one had an ambivalent relationship with the father. The relationship in one case is unknown.

TABLE 1.

REASON FOR REFERRAL TO THE CLINIC

Type of Disorder	Number of Cases
Psychosomatic	3
Psychoneurotic	5
Mixed	7
Total number	15

The cases, according to the reason for referral to the clinic fell into three general groups; those in which the emotional disturbance manifested itself in a somatic complaint, those in which a psychoneurotic disorder was predominate, and those which had components of both. The largest number of

cases were those in which there was a combination of psychosomatic and psychoneurotic disorders.

TABLE 2.

REASON FOR REFERRAL TO SOCIAL SERVICE

Reason for Referral	Number of Cases
Employment and Vocational Training	5
Educational	2
Avocational Interests and Social Contacts	2
Combination of Interests	6
Total number	15

Employment and vocational training were used most frequently as a social outlet. In addition to the five women who were referred for employment plans and vocational training alone, five others were referred for employment plans and social contacts, and one other was referred for employment plans, vocational training, and education (listed under Combination of Interests.)

The reality problems for which these patients were referred to social service are equally distributed among the various social outlets. However, in helping the patient to meet these reality problems, in all cases the worker offered psychological support which included environmental modification in ten of the cases and clarification in four. The

supportive relationship in ten cases was aimed at helping the patient accept herself as a potentially good mother; in thirteen cases the worker played a mother role to help patient make other relationships; in two cases the worker assumed the role of a supportive contemporary figure to help the patient make other relationships.

Environmental modification included the use of governmental agencies for financial aid, child welfare, housing and employment in five cases, the use of private community resources for employment, housing, schooling, financial aid, transportation, social contacts, recreational and avocational facilities in five cases.

Clarification was offered in four of the cases, in two of which the worker helped the patient use the insight she had developed in psychotherapy.

TABLE 3.

USE OF SOCIAL OUTLETS BY PATIENTS

Social Outlets	Attempted and Continued	Attempted and Discontinued	Not Attempted
Employment and Vocational Training	3	2	6
Education		2	1
Avocational Interests and Social Contacts	1	2	4
Total number	4	6	11

In the six cases where there was a combination of interests, one patient attempted and continued employment plans but did not attempt social contacts; two did not attempt either employment or social contacts; one attempted but discontinued social contacts and did not attempt employment; one followed through on social contacts but did not attempt employment; and one attempted but discontinued both vocational training and education.

In three cases, a job meant not only self-maintenance but symbolic independence from a dominating, overprotective, restrictive mother; in two cases it meant material security as compensation for emotional insecurity; in one case, it was a bid for acceptance since she felt valueless without money, also a result of a pattern established by her relationship with her mother.

Four women felt themselves to be inadequate mothers, and a job meant an opportunity to escape, without guilt, from their children towards whom they are ambivalent. To one woman, a job or other social outlets is a means for sublimating her narcissism and masochism and compensation for the growing independence of her son towards whom she is overprotestive and ambivalent.

To two women, education meant symbolic acceptance; in one case it appeared to be an attempt to emulate a sibling rival who was preferred by the mother. Both women were

inadequate mothers, devaluated themselves as women and attending classes was an excuse to get away without feelings of guilt, from their children towards whom they were ambivalent. It is interesting to note that these educational pursuits were abandoned when they began to find satisfaction in their roles as mothers and in feminine pursuits.

In all cases where social contacts or avocational and recreational facilities were sought, the women were isolated to a certain degree, felt rejected or feared rejection, were infantile, dependent, were often narcisstic, often masochistic because of guilt feelings. They all had a history of parental rejection, actual or fantasied. The social outlets which they sought were an attempt to feel more adequate and hence more acceptable to others.

TABLE 4.

COMBINATION OF TREATMENT AFTER REFERRAL TO SOCIAL SERVICE

Work with Psychiatrist and Social Worker	Number of Cases
Cases carried jointly	8
Cases carried jointly then by social worker alone	6
Cases carried jointly then by psychiatrist alone	1
Total number	15

The seven cases carried jointly are seen on the same

day by the doctor and the worker. The psychiatrist deals with psychic conflicts and the worker with the reality problems and the emotional problems that relate to them. Of the six cases carried by the social worker alone, one is seen in the home because her symptoms prevent her coming to the clinic. Psychiatric treatment for the other four was discontinued because the doctor felt that their symtoms were sufficiently improved so that they can function adequately enough. One of these four has requested readmission to the Clinic but her request was denied after an evaluation interview. She is being seen in social service because her children are in treatment in the Child Guidance Clinic. The case which is being carried by the psychiatrist alone after being carried jointly, is one in which the reality problem was adequately solved but other psychic conflicts remained.

The length of contact with Social Service varies from two months to thirty-three months. The following table shows the distribution.

TABLE 5

LENGTH OF CASEWORK TREATMENT

Months	Number of Cases	
1 - 4	2	
5 - 9	6	
10 - 14	1	
15 - 19	1	
20 - 24	0	
25 - 29	3	
30 - 35	2	Total 15

The largest number of cases was seen for six months. Five cases have been in casework treatment over two years, eight for less than one year.

CHAPTER VI

Case Presentations

The following six cases have been chosen to represent the group being studied. No attempt has been made to group them since the problem they present does not lend itself to grouping. The women chosen in these presentations show a distribution in age and presenting problems in regard to various social outlets.

Alice Atkins

Mrs. Alice Atkins is a nineteen year old Negress born in Virginia. She is married to a Northerner. She was referred to the Clinic in December, 1949 because of psychosomatic complaints. Six months prior to referral, she had a miscarriage and following that, had been depressed. Patient had ambivalent feelings about having a baby. She stated that during her pregnancy she wanted a baby, but now she does not; her husband still wants a baby.

Several weeks after referral to the Clinic, she was referred to Social Service for help in finding social contacts. She said she was lonely since her husband goes to school and works, leaving her alone a good deal of the time. She was interested in cooking but not in sewing, and wanted to go to a cooking class. She was interested in church, but did not know any church near her home. Her opportunity to become acquainted with her neighborhood was impeded by the fact that she has moved frequently. Her desire to become a nurse was discouraged by her husband.

Patient related a history of deprivation. Her mother died when she was four. No one in the family will talk to her about the cause of death but patient thinks her mother died in childbirth. However, she mentions no siblings. After her mother's death, Alice lived with her grandmother who, in turn, died of tuberculosis when patient was eight. From eight

to eleven she lived with various relatives. From eleven to fifteen she lived with a maternal uncle and was happy. Her relationship with her father was poor. He would not let her stay with him but now wants her to support him. She was not robust and remembers attending a special class for underweight children. She had a traumatic onset of menses following sexual intercourse. She feels that the people in her environment were filled with all sorts of fantasies and superstitions which were taught to her as truth. She felt rejected by her family, especially in reference to the fact that they refuse to talk about her mother to her.

From age thirteen she had a checkered work history, employment usually terminating because of poor relationship with some member of the employer's family, either male or female. She states that she never had friends but wants friends now.

Patient met her husband while he was in service and she was working for a captain's family in Norfolk. They came North after their marriage. She apparently gets along well with her in-laws but at times thinks her sister-in-law is "using" her. (Patient is suspcious of people's motives and often thinks she is being " used" and is unappreciated.)

Patient feels inferior to her husband intellectually, but resents his criticism of her. She also resents criticism from her friends. She tends to identify with those who, she feels, are lonely or ill-treated.

Early in her contact with the worker, it appeared that her greatest concerns were around her acceptance of motherhood and her uncertain relationships with people. Two figures who offered her opposite possibilities for identification outside of the Clinic were a woman for whom she did domestic work and a cousin with whom patient lived. The former had four children, was a warm accepting mother with positive attitude towards pregnancy and confinement. The latter was a rejecting mother, neglectful of her son and promiscuous in her behavior. Patient was very critical of her.

The worker's earlier role was that of a friend and confidante. Although there was discussion of recreational activities, especially of cooking school, no definite action was taken.

In September, 1950, patient became pregnant. She had a great deal of ambivalence about the baby. She had fears about pregnancy and delivery. She had doubts about her own ability to be a good mother. The worker's role changed to that of a warm, accepting mother figure with whom patient could identify. The worker's aim was to help patient acquire a positive attitude towards the baby and accept herself as a potentially good mother. Worker planned with the patient to get things for the baby. At one time she helped her to get furniture. Patient joined a mothers' club sponsored by the Visiting Nurse Association (the first positive relationship towards the baby), planned to nurse her child, and began to do creative sewing as a hobby at this club. She began to sew for the baby.

The birth of her baby girl in May meant a great deal to her, because she was able, she said, to produce something of her own. She is able now to stand up to her husband when he criticizes her. Motherhood, however, did not make her feel more secure in other relationships. She was jealous of her husband's attention to the baby and feared his rejection of her. This fear of rejection was increased when he again went back to school and took a night job in the fall.

In the fall of 1951, patient again became pregnant. She is again ambivalent about this pregnancy, and her present worker's goal is to help her accept this child and to help her in making friends.

Interpretation

This patient's history presents a picture of rejection and fantasied rejection. The death of the mother in the patient's oedipal period was a traumatic experience. It is

interesting to note that the patient apparently successfully repressed all memory of her mother and thought that her grandmother was her mother until after the grandmother's death. This mother surrogate, too, "rejected", "deserted" her by dying when the patient was eight. The patient's memory of attending classes for undernourished children, also gave her a feeling of rejection, rejection by denial of food. The father, too, rejected her. Her relatives, she felt, rejected her by refusing to discuss her real mother and the cause of her death, reactivating her own guilt feelings about her mother's death.

Mrs. Atkins received no love and therefore can give no love. This patient's pattern for object relationships was formed in childhood. Never having felt accepted then she looks with a suspicion of people now, expecting rejection and interpreting their actions in terms of her expectations. When her husband gets a night job, she feels rejected.

Her guilt feelings make her feel unworthy of love; she devaluates herself, feels inferior to her husband. Her unsatiable need for love makes her a rival to her own child and she resents her husband's attention to it.

Never having had a positive loving mother figure with which to identify, patient is unable to see herself as a mother and doubts her ability to be one or her worthiness to be one.

Her doubts about pregnancy and delivery are natural to some extent, but her fear is increased by the belief that her mother died in childbirth.

Her desire to make friends, to make social contacts, was in answer to her need to find acceptance, but since a pattern of rejection impeded her from making positive object relationships, she needed help in this area. The referral to Social Service was made on this basis.

In the two and a half years that the patient has been in treatment, she has not actually formed any close friendships on a social basis, but teached out in her relationship with her social workers. This may prove a corrective experience in time so that she can make other friends.

The patient's pregnancies changed the worker's role to give the patient a corrective experience by identification with a "good" mother so that she could accept her own role as a potentially good mother and as such, accept her children. It was in preparing for the birth of her first child, with the psychological support offered by the worker, that the patient actually began to make social contacts in the mothers' club and to cultivate a hobby. It was as if she had had to wait until she had permission in order to be creative.

With the birth of her child, she stopped devaluating herself to such a great extent. She had proved that she could produce something of her own, something good and

acceptable. It is interesting that after this, she did not feel quite so inferior to her husband and was able to stand her ground against his criticism. She probably had latent hostility to all men derived from her unsatisfactory relationship with her father, but had not dared to express any of it towards her husband whom she is dependent on, emotionally and financially, until now.

The patient is still in treatment with both the psychiatrist and worker.

Blanche Barton

Mrs. Blanche Barton, a thirty-one year old, white woman, was referred to the Clinic in 1949 because of a combination of psychosomatic and psychoneurotic symptoms. In a few weeks she was referred to Social Service for help around employment.

The patient presents a history of emotional and economic deprivation. Her mother and father separated when patient was very young. The mother married three times. Patient has one sister.

Between the ages of one and three, patient stayed with her father. Then when she returned to her mother, patient used to run away. The father died in a mental hospital ten years ago.

Patient married four times, but none of her marriages was successful. Her first marriage was at fifteen to a man of twenty-two. Patient states that her husband bought her from her mother for fifty dollars and a promise to stay on with the mother, presumably for the purpose of contributing financially to the household. When the husband did not pay the fifty dollars, the mother began insinuating that the patient ran around with other men. The marriage ended in divorce. The mother permitted patient to remain at home only when she was working.

The second marriage was to a man with a prison record. Two girls were born of this marriage. The husband acquired a mistress, had a child by her, and brought them into the home. The patient went to work and the marriage ended in divorce.

The third marriage was to a man she met in a mission organization. He was actually interested in the sister of the patient. When patient came home one day and found her husband and sister together, patient left. The marriage ended in divorce. Later the husband married the sister after their three children had been born. Patient's mother permitted her to stay with her only when she was working.

The fourth and current marriage is to a dependent alcoholic who is punitive to her children. She states that he really like them and intends to adopt them. The mother-in-law is protective to the husband and hostile to the patient. Patient stated that the marriage ran more smoothly when she was working.

At the time of referral, patient's sister was in a mental hospital and patient was caring for the eight year old daughter of this sister. Patient was showing an interest in Christian Science. She was having difficulty in handling her daughters, one of whom was exhibiting somatic complaints and the other pre-delinquent behavior. (Both children are now being treated in the Child Guidance Clinic.)

Patient presented many problems: she had feelings about mental illness and a fear of it; she had problems around being a mother to her children; had financial problems; problems around her husband's drinking; problems of guilt about her multiple marriages which she almost equated with promiscuity. (She felt that only the first marriage was sacred); she had problems of handling her hostility towards her mother; and fears of pregnancy.

To meet her immediate reality problems, the worker helped patient with application for Welfare. When her older daughter became a school problem and a possible social problem and was placed in a study home, worker had contact with the School Department. W hen the possibility had come up of foster

home placement for this girl, worker had contact with a child placing agency.

To help patient with her feelings of inadequacy, worker sought to build her ego strength by stressing the positive aspects of her relationships: her being a helpful sister, a good aunt. Her interest in Christian Science was encouraged. It gave her support in refraining from drinking and made her feel accepted.

Worker felt that the patient's increasing ego strengths were due as much to her activities in the church as in her contact with the worker.

Interpretation

This case is an interesting study of the repetition of a pattern of behavior in three generations, and the projection of the anxiety over this behavior from mother to mother which thus recreates the pattern in each generation. The mother married three times which implies a degree of promiscuity, projected this onto the patient who subsequently married four times, considers her multiple marriages synonymous with promiscuity, and now projects her fears of promiscuity onto her twelve year old daughter who presumably has begun to accept money from men.

Patient's childhood shows strong evidence of maternal rejection. Much emphasis was put on money, and the patient was made to feel that the only times she had value to her mother was when she could earn money. In other words, the patient had no intrinsic value, was worthless. She carries this feeling through to other relationships and feels that her

marriage runs more smoothly when she is earning money.

Her marriages follow a pattern also; she marries weak, dependent men who desert her or fail to support her. Patient appears to be strongly masochiatic and seems to ask for punishment by repeatedly putting herself into such a marital relationship. She feels unworthy of love and appears to need to work to bring something more than herself to the marriage in order to be accepted.

Her fear of mental illness may be partly due to her experience with her father and her sister and her belief that it is hereditary. It may also be due to her fear of it as punishment for her promiscuity. The sister became mentally ill after a history of promiscuity involving patient's third husband.

It appears that patient's request for help in finding employment was only partly due to financial need. Employment and earning money had become unconsciously her only means of finding acceptance because of her former experience.

Worker's aim was to relieve patient of some of her guilt feelings and to accept herself as a person who has a potential for being good and adequate and, therefore, acceptable. To relieve situational pressures, environmental modification was used in contacting other agencies. Psychological support was used in accepting patient and in stressing her positive values in her relationships with her sister and her niece, thus

helping her to feel that she also had the potentiality for being a good mother. Her interest in religion was also fostered because it helped her feel accepted in the congregation and, therefore, to herself without paying for this acceptance.

Patient is at present being seen by the social worker alone for help in handling her children who are patients in the Child Guidance Clinic. The aim of the worker is to help patient accept herself as a mother and to be more accepting of her children.

Clara Carter

Mrs. Clara Carter, a thirty-eight year old white woman, was referred to the Clinic because of a combination of psychosomatic and psychoneurotic symptoms. She was referred to Social Service several months later for help in arranging for evening courses and help with her relationships with her children.

Patient is one of four siblings. She has an older brother, and older sister and a younger sister. The mother was a large, domineering woman who worked outside the home and placed the responsibility for all the household duties upon patient. Mother was very restrictive. No housework was required of the other siblings who went out and enjoyed themselves whereas patient had to stay home and look after their needs. They all completed high school; patient had to leave school in the eleventh grade. Patient's father was a passive man who drank at home but was not an alcoholic. Patient received little affection from her parents and felt rejected. Patient was hostile towards her mother, resented her siblings, had a better relationship with her father. She is fairly close to the older sister now.

The brother was mother's favorite. He was interested in mathematics and wanted to be a teacher. Mother, however, frowned upon an academic career and persuaded him to study engineering at college.

Recently, he again expressed a desire to teach mathematics.

Patient had few positive relationships with women, but one of these was with her mathematics teacher in high school whom she admired very much. She had few friends when she was a child, and her current friends are usually older women who are almost like accepting mother figures.

Patient's husband takes courses to advance in his job. There are three children, all of school age; the eldist, a son, had difficulty with mathematics; a daughter, who is heavy-set, to whom patient could not relate; and a younger son to whom patient was indulgent and to whom she made the other children defer.

Patient came to Social Service for help in arranging for evening courses in mathematics and typing. She was ambivalent about these courses because she felt uneasy about leaving the youngest child unsupervised. She said she wanted to learn mathematics so that she could help her older son do his problems.

Patient was compulsively active, irritated with her children, had conflicts over her relationship with her mother. It became apparent that her problems centered around her relationships with these relatives and around her activities in the home rather than in her need for further education as such. Sensing this, the worker played a supportive role, accepting patient's feelings and helping her find satisfaction in her activities as a woman and as a mother and as a homemaker.

Patient abandoned all thought of taking courses after the first few interviews. She began to bring crocheting to the interviews. Worker recognized her interests in such feminine pursuits and encouraged her, stressing positive values in these activities. Finding that the worker accepted her feelings of irritability with her children without being critical or punitive, patient was able to accept her ambivalent feelings about them and to accept herself as a good mother in spite of these feelings. She became less restrictive to her children and began to relate better to them.

Interpretation

Patient's mother was a woman with a great deal of masculine aggressiveness. She shunted her feminine responsibilities onto the patient and at the same time rejected her in favor of her brother. Using the mother figure for identification, patient regarded feminine pursuits as of little worth. Since the mother imposed these duties of little worth on her, she must be of little worth herself, unfit for anything else. Her mother's preference for the brother rather than for any of the girls intensified the feeling that feminine pursuits were of little value.

Her desire to take courses in mathematics was an attempt to get for herself something which the mother found of value in the brother. Education to her meant acceptable accomplishment, something worthy of esteem. It may also be an indication of her latent hostility to men in that she may have been competing with her brother and her husband in their activities rather than finding satisfaction in her own.

Her relationships with her children were in part determined by their order in the family group. She equated her older son with her brother. She could not accept him for apparently contradictory reasons: he was a male figure to whom she was hostile because he reminded her of her brother's preferred position in the mother's affections; she could not tolerate his lacking any of her brother's attributes. Her

indulgence towards her younger son and her insisting that the other children defer to him, appears to be a result of her identification with him. Both the patient and her son are the third children in the family and she treats this boy as she would like to have been treated.

Her hostility towards her daughter appears to be a result of her being built like patient's mother rather than because of personality traits, since the girl is quiet and a good scholar like the patient's brother.

The resentment the patient feels towards her children may be a reactivation of the resentment she felt at being made responsible for the care of her siblings. She felt guilty over this hostility and felt that she was an inadequate mother.

The worker sensed the artificiality of Mrs. Carter's interest in education, recognizing it as a symptom of an underlying emotional need. She used psychological support in playing the role of an accepting mother figure. The patient identified with her and became more accepting of her children, found greater satisfaction in her own role as a mother and a homemaker. She no longer needed courses in mathematics as an escape from her home and her children or as compensation for her feelings of inferiority as a woman. She found acceptance in the worker in contrast to the rejection she found in her mother.

Dora D'Amico

Mrs. Dora D'Amico, a forty-two year old, white Jewish housewife, was referred to the Clinic in 1946 because of psychoneurotic symptoms and paranoid ideas. Two years later she was referred to Social Service for help in making vocational plans.

Patient is one of seven children. She has a brother and two sisters who are older and a brother and two sisters younger than herself. Patient's mother died of cancer when patient was thirteen and mother was forty-two. The mother had a psychotic episode during which she was abusive to all the children except to the patient. Patient took over the care of the children at this time as she did after mother's death.

Patient recalls abject poverty in the home. The mother used to peddle fish and often her hands were badly frost bitten. Patient was the only one who helped the mother. Patient states that her mother thought that it was sinful to spend money except for food and for doctors. Relatives used to give mother money, but she used to give it away instead of buying more things for her own children.

Patient had a dependent relationship with her mother which she transferred, after her mother's death, to an aunt who had paranoid ideas and who died in a mental hospital. The father never provided adequately. He and an older sister tried to prevent patient from having any social contacts. Patient's relationships with the other siblings were good, especially with her younger brother. He is now married and has grown away from her. Patient feels that she was never appreciated. She had to go to work to earn money for the things her family denied her.

W hen patient was being courted by her husband, he was still married to his first wife and patient worked to earn money to pay for the divorce. Her family opposed the marriage because the man was of a different faith. The husband is unfaithful and patient contemplates divorce but is ambivalent

about it because, she says, it would bring about a loss of financial support and so deprive her son of material things she wants him to have.

Patient has one son, born after several abortions. He is eighteen. Her feelings towards him are mixed. She has a warm feeling for him, she wants him to compensate her for the rejection of her family and her husband and tries to keep him with her. She prevents any relationship between him and his father. On the other hand, she wants him to be independent and makes half-hearted attempts to foster his friendships with his contemporaries of both sexes and of urging him to live at school. She is overprotective of him on the one hand and has fantasies and fears of killing him or his being killed on the other. She equates him with her younger brother who "deserted" her.

Mrs. D'Amico feared people, feared seeking a job, but she wanted a job so that, she said, she could leave her home and still provide for her son. However, she was afraid of change and was ambivalent about leaving her husband and about getting a job. She was unable to use money to buy things for herself, for her own enjoyment. She was depressed and had suicidal thoughts.

Her choice of possible jobs or vocational training courses was unrealistic but catered to her emotional needs; interior decorating, house mother in an orphanage, companion to an elderly woman, hostess, charm school, etc. She was interested in dressmaking and made her own clothes with great skill.

Worker encouraged patient to make vocational plans and helped by getting information about courses and making a referral to an employment agency. When none of these contacts proved successful, patient became angry at worker for encouraging her to undertake activities which led to failure. Worker interpreted patient's feeling to her and accepted them. Worker recognized that patient was not actually ready for these activities and also recognized patient's hostility and her fear of forming a relationship with the worker and the psychiatrist because of the possibility of rejection through loss. Worker gave patient support in this conflict.

The contact with the patient has been fairly long, and the relationship is strong. Patient is able now to tolerate worker's interpretation of her feelings. Patient has begun to have some respect for herself and is able to spend money on herself and to enjoy some luxuries without guilt, or if she feels guilty, she recognizes the feeling and can explain it to herself.

She is able to go out, to face people, and fight back at real or fancied wrongs. She understands her own symptoms and can discuss them with her worker.

Interpretation

Mrs. D'Amico had a warm dependent relationship with her mother and identifies strongly with her. However, since the mother's illness burdened her with household duties, she must have felt some resentment. The strong masochistic tendencies are indicative of guilt. This guilt may have been increased by her mother's death and that of her aunt, and by her own marriage to a man of another faith, a marriage of which her family disapproved. (Patient feels especially depressed during her religious holidays.) The inability to spend money on herself or to enjoy luxuries and the need to do for others rather than for herself are evidence of this masochism. Also the inability to spend money on herself has the ear marks of strong identification with her mother. It seems as if she is unable to allow herself to have more than her mother had or to disregard her mother's precepts.

Her relationships with sisters fluctuate. Even when they make overtures to her, she is unable to accept token of

their affection and concern for her. It is as if she has to cut herself off from all warm relationships. Part of this may be due to her masochism and part to her distruct of relationships since so many times she had become close to someone only to lose him, e.g. her mother and her aunt through death, and her brother through marriage. This attitude also carries over into her fear of relating to her therapist and to her worker. Masochistic needs of the patient are met to some degree by her marriage which she hesitates to dissolve. This need was also fed by her acceptance of abuse and injustices, actual or fantasied, at the hands of salespeople and others.

Her narcissism is evidence of dependency needs inadequately met. It is an antidote to her strong masochism and self-devaluation.

Her attitude towards her son is ambivalent. The series of abortions preceding his birth indicate basic rejection. Her deep concern for him and her over-protection, her attempt to almost incorporate him with her solicitude appear to be compensation for basic rejection. She identifies with him, interprets his feelings and attitudes in the light of her own, yet resents his having the material and emotional satisfactions she was denied. His constant companionship and dependence on her give her satisfaction she was denied in other relationships. She needs his need for her, yet she has doubt of her adequacy as a mother.

Her desire to get a job is partly due to a desire for financial independence to escape from an unsatisfactory marriage, but is mostly a need to find some compensation for her son's growing independence from her.

The worker recognized that this patient needed to be dependent on a woman whom she could trust. She fostered this dependence by making all kinds of telephone calls and contacts for her to give her a feeling of security.

The worker used environmental modification in making referrals to an employment agency and in getting information regarding courses for patient, and school placement and living quarters for her son. She used some clarification in interpreting patient's feelings to herself. Psychological support, however, was the predominant type of casework employed. The worker recognized the patient's narcissistic and masochistic needs and aimed at helping the patient sublimate these tendencies in socially acceptable activities. By accepting the patient, she gave her a new kind of experience which gave the patient some confidence in herself and helped her begin to release her hold on her son. Since the worker found the patient an acceptable person, the latter was able to find value in herself and began to allow herself to spend money on herself and to enjoy "nice things" so necessary to her narcissism. She still has some guilt about indulging herself, but understands this and can cope with it. She also understands her

symptoms and recognizes their cause. Having found new confidence in herself by being allowed to be dependent on the worker, she can now be more independent, and now makes her own telephone calls and stands on her rights.

Evelyn Elliot

Evelyn Elliot is a twenty-one year old, single, white woman who was referred to the Clinic in 1951 for a combination of psychosomatic and psychoneurotic symptoms. Eight months later she was referred to Social Service for help with vocational planning and social contacts. At this time, the psychiatrist felt that the social service contact would meet her needs sufficiently and discontinued treatment.

Patient is an obese girl, quite isolated, insecure, and has few friends of either sex. She seems to resent those who can form heterosexual relationships. She has great difficulty in expressing hostility towards those on whom she is dependent.

Patient lives with her family whose standards make them live beyond their means. The mother is described as domineering, immature, dependent. She sets great store by material things and social position. Patient questions her sincerity. She feels that her mother is overprotective, resents any show of independence on the part of the patient and tries to discourage patient's contact with the clinic for this reason. Mother has imposed a standard of achievement which patient is unable to meet.

The father is an insecure, inadequate person who is unable to assume responsibility either at home or at work and has, thus, incurred the wrath and contempt of his wife in a genteel sort of way. He cannot accept success. He had to leave college prior to graduation. Patient feels that he understands her more than does the mother. The mother feels that he is not the equal of the other members of his family.

Patient has one sibling, a seventeen-year old brother, who is favored by the mother. This

brother is not so bright intellectually as the patient, but he is athletic, gregarious and more secure in his relationships. There is great rivalry and the patient's attitude towards him is ambivalent: she resents her mother's preference for him but admires him and wants to be like him. The nrother attends an expensive preparatory school.

Patient wanted to study nursing but her mother disapproved and persuaded her to enter a school that trains kindergarten teachers. Her patient did well in her first year, but failed in her sophomore year when she had greater responsibility. Similarly, in camp experience with children she did well as a junior counselor but the following year was unable to assume the responsibility of a senior counselor.

Following her leaving school, patient went to live for the rest of the winter with her paternal grandmother and two unmarried aunts. The grandmother and one aunt are domineering like patient's mother. The other aunt is a social worker, a permissive, accepting person. Patient wanted to be a social worker but felt unequal to meet the standards of the profession. She has similar feelings about being a teacher.

Patient feels guilty about failing in school because she feels that she has "shirked her duty" and let her parents down. She is ambivalent about going back to school and states that she doubts her ability to measure up to the standards of the teaching profession. She also thinks that by going back to school she might deprive her brother of tuition.

On returning home from her grandmother's house, patient decided to get a job to earn enough money to pay for tuition in a school of nursing. This would serve as a means of getting away from home in an acceptable manner, thus permitting her to achieve some independence without incurring the anger and displeasure of her mother. Furthermore, in paying her own tuition, she would not be depriving her brother.

Patient's job is that of children's librarian.

Her supervisor is an elderly domineering woman to whom patient finds it difficult to relate.

The worker is letting the patient set her own pace in achieving the independence she thinks she wants. She does not discuss nurses training except as the patient brings it up. She recognized that this girl has a mutually hostile-dependent relationship with her mother which is at present necessary to her. The worker is creating an atmosphere of permissivness. In this atmosphere, the patient finds it easier to express her hostility towards her supervisor who, to her, is a ptototype of her mother and her grandmother. The aim of the worker is to help this patient establish object relationship with girls first since she is emotionally still in the prepuberty state of development.

Interpretation

This patient feels that her brother is favored over her. A feeling of rejection is here implied. Any identification she might have sought with her father was unsatisfactory because he too is criticized by the mother as being inadequate.

The mother's favoring the brother gives the patient a further sense of inferiority both as a person and as a woman and there is some evidence of her rejection of femininity. This is noted by her psychiatrist on her psychosomatic chart. Her orality, manifested in her obesity, is a means of achieving satisfaction on a primitive level and a protection against possible heterosexual relationships, both because she does not want to be a woman and because she fears she cannot be an adequate one.

Because Evelyn has this infantile, dependent relationship with her mother, and because of the satisfactions she derives from it, she is unable to permit herself to form relationships with other girls as is normal in the latency and early puberty periods, lest such friendships interfere with her relationship with her mother. The mother, being herself an infantile person, fosters this dependency and reacts with overprotection.

Because of her emotional dependence on her mother, she is unable to express the hostility she feels towards her for fear of retaliation by withdrawal of protection. And, by the same token, she is unable to express hostility towards any older domineering women, since they symbolically represent her mother.

An expression of hostility towards her brother, too, would bring retaliation - displeasure - from her mother.

This girl's choice of vocations, i.e. camp counselor, children's librarian, nursery school teacher, even nursing, bears witness to her ability to relate only on an infantile-dependent level, to people who are as infantile-dependent as she is; a sort of mutually dependent relationship like the one she has with her mother. Her inability to assume responsibility in these vocations shows her lack of maturity and her inability to tolerate success.

The worker, in being permissive allows the patient to express hostility without meeting it with counter-hostility. This helps her to dilute some of her guilt and thereby to dissipate some of her need to devaluate herself. Psychological support is being given as corrective experience in forming a relationship with the worker. This will serve as a pattern for beginning to form object relationships with other girls as are necessary to, and typical of, early puberty.

The worker purposely does not encourage discussion of a nursing career because the patient does not feel adequate and is not ready to carry out such independent action. Such being the case, the worker would be pushing her into independence which the patient cannot accept, and would be encouraging a negative transference by falling into the role of the demanding mother who sets up unattainable standards, who keeps her dependent, yet does not satisfy her dependency needs.

Frances Farnum

Mrs. Frances Farnum is a fifty-seven year old, married white woman who was referred to the Clinic in 1949 because of hypertension, depression, anxiety attacks, and mild agoraphobia. In 1951 she was referred to Social Service for help in making social contacts and vocational planning.

Patient is the only living child of parents who separated when she was three years old. Two siblings died when she was two. The father visited patient after the divorce, but she was hostile to him because relatives told

her he had been abusive to the mother. The mother worked after the divorce, was depressed and the relationship between patient and mother was not close. Patient was close to two maternal aunts.

At five, patient had tuberculosis of the right hip and used crutches through high school. She says she had some friends, dated some, but was on the whole, rather shy and isolated. At present she wears a hearing aid.

After high school, patient found satisfaction in work as a hairdresser and a stenographer. She stopped working at twenty when her mother developed cancer. Even then the relationship was not close. After mother's death, patient married. A daughter and a son, in that order, were born of this marriage. She had an abortion between these births and one after the son's birth, pleading insufficient income for curtailing the size of the family.

Patient's relationships with women is closer than it is with men. She is more attached to her daughter who, she feels, is competent than she is to her son who, she feels, is passive and inadequate. Her husband, too, is inadequate as a father and as a provider. She relates better to her granddaughter than to her grandson. Her strongest current relationships are with two aunts and a neighbor, all elderly, comineering and dominating women whom the patient resents but from whom she cannot free herself. She is subservient and compliant.

It is interesting and important to note that the onset of the acute state of her symptoms occurred about the time of the daughter's pregnancies.

The patient had a home which she enjoyed and in which she entertained a great deal. These activities were interrupted during the war when patient's daughter married, moved to the west coast, and patient's husband was commissioned by the Army. During his service, patient successfully ran her husband's restaurants. The husband made her sell the business and the home in spite of the fact that they spelled security to her. She enjoyed being

an officer's wife and did not want her husband to resign from the Army because she felt he could not compete successfully in civilian life with younger men. However, he resigned and has not been able to find a job that pays well. She has visited back and forth with her daughter. Patient has been unable to establish a home again and lives in a one-room apartment. She is hostile to her husband and has pushed him into a job he dislikes and now feels guilty about it. She does not leave him because of a sense of duty to him.

She feels isolated, unhappy, has a sense of insecurity, has fears of starving, of her sons' starving, and of death. She expressed a desire to belong to clubs, but fears being in groups.

The caseworker encouraged patient to come to the Clinic by making arrangements for her transportation with a local agency. When patient expressed interst in club activities, worker made inquiries about local activities which might be of interest to her. These assured patient that worker was interested in her even though she was not ready to take part in these activities. Worker accepted patient's expression of hostility towards the dominating elderly females in her life and towards her husband. Worker shows interest in patient without being directive or domineering. She accepts patient as she is, but encourages her to talk about the positive factors in her life in the past.

Recently patient stated her feelings of depression and anxiety have left her and she drove an automobile alone for the first time since treatment began. However, just before patient was to visit her daughter, her symptoms returned.

Interpretation

This case was presented at a staff conference. The dynamics indicated below were brought out by the discussion of the psychiatrists and the finding of the psychologist based upon the results of projective tests.

Patient's family constellation was disrupted by divorce at the age of three. Neither parent offered her the security of a warm accepting love relationship. The hostility she felt at this rejection she directed mostly towards her father and then to men in general, since at this age, the mother's protection was more necessary to her than was the father's. Her hostility towards her mother was accompanied by guilt which created further hostility which she had to repress. This guilt deepened the mosochism characteristic to women which marks her subservient but hostile-dependent relationship towards older women who dominate her. Her dependency needs of the pregenital period had apparently never been adequately met. With the father figure removed, the genital period offered little opportunity for the normal working through of relationships with the parents and for the normal identifications which serve as a basis for later heterosexual adjustment. In later marital relatinnships, patient found little satisfaction in being a wife and a mother. The satisfactions she found in her jobs, in her home and in material things were compensations for the lack of satisfaction she found in her affective life. When, in treatment, she sought help in making social contacts and vocational plans, she sought to regain those satisfactions she had previously found in her work and in the material possessions which gave her substitute security for emotional security.

The fact that she was ill and on crutches through pre-puberty and adolescense served to set her off even more from the normal activities and companionships of her peers and made her even more isolated than ever. Her later relationships with people seem to have been based more on the satisfaction of being able to entertain them in a well appointed home than in the satisfaction she found in their companionship.

The fact that she is able to relate better to women than to men speaks of her preoccupation in gaining a mother's love which she seeks from a succession of mother figures on whom she is dependent and whom she resents.

She needs to repress her resentment in order to retain the protectionof these women. Her symptom of hypertension is indicative of repressed hostility; the depression and the phobias are evidence of guilt and resulting hostility projected onto her environment. The phobias also serve the purpose of always having someone with her to protect her against a hostile environment lest it punish her and she die.

Her relationship to her daughter is more of a reversed mother-daughter relationship with the daughter being strong, adequate, and competent in contrast to the patient's own weakness, inadequacy, and incompetence as a mother and a wife. There appears to be great dependence here on the part of the patient with implied hostility which she displaces onto these older woman and a fear of rejection. The fact that her

symptoms were exacerbated when the daughter became pregnant would seem to indicate that she regarded her grandchildren almost in the light of sibling rivals and feared her daughter would reject her upon their birth.

The patient's fear of starving and of her son's starving accompanied by a feeling that she had failed him, is an indication of her great dependency needs on a primary level and her swareness of and guilt at not having been able to meet his dependency needs.

The worker's aim is to give the patient an experience of relating to an accepting femal figure, a combination of a good mother and a good daughter who will not criticize her, who is genuinely interested in her and who will not dominate her, and whom the patient can trust to meet her dependency needs.

The worker allowed the patient to become dependent on her and without pussing patient, made contacts for her with other agencies even though the patient was not ready to follow up her own suggestions for social contacts. This, hoever, gave the patient the experience of feeling protected and secure in a relationship with a female figure.

Patient sees the clinic as a whole as a sort of mother, a haven of acceptance, and her latest relapse may be due to a fear that if she interrupts treatment to visit her daughter, she may not be taken back into treatment and will lose the

security she found there.

At the staff conference at which the psychiatrist, the psychologist, and the social worker presented summaries of their work with the patient for further suggestions for treatment, it was recommended that psychiatric treatment be given at longer intervals, but not discontinued so as not to repeat a situation similar to the desertion of the father. Her contact with social service is to continue and supplement therapy to help her in the area of relating to female figures and to find satisfaction in social contacts.

CHAPTER VII

Summary and Conclusions

This has been a study of fifteen women referred by their psychiatrists in the Psychosomatic Clinic to Social Service for help in finding social outlets. Underlying the referral was the concept that these outlets would meet an emotional need and would thereby relieve pressures which impeded psychiatric treatment.

The purpose of the study was to determine whether the kind of social outlet chosen was indicative of the patient's problem or whether it was an expression of another need she had.

The writer's thinking regarding dynamics, casework practice, and treatment goals, was discussed with the caseworkers wherever possible. Case record material was supplemented by conference notes and psychosomatic charts.

The study attempted to find answers to the following:

1. What social outlets did these women seek?
2. What emotional needs did these women seek to meet through these social outlets?
3. To what extent did these patients make use of these social outlets?
4. What factors contributed to the creation of these needs?
5. How did the social worker use her awareness of these facts in making treatment plans to help patient meet these needs?

The social outlets these women sought were employment and vocational training, education, and avocational activities and social contacts.

Basically, all patients hoped to find compensation in these social outlets for some of their own inadequacies as people, as mothers, or as women. They had a need to be dependent and to be accepted. Specifically, these women looked to these outlets for help in the following areas: three needed a job to give them symbolic independence from a dominating, overprotective mother; two needed the material security offered by a job to compensate for emotional insecurity; four felt themselves to be inadequate mothers and wanted a job as an excuse to get away, without feeling guilty, from their children towards whom they were ambivalent; one woman needed a job or other social contacts as a means of sublimating her strong narcissistic and masochistic tendencies and to compensate her for the growing independence of her son; one felt she had so little intrinsic value that she had to have a job to bring more than herself into any relationship; two women who were interested in education sought from it a two-fold satisfaction: as an escape without guilt feelings from their children towards whom they were ambivalent, and as an acquired attribute to enhance their value as people since they devaluated femininity; one woman needed avocational activities as a means of making object relationships; one

woman needed social contacts in which she could be of use to others to sublimate her masochism. One of the women who wanted a job as a means of escape from her children, also needed avocational activities to sublimate her narcissism.

The choice of social outlet has no particular relationship to the emotional need since one woman chose one kind of outlet and another chose a different outlet to meet the same emotional need. Striking evidence that the emotional need required satisfaction rather than the desire for any specific social outlet, was the cases of four women who felt themselves inadequate mothers and were ambivalent towards their children and who asked for jobs (in two cases) or for courses (in two cases) but who lost interst in these outlets after being seen by the social worker and found her accepting and interested in them. These women began to feel that they were potentially good mothers, found their children more acceptable to them, found greater satisfaction in their roles as mothers and women and needed no compensating social outlets. Another interesting fact is that one woman who had expressed an interest in avocational activities as a means of making object relationships (friends), did not follow through on her own suggestions until she bacame pregnant and had accepted herself as a potentially good and adequate mother. Her avocational activities began when she joined a mothers' club.

In all fifteen cases there were elements of parental

rejection, actual or fantasied, and in eleven there were elements of sibling rivalry. However, parental rejection can be found in the histories of almost all neurotics. The material presented by these patients in this study does not definitely trace in every case emotional need back to parental rejection and/or sibling rivalry. Therefore, the writer hesitates to conclude that these were the actual precipitating factors in the specific emotional needs which these women expected filled by social outlets. They may have been contributing factors.

Awareness of the emotional needs of these women served as the basis for formulating the diagnosis and for setting treatment goals by the case worker. In each case the worker aimed to meet the need of the patient for dependency and acceptance so that help in finding social outlets was a by-product or a tool in helping the patient. In thirteen cases the worker assumed the role of an accepting mother figure to help patient be more acceptable to herself, to accept herself as a potentially good mother, or to form other object relationships; in two cases, the worker assumedthe role of a contemporary figure to help the patient make other object relationships. In one of the above named cases the role of the worker changed with the need of the patient, and in another of the cases, the worker's role was a combination of mother and figure and contemporary figure.

Psychological support was used in all cases. In ten cases environmental modification was used as an adjunct of psychological support to relieve environmental pressures which impeded treatment. Clarification was used in four cases where the relationship was strong and the patient was ready for it.

The women in this study were all immature, dependent, isolated in varying degrees, tended to devaluate themselves, had difficulty in forming object relationships. Their relationships to their parents, especially to the mother, were ambivalent. Narcissism, indicative of unmet dependency needs, was prevalent as was masochism, indicative of guilt feelings.

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APPENDIX

Schedule

1. Name.
2. Age at time of referral to Social Service.
3. Date of referral to Clinic.
4. Date of referral to Social Service.
5. Reason for referral to Clinic.
6. Reason for referral to Social Service.
7. Education.
8. Color.
9. Religion.
10. Occupation.
11. Source of Income.
12. Living arrangements.
13. Marital status.
14. Psychiatric diagnosis.
15. Relationships with:
    a. Mother
    b. Father
    c. Siblings
    d. Husband
    e. Children
    f. Friends
    g. Other significant figures.
16. School adjustment.
17. Work adjustment.
18. Presenting problem according to patient.
19. Emotional problems involved.
20. Social outlet requested:
    a. Education and Vocational Training.
    b. Avocational activities and social contacts.
    c. Employment.
21. Caseworker's activity:
    a. Environmental modification.
    b. Psychological Support.
    c. Clarification
    d. Insight Development.