Role of the caseworker in the treatment of five mothers rejecting their schizophrenic sons

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ROLE OF THE CASEWORKER IN THE TREATMENT OF FIVE MOTHERS REJECTING OF THEIR SCHIZOPHRENIC SONS

A THESIS

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BY

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DEDICATION

To my family
Mother, Daddy and Siblings
CHAPTER I

INTRODUCTION

Significance of the Study

The process of molding the child begins in the family. In countless interactions with their child each day, the parents teach him their interpretations of how a child should behave; in learning the parental version of cultural behavior, a child develops his own unique personality.¹

The initial interpersonal relationship for the child is that which develops between him and the important parental figure. This initial relationship provides the basis for all of the child's future relationships. It provides the means by which the child learns to perceive himself and others, and, in turn, to react to his environment.

As a result of the relationship with his parents, the child accepts their ideas and perceptions as his own. Most important, he accepts their concept of him as his concept of self. If the parent is accepting of the child, conveying approval, love and worthiness, the child is able to so accept himself. These feelings of love, acceptance and approval are important to the child for they provide him with a sense of security. They provide him with a feeling of self-worth and acceptance. He can accept himself because he has been accepted by them.

By contrast, the child who is not accepted by his parents; who is not given love, approval and a sense of security does not perceive himself


as worthy of such.

If...the parents (or mother) are rejecting, the child is faced with the dawning realization that...he is considered worthless and wicked, and unacceptable because of some inherent grievous and unchangeable fault of his own.¹

The child who is rejected by his parents is unable to accept himself. Rejection has been defined as "overt behavior toward an individual leading him to believe that he is neither loved nor valued".²

Parental rejection may be expressed in many forms. Some forms have been listed by Thorpe as follows:

1. Emphasis on the child's shortcomings
2. Severe punishment and negative attitudes (reproach, scorn, disgust, humiliation, ridicule, nagging, threats)
3. Rigid discipline
4. Desertion of the child
5. Eviction of the child
6. Unfavorable comparison with other children, and
7. Deliberate statements to the child that he is unwanted.

Parental rejection does not always take the form of overt negative action; it may be expressed in the more subtle form of overprotection. David Levy has set forth five forms of maternal overprotection as follows: (1) excessive contact of mother and child, (2) infantilization, (3) prevention of independent behavior, (4) lack of maternal control, and (5) excess of maternal control.

¹Ibid., pp. 278-279.
³Ibid., pp. 97-98.
⁴Ibid., p. 97.
In this type of rejection, the parent overprotects the child, rather than prepare him to meet conflicts he may encounter. The effect of overprotection is similar to the effect of overt negative rejection. By its use, the parent implies a belief that the child will be unable to cope with the external world; and in this way, reinforces the child's conception of self as helpless.

The parent-child relationships which are based on parental feelings of rejection are possibly the relationships leading to the greatest amount of emotional insecurity in the child's life. Likewise, parental rejection contributes to the formation of the background for the psychosis, schizophrenia. Characteristically, schizophrenia is a retreat from reality. The schizophrenic process is a method of "adjusting to an unbearably hurtful world...of protecting oneself against feelings of helplessness and worthlessness." In schizophrenic disorders there is a history of either parental neglect, denial, censure and rejection or else of parental overprotection. Abnormal behavior in adult persons has significant roots in the experience of childhood integration into a particular family but continues to be molded by current family

1 Coleman, op. cit., p. 98.


3 Coleman, op. cit., p. 98.

Workers in all fields concerned with the nature of personality development and the treatment of emotional disorders accept the need for understanding the intimate connection between an individual's adaptation and his family experience.2

As a result of the understanding and acceptance of this need has come the development of casework techniques to treat the "family as a whole". In family centered casework an effort is made to understand the interaction between various family members and to endeavor to reduce the points of undue conflict and strain. Not only is this true in family-centered casework, but in casework which primarily treats one individual the family members must be considered. The focus of social work has widened to include not only the client and the situation, but the client, his family and the situation. In this way, social work has made use of the dynamics of the family relationships as they influence and are influenced by the problem situation.


3 Ibid.


In a psychiatric setting such as the one in which this study takes place, the social worker also includes work with the relatives of the patient in an effort to maintain family ties. This effort is more difficult in this particular setting because of the guilt feelings that the family of the mental patient experiences. Often family members are unwilling to involve themselves in treatment, and, as a result, may jeopardize the patient's ability to adjust after hospitalization. In working with the family of the patient, it is necessary to recognize that their attitudes are important elements in facilitating or retarding the patient's progress. For treatment purposes it is necessary to define the conflicts in which the patient is locked with other family members and to mark out the patterns of family interaction that are potentially available for solution of conflict or for restitution.

Purposes of the Study

This was a descriptive study of the caseworker's role in the treatment of five mothers rejecting of their schizophrenic sons. The purpose was to present the following: (1) a description of the maternal attitudes toward the son; (2) a description of the effect of the maternal attitude

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3 Ackerman, op. cit., p. 304.
on the son with special emphasis on his progress in treatment; (3) a
description of the caseworker's role in the treatment of the mothers; and
(4) a description of the resulting effect on the son.

Method of Procedure

The case study method was used. The initial steps in this study
involved a preview of the literature. In order for a case to be used in
the study (1) the patient had a diagnosis of schizophrenia; (2) mother-
son relationship evidenced maternal rejection; and (3) the mother's
attitudes proved hindering to the patient's progress. The first five
cases of this kind assigned to the writer for casework were used.

For the purposes of this study, rejection was divided into (1)
overt negative action and (2) overprotection. Rejection was defined as
"overt behavior toward an individual leading him to believe that he is
neither loved nor valued". The operational definition for overt nega-
tive action is presented by seven forms of rejection set forth by Thorpe.
Levy has provided five types of overprotection which served as criteria
in this study.

A schedule was used to obtain pertinent information from the case

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1 Thorpe, op. cit., p. 97.
2 Ibid., p. 97.
records, from contacts with the patient and his mother and from actual observation of the mother-son relationship. The schedule was not used in the interview situation.

The data collected were presented quantitatively by the use of case illustrations in an attempt to point out the caseworker's role in treatment. Descriptive evidences of the maternal attitudes were presented before and after treatment as certain modifications may or may not have been evident.

Scope and Limitations

This study was limited in reference to sex, type of psychosis and the number of cases used. It was limited in that it represented casework by one particular worker over a limited period of time. The study was done during a six month placement at the Northport Veterans Administration Hospital.

Agency Setting

Northport Veterans Administration Hospital is the largest Veterans Administration Hospital in the United States. The hospital was opened in November, 1928 and since that time has grown to be a community within itself. It has its own power and heating plants, water supply, laundry, fire and police departments and sewage disposal facility.

Although primarily a neuro-psychiatric hospital, Northport Veterans Administration Hospital is equipped to meet any type of medical, surgical, dental, neurological or tubercular problem.

1 "The Bulletin of the Suffolk County Medical Society" (New York, 1956), p. 66.
The hospital's official bed capacity is 2,488 and it is currently operating beyond its capacity under a staff of 1,500 employees.

The hospital is divided into two services: administrative and professional. Included under administrative are the Manager and departments of Supply, Finance, Engineering, Personal, Communications, and Records and Registration. The professional services are Chaplaincy, Dietetic Service, Dental Service, General Medical and Surgical Service, Nursing Service, Pharmacy, Physical Medicine and Rehabilitation, Laboratory, Special Services, Neuropsychiatric Service, Psychology and Social Work Service. Each department works in conjunction with the other in providing the therapeutic atmosphere conducive to the patient's progress. Each offers the patient help in working through either the internal or external problems which hinder his total adjustment.

For treatment purposes the hospital is divided into two services: Acute Intensive Service (AITS), and Continued Treatment Service (CTS). The primary difference in the two is that AITS is for patients who it is felt will recover quickly with intensive treatment and CTS is for patients who are considered chronically ill and who it is felt will require a longer period of treatment.

All admissions in the hospital are handled by AITS.

Each neuropsychiatric patient admitted to Ward A30 (Admission Ward) is given thorough physical and neurological examinations, and his mental condition is evaluated by his assigned psychiatrist, psychiatric social worker and psychologist. After records are assembled, a complete NP(neuropsychiatric) report is typewritten and he is presented before a diagnostic staff conference. At this time a definitive diagnosis is made and a program of treatment is outlined for his future stay in the
hospital.

The hospital utilized the "team approach." This idea entails the belief that each person who comes in contact with the patient during his hospitalization is responsible for some aspect of his treatment. Primarily, the team consists of the psychiatrist, the psychologist, the psychiatric social worker, the nurse, physical medicine and rehabilitation personnel, the chaplain and nursing assistants. As a result of his training it is felt that the psychiatrist is best able to assume the responsibility for the total treatment of the patient. As the head of the ward team, he collaborates with the psychologist and the psychiatric social worker in preparing the diagnosis and the over-all treatment plan for the patient.

Clinical social work is an integral part of medical care. Clinical social work contributes to medical treatment...a skilled appraisal of the source and significance of the social, emotional, and economic complications of the veteran's disablement and provides a resource for reducing the force of their impact upon him as a sick and disabled individual.²

¹ Station Handbook, HB-10, Veterans Administration Hospital, Northport, New York (1957), Section H-1B.

CHAPTER II

MATERNAL ATTITUDES

It is generally accepted that the most potent of all influences on social behavior is derived from the primary social experience with the mother. The play of social response between mothers and children would then represent the foundation of social life, and its investigation the pivotal attack on the problem of social behavior.¹

Various studies and papers stress the importance of involving the mothers in the treatment of disturbed children and adult patients. Sid Hirsohn in a paper, "Casework with Compulsive Mothers," pointed out that the aim of treatment with the mothers was to attempt to enable them "to lessen some of their pressure on the child," thus enabling the child toward better adjustment.² Such also was the case with the mother-son relationships described in this study. It was felt that in the cases presented there was evidence that certain maternal attitudes toward the patient had negative influences on his progress in treatment. Attitudes always relate to situations around which we have constructed various images and concepts; it has been observed that psychological and social contacts result in the establishment of conscious adjustments and reaction tendencies.³ Maternal attitudes toward children are a form

¹Levy, op. cit., p. 4.


of behavior and, like other behavior, have causes. These causes are varied; they may range all the way from simple lack of knowledge about children and their behavior to some disturbances in the parent-child relationships.

In this study, the maternal attitudes throughout the cases were similar in reference to their effect on the patient's ability to move in treatment. This was due, in part, to the fact that all mothers represented one particular type—the covertly rejecting or overprotecting mother. This type of mother dominates her child by overprotecting him. She aims, by babying the child, to prevent him from ever becoming independent. This leads to the development of a kind of symbiotic relationship between the mother and child "in which the two egos remained so fused and intermingled that the boundaries between them never become clear. This is, by far, the most common pattern of parent-child relationships in schizophrenia. This mother is reacting to her child, not in terms of his own welfare, but in terms of her own needs as projected onto him.


3. Ibid.

4. Ibid.
Case 1

A. G. was a thirty-one-year-old, Catholic, Korean War, Army veteran. He was single and resided with his mother and father. He was readmitted to the hospital after fourteen months on Trial Visit. He was unable to make a successful adjustment at home and voluntarily returned to the hospital. Upon his return he stated that he could not keep a job, he had heart palpitations and "felt uncomfortable at home". A. G. was an only child. He was very close to his mother who dominated and smothered him with attention. She cared for the patient in an infantile manner. She would not allow him to decide what he would eat or prepare it for himself. She sat with him during all his meals and coaxed him to eat. She stated that she must constantly wait on the patient in this manner or he would feel that he was not loved or wanted. She appeared extremely concerned for the patient, stating that she wanted him to be "more of a man", yet continued to foster his dependency on her. She seemed unable to accept her son's illness or his great need and desire to develop more independence. Her conception of him was seen most vividly in her own description of him as a "saint and a wonderful boy". Mrs. G. was unable to accept the recommendations by the Medical Staff in reference to her son's need to develop more independence, i. e., going on gate passes in his own custody. She objected to this recommendation, stating that she wished to accompany him on his gate passes because she "wants to be near him".

The attitude expressed by this mother served to illustrate Levy's third criterion for overprotection—prevention of independent behavior. In general, this maternal activity is a continuation of behavior toward the child which reinforces closeness and infantilization, with the added gesture of pulling the child back, and of preventing his growth into more independent behavior.

Case II

J. W. was a twenty-eight-year-old, Jewish, Korean War,
Army veteran. He was readmitted to the hospital after an unsuccessful Trial Visit. This patient was the middle child in a family of five children. He was single and resided with his mother, younger sister and brother. The patient's father was deceased. The patient's mother was passively aggressive in her interpersonal relationships. She was protective of the patient and showed favoritism toward him. She used her domination of the patient to limit his contacts outside the home. She spoke proudly of his desire to spend more time with her than with any of the other children. Her attitude toward the patient was seen more vividly in contrast to her attitude toward his siblings. In disturbances in the home which usually result out of the mutual resentment between the patient and his younger sister, Mrs. W. inevitably took the side of the patient.

This example was not evaluated as negative in itself, but must be evaluated in terms of the mother's reasons for reacting in this way and the effect such reaction had on the patient.

Mrs. W. felt that she must be protecting of the patient because he was a "good, quiet boy and unlike the other children, who can take care of themselves". Mrs. W. used denial of her son's illness to preserve her conception of him as a "perfect child".

Denial is a "mental mechanism, operating unconsciously, and used to... ally consequent anxiety by denying some of the important elements. What is consciously intolerable is simply disowned by protectively automatic and unconscious denial of its existence.

She was unable to understand or accept the real significance of the patient's problem, assuring herself that he had only worked too hard and needed to stay at home and rest. During the patient's Trial Visit, she had thwarted his efforts to work, insisting that he remain at home with her.

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1 A Psychiatric Glossary (Committee on Public Information), American Psychiatric Association, 1957.
In light of the patient's age and level of development, these particular reactions of the mother were seen as attempts to increase the amount of contact with the patient. Excessive contact is manifested in continuous companionship of mother and child. When contact is excessive, infantilization and prevention of child's independent growth are natural outcomes. In this case, the mother's insistence that the son remain at home served to hinder his ability to get a job, a step which to him would have been important in developing independence and self-initiative.

Case III

E. M. was a twenty-eight-year-old, Catholic, Korean War, Army veteran. This was the patient's first hospitalization. He was the youngest of three children. He was single and resided with his mother and sister. The patient's father was deceased. The patient's mother was an overly anxious person. She appeared psychotic with hebephrenic tendencies. Her behavior and mannerism were inappropriate, her conversation rambling and out of context. She seemed frightened of any interpersonal relationships except that which existed between her and her son (patient). She had no real understanding of the patient's condition. She seemed only to repeat phrases that her oldest son related in reference to the patient. She was extremely affectionate toward the patient, almost to the point of sexual seduction. She kept the patient close to her during his visits at home, took him shopping with her and engaged him in house cleaning activities.

This case was unlike the others in reference to the amount of actual physical contact, in the form of kissing and fondling between mother and son. Social and physical contact are differentiated to determine the special influence, if any, of body contact.  

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1Levy, op. cit., p. 40.

2Ibid., p. 41.
Mrs. M. was the initiator in the physical contact, but seemed unaware of the implications of it or the effect it had on the patient. She regarded the patient as a "sweet, affectionate and good boy". She assumed the dominant role in the relationship yet did so in such a way as to appear that all activities between her and her son were mutual and automatic. She constantly told the patient that he needed to get a manual job that will "enable him to develop muscles", yet continued to keep him at home performing more feminine roles.

This would seem to be indicative of this mother's inner conflict between her desire to have the patient develop more masculinity and her desire to have him submissive and close to her.

Case IV

A. S. was a twenty-nine year old, Jewish, Korean War, Army veteran. He was the youngest of three children. He was unmarried and lived with his parents. This patient had lived away from home at intervals, but had always returned home, usually at his mother’s insistence. The patient had had one unsuccessful hospitalization. The patient's mother was distant and cold in her manner and suspicious in her relationships. In relation to her husband, she assumed a submissive manner and appeared to leave all decisions concerning the patient to him. She was, however, subtly dominating of the patient. She took extra care of him in reference to caring for his clothes, selecting his wardrobe and in preparing his food. She was extremely concerned about the patient's eating habits, desiring to prepare tremendous amounts of food for him. She was overly anxious about the patient's eating.

In overprotection compensatory to hostile attitudes, special stress on the child's eating is understood as proof to the conscience of beneficent motherhood, a denial of the tendency to deny, neglect or starve the child.

The patient's father took the initiative in making preparations

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1 Hilde Bruch and Grace Touraine, "Obesity in Childhood; V; The Family Frame of Obese Children", Psychosomatic Medicine, II(1940), p. 142.
for foster home placement for the patient. The patient desired this move from his own home. The patient's mother agreed to the plan, but desired to carry her overprotection into this situation. She desired to choose the home, stating that she wanted it to be a "nice, clean, Jewish home". She seemed to want to select a duplicate of the environment that she had provided for him and in this way her close identification with the patient would not be completely destroyed.

Case V

H. M. was a twenty-four-year old, Catholic, Korean War, Army veteran. This was the patient's third hospitalization. He was the oldest of three sons. His father was a chronic alcoholic and was considerably older than the patient's mother. He died when the patient was seven years old. The patient was unmarried and resided with his mother. The patient's mother was cold, withdrawn and suspicious; appearing to remain on the offensive at all times. She has been medically described as schizoid. She was unaccepting of the patient's illness, stating that he had to be hospitalized because he was over-worked. She described the patient as a wonderful boy. Initially, she refused to discuss the patient, stating that all of the information was in the records. She seemed always to desire to keep the child to herself and, particularly, to keep her image of him unharmed by the reality of his illness. The patient's mother was in labor for a period of twenty-four hours when the patient was born due to the large size of his head.

This one factor may be considered as contributing to the mother's need to overprotect the patient. When pregnancy has been difficult or labor long, painful or complicated, the experience arouses in the mother anxiety which is not immediately resolved by the birth of the child and tends to complicate the early days of rearing. When the child becomes a hazard for survival the incentive for overprotection becomes exceedingly strong.

1 Symonds, op. cit., p. 71.
CHAPTER III

EFFECT OF MATERNAL ATTITUDES ON SON

Reaction to maternal overprotection varied from case to case, depending upon other influential factors in the environment. However, due to the potency of the maternal effect, certain similar effects were evident in all cases. According to Symonds, the usual reactions to overprotection are: (1) the child's failure to grow up, (2) the child's over dependency and helplessness, (3) the child's inability to develop social habits in relation to his peer group, (4) the child's submissiveness and docility, and (5) his development of feelings of inferiority, inefficiency, and inadequacy. Coleman states that children of overprotecting mothers usually lack self-reliance and ability to cope realistically with their problems and may find it extremely difficult to accept adult responsibilities.

It is important to distinguish the two types of overprotection; (1) indulgence and (2) domination. The children of dominating mothers are submissive; children of indulgent mothers are undisciplined. The fact that the mother has indulged or dominated is implied in the description of the child's behavior as undisciplined or submissive.

1 Symonds, op. cit., pp. 67-69.
2 Coleman, op. cit., p. 116.
4 Ibid.
It has been noted that the type of overprotection may be determined by the response of the child rather than by the maternal attitude per se. In the cases presented in this study maternal overprotection represented domination.

It is to be noted that the presentations given in this chapter did not pertain, primarily, to the patient's behavior in reference to his psychiatric diagnosis. Case descriptions were focused primarily on the patient's general personality and on his relationship with his mother.

Case I

A. G. was quiet and withdrawn in manner. He had a low feeling of self-esteem and often stated that everything was hopeless. He did not make friends, associate with others or participate in any activities in the hospital program. He spent most of his time reading or sleeping. This patient had no significant interpersonal relationships other than that which existed between him and his mother. He had no important or lasting relationship of a romantic manner and stated that the idea of marriage and all of its responsibilities frightened him. He had no real masculine identity with his father, and was resentful of his father's submissive role in relation to his (patient's) mother, stating that he wished that his father would show more interest in him and not allow his mother to make all of the decisions. The patient was very much aware of his mother's domination over him. He stated that "it's like being married to some one for thirty-one years". He resented his relationship with his mother, but seemed unable to make any moves independent of her. He verbally expressed his resentment in the casework relationship, but was unable to voice his feelings to his mother. He stated that he wished she would allow him to make decisions for himself, but that he cannot venture to do things on his own or she will hate him.

The patient presently feels extremely uncomfortable at
home because of the extra attention his mother gives him, while at the same time she ignores his father. He stated, "She has begun to call me Darling, as if I were her lover and I don't like it". He felt guilty when his mother gave him so much attention and obviously disregarded or neglected his father.

Even though submissive in his relationship with his mother, the patient assumed a passively aggressive manner in societal contacts. He rebelled against the authority and rigidity of other contacts, a pleasure which he was not allowed in his relationship with his mother. His rebellion was seen in his refusal to continue in school after the tenth grade and his employment experiences, he either quit his jobs or put himself in a position to get fired. His longest period of employment was six months.

Because of the obvious ill affect that the patient's home life had on his ability to adjust outside of the protective setting, it was felt that he would profit by foster home placement or member employment. Foster home placement is the name given to the program which involved placing patients with families other than their own when they were ready to leave the hospital on a trial visit. A patient could be placed in a foster home if (1) he had no family to which to return or (2) it were felt by the Medical Staff that return to his real family would not be conducive to his further progress. Member employment was a program which placed the patient in the employ of the hospital for a year if it were decided that such employment had therapeutic value for him.

Each of these programs would allow A. G. an opportunity to develop more independence and responsibility apart from his mother.

The patient became very upset when the plans were discussed with him. He stated that he could not do it because his mother would not "allow him to", Either plan would have necessitated psychological, if not physical separation from his mother. He begged the worker not to "make him do it" because his mother would hate him if he left her.

In light of this patient's fear of the consequences of any independent
movement, it was felt that attention should be given to the mother in an attempt to enable her to understand, and if possible, modify her attitudes so as to allow the patient to make more movement.

Case II

J. W. was quiet, passive and withdrawn. He did not associate with fellow patients, but preferred to sit quietly on the ward. This patient had no self-initiative and attempted to manipulate others to make decisions for him. He had no significant relationships outside the home, either with males or females. He had a low concept of self and underestimated his ability to perform on any level.

During his trial visit at home, he spent most of his time looking at television or "taking care of the house". He was the recipient of much resentment and hostility from his younger sister and brother, who also lived with the mother. He continued to live at home, even in light of this conflict, because of his lack of initiative to make the move away from home and his mother. He felt very close to his mother and spent a great deal of time with her. The patient felt more comfortable in his relationship with his mother than in any other interpersonal relationships. He did not, however, assume the attitude of resignation and contentment with this relationship, as he did in the past, but began to show more desire to move out on his own. His desire, however, exceeded his strengths, as he remained psychologically close to his mother.

During the process of individual therapy with the psychologist, the patient was able to show movement in the area of development of ego strengths and, thus, more confidence in his own abilities to function independently of his mother. Planning was begun for trial visit.

Realizing the importance of the mother's effect on the patient, it was felt that she should be seen in an effort to develop in her an understanding of her role in the patient's struggle for independence.

Case III

E. M. was childish, submissive and seemed to have a strong need to please. He constantly sought approval and seemed to fear displeasing his mother, in particular. The patient had no contacts outside the home and stated that his sister would not invite him to go out with her for fear that he would embarrass her. He spent most of his time at home in the company of his
mother and helped her perform household duties. He often stated that fellow patients tease him about this, saying that he "wears a dress and an apron at home". The patient cries easily and had an obsessive fear that someone would "beat him up".

The patient had a real problem around sex. He masturbated often with the use of pictures as stimuli. He stated that he had sexual intercourse "only twice in his life and did not ejaculate either time".

He revealed this with an air of pride, as if to reassure himself, that he did not really do wrong. The "wrong" to this patient would be giving a part of himself to a female, as such would constitute unfaithfulness to his mother, who, psychologically, is his love object. More than any other, this patient's illness seemed to be tied more closely to his relationship with his mother. He was less able to realistically discuss his feelings toward her, but revealed such in delusional material.

He was very affectionate toward his mother and stated that he likes to kiss her. Much of his confusion concerning her relationship to him and his concept of her as his love object was seen in his statement, "when I get married I will kiss my wife's breast...that's alright because that's like your mother."

Although no definite treatment plan was set up for the patient, it was felt that his progress in long range planning was dependent on special treatment emphasis on the mother-son relationship.

Case IV

A. S. was quiet, but prone to aggressive outbursts. He shunned contact with others and refused to attend his work activity or any social activities in the hospital program. He did not have any friends, male or female. He liked sports and attended games of all sorts on his gate passes at home. His parents visited him often at which time he preferred to remain in the company of his father. He seemed uncomfortable in his relationship with his mother and seemed to shun contacts with her. He is resentful toward her and had sought on several occasions to free himself from her by moving away from home, yet at each time
he made an unsuccessful adjustment, financially or psychologically and returned home. The patient's father served as a butress between him and the mother and was sufficiently strong, to lessen her impact on the patient. Recently, the patient requested foster home placement as he stated that he "does not have a home".

This request was seen as his desire to, again, attempt a move away from home and also as his lack of the feeling of a sense of belonging at home. This patient was different from the others in reference to his reaction to maternal overprotection. He seemed not to be as resigned to her attempt to keep him dependent, but had constantly fought it, while at the same time revealing a great deal of resentment toward her. Unlike A. G., who felt resentment but was unable to express it, this patient had sufficient strength to express his resentment.

This patient's ability to emancipate himself did not, however, guarantee his mother's desire for such. Because of her own needs in reference to keeping the patient overprotected, and the consequent effect on him, it was felt that an attempt should be made to involve her in treatment.

Case V

H. M. was friendly and pleasant. He was an intelligent and interesting conversationalist, in primary relationships. He lost his dynamic enthusiasm in a crowd as he felt he becomes conspicuous and felt uncomfortable in a group. He had a few close male friends, but shunned relationships with females. In fact, he stated that he did not associate with girls at all during his adolescent years. The patient set high ideals for himself, especially in terms of moral standards and attempted to live "a perfect life".

He was very close to his mother, but was not dependent on her. He had, rather, assumed a more dependent and self assertive manner and was not now so influenced by his mother's desires as in the past. He was subtly hostile to her and her attempts to control him. During a recent psychotic episode this hostility became evident in his verbal and physical
attack on her. He became upset when his mother refused his request for money to leave home. His desire to leave had, in the past, revealed itself only during psychotic episodes, however, recently he had begun plans for member employment, which would keep him in the employ of the hospital for one year.

Involvement with this patient's mother was an attempt to enable her to develop more understanding of her role in relation to the patient.
CHAPTER IV

CASEWORKER’S ROLE IN THE TREATMENT OF MOTHERS AND SUBSEQUENT EFFECT ON SONS’ TREATMENT

Hospital social workers can aptly be described as the link between the patient and the community. In this role, it is the responsibility of the social worker, to become cognizant of all factors in the patient’s immediate environment which affect his overall adjustment. Her responsibility goes further as she gives necessary attention to the factors as will bring about positive influence on the patient's adjustment.

Mental illness creates social difficulties for the patient and for those near him, and social difficulties often create, or at least enhance emotional difficulties. This means that the social worker must give attention to the social aspects of the patient's life if treatment is to be useful.2

Within the hospital setting, the patient's degree of adjustment may improve to such an extent that it is felt that he is ready to return to the community. However, without due consideration given to the environmental and familial factors, the same degree of adjustment may not necessarily be expected outside the hospital setting. With this point in mind, the social worker turns her focus to the outside factors. Because the primary patient is viewed as an individual in distress and as a "symptomatic expression of family pathology", the disturbances of


the patient becomes the entering wedge for the appropriate levels of intervention into the disorders of the family relations.

The support and understanding offered families of schizophrenic patients has led to striking changes in the attitudes toward the child. In some cases, changes in the parents have been followed by striking improvement in the patient.

This chapter is focused on the description of the caseworker's role in the "direct treatment" of mothers of male schizophrenic patients. By "direct treatment" is meant "a series of interviews carried on with the purpose of inducing or reinforcing attitudes favorable to maintenance of emotional equilibrium, to making constructive decisions, and to growth and change". The treatment was directly related to the son's treatment. It involved an attempt to enable the mother to develop understanding of her role in reference to the patient's progress in treatment. Such development in the mother would, it was felt, lead to certain modifications in her own attitudes toward the patient.

Because of her close relationship to the patient, the mother, in most cases, viewed the worker as a threat and as a tentative replacement of herself as the significant female in the patient's life. In general, mothers respond more favorably to men than to women, possibly because

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1 Ackerman, op. cit., p. 304.


of their fear another woman might deprive them of their sons or might become a better mother, thus confirming their own inadequacies. Especially was this so when the patient showed an indication of reacting positively to the worker's influence. It must be remembered that, because of their own needs to be overprotecting, these mothers felt a much stronger psychological tie to their sons than would be true in the "normal" mother-son relationship. This fear of or resentment toward the worker caused the mother to be initially rejecting of casework treatment, especially in reference to an examination of her own attitudes toward her son. The guilt feelings that the family of the mental patient experiences also enter into the mother's resistance to involvement. Because of these feelings, it was extremely important to offer the mother an accepting, supportive relationship. All growth producing relationships, of which the casework relationship is one, contain elements of acceptance and expectation, support and stimulation.

Case I

A. G. had identified his relationship with his mother as a problem. He felt that she was too attentive to him, allowed him no opportunity to make decisions for himself, and in other ways, made life uncomfortable for him. Because of this thwarting effect that Mrs. G. had on her son, it was felt that she should be involved in the treatment process. Initially, she did not respond to requests that she come in for an interview with the social worker. However, once she was assured of our own interest in her son and the need for a discussion of him, she responded less hesitantly. Although her son had been hospitalized prior to the present hospitalization, Mrs. G. had not been responsive to involvement before. She would come to the hospital every other Sunday to get the patient and take him home for a six day pass.

1 McGriff, op. cit., p. 64.

Before the patient was granted gate passes, she would visit him every week, bringing amounts of food. On none of these visits did she make any attempts to talk to hospital personnel concerning her son's condition or progress. She seemed to feel that everything was fine with the patient. Mrs. G. was concerned that the patient never wanted to return to the hospital after a gate pass at home, for he always "seemed to enjoy a week at home". In discussing some of the things that the patient did during his gate passes, she stated that he "looks at television", until she comes home from work and then they would have dinner. I asked if she felt it might not be well for the patient to occupy himself with some activities during his visits at home. She stated that she attempts to encourage him to take interest in things, but he refuses. She was very concerned that the patient does not respond to her attempts to talk to him or to her attentiveness. She questions him consistently about what he's thinking in his silent moods, which proves annoying to the patient. She stated that she tries to get him to do things and to lead a "man's life".

This mother had no awareness of her attitude or of its effect on her son. She believed that her verbal expressions to her son that he "be a man" were sincere and in keeping with a desire that this happen. However, her behavior was not in keeping with the expression and the patient was able to sense such. He closed himself off from her verbal demands, and in this way, rejected adhering to them. The mother's concern that the patient did not talk to her was valid. He did not reveal his feelings to her for many reasons. Foremost, was his learned resignation that it did not matter if he voiced his opinion for nothing would change as a result of it. Also, the patient had a need to keep to himself some part of himself which had not been revealed to or invaded by his mother.

In an attempt to be supportive to Mrs. G. in her own feelings of "being left out" by her son, I attempted to interpret the son's need for silent periods at times, and stated that such, I am sure was not intended to offend her. I wondered what she attempted to talk about with the patient. She stated that her greatest concern was him and that she tried to get him to talk
about himself. I suggested that may be he felt uncomfortable discussing himself and would prefer discussing more neutral things. She felt that this may be possible.

This shows how the worker used self in offering support to the mother as well as interpreting some of the patient's own needs.

Mrs. G. stated that the patient had mentioned the possibility of getting gate passes in his own custody if she requested them. I explained that this was possible and asked how the patient felt about it. She stated that he wanted them, for he had told her that it wasn't necessary for her to come for him, as he knew the way home.

The patient's ability to express such was indicative of movement. He had been able to develop enough confidence in himself to question whether what his mother was doing was necessary.

In discussing her own feelings about it, Mrs. G. stated that she did not want her son to travel alone. I wondered if she felt that he was not able. She was evasive in answering, but finally said, "I want to come for him, because I want to be near him." I assured her that I could understand her apprehension at having him travel alone, but that this step was a part of the process of developing more independence and that such is necessarily a part of the preparation for the move out of the hospital. I emphasized the importance of the patient's desire to have gate passes in his own custody, stating that it is really in keeping with her own desire to have him lead a man's life. Mrs. G. remained skeptical about this move and stated that she would think about it.

Here, Mrs. G. was faced with her own conflict to have her son lead a man's life or to have him remain dependent on her. The basis of her problem centered around her own need to keep the patient dependent and her recognition that his ability to develop more independence was a necessary part of his overall progress.

Member employment was discussed with the patient and his mother as a proposed treatment plan. It became evident that little could be expected of Mrs. G. in terms of her behavior toward the patient, especially in the home situation. It was also evident that the patient could not exert himself to exhibit more independent movement while in the home situation.
Mrs. G. continued to lavish all of her attention on him to the extent that he became the center of disturbance between her and Mr. G. The familial relationships were growing progressively worse and, consequently, the patient was adversely affected by it.

The Member Employment program was interpreted to Mrs. G. I explained that the Medical Staff felt that the patient would profit by such a program as it would allow him the opportunity to develop work habits, to earn and handle his own money, and in other ways, live in a semi-dependent position to the hospital. He would abide by all the work regulations of the regular hospital staff, would reside with other member employees in the residential home, rather than a ward. Mrs. G. was concerned as to whether she could see the patient. I explained that he would be free to go wherever he desired after work hours and on week-ends and could certainly visit if he desired. I stressed that the main objective of the plan is to prepare the patient for the move back into the community. She felt that this was a good plan, stating that it would help him "learn to do something".

In discussing the plan with the patient, he revealed much of his dependency on his mother by stating that he would consider it if his mother felt it was alright. Upon finding out that she was in agreement with the plan, he was able to think more positively about it.

Case II

J. W. was being seen by the psychologist in therapy sessions. In a discussion with the psychologist, we discussed the patient's preparation for a Trial Visit in his mother's custody and the need to involve her in Trial Visit planning.

Mrs. W. was contacted as to an appointment time. She responded readily to my contact. At the first interview, Mrs. W. brought along her oldest son, who since the death of her husband, had assumed the father role in the family. Upon being seated, he explained that Mrs. W. had a heavy accent, which was difficult to understand and, therefore, felt that he should be present as "interpreter". Even though I could understand Mrs. W., I made no objection to this because I wanted to observe this son's relationship to her and to get some idea of his relationship with the patient. I interpreted my role in reference to the patient's overall treatment and explained our plans to prepare the patient for a Trial Visit. I explained that I was interested in knowing something about the patient's relationship with others in the household as these things are important factors in his adjustment at home. The patient's brother assumed the lead and provided pertinent information concerning familial relationships. He stated that he and the other brother have attempted to "push" the patient, as he always showed so little self-initiative. Mrs. W. was very
subjective and projecting in her discussion, denying much of what her son said. She was in agreement with the Trial Visit plan, but showed no awareness of the implications of the family situation for the patient's adjustment while at home. Especially, was this felt to be necessary in light of the patient's inability to adjust on a previous Trial Visit. Mrs. W. felt, as she had during the previous TV (Trial Visit), that the patient should come home and take it easy. She was concerned that he be given medication to take during his TV and felt that this would be sufficient to guarantee his successful adjustment.

During the initial interview, Mrs. W. was relieved of much participation because of her oldest son's presence and the role which he assumed. It was significant to observe her submissive relationship to him and her concept of him as "the stronger one" in contrast to her protective role in relation to the patient as "the quiet, weak one".

It was felt that Mrs. W. should be seen alone several times, as her role was the important one in considering the patient's stay at home.

After several contacts with Mrs. W., she became more responsive to interviews, without the presence of her oldest son. She became more accepting of me as a helping person and began to voice her pleasure at the "wonderful work" we were doing with the patient. Even though her level of acceptance had increased, she continued to assume an air of aloofness in the interview situation. She used her "inability to understand and to make herself understood" to avoid total involvement. A great deal of support was given her in this area and every attempt was made to simplify interpretations for her, as there was some reality to the language barrier. In interpreting the patient's progress and preparation for TV, I stressed his need and desire to be given opportunities to exert himself in his own behalf. I explained that this was important to him at this particular time because of his increased feelings of adequacy and competency, and his need to prove it a recognition that he had so long denied himself. I wondered if she and the other family members might continue to carry out what he had begun by encouraging, not "pushing", him to do those things which he feels are important.

With encouragement and expressions of pride from his family, this
patient would show more movement, for such would represent to him their belief in his abilities.

The movement that this patient and his family were able to make was evident in his adjustment at home. After having been home on TV for a few weeks he had secured a job and was planning to get an apartment of his own.

Case III

E. M. was unaware of his problem in relation to his mother. His lack of ego integration and reality contact hindered his ability to discuss such realistically.

Mrs. M. came for an interview at my request. She seemed frightened and confused and exhibited hebephrenic tendencies in her behavior. I explained that I had requested that she come so that we might discuss her son. She did not respond unless asked a direct question and would only sit and stare, nodding her head at intervals. I stated that I felt she might tell us something about the patient that would aid us in our treatment program for him. She stated, "He is a good boy and wants to come home". I explained that the Medical Staff does not feel that he is ready to go home at the present, but that all of our work with him is geared toward preparing him for eventual return to the community. She only replied with "Okay". I asked how her son was doing on his gate passes at home. She said that he was doing fine and was very glad to be at home. She seemed unable to discuss her relationship to the patient or his relationship with his sister.

Because of her level of functioning, Mrs. M. was unable to respond to or understand many of the reality aspects of her son's condition. This mother was very much involved in her feelings about her son, some of which she was not aware. It was early evident that this mother's own condition and her subsequent attitudes toward her son were influential in sustaining, if not actually causing, the patient's problem. She was, basically, a weak, dependent person and drew continually on the patient's limited strengths while remaining the initiator in the "sick" relationship which existed between them.
Mrs. M. continued to come for interviews, during which time she continued to assume a childish, passive manner. Attempts were made to reach her on a level which would be helpful to and be understood by her. She asked questions concerning the hospital's treatment intentions for her son and, continually, such were interpreted to her. She needed a great deal of support as she sought to understand the hospital's role and its reasons for keeping the patient. She felt that he was fine and would be alright if he were allowed to go home and stay. No amount of interpretations or explaining would break through her feelings and desire to have him home. I attempted to impress upon her the importance of treatment for her son and to relate to her our (hospital's) concern for the patient and our desire to have him return home as soon as he was able. She seemed distrusting of my concern, but also seemed fearful of expressing her feelings about involvement to me.

Because of this mother's inability to understand and, thus, modify her attitudes toward her son it was felt that he might profit by Member Employment. Because of the mother's influence on him, it was felt that he would be unable to continue his progressed degree of adjustment at home. Evaluation of the patient showed that he lacked the experiences or degree of independence to function adequately in the community. Although, it is possible to improve in these areas from a home setting, it was felt that his home setting was not conducive to such.

Mrs. M. was not in full agreement with the plan for her son. She persisted in requests to have him come home. I explained to her the treatment gains that such a plan had for her son. I explained that it was a part of the treatment program and, thus, the final decision was left to the Medical Staff. I assured her that the patient's health is our foremost concern and that any plan adapted for him was felt to be the best in reference to contributing to his improvement and eventual return home. Although not thoroughly convinced of the validity of the plan, Mrs. M. said she agreed to it. She did, however, attempt to persuade her son to express to us his objection to the plan.

This mother was not disagreeable to our treatment of her son simply for the sake of disagreement, as might be true in some cases. Rather, she was so involved in her own protection of and concern for her son that
she was unable to understand or accept this concern from others, for such represented a threat to her position.

Case IV

A. S. was subtly hostile toward his mother and sought to tear himself away from her hold. He was fortunate in the identification his father offered, which served to counteract his mother's hold on him. This patient was aware of his discomfort in the relationship which existed between him and his mother. However, he was unable to verbalize his feelings. His hostility showed itself in other ways, such as avoidance of her.

Mrs. S. was persistent in her attempts to continue her over-protection of her son. She related to me her dissatisfaction with the hospital treatment of her son. She stated that we (hospital) did not take as good care of him as she does in terms of caring for his clothes and seeing that he eats the right foods. I supported her in her concern for him and added that we were concerned about the patient's welfare. I explained that because of the number of patients we must care for it was impossible to supervise the dressing and eating of those who are as improved as her son. I explained that giving the patient the responsibility for caring for himself in these small areas was important to his overall progress.

As time progressed, Mrs. S. began to show more ability to accept her son's need to perform independent of her. During one of his gate passes at home he had gone to _____Stadium to a ball game alone. Mrs. S. expressed her apprehension at having him go alone, but was able, without my support, to realize the importance of this move for his progress. She stated that she was concerned and anxious about his going alone, but made no attempt to insist that her husband go with him.

This decision was indicative of movement for Mrs. S. She was able to make use of my interpretations of the patient's needs to function independently and to allow this, rather than her own feelings, to guide her decision.

Mrs. S. was in agreement with the Foster Home placement plan for her son because he wanted it and because her husband had agreed to it. She requested, however, if it were possible for her to choose the home. I explained that the hospital has a list of Foster Homes which have been carefully evaluated and chosen by foster home social workers and it is the hospital's policy that the patient choose the home of his choice, with the
help of a social worker. I assured her that the home is chosen carefully with all of the patient's needs in mind. I stated that we feel that the patient experiences a feeling of accomplishment in being given the responsibility for choosing his own home. I assured her that she would not be completely separated from the patient, for he could visit her and she him. She stated that she understood if this were hospital policy, but was still concerned that the home be a "private, Jewish home". I assured her that there were homes of various types in reference to religion, but that I could not be sure that her son would choose a Jewish home. I reassuringly explained that we felt it best that the patient make his choice on the basis of what he felt to be important.

It was significant that the patient desired a boarding type home, rather than a private home. This was indicative of his continued struggle to break away from the closeness and to avoid the necessity to relate to a mother figure that the private home would provide. He was not concerned about the religion of the care takers - the persons who provide foster homes. He was most concerned about the amount of freedom the home would allow.

Case V

H. M. was not responsive to discussing his relationship with his mother, except on a superficial level. He seemed to shut off his feelings about her and to attempt to deny them to himself, although certain of his behavior toward her was indicative of hostility. He was, basically, a stronger person than his mother and, as his condition improved, began to assume a dominant role to her. He seemed to have built a conception of her in his own mind in an attempt to deny his true feelings. For instance, he described her as an affectionate person, which is not indicated in her relation to him or to others.

Mrs. M. was not responsive to a discussion about her son. She responded evasively to questions concerning him. I assured her of my concern for her son and of the need to talk with someone close to him. I explained that I was interested in knowing something about his relationship to other members of the family. She was evasive, stating, "It's all in the records". She requested that we allow her some money from the patient's funds for travel expenses to the hospital. I stated that the patient's funds had not yet arrived at the hospital, but that
she could be assured of getting money when it did arrive.

On Mrs. M.'s next visit, she requested that I write a letter to the Housing Authority to enable her to get an apartment. She stated that they wanted confirmation that her son would be coming home on the weekends as there must be at least two persons in the family in order to get an apartment. I stated that I would write the letter and hoped that it would be instrumental in getting the apartment for her.

This mother, because of her own needs for acceptance, used these methods to test me. She made demands on me for tangible assistance, in the beginning, as she did not feel that she could fully trust me.

Mrs. M. assumed a distant, distrusting manner toward me. She would not relate to me directly, but would have her son thank me for "what I had done for her". The patient would also constantly thank me personally for the assistance I gave his mother.

The patient began to show sufficient improvement to begin consideration of discharge plans. He requested Member Employment as he felt that he needed to develop more adequacy in the area of employment. We felt that this was a good plan for him. Mrs. M. stated that her son had already discussed the plan with her and had said that he liked the plan. I asked how she felt about it. She did not show much concern, but stated that it was alright with her if he wanted it. In the patient's developing feeling of adequacy, she seemed to have assumed an attitude of unconcern and seemed to have withdrawn to a position of submission. This may have been her reaction to the patient's increasing independency.

It was felt that this patient's own improvement, and thus, his increased ability to use self, was instrumental in the modification of his mother's attitudes toward him.
CHAPTER V

SUMMARY AND CONCLUSIONS

It is felt that the family relationships of the mental patient are important influences on his ability to respond to treatment. Often the relationship is a "sick" one which does not allow the patient the opportunity to develop sufficient ego strengths necessary for adequate social adjustment. This study concerned itself with the examination of five mother-son relationships of this nature. The cases used were of five male schizophrenic patients at the Northport Veterans Administration Hospital in Northport, Long Island, New York. All five cases were included in the researcher's caseload during a six month training period at the hospital.

In the five cases used the mothers were overprotecting of their sons and such attitude was seen as hindering to the patient's progress in treatment. It was felt that each mother should be involved in the treatment process in an attempt to enable her to understand and modify her attitudes toward her son. It was felt that if the mother were enabled to modify her attitudes her son would be able to make progress in treatment.

In all five cases there was evidence that the maternal attitude had a negative influence on the patient's progress in treatment. In all five cases the mother's behavior served to hinder the patient's development of independent behavior as it was directly related to his movement in treatment. In two of the five cases the mother's insistence on excessive contact with her son proved a hindrance to his ability to
function independently of her. In only one of the five cases was there
evidence of any positive paternal relationship. In this case, the
father-son relationship served to lessen the impact of the maternal
effect on the son. In only one of the five cases had the son ever lived
apart from his mother, except for his military career. In this case the
son lived away from home for a short period, but returned home when
he was unable to adjust successfully. In two of the cases there was
evidence of emotional disorder of the mother. In one of these the son's
condition seemed to be directly influenced by the disorder.

The patients' reaction to their mothers' overprotection was similar
in all cases. Two of the patients were aware of the ill effect that
their mothers had on their ability to move. One of these patients was
unable to move beyond verbal expression of his discomfort with the
situation. The other made attempts to free himself of his mother's
influence. Only one patient showed any ability to make movement without
any encouragement from his mother. The remaining four showed increasing
ability and desire to move after they were sure that their mothers were
in agreement with such movement. Basically, the overprotecting mother's
effect on her son was to make him more dependent on her and less able to
make decisions for himself.

Treatment of the mother was primarily in the form of acceptance and
psychological support in reference to her attitudes concerning her son.
In all cases the mother was given understanding in her feelings for and
behavior toward her son as her attitudes were realized to be a part of
her own needs. In four of the cases clarification was used in an attempt
to enable the mothers to understand their effect on the son's progress.
In the remaining case it was felt that the mother's own level of functioning would not allow for the use of this technique. Therefore, the treatment focus in this case was to assure the mother of the son's need for continued treatment without reference to her effect on him. In all of the four cases in which clarification was used there was some evidence of modification in the maternal attitudes. In only one was the mother able to modify her attitudes to the extent that it was felt that the patient should return to the home. However, it was felt to be significant that the remaining three mothers were able to modify their attitudes to the extent that they could agree to the necessity of a treatment plan for the patient that would take him away from the home situation. It was felt that these plans were most conducive to the patient's progress as they provided greater opportunity for him to develop independence. It was significant that in these cases the most positive outcomes were those which resulted in the patient's separation from his home and family in contrast to social work's usual attempts to unite the family.

In all of the cases the mothers were initially rejecting and mistrusting of casework involvement. This initial rejection was overcome, however, when the mother was assured of our concern for the patient and for herself.

In four of the cases the patients were able to make progress in treatment as a result of the mother's treatment. In these four cases definite treatment plans were begun and in one case the treatment plan was carried out. It was significant in the latter case that there was evidence of the movement which had been accomplished by the patient and
his mother, even after the patient's discharge to Trial Visit. Of importance was the fact that further movement on the part of this patient was to prepare to move out of the home, this signifying independence. In only one case did there seem to be no evidence of the mother's ability to understand or modify her attitudes. In this same case there was less evidence that the patient was able to make any progress or that there was any modifications in the mother-son relationships. As a result of this, it was concluded that the patient's ability to progress in treatment is directly related to the effect of the maternal attitudes on him, thus if the maternal attitudes affect him negatively, his progress will be hindered; if such attitudes can be modified to some degree they will have a more positive effect on his progress. As a result of this study, acknowledging the limited number of cases, it is felt that attention should continually be given the family of the mental patient and that social work should continue to focus on these relationships, attempting to strengthen the positive ones and to modify those which tend to interfere with movement toward the restoration of social functioning.
SCHEDULE

I. Age of patient at present hospitalization.

II. Current marital status.

III. Family Composition:
   a. Number of siblings in family
   b. Patient's rank in family constellation

IV. Maternal Attitudes.
   a. Overprotection
      1. Excessive contact
      2. Infantilization
      3. Prevention of independent behavior
      4. Lack of maternal control
      5. Excess of maternal control
   b. Overt negative action
      1. Emphasis on child's shortcomings
      2. Severe punishment and negative attitude
      3. Rigid discipline
      4. Desertion of the child
      5. Eviction of the child
      6. Unfavorable comparison with other children
      7. Deliberate statements to the child that he is unwanted

V. Effect of maternal attitudes on son's progress in treatment.
VI. Caseworker's role in the treatment of mother

a. Attitude toward treatment

b. Type of treatment

1. Supportive
2. Clarification

c. Effect on son's treatment
BIBLIOGRAPHY

Books


Articles

Bruch, Hilde and Grace Touraine, "Obesity in Childhood; V: The Family Frame of Obese Children", Psychosomatic Medicine, II (May, 1940), pp. 141-206.

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