ROLE, STRESS AND SOCIAL CASEWORK PRACTICE

An Assessment of the Concepts of Role and Stress in Relation to a Sample of Social Casework Practice.

by

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ABSTRACT

Late in 1959, the Council on Social Work Education published a thirteen volume study on the desirable objectives of social work education. In the volume on casework method, it is proposed that the concepts of "role" and "stress" be used in combination for the assessment of clients' problems. Leading social workers have expressed much interest in these proposals but have agreed that extensive research and testing are necessary to bring the theory to the level of practice. This thesis attempts a contribution in this area, applying the "social role theory" empirically to a sample of social casework practice. Such an evaluation must be made in relation to the social work profession's ultimate responsibility to the client. The criterion: Will this theory enable the social worker to help the client more effectively?

The sample group are twelve cases from the files of the Children's Clinic, Mental Health Centre, where both parents and children receive treatment services. The social functioning of the parents has been examined in relation to the social functioning of the primary client, the child. The case record material was first analyzed on the basis of the concept of stress, the attempt being made to identify a) the sources of stress, b) the values threatened, c) the duration of stress, d) the response to stress, e) the major roles impaired and f) the reciprocal roles affected. The concept of role was utilized to describe and rate child and parents in terms of a) performance in major social roles and b) the interrelatedness of roles in the family network. The degree of role impairment was rated for the roles of husband, wife, father, mother, son or daughter, sibling, employee, student and member of community (for adults) or peer (for children). Assessment and redefinition of the client in relation to his problem was then attempted for each case.

This study has brought a number of analytical features to light. There is need for clarification of specific roles, e.g., "employee," where there are intersecting roles. Sibling relationships require considerably more study. It suggests the need for obtaining information regarding the adequacy of the client and those in his immediate role network in the early fact-finding phase of treatment, in such a way as to minimize additional resistance. It also suggests the necessity of eliminating confusion in the client role through a mutual understanding of the client-worker expectations in the early stage of treatment. An important feature of the theory that must be considered if it is to be put into practice, is that the client must be perceived not only in terms of general emotional responses to stress e.g., "anxiety" but in terms of how this reaction has affected his social functioning, i.e., which roles in his network of relationships are impaired and which threatened.
ACKNOWLEDGMENTS

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An Assessment of the Concepts of Role and Stress in Relation to a Sample of Social Casework Practice
Chapter 1

THE SOCIAL ROLE THEORY - ENDORSED IN PRINCIPLE
BUT UNTESTED IN PRACTICE

The New Knowledge

"This is a period of ferment in social work. Old knowledge and old ways are being challenged. New knowledge is flooding in, new ways are being tried."¹

Much new knowledge that has potential significance for the social work profession comes from work in the social sciences, notably sociology. Unfortunately, but not surprisingly, the new findings and theories are not ready-made for use by social workers, and the terminology is frequently unfamiliar. Perhaps for these reasons, there has been a hesitancy on the part of many social workers to attempt to adapt these theories for use in the social welfare field. There is also some apprehension lest acceptance of the new theories might mean discarding the older, more familiar psychoanalytic theories which have proved so valuable. Dr. Herman Stein, in a talk to the Supervisors Conference, Smith College School of Social Work, had this advice for social workers with regard to this new knowledge:

The development, first of all, is not a fad; when content is relevant and important, it has to be studied and not brushed on lightly.

We should have no interest in substituting one jargon for another, or adding a new jargon. This is content to be mastered and not a bundle of impressive terms and phrases to be added to our vocabulary. It is content to be approached with respect for its complexity and its contribution, and also its limitations.¹

As professional people dedicated to the betterment of society, there is no denying our responsibility to examine new knowledge critically to determine how it can be useful for improving social work techniques and facilitating the realization of social work goals. The social worker's ethics require that this examination or evaluation be undertaken in relation to his ultimate responsibility to the client. His criterion should be: "Will this theory enable me to help the client more effectively?"

This thesis is particularly concerned with the evaluation of one of the most currently popular sociological concepts, the concept of role. Role refers basically to the way in which an individual perceives himself and is perceived in relation to the expectations of society. The concept has been widely used in recent years in the social sciences, especially in social psychology and sociology. Social psychologists have generally concentrated on group-related roles, the role of leader, helper, idea-man, clown and so on, in order to study group dynamics. Sociologists have been more concerned with institutionalized roles, those roles in our society such as wife, mother, husband,

father, pupil, teacher, for which there are prescribed behaviour patterns embodied in law, custom, tradition or other norm. It is this sociological concept of social role which is of most interest to social caseworkers.

Some effort has already been made to integrate this concept with social work theory. The Council for Social Work Education's Curriculum Study, directed by Werner W. Boehm, recommended that this concept be used conjunctively with the concept of stress, as a diagnostic tool in social casework. The basic premise of the Study is that the purpose of social casework is to help the client achieve more effective role performance and thereby improve his social functioning. The concept of role is recommended as a means of viewing the client in terms of his social functioning. The concept of stress is suggested as a means of determining the cause of impairment in role performance. For the purposes of this thesis, these two concepts, used in combination as proposed in the Study, will be referred to as the social role theory.

Although this terminology may have a ring of the new and the strange, social workers have been concerned with the

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2 Originally developed in relation to the study of disease, this concept has been used by sociologists in the context of social problems. See Jessie Bernard, Social Problems at Mid-century, The Dryden Press, New York, 1957.
social aspects of their clients' problems since the days of Beatrice Webb in England and the Charity Organization Societies in America. The theory, however, appears to provide a sharpened and more clearly defined focus for social work, in the problems which arise in the interaction of man and his environment, in man's social functioning. Thus is avoided the two extremes of a specific focus on man and his intrapsychic performance, or on man's environment, the whole wide world around him.

Boehm has suggested that the theory would be particularly useful in two areas. First, as a means for clarifying problems amenable to casework help. Second, as a means for assessing the person in relation to his problem. The theory has not been fully accepted by the profession and its future status is still uncertain. Boehm was the first to stress that it is highly abstract and that considerable research and testing are essential to bring it to the level of practice. To date, little research has been done. This thesis will attempt an evaluation of the social role theory as a means for assessing the person in relation to his problem. On this basis, the theory will be applied to the assessment (or diagnostic) phase of casework practice and an attempt will be made to redefine the client and his problem in terms of his social functioning. The purpose is to determine whether social role theory can be adapted for practice, and if so, whether it will meet the criterion of enabling caseworkers to help their clients more effectively.
Before the theory as outlined in the Curriculum Study is presented in more detail, it is important to consider it in relation to the present trend of casework thinking. Is the theory so different, so radical? Is it diametrically opposed to current trends? Or is it compatible with the trends of the 1960's?

Social Role Theory in Relation to Trends in Casework Theory and Practice

The significance of this theory is that it defines new boundaries for the profession. It is not to be assumed that these boundaries will forever more remain static, for such is the ever-changing nature of our society that the profession must remain flexible to meet new needs which are constantly arising. But however flexible a profession may be, it is still essential that at any point in time, it have a clear definition of goals and objectives, of limits, of area of competence, of specific tasks which it is equipped to undertake. In recent years, there has been confusion and controversy within the profession itself, as to its functions and purpose. After a review of social work literature, Boehm came to this conclusion:

A clear-cut view or a generally acceptable and accepted position about the purpose of social casework does not now exist. The goal of social casework has frequently been stated in rather broad terms leaving considerable room for interpretation.¹

The picture of man as a social being, influencing and being influenced by his environment, has always been within the range of vision of social workers, but their focus has shifted back and forth as new knowledge and new theories illuminated first one part of the picture and then the other. Before the turn of the century, social workers, understanding little of the meaning of behaviour, tended to think that moral defects, idleness, drinking and gambling were the causes of poverty and thus attempts at rehabilitation were directed toward a behaviour reform of the destitute client, by personal visits, advice and directions to become independent.

Early in the twentieth century, there was more understanding of the significance of physical, social and economic factors, illness, poor housing, low wages, economic dislocation, and subsequently, much concern among social workers with social reform and social legislation. This was the era of social action, of Jane Addams, Edith and Grace Abbott and others in the United States, and Beatrice and Sidney Webb in England. The social action fervour was fading by the First World War, and the science of psychology which was becoming more popular, led to increased interest in personality development. Some of the writings of Mary Richmond about this time could easily be incorporated into the theory outlined by Werner Boehm.

Social casework...in addition to its supplementary value in other tasks has a field all its own. That field is the development of personality through the conscious and comprehensive adjustment of social
relationships, and within that field the worker is no more occupied with abnormalities in the individual than in the environment, is no more able to neglect the one than the other.¹

This equilibrium was not long maintained. Sigmund Freud's writings were penetrating America. His theories about the organization, dynamics and development of the human personality caused a revolution in social work, thought and practice. Gordon Hamilton, who was then practising casework in the Eastern States, has written a colourful account of this period.² She relates that Freud's theory of personality "burst like an atom, and the 'fall-out' from the explosion proved extremely frightening to many people both in and out of the profession."³ There was great controversy, but most social workers grasped the opportunity to learn psychoanalytic techniques.

There were all sorts of cults—the analyzed and the unanalyzed, those who were being analyzed by the wrong people, and those who were dedicated to therapy as opposed to analysis.⁴

Indeed, social workers became so preoccupied with inner life, with individual-centred therapy, as to almost lose touch with outer reality and the social factors with which social workers

⁴ Hamilton, op. cit., p. 27.
were most familiar. Stein has referred to the period as "the psychiatric deluge."\(^1\)

In recent years, the trend has been away from the area of psychiatry to a consideration of man as a social being, for now sociological theory has begun to catch up with personality theory in developing material of use to the caseworker. Stein points out:

There is no escape. The social sciences are with us and we cannot look to psychiatry as a haven against these new winds that are blowing our way. They are blowing just as strongly within psychiatry.\(^2\)

More and more frequently there have appeared references in social work literature to "social environment," "social functioning," "social role." Helen Perlman has defined casework as "a process...to help individuals cope more effectively with their problems in social functioning."\(^3\)

There has been general agreement in the field that social work is on the verge of a new period of development. Gordon Hamilton wrote in 1958:

The practice of social work, including casework, is undergoing profound changes. Social work is in one of its most critical phases of reorganization and assimilation of new materials.\(^4\)

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\(^2\) Ibid., p. 188.


\(^4\) Hamilton, *op. cit.*, p. 35.
That this new phase, like all new phases, will meet with resistance and constitute a threat to the practitioner is evident in her following statement:

Those of us who have studied and followed Freud, will, I am sure, find out what to hold onto.¹

Swithin Bowers, on the other hand, is representative of that segment of the profession that is welcoming the new sociological concepts with more enthusiasm.

There is a change coming about in social work, a good and healthy change, a going back to social work's original emphasis on the family and on the crucial social roles that exist within this primary group and primary environment.²

But the need for sound, well-tested theories has also been acknowledged. Dorothy Fahs Beck, in an article on the need for research, has written:

All in all, it is evident that in the family service field we are still standing at the threshold of an unknown and scarcely visualized pioneer research task. Our tools and guidelines include neither well-formulated hypotheses nor well-tested instruments.³

Will the social role theory fill this need for the

¹ Ibid., p. 36.
profession? Will it permit, as Boehm hopes "a more effective translation into practice of the often expressed social work emphasis upon the psychosocial situation?"¹

Swithin Bowers has pointed out that the social role performance of persons "is an area which is of the greatest importance not only for the good of the individual but for the good of society." He adds:

The measure of social role adequacy is determined not solely by what is good for the individual, but also by the good of the group (particularly the good of the family group), and by the good of society.²

The journals of Social Casework and Social Service Review both devoted an issue to reviews and comments on the Curriculum Study by recognized leaders in the social work profession, shortly after the Study was published. The application of social role theory to social work practice met with general approval, but it was realized considerable research and testing would have to be done. Helen Perlman, writing in the Social Service Review of December, 1959, pointed out:

Social work must take account of the infinite labors that will be required if we are to understand the concepts involved, gauge their reconcilability--

¹ Boehm, op. cit., p. 36.
² Bowers, op. cit., p. 34.
or lack of it—with our present theory systems, fill in and test out the specific, practical details which fall—or which may refuse to fall—under these broadly sketched ideas.¹

Jeanette Regensburg, in the January 1960 issue of Social Casework, has written:

The framework is not to be viewed as a final product; much of it will undoubtedly be reformulated as experimental work proceeds. The choice of this particular concept [social functioning] and of other concepts which logically precede and follow it, is a matter for thorough testing and research....

Granted that there will be much floundering and trial and error while further study and research proceed, I suggest that, even so, the gains of social casework practice can be great.²

Since that time, there has been little direct reference to the theory and it would seem the profession is awaiting the necessary testing and research. It may take some years before the value of the theory is known, but it is the purpose of the writer that this thesis will contribute to the important research task which challenges the social work profession.

The social role theory is so complex, that for the purposes of clarification it is necessary to review it in detail


before proceeding further. Here is the theory in summarized form as presented in the *Curriculum Study*.

**Social Role Theory: General Outline**

In the first volume of the *Curriculum Study*, "Objectives of the Social Work Curriculum of the Future," the goals and objectives of social work are expressed:

> Social work seeks to enhance the social functioning of individuals, singly and in groups, by activities focussed upon their social relationships which constitute the interaction between man and his environment. These activities can be grouped into three functions: restoration of impaired capacity, provision of individual and social resources, and prevention of social dysfunction.¹

Social functioning, then, is the basis of the role theory, and social functioning can be understood only by assessing the social, somatic and psychological factors and their combinations which determine the quality of this functioning. Boehm has defined social functioning as "the sum of the individual's activities in interaction with other individuals and situations in the environment."²

Because social functioning is such a broad concept, for the purpose of analysis it can be broken down into manageable

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units: social roles. It is the sum of the roles (e.g., wife, mother, daughter, employee, neighbour) performed by a person. By viewing an individual in terms of his social roles, we can deal with the major roles, usually the family, school and employment roles. We can determine which roles are performed adequately and inadequately, and we can examine the effect of the individual's performance in a given role or roles upon his performance of other roles. In this theory,

Social role describes the activities and tasks which an individual is expected to perform by virtue of his membership in social groups and his participation in social institutions. These tasks and activities are patterned and prescribed by social norms, such as law, custom, tradition, convention and others. ¹

The core idea of the theory, then, is that social casework's purpose is to help the client achieve more effective role performance and thereby improve his social functioning.

In the tenth volume of the *Curriculum Study*, which deals specifically with the casework method, social casework is defined. This definition is reproduced here in full because it provides the general framework for the whole theory.

Social casework is a method of social work which intervenes in the psychosocial aspects of a person's life to improve, restore, maintain, or enhance his social functioning by improving his role performance. Intervention occurs when the person, or members of his group or community, realize that his role performance is hampered

or threatened. The intervention takes place through a professional relationship between the worker and the person, and also between the worker and other individuals whose interaction with the person affects his role performance. Since social functioning is the product of interaction among intrapsychic, somatic and social forces, social casework involves assessing the internal and social factors which impair or threaten the person's role performance and helping him to find and use the somatic, psychic and social resources at his disposal, to eliminate or reduce malfunction and to enhance functioning in social roles.¹

Concepts of Role, Stress, Problem and Their Components

In order to understand this theory, it is necessary to explore its major components. The three concepts of role, stress and problem are defined and described on the following pages. The nature of the material does not easily lend itself to a smooth and interesting manner of presentation, but the theory may be more readily grasped in this form.

Concept of Social Role

It has been pointed out that the goal of social work has been established to be effective social functioning, and in this theoretical perspective social roles are viewed as units of social functioning. It should be noted that although the activities and tasks described for specific roles are defined by society, there is a certain amount of leeway permitted. There are many ways of performing standard roles. Jessie Bernard,

¹ Boehm, op. cit., pp. 44-45.
whose descriptions of the concepts of role and stress were used extensively in the Study, stipulates: "We are not to think of roles...as rigid straitjackets."

The concept of social role has a number of components. **Range**: refers to the socially accepted ways of satisfying needs. **Role Expectation**: refers to the activities considered appropriate for the role in the light of the social norms which prescribe role behaviour. There may be a discrepancy between actual role performance and social expectations of the role. **Role Perception**: refers to the way the role is viewed either by the person performing the role or by the reciprocal person. Personality, class, culture and caste may affect the perception of the role. Views and values of the reference group may also affect role perception.

A social role must have a counterpart. It cannot be performed alone. For example, the role of husband indicates a reciprocal role of wife, of employer, employee. This premise is the basis of the following components. **Reciprocity**: refers to the relationships of reciprocal roles. The definition of the reciprocal role is affected by the clarity of the definition of the role. If the role of mother is not clear, then the role of child is not clear. **Interrelatedness of Roles**: refers to the repercussion and

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effects of changes in performance of one role upon performance of other roles. For instance, improvement or deterioration of a person's performance as a worker may affect his performance as husband and father. The intensity of the repercussion and its scope may vary a good deal according to the closeness of certain social roles (e.g., parental and spouse roles) and in relation to the capacity and motivation of the client.

**Role Network**: combines the concepts of role interrelatedness and role reciprocity, and provides a view of the client as an interacting unit in a system of roles. It refers to all the client's social relationships. So impact of stress on any role may have repercussions of varying degrees upon all of the other roles. It refers not only to the several roles the client performs but also to the reciprocal performance of those with whom he interacts.

**Determinants of Role**: It is in this component that we see the breadth of scope of the role theory, for not only are the manifestations of behavior examined, but the causes: physical endowment and functioning; ego functioning, comprising both intellectual and emotional factors; and social factors, the persons in reciprocal roles, reference groups, social resources, and less tangible influences of physical, economic, political and industrial circumstances in the person's environment.

**Role-Related Problems**

**Role Impairment**: refers to the individual's inability to perform adequately in a given role. Impairment of one role may lead to
impairment of other roles in the network, thus it may be both cause and effect of stress. For example, impairment in the mother role will result in impairment in the child role.

Role Confusion: may be the result of lack of clarity in the definition of the role—a common problem in today's dynamic society. Class and geographic mobility complicate this problem even further. As a result, many people are never certain what is expected of them or what they may expect from others. Or confusion may result from conflict among roles, for example, wife, mother and worker.

Concept of Stress

This concept is closely related to the concept of social role, for stress is defined as a situation which involves a threat to the performance of a social role or roles. The term is not used synonymously with the term "anxiety," for "anxiety" refers to the stress reaction. Stress can be analyzed in terms of three components: stress factor, value threatened and stress reaction.¹

Stress Factor: refers to the threats which arise within the individual (physical or psychological) or from the environment, within his network of roles or the social system. The resultant role impairment will be an additional, secondary, source of stress.

¹ Boehm, op. cit., p. 106.
Value Threatened: A threat to any value may produce a stress reaction. The value may be objectively great or small, but it is the subjective value that determines, to some extent, the degree of reaction. The value may be life, property, status, appearance, security, self-respect, and so on, but it is the meaning of the value to the person involved that is most important.

Reaction to Stress: These are the reaction responses made by the individual with the goal of maintaining the level of social functioning which existed prior to the occurrence of the stress. This reaction may or may not produce problems, depending on the effectiveness with which the stress is eliminated or alleviated.

The individual's reaction will take place on several levels, physiologically, emotionally or socially (role-related) involving some impairment in role performance, thus affecting the whole role network.

Boehm's hypothesis concerning stress sets forth the following:

1. Stress is an inevitable aspect of life.
2. Source of stress can be internal, and due to somatic or psychological factors, or external, and due to environmental factors, (physical and sociocultural), and there can be a combination of all three.

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1 Boehm, op. cit., p. 109.
3. Regardless of its point of impact, stress may affect the functioning of the personality in any of its aspects, physical, emotional, mental, spiritual, social,—and may manifest itself through lowered performance in one or several social roles.

4. Because of reciprocity of role behaviour and interrelatedness of roles, role performance difficulties may themselves constitute a source of stress which may further reduce performance in the roles so affected and may affect performance of other roles. This is known as "secondary stress."

5. Prolonged stress in one area or stress affecting several areas of functioning (social roles) can lead to extended role breakdown, and, in turn, to personality disorganization. However, stress does not automatically lead to dysfunctioning.

6. Man tends to absorb stress situations through various types of defensive and adaptive responses in an effort to maintain and establish a dynamic equilibrium which expresses itself in a certain level mode of social functioning.

7. Major forms of adaptation are fight or flight (physically, psychologically or socially or all three or combinations of the three).

8. The physical or psychological or combined responses available to the individual may not be adequate to cope with stress and therefore social intervention from outside may be necessary.
9. These outside forces take the form of role support and constitute widening of the role network.

**Concept of Problem**

Problem is defined as a person's response to stress situations which affects his role performance in such a way as to result in role impairment.

Such problems may be perceived by the individual, by someone in his immediate role network (mother, father, sister, etc.) or by society (school, public health, police, neighbours). The person's degree of motivation to use casework service will depend, to some extent, on who perceived the problem and who decided professional help was needed. It is probable that a person referred by the court, for example, would not have as much motivation as a person who, aware of his own role impairment, voluntarily sought help.

Boehm writes:

The concepts of social role and stress used in combination are suggested here as tools for understanding and describing the typical or core problems which come to the attention of the various fields of practice.¹

He sees the problem in child welfare, for instance, as the inadequate performance of the parental role and its effects upon the reciprocal role of the child.

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Purpose, Setting and Scope of This Study

It has already been noted that the purpose of this study is to apply the social role theory to the assessment (or diagnostic) phase of social casework. The setting chosen was the Children's Clinic, Mental Health Centre. A few words about the Clinic are indicated at this point to give an understanding of the source of the material used in this study. The Children's Clinic is the place of the writer's field work placement and has been chosen primarily for the sake of the writer's convenience, but other advantages cannot be overlooked. Although the child is considered "the client," services are extended to at least one parent, or parent-substitute. Therefore in this setting, considerable information is available concerning the client's role network. The Clinic, operated by the Provincial Mental Health Services, is the only non-residential treatment centre for emotionally disturbed children on the British Columbia Mainland. It is a multi-discipline setting, where psychiatrists, psychologists, social workers and nurses work together in groups as teams.

The admission procedure requires an intake interview with one or both parents, following which an Intake Conference\(^1\) is held to decide whether the case should be accepted or referred

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\(^1\) At the weekly Intake Conference, the intake worker presents the case to the appropriate team for decision as to disposal.
to another agency. If the case is accepted, the social worker holds four or five interviews, usually with the mother, and at least one with the father, and on the basis of information obtained, prepares a Social History.\(^1\) The child, in the meantime, is examined by the psychologist on the team, who administers the psychometric tests. And finally, the psychiatrist has an interview with the parents and child, individually or together.

Following this preliminary investigation, the team meets for a Diagnostic Conference and each team member presents his findings and evaluation. It is at this conference that it is decided what services can be offered the parents and child and which family members should be involved in treatment.\(^2\)

Although further information about the client's social functioning is sometimes revealed in treatment interviews, and diagnosis must be an on-going process, we are using, for the purposes of this study, the information about the client and his role network obtained prior to the diagnostic conference. The diagnosis or assessment\(^3\) as it appears in the case records, will then be rewritten in terms of the social role theory.

Let us now turn to a description of the methodology of the study, which forms the body of the following chapter.

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1 See Appendix D for a copy of the social history outline used at the Clinic.

2 See Appendix A for recording of the Diagnostic Conferences, taken verbatim from the files of the cases selected for this study.

3 The term "assessment," preferred by the writer to "diagnosis," will be used henceforth in this paper.
Chapter 2

TRANSLATING THE SOCIAL ROLE THEORY INTO PRACTICE

Leading social workers have agreed with Boehm that this theory is highly abstract and that much testing and experimentation is necessary before its value can be determined. There is, however, no established plan to follow for testing purposes. This chapter describes the method devised for this study for applying the theory to the case record material. The selection of case material, the scope of the study and the way in which the concepts or role and stress were applied to the material, are dealt with in this chapter.

Selection of Cases

In the first chapter, it was explained that the case record material for this project was taken from the files of the Children's Clinic, Mental Health Centre. To ensure that sufficient information would be available, it was decided that the cases to be used must have been presented at a Diagnostic Conference, and the Conference notes recorded in the client's file. As some of the files contained a considerable amount of recording, and time did not permit a thorough study of the records to date, the information for this project was taken from the recording done prior to the Diagnostic Conference. This included the intake worker's initial interviews and subsequently, the social workers interviews with the parents, the
psychologist's reports of interviews with the child, and in some cases, the psychiatrist's record of his interview with parents and child. It also included, in some cases, information from previous referrals to the Clinic. The transcripts of the Diagnostic Conference records appear in the appendices to this thesis.

As Diagnostic Conferences are sometimes conducted several months after application is made to the Clinic, an arbitrary time limit for applications was made. The time span selected was from January 1, 1960 to June 30, 1960, to ensure that Conferences had been held for all the cases by the commencement of this study. There were about sixty applications made to the Clinic during this period, most of them being carried to Diagnostic Conference, and a further selection of cases was essential. The following criteria were finally adopted.

1. Application for service was made between January 1, 1960 and June 30, 1960.

2. A Diagnostic Conference was held and a record of the Conference appears on file.

3. The children were six years of age or older at time of application.¹

There were twenty-four cases to which the criteria applied.

¹ This provided that the role of student could be included in the analysis, in most cases.
These were then listed by surname in alphabetical order, and every alternate case was used in this study, thus assuring impartial selection of case material. In the twelve cases used, identifying data was omitted or disguised as much as possible. All names are fictitious.

The Extent of the Analysis

The material in these twelve case records seemed well-suited to this test. Essential to any study of an individual’s social functioning, is information about the performance of those persons with whom he interacts, and at the Clinic, both parents are usually interviewed. One of the requirements for treatment of a child at the Clinic is that one, or if at all possible, both parents also become involved in treatment. In most cases, the mother was interviewed more frequently than the father, but there was in each case some reference to the attitudes and behaviour of the father.

A more thorough study of the material indicated the primary focus is on the mother-child relationship, at least in the beginning phase of treatment. The mother-child relationship, once referred to by Freud as the "smallest group,"¹ has traditionally occupied an important place in psychoanalytic theory. Psychiatric social workers, particularly in child guidance clinics, generally begin the fact-finding process with an

exploration of this relationship. From another aspect, it is usually the mother who applies to the Clinic for help with her child, and it is the child and his problems she often wants to talk about in the first few interviews. Possibly for these reasons, there was less information in the records regarding the father-child relationship, husband-wife relationship, child-sibling relationship and parent-sibling relationship.

On the basis of the material available, it was decided to apply the theory to the child and both parents, although information about many of the fathers was somewhat sketchy. Not enough information was available to analyze the performance of the sibling or siblings in many of the cases, although they do fill major reciprocal roles.

**Concepts of Role and Stress**

The next step was to apply the two concepts of role and stress. Information was carefully sifted from the records regarding each child and parent's social functioning in terms of roles, as perceived by themselves, by others in their role network, and by the Clinic staff. This did not, however, provide a very clear picture of the person's role performance. A more fruitful approach seemed to be through the concept of stress. In this psychiatrically-oriented setting, where the focus is primarily on the psychological aspects of the client's functioning, there is abundant material regarding the client's mental, physical and emotional development. The case material was first analyzed, therefore, using the concept of stress.
Concept of Stress

In the Curriculum Study, the three component elements of the concept of stress were defined as the stress factor, the value threatened and the reaction to stress. When treatment is to be a factor in the assessment, the duration of stress and modifiability of stress factors must also be considered, according to the hypothesis. An analysis was made on this basis for each parent and child.

The stress factors, or sources of stress, which term will be used in this paper, were generally clarified in the records, although not in the order shown in this analysis. The values threatened were not clarified, and in all cases, the decision as to which value was threatened was arbitrarily made by this writer. The information on the reaction to stress was interwoven throughout the case records, as in the case of the sources of stress. In most instances, the reaction seemed to be a cumulative response to all the stresses experienced by the person. Only occasionally, as with Frank F., Case 6, who started to wet his bed again, masturbate and have temper tantrums following the birth of his sister, was the reaction to stress traceable to one major source. Even then, there were supplementary sources, for his mother was depressed and anxious at that time, and his grandmother, who was toilet-training the child, was particularly harsh. The response to stress, therefore,

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1 Boehm, op. cit., p. 109.
as shown in the analyses, should be considered as a cumulative response to the stresses past and present.

In the analyses, the sources of stress and reactions to stress were categorized by order of the major role impaired. This was done with a view to making the material more presentable, and with the thought that it must be integrated with the concept of role.

Concept of Role

In the Curriculum Study, in a section devoted to the implications of the social role theory for diagnostic purposes, the following statement appears:

In order to assess and understand a person's role performance, the worker needs to view this role performance against certain norms. Diagnosis is unthinkable without norms, but unfortunately, norms are not and cannot explicitly be stated in all problem situations coming to the attention of social caseworkers. The determinants of role performance are numerous - somatic, psychological and sociocultural. Standards of somatic or psychological functioning are more readily available than standards of social functioning.¹

While we may accept the statement that explicit norms are not available for all roles, we cannot overlook the fact that there are certain general expectations for the performance of major social roles, particularly family roles, in our society. Currently a good deal of attention is being focused by social

¹ Boehm, op. cit., p. 121.
scientists on the family system as an interacting network of roles, with complementary role expectations. Dr. John Spiegel, a psychoanalyst with an interest in the social sciences, has written with respect to family role differentiation:

For example, an American middle-class wife tends to expect her husband to treat her as an equal. She expects of her husband a good deal of independence, initiative, and planning for future success in his occupation, but in his relations with her and the children she expects cooperation, sharing of responsibility, and individual consideration. Reciprocally, the husband expects his wife to help in his plans for future economic and social success, notably by putting his success goals above any personal career or occupational goals of her own, and by developing the social and domestic skills suitable to his particular occupational status.¹

In a paper entitled "Role Differentiation in the Nuclear Family," Dr. Morris Zelditch pointed out that in our society it is acceptable that the wife may supplement the family income.

Nevertheless, the American male, by definition, must 'provide' for his family. He is responsible for the support of his wife and children. His primary area of performance is the occupational role, in which his status fundamentally inheres; and his primary function in the family is to supply an income, to be the breadwinner.²

Zelditch emphasizes that the father is 'supposed' to remain the primary executive member in the family unit. Even in the most

democratic families, Zelditch states, the father has the balance of authority.

While we may concede that the statement in the *Curriculum Study* is correct in that explicit norms are not available, there do seem to be some generally accepted norms for major roles. For an analysis of case material using the concept of role, the writer believed that some technique for measuring role performance would prove valuable. As was previously noted, the information on social functioning taken from the records did not give too clear a picture of role performance. Therefore, the writer has formulated criteria for each of the major social roles under consideration in this study,—husband, wife, father, mother, son or daughter, sibling, community member, employee, student. On the basis of these criteria, rating scales were devised for the measurement of role performance. (See Appendix B)

Some comment is necessary here about the roles and criteria used. Three of the roles, peer, community member, and student are general, not specific roles, such as husband and wife. Each general role has many facets of interaction with various reciprocal roles. For this study, the role, *member of community*, includes the roles of friend, neighbour, person in a group,—in fact, all the other roles performed by an adult outside of familial and employee roles. It was not within the scope of this thesis to explore the performance of each separate role, but this accumulation of roles under the heading "member of
community" permitted measurement of the individual's social behaviour, where adequate information was available.

For the peer role, the same rating scale was used. It should be noted that although allowance was made for the fact that children in certain age groups do not naturally gravitate to group activity, the children in this study, all six years of age and older, were rated on this ability to participate to some extent in group play, when such group play was provided at the Day Centre for Children,¹ the school, kindergarten or at other such settings.

The student role would normally be a reciprocal role to teacher. However, for the purposes of this study, the student's relationship to other students was also taken into consideration in the child's over-all performance in school. So also was his academic progress, for it is assumed this would influence his relationship with the teacher and other students, and perhaps, with his parents. Therefore, the student role criteria are extended beyond the student-teacher relationship.

For criteria for husband and father roles, the writer referred to a thesis written for the School of Social Work, U.B.C., in 1957, in which the author, Betty Marie Morton, suggested criteria for evaluation of performance in the

¹ A daily group-therapy program held at the Clinic for those children who may benefit from group activities.
masculine role,\(^1\) and to current literature, such as Ackerman's book, *The Psychodynamics of Family Life.*\(^2\) It will be observed that one major area of shared experience between husband and wife, sexual adjustment, has been omitted from the criteria. This glaring omission was decided upon because little information was available about the parents' sexual adjustment. It is probable that the sexual aspects of married life were discussed in treatment interviews, but material for this study was taken from the records up to and including the Diagnostic Conference, before treatment interviews had commenced.

The *sibling role* criteria were formulated by the writer from her own knowledge and experience. There would seem to be a paucity of literature on this subject.

The *employee role* is used here to indicate occupational performance. In the case of the two persons who are or have been self-employed (Mr. A. and Mr. L.), there is no one reciprocal role. Their performance was evaluated on the basis of their training and interest (criteria 2 and 3).

**Scoring of the Rating Scales**

The rating scales were scored for each criteria on the basis of Not Impaired = 0, Moderately Impaired = 3, and

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Severely Impaired = 5. This allowed for intermediate ratings of Slightly Impaired and Extensively Impaired, scores 2 and 4 respectively.

The total score for each individual on each scale was divided by the number of criteria on that scale, providing an average figure. Fractions were taken to the nearest whole number.

The role performance was computed as follows:

<table>
<thead>
<tr>
<th>Average Score</th>
<th>Measurement of Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>Not Impaired</td>
</tr>
<tr>
<td>2</td>
<td>Slightly Impaired</td>
</tr>
<tr>
<td>3</td>
<td>Moderately Impaired</td>
</tr>
<tr>
<td>4</td>
<td>Extensively Impaired</td>
</tr>
<tr>
<td>5</td>
<td>Severely Impaired</td>
</tr>
</tbody>
</table>

From this information it was possible to estimate how adequately each person performed in his major roles. The limitations of the material and of the rather primitive tools make for a rough measurement, it is true, but it does provide some insight into the individual’s social functioning. (See Appendix C)

Charts Depicting Performance in Major Social Roles

The final step in this phase was the preparation of charts which portrayed the role performance of each child and his parents. The purpose of the chart was not only to portray which roles were impaired and which were not, and the degree of impairment in the former, but also to portray the reciprocal roles, the interrelatedness of roles, and indeed, to give a
picture of the child as an interacting unit in a system of roles. In this thesis, it was not possible to explore this area very far, but it could provide substance for extensive study.

**Assessments**

The analysis of the case material on the basis of the concepts of stress and role provided the data for the final phase of the test, the formulation of an assessment. The assessment is a redefinition of the problem in terms of the social role theory.
Chapter 3

APPLICATION OF THE CONCEPTS OF STRESS AND ROLE

The Children and Their Parents

This chapter presents the application of the social role theory to the twelve cases from the files of the Children's Clinic, Mental Health Centre. The case material is analyzed in terms of the concepts of stress and role, and the problem re-defined, in the form of an assessment.

A little general information about the children and their families represented in these twelve cases, might help bridge the gap between the abstract theory and the persons to whom the theory is being applied.

There are three girls and nine boys involved in this study, all of six years of age or over. Their parents have presented a wide variety of problems in connection with their offspring: poor school progress, stealing, antagonizing mother, temper tantrums, soiling, enuresis, masturbation, unmanageable behaviour. The youngest child of the twelve is six years of age, the oldest, fifteen. Their intellectual ability varies from the superior range of general intelligence to the borderline range. The case histories reveal a variety of physical disabilities,—epilepsy, sight disorders, speech disorders, allergies and eczema.
In each of the twelve cases, the child is living with his natural mother, and in nine cases, with his natural father. In Case 3, the father died several months before application was made to the Clinic; in Case 7, the father had died when the child was very young and the mother subsequently remarried; and in Case 8, the parents were recently divorced but the child still visits with his father. In all cases, there is at least one brother or sister living in the home. Only two of the mothers are employed outside the home (Cases 3 and 8). The fathers are engaged in various occupations ranging from labouring to professional work. One father is unemployed, another doing post-graduate study at university.

These then, are the children and the parents on which this study is focused. Although they dwell in different geographical areas, and move in different strata of society, each child and parent is functioning in roles according to his biological grouping (age, sex), to his status in society, to his social adequacy acquired by growth and training. All the children have been brought to the Clinic because they are not meeting the expectations of at least one of their parents in the performance of one or more major social roles. It should be noted, too, that the precipitating factor in requesting service has been, in most cases, the parents' awareness that the child's performance is not meeting the expectations of society, represented by the school, the family doctor, and in one case, the landlord. The child is the primary client, but because his role network
embraces the reciprocal roles of mother and father, this thesis, while not attempting a family diagnosis, will examine the parents' performance. In this chapter the concepts of role and stress will be applied to each of the twelve cases, and a redefinition of the problem will be made on the basis of the information so obtained.

Presentation

Each case will be dealt with separately. A short case summary with some pertinent data concerning the family and the child's developmental history is presented first. This is necessarily brief and concise, and does not include all the information on which this study is based. It is intended, however, to give a picture of the child in his family setting.

Following the case summary is a detailed exposition for each individual of the stress factors, values threatened, duration of stress, reaction to stress, and roles which are consequently impaired. This is the "concept of stress" as defined in the Curriculum Study, applied to the specific individuals. In the cases where sufficient background information is available, it can be observed that one of the sources of stress for the parents has been their earlier impairment in the role of child, a consequence of their parents' failure to perform adequately in their family roles.

The role performance chart which follows is a graphic portrayal of the "concept of role." It depicts the major roles
of the child, and of the parents, who are in his immediate role network. It shows the degree of impairment of major social roles, as measured on the rating scales. And each chart depicts the reciprocity of roles and interrelatedness of roles. An examination of the chart reveals how performance in one role can affect performance in other roles in the network. For example, in Case 1, Figure 1, Mr. A's concentration on his business career has seriously affected his performance in the roles of husband, father and community member. It has also added to Mrs. A's difficulty in moving from role of employee to role of mother. This, in turn, has affected her performance as a wife. Alan's impairment in the role of son, a result of his parents' poor performance in their marital and parental roles, has caused extensive impairment in his role of sibling. As he has moved into each new role, his inability to perform adequately in other roles has added to his stress.

By the use of this concept, the child is perceived not as an isolated psychological structure, but as a social being, constantly interacting with other social beings, both influencing them and being influenced by them. It is also apparent that the concepts of role and stress, in combination, might well be used as a tool for family diagnosis. This will be discussed further in the last chapter of this thesis.

1 Or, it is possible that his inability to perform well in these roles has produced an overemphasis on his work role.
It is important to note here that the intervention of the Clinic in the client's role network has provided an additional major role, that of client, for each of the persons involved in treatment. The worker's entrance into the client's role network has both positive and negative implications. On the positive side, the client-worker relationship is fundamental to the problem-solving process. On the negative side, it imposes a stress situation for the client by fear of the new relationship and its possible impact on other relationships. If role confusion exists, the stress will be multiplied and impairment in the client role may be expected. This would indicate there would need to be a specific attempt to clarify the mutual expectations of the client and worker, and to recognize and resolve any differences at an early point in the relationship. This whole area of role expectations seems to be relatively unexplored. For this reason, the role of client was not included in the analysis, but it could provide a very fruitful area for experimentation and research.

The Assessment of the child in relation to his problem follows the role performance chart. In each case, the writer has attempted to redefine the problem by adapting the information contributed by social worker, psychologist and psychiatrist to the structure of social role theory.

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In summary, the ensuing presentation consists of twelve cases, each with a case summary, an interpretation of the concepts of stress and role, and an assessment.
CASE I - ALAN A.

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. A.</td>
<td>32</td>
<td>Student - Post-graduate course at University</td>
</tr>
<tr>
<td>Mrs. A.</td>
<td>29</td>
<td>Housewife</td>
</tr>
</tbody>
</table>

Children

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan</td>
<td>6</td>
<td>Student - grade I</td>
</tr>
<tr>
<td>Brian</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Referral by: Mother, because of Alan's poor first school report.

Presenting Problems: The mother thinks that Alan is overactive and that he does not play well with other children, and he is not doing well in school.

Case Summary:
Mr. and Mrs. A. and their two children recently moved to the City from the Prairies so that Mr. A. could enroll for a post-graduate course at the University. The family is under considerable financial strain, but Mr. A., a professional man, previously self-employed, hopes to obtain an administrative position with a large organization following his graduation.

Mrs. A. is a slim, blonde woman appearing pale, depressed, listless, who cries easily but tries very hard to control herself in front of her husband.

Mr. A. is a pleasant-mannered, dark, heavy-set man who does not show his feelings.
They were married about eight years ago, shortly after Mr. A. had finished his university training. According to Mrs. A., he worked hard to build up his business and spent long hours away from home. Mrs. A. continued to work, for she enjoyed her office job, and her husband was not yet fully able to support them.

Mrs. A. told the worker that she was shocked to discover she was pregnant about a year after marriage. Neither she nor her husband wanted a baby at this time. She left her job and stayed home for the next two years. Her husband often did not get home until late in the evenings, and Mrs. A. who had always been afraid of the dark and depressed when left alone, was particularly unhappy during this period. Her husband did not want her to return to work, but when Alan was two, Mrs. A. could no longer tolerate her situation, so hired a housekeeper and went back to her job. She worked for a year and half, until she became pregnant with Brian. Since then, she has remained at home.

Mr. A. has had little time to devote to his family, and Mrs. A. has few opportunities for recreation or other interests.

Alan was born with a "wandering" eye, (a weakness in the function of the lateral muscles), a condition not yet corrected. He has been wearing glasses since he was four. As a small child, he had frequent colds and ear trouble. At the age of three, he was hospitalized with meningitis, caused by neglected tonsil infection. Three months later, he was hospitalized for tonsilectomy. At four he was sent to play school; but did not
seem to enjoy this experience. During his fourth and fifth years he awakened every night with nightmares and crawled into his parents bed - like his mother, he is afraid of the dark; he has difficulty going to sleep and still wakens during the night quite frequently, and goes into bed with his parents.

Mrs. A. told the worker that during the time she was working, Alan was well behaved with the housekeeper, but cried when his parents left for work and screamed, ran around acting silly and babyish when she came home every evening. His behaviour did not improve after Brian was born, and when he was four or five, his mother disliked him so much she "could have shaken the stuffing out of him." She has always found him lively and troublesome, but has been most concerned about him for the past two years. According to Mrs. A., he demands constant attention, never allows her to sit down and read, never finishes his meals, is fussy about his food, is rough with other children, but at the same time, is somewhat of a sissy and is not very boyish. Alan loves his baby brother, according to Mrs. A., and always kisses him before leaving for school, and at bedtime. Mrs. A. much prefers Brian, who is quiet and easy to manage.

Mr. A. also prefers Brian, although he is not too concerned about Alan's behaviour because his cousins were much like Alan. He does not think Alan is feminine, but says he does seem very grown up and then acts in a silly, childish way. He feels Alan has a good relationship with Brian because he lets Brian push him around.
Alan makes friends easily, but can't keep them because he becomes silly and annoys them. He prefers adults, and will talk with them in a grown-up way.

At school, the teacher thinks he is lazy. He daydreams; will sit in front of one piece of work all morning and not accomplish anything; brings his homework back undone, saying he did not feel like doing it. Towards the end of the term, he was driving the teacher to distraction and she kept him in virtually every night to finish his work.

At the Clinic, according to the psychologist's report, Alan tested in the "very superior" range of general intelligence. In tests, he proved sensitive, angry, guilty about his hostile feelings. He feels lonely and friendless, unaccepted by other people. He also feels left out of the family because his parents favour Brian, and so is intensely hostile to Brian. He displays such silly attention-seeking behaviour that he provokes annoyance and further rejection.
SCHEDULE $A_1, A_2, A_3$

The A. Family
### Schedule A₁ - Mr. A.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long working hours and relatively small returns</td>
<td>Success in business, marriage</td>
<td>8 years</td>
<td>Return to university for post-graduate work</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Alan's birth</td>
<td>Financial security, marital relationship</td>
<td>6 years</td>
<td>Displeasure with child</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Alan's attention-seeking behaviour</td>
<td>Father-image</td>
<td>4-5 years</td>
<td>Annoyance with Alan, obvious preference for Brian</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Deprived childhood—felt she was unwanted, unresolved oedipal conflict (?)</td>
<td>Self-respect, security</td>
<td>Since birth</td>
<td>Phobic fear of dark, depressions, dependency on other adults for protection and companionship</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Husband sees wife's role as being that of homemaker</td>
<td>Independence</td>
<td>Since Alan's birth</td>
<td>Hostility</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Alan's birth plus her husband's expectations plus her dependency needs</td>
<td>Freedom—opportunity for social relationships</td>
<td>6 years</td>
<td>Depression and rejection of the child</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Family's financial difficulties plus her dependency-hostility</td>
<td>Security—material comfort</td>
<td>6 years</td>
<td>Anxiety—additional hostility</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Alan's silly, babyish behaviour</td>
<td>Mother-image</td>
<td>4 years</td>
<td>Guilt, hostility, rejection, thinks she may have spanked Alan too much</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Alan's problems in school</td>
<td>Mother-image, social status, family ego</td>
<td>6 mos.</td>
<td>Application to Clinic</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Mother's rejection</td>
<td>Life, security, self-respect</td>
<td>Since birth</td>
<td>Generalized hostility and guilt—demands for attention and insecurity</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Birth of younger brother plus generalized hostility</td>
<td>Place in family</td>
<td>2 years</td>
<td>Additional demands for attention—hostility</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Father's lack of understanding affection and his preoccupation with business plus Alan's insecurity</td>
<td>Self-esteem, male identification</td>
<td>Since birth</td>
<td>Added hostility and insecurity, babyishness</td>
<td>Son</td>
<td>Father</td>
</tr>
<tr>
<td>Parents' preference for Brian plus Alan's insecurity, hostility</td>
<td>Self-esteem</td>
<td>2 years</td>
<td>Hostility to Brian</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Demands of teacher plus Alan's insecurity, hostility</td>
<td>Self-respect, achievement</td>
<td>6 mos.</td>
<td>Demands teacher's attention—daydreams, does not work up to capacity, is &quot;driving teacher to distraction&quot;</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>Alan's insecurity and hostility</td>
<td>Self-respect</td>
<td>Since birth</td>
<td>Demands attention from other children by same pattern of behaviour.</td>
<td>Peer</td>
<td>Peers</td>
</tr>
</tbody>
</table>
CASE I

THE A. FAMILY

MR. A.

EMPLOYEE

COMMUNITY MEMBER

HUSBAND

FATHER

SON

PEER

SIBLING

ALAN. A.

STUDENT

MRS. A.

EMPLOYEE

COMMUNITY MEMBER

WIFE

MOTHER

LEGEND

Not Impaired - ○
Slightly Impaired - ●
Moderately Impaired - ○
Extensively Impaired - ○
Severely Impaired - ●
Not Performing Role - ✗
Not Known - ?

FIG. 1 PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case I

Alan A., a six-year-old boy, has reacted to stress by exhibiting silly, demanding, babyish behaviour which has impaired his performance in all major roles. He has antagonized his parents to the point where his mother can barely tolerate him and his father is generally annoyed with him. This behaviour has caused extensive impairment in his performance in his peer and student roles. In his desire for acceptance, he reaches out to others, and according to his mother, he makes friends easily. However, when they cannot give him all the love he needs, his behaviour becomes even more demanding. He gains some attention in a negative way from his teacher who keeps him at school virtually every night to finish his work. Intellectually, he tested in the very superior range of general intelligence.

The original source of stress for this child is rejection on the part of his mother who did not plan, and did not want to give up her role of employee for the role of mother. Her resentment has been directed mainly at Alan. Mr. A. expected her to remain in the home, but was unable to give her the emotional support necessary to help her make this adjustment. Her return to work, when Alan was two, increased the child's sense of rejection. Brian's birth, when he was four, added to the stress. The parents' obvious preference for Brian has caused Alan to feel extremely hostile to him and to feel left out of
the family. This reaction has resulted in severe impairment in his role of sibling.

The most modifiable factor in the situation would seem to be the time Mr. A. can devote to his family following his graduation. If his concentration on business was a result of his desire to improve his family's standard of living, casework services could increase his awareness of the emotional needs of his wife and son, and may be of short-term nature. If the result of a sense of inadequacy in the roles of father, husband and community member, casework could, perhaps, serve to strengthen his performance in these areas.

Mrs. A., it appears, could benefit from casework services, particularly directed to strengthening her performance in the mother role.

Alan, who must learn a new pattern of behaviour so that he will be more easily loved and accepted, has a problem which is appropriate for casework service. When he has gained more security, group activity might expedite the reeducation process.
CASE II - BOB B.

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. B.</td>
<td>?</td>
<td>Factory employee</td>
</tr>
<tr>
<td>Mrs. B.</td>
<td>?</td>
<td>Housewife - takes in sewing to supplement income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>7</td>
<td>Student - grade I</td>
</tr>
<tr>
<td>Norman</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Sally</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Referred by: Mother, because of indication Bob may fail again grade I.

Presenting Problems: Mr. and Mrs. B. are most concerned about Bob's poor school progress. Mrs. B. feels that Bob does not seem to have any purpose in life, and that he is very unhappy. He wet and soiled until he returned to school this year; still wets the bed occasionally; cries easily; masturbates. She says he does not get along with other children of his age group, but plays with younger children. He fights continually with his brother.

Case Summary:
This family lives in a new home in a new subdivision. Mr. B. has been working at his present job for some years, and although
his income is steady, his wages are relatively small. Mrs. B. earns a little money by taking in sewing. Finances are a concern to this family.

Mr. B. is a dark, slightly-built man, with a widespread birthmark on his face. He feels his appearance has been a tremendous disadvantage, that people are against him, that even his own family have treated him badly and that he has had a hard time in life. He has had seven skin-grafting operations which have partially removed the birthmark, and carries with him—for display—pictures showing his countenance before and after the operations. The psychologist noted that he had paranoidal tendencies.

Mrs. B. is taller than her husband and quite obese. She feels Mr. B.'s attitude to people is a real problem for the family. He criticizes her appearance, but she says she lacks the will power to diet. He is very strict with the children, and when he straps them with his belt, she cries with them. She admires his will power, ability to stick to his decisions and to save money.

According to Mrs. B., Mr. B. did not want children and was quite displeased when his wife became pregnant. Mrs. B. who wanted children was so concerned about her husband's attitude, that she fed the first baby (Bob) every two hours on the twenty-four hour, to keep him quiet for her husband's sake.

Bob was born with a congenital hip dislocation, for which he
received treatment for several years. At two years of age, after various illnesses, his eyes crossed, and he had two eye operations. In his early childhood, according to his mother, "he was always sick and screeching."

At the Clinic, the psychologist reported that Bob tested "low on the average range of general intelligence." According to the psychologist, he fears relationships and is emotionally immature and dissatisfied. He also fears his parents and is much concerned about spankings and punishment.
SCHEDULE $B_1, B_2, B_3$

The B. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe facial birthmark</td>
<td>Self-image</td>
<td>Since birth</td>
<td>Hostility--feels at a disadvantage in life, distrustful, suspicious, demanding of attention</td>
<td>Member of Community</td>
<td>Husband</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commuity</td>
<td>Wife</td>
</tr>
<tr>
<td>Bob's birth plus</td>
<td>Relationship with wife</td>
<td>7 years</td>
<td>Rejection of child, harshness</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Mr. B's need for attention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bob's failure in school</td>
<td>Family ego</td>
<td>1 1/2 years</td>
<td>Involvement in treatment at Clinic</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Her obesity plus husband's criticism of her appearance</td>
<td>Self-image</td>
<td>?</td>
<td>Feelings of inadequacy, self-blame; refers to herself as &quot;disgusting, without will power, soft&quot;; hostility to husband</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Husband did not want children</td>
<td>Mother role</td>
<td>Since marriage</td>
<td>Hostility—blames husband for some of children's problems</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Bob's birth plus her inadequacy feelings</td>
<td>Marriage</td>
<td>7 years</td>
<td>Anxiety and overfeeding child to keep him quiet for father's sake</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Bob's early sickness, treatments, operations etc., plus her self-blame, guilt, feelings of inadequacy</td>
<td>Mother-image</td>
<td>4-5 years</td>
<td>Inconsistent handling, overindulgence</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Bob's failure in school plus her guilt, inadequacy, etc.</td>
<td>Family ego</td>
<td>1 year</td>
<td>Application to Clinic</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Mr. B.'s suspicion and distrust of others plus her feelings of inadequacy</td>
<td>Friendships</td>
<td>Since marriage</td>
<td>Withdrawal from social relationships</td>
<td>Member of Community</td>
<td>Member of Community</td>
</tr>
</tbody>
</table>
### Schedule B \(_3\) - Bob B.

**Age 7 years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's anxiety and feelings of ambivalence to him</td>
<td>Security, self-esteem</td>
<td>Since birth</td>
<td>Feelings of insecurity, inadequacy, hostility, dependency on mother, sees her as a &quot;directive, unhappy person&quot;</td>
</tr>
<tr>
<td>Early hip treatments, eye operations, illnesses plus his fearfulness, insecurity</td>
<td>Self-esteem</td>
<td>Since birth</td>
<td>Fearfulness, anxiety, hostility</td>
</tr>
<tr>
<td>Father's harshness</td>
<td>Self-esteem</td>
<td>Since birth</td>
<td>Fearfulness, hostility</td>
</tr>
<tr>
<td>Birth of younger brother plus his fearfulness, hostility</td>
<td>Place in family</td>
<td>6 years</td>
<td>Hostility to brother, continual fighting</td>
</tr>
<tr>
<td>Demands of teacher plus his fearfulness</td>
<td>Self-esteem, achievement</td>
<td>1 1/2 years</td>
<td>Underachieving in school, failed grade I (does not read coherently, goes blank)</td>
</tr>
<tr>
<td>Fearfulness, feelings of inadequacy, etc.</td>
<td>Self-esteem</td>
<td>3-4 years</td>
<td>Plays with children 2-3 years younger</td>
</tr>
</tbody>
</table>

**Major Role Impaired**: Son, Mother, Son, Father, Sibling, Sibling, Student, Teacher, Peer

**Reciprocal Role**: Son, Mother, Son, Father, Sibling, Sibling, Student, Teacher, Peers
CASE 2 THE B. FAMILY

MR. B.
EMPLOYEE
COMMUNITY MEMBER
HUSBAND
FATHER
SON
SIBLING
STUDENT

MRS. B.
EMPLOYEE
COMMUNITY MEMBER
WIFE
MOTHER
PEER

LEGEND
Not Impaired — O
Slightly Impaired — ©
Moderately Impaired — ●●
Extensively Impaired — ●●●
Severely Impaired — ●●●●
Not Performing Role — X
Not Known — ?

FIG. 2. PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case II
Bob B., a seven-year-old boy, has reacted with fear and hostility to the stresses imposed on him to an extent that his emotional and mental development have been stunted. His reaction to stress, has resulted in extensive impairment in his performance in the roles of son, sibling, and peer and severe impairment in the role of student. Although he tested low in the average range of general intelligence, he is repeating Grade I and may fail again this year.

The sources of stress have been his mother's anxiety and feelings of ambivalence towards him because of her own insecurity and her husband's reluctance to share her with the baby; his father's harshness; his early hip treatments, eye operations and other illnesses, some of which were possibly also a reaction to stress; and the birth of his brother when he was a year old.

Intervention should be in the stress producing area, rather than in the area of the child's reaction to stress. Casework services to Mrs. B. might be directed to developing her sense of self-worth and adequacy and towards helping her be more consistent in her handling of Bob. Mr. B. who has paranoidal tendencies, and is performing poorly in all major roles, may require long-term treatment to strengthen his performance in all areas, but particularly in the father role.
Concurrent with casework services to the parents, casework services would seem appropriate for Bob. A warm, consistent relationship may help him overcome his fearfulness and move towards greater maturity.
CASE III - CARL C.

Parents

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. C.</td>
<td>(deceased in 1959 at age 59)</td>
<td>Carpenter</td>
</tr>
<tr>
<td>Mrs. C.</td>
<td>42</td>
<td>Part-time grocery clerk</td>
</tr>
</tbody>
</table>

Children

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carl</td>
<td>13</td>
<td>Student-special class</td>
</tr>
<tr>
<td>Sam</td>
<td>12</td>
<td>Student-Grade ?</td>
</tr>
</tbody>
</table>

Referred by: Mother, first in 1950 because of Carl's speech impediment, again in 1952 because of Carl's violent behaviour. He used a hammer on the bedroom door and chopped the asbestos covering on the furnace pipes with a hatchet. Carl told his mother that Sam committed these misdemeanours.

Presenting Problem: Mrs. C. said she fears Carl is getting out of control. He has been dressing up in her clothing and she fears sex attacks on other children. He has become increasingly withdrawn and uncommunicative. She is also concerned about his poor school performance.

Case Summary: Mrs. C. is a widow whose husband died suddenly five months before she appealed to the Clinic for help with Carl. A week after her husband's death, she took part-time work in
a grocery store and is now also taking night-school courses. She hopes to return to full-time employment as a stenographer next year.

Mrs. C. told the worker that Sam, the younger boy, was sent to her brother's farm following Mr. C.'s death last summer, but Carl was kept at home. His mother needed him and thought he was particularly upset. She said Mr. C. had always been very kind to Carl and the boy was very disturbed by his death. It was during this time when his mother was working and Carl was home alone that he started dressing up in her clothing. Her brother subsequently came back to spend the winter months with the family, but has recently returned to the farm. Mrs. C. is presently living alone with the two boys.

According to Mrs. C., Carl has always been a source of concern. She and her husband, who had been divorced, planned to have their family early, but after ten years, finally adopted a baby privately. This child died at four months and about this time, Mrs. C. became pregnant. Carl's birth was a very difficult one. Labour continued thirteen hours and the baby's head and face were badly bruised by instruments. Mrs. C. was given drugs for infection and this so severely affected the baby he nearly died but was revived by treatment in an oxygen tent. He had "stomach trouble" for the first six months. At one year, he ran a high temperature with what the doctor thought might be polio. He had started walking at this time,
but regressed considerably, and did not try walking again for another few months.

Sam's birth, for which Carl was not prepared, was a shock to the child. He cried and hid behind the chesterfield when Sam was brought home from the hospital.

In 1950, when Carl was four, the family doctor referred him to the Clinic because of his speech difficulties. Presumably, through some misunderstanding, Mrs. C., who had arranged an appointment with the intake worker on the phone, took the child to the Health Centre for Children. In their report on file, the problem was diagnosed as "speech impairment and drooling." Physical findings were negative. The speech therapist considered the difficulty was due to Mrs. C.'s anxiety and sibling rivalry, but the possibility that Carl was mentally defective was discussed with Mrs. C. Shortly afterwards, Mrs. C. had Carl's tongue snipped (it was rather short) and tonsils removed. In the next two years, when Carl was four and five, he had blackouts when he was frustrated or reprimanded. His father described these as fainting spells, with bubbling at the mouth. These had stopped by the time Carl started school.

In 1952, Mrs. C. again applied to the Clinic because of Carl's poor progress in Grade I. She also mentioned that he was nervous, stubborn, fearful of crowds, complained of headaches, and stomach aches. The psychologist's report indicated Carl
showed confused behaviour, feeling of rejection by both mother and father, lack of sense of personal worth, hostility towards all members of the family, and tested in the "slow normal range of general intelligence." The case was closed a year later at the parents' request as the situation had shown some improvement.

Mrs. C. has had considerable illness, "nervous breakdown," peptic ulcer, sinus and other troubles. She attributed the ulcer to worrying about Carl being "mental" when he was having so much speech difficulty.

Carl, now thirteen and a half, is in advanced special class (for slow learners). His mother is concerned about his poor school showing but even more concerned that, alone, she will not be able to keep him in control.

At the Clinic, the psychologist reported that Carl tested "in the borderline range of general intelligence," but it is thought that his potential is "slow normal." The psychologist's tests indicated a signal lack of control. Carl was diagnosed as a "character disorder" type personality.
SCHEDULE $C_1, C_2$

The C. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of adopted baby</td>
<td>Family self-esteem</td>
<td>?</td>
<td>Anxiety, fearfulness, guilt</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Carl's early illnesses plus her anxiety, guilt</td>
<td>Family self-esteem, Mother-image</td>
<td>3-4 years</td>
<td>Additional anxiety, over-protection</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Carl's speech difficulty and suggestion of mental illness</td>
<td>Mother-image Son's future</td>
<td></td>
<td>Application to Clinic (1950)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Carl's poor school progress, fears, head and stomach aches</td>
<td>Mother-image Son's future</td>
<td>6 mos.</td>
<td>Application to Clinic (1952)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Husband's death</td>
<td>Security, home</td>
<td>6 mos.</td>
<td>Return to work, night school classes, additional anxiety</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Carl's disturbed behaviour--dressing in her clothes, violent acting out</td>
<td>Mother-image security, emotional equilibrium</td>
<td>6 mos.</td>
<td>Application to Clinic (1960)</td>
<td>Mother</td>
<td>Son</td>
</tr>
</tbody>
</table>
### Schedule $C_2$ - Carl C.

**Age 13 Years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor seizures (4-5 years of age), early illnesses, less than average intelligence, protruding teeth</td>
<td>Security, self-esteem</td>
<td>Since birth</td>
<td>Confusion, hostility, fearfulness, inadequacy</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Birth of younger brother</td>
<td>His place in family</td>
<td>12 years</td>
<td>Additional fearfulness, hostility</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Mother's anxiety re his being &quot;mental&quot; and her overprotection</td>
<td>Self-esteem</td>
<td>9 years</td>
<td>Additional inadequacy, hostility, confusion</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Sam's superiority and rejection plus his inferiority feelings, hostility, etc.</td>
<td>Self-esteem</td>
<td>9-10 years</td>
<td>Hostility, rivalry</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Demands of teacher, plus his inferiority feelings, confusion, hostility, etc.</td>
<td>Self-esteem achievement</td>
<td>7 years</td>
<td>Functioning below capacity</td>
<td>Student</td>
<td>Teacher</td>
</tr>
</tbody>
</table>
CASE 3  THE C. FAMILY

LEGEND

- Not Impaired
- Slightly Impaired
- Moderately Impaired
- Extensively Impaired
- Severely Impaired
- Not Performing Role
- Not Known

Fig. 3. Performance in major social roles.
Assessment

Case III
Carl C., a thirteen-year-old boy, is displaying extensive impairment in his role of son and moderate impairment in his roles of sibling and student. Nothing is known about his relationship with his peers but it may be assumed that his reaction to stress which has caused impairment in other roles has affected his performance in this area. He is generally immature and lacks self-control. Psychometric tests give evidence of greater emotional disturbance than is shown in his role performance. The clinical diagnosis is "character disorder."

The original source of stress in this situation was the mother's over-anxiety around this child. (Her husband's desire to have a family, the long wait of ten years before Carl's conception, the death of the adopted baby and Carl's early illnesses all added to her anxiety.) Sam's birth, when Carl was one year old, was another source of stress. He responded to these stresses by clinging to his infantile behaviour. His mother's fears that he was "mental" further added to the stress imposed on him. Carl's rather low intellectual capacity has not helped him cope with these stresses. His jealousy of Sam, who is brighter and more outgoing, has further complicated the situation.

The recent death of Mr. C. added to other stresses which were already overwhelming the boy, resulted in fear of masculinity, as indicated by his dressing in his mother's clothing.
Casework services for Mrs. C. may relieve some of her anxiety and may enable her to accept Carl's intellectual limitations. However, the other major sources of stress for Carl cannot be modified by services to persons within his role network. Therefore, the major area of intervention should be in Carl's reaction to stress, which may involve long-term treatment for the boy.
CASE IV - DON D.

Parents

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. D.</td>
<td>?</td>
<td>Mechanic</td>
</tr>
<tr>
<td>Mrs. D.</td>
<td>?</td>
<td>Housewife</td>
</tr>
</tbody>
</table>

Children

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Doug</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Barry</td>
<td>16 (in institution for mentally defective)</td>
<td></td>
</tr>
<tr>
<td>Mike</td>
<td>15</td>
<td>Student - Grade ?</td>
</tr>
<tr>
<td>Don</td>
<td>6</td>
<td>Kindergarten pupil</td>
</tr>
</tbody>
</table>

Referred by: Adult Clinic, where Mrs. D. had been receiving treatment. Her diagnosis was "psychoneurotic reaction, anxiety state." The psychiatrist at the Adult Clinic decided it was Don's behaviour which was triggering her anxiety.

Presenting Problems: Mrs. D. is most concerned about Don's temper tantrums. She said, too, that he is bed wetting and nail biting.

Case Summary:

Mrs. D., described by the Social Worker as a shy sensitive woman, has never been very healthy and recently suffered a facial muscular contortion which causes her to be even more self-conscious. Mr. D., a mechanic, described by the worker as shy,
slow-thinking, unsure of himself, has had an erratic job-history. Shortly after application to the Clinic, he was sent out of town by his employer for a six-months period.

Mrs. D. expressed much guilt about Don's difficulties, blaming herself because neither she nor her husband had wanted another child, although she felt differently about the baby after he was born. After the birth of her first two children, the doctor had said she should have no more children. However, the contraceptive measures used were not successful, and Barry was born, mentally defective. Mrs. D. has always felt responsible for his retardation. Mike followed the next year and then, ten years later, Don was born.

Mrs. D. told the worker that, during her pregnancy with Don she was quite ill. It was a particularly unhappy time, because she was also nursing an aunt who was dying of cancer. It was a difficult labour period, and she became exhausted and gave up halfway through the birth process. The baby (Don) was hospitalized for the first month, and this was followed by intermittent hospitalizations for the next year for bronchial congestion. Mr. D. was also ill at that time.

Don has suffered from various allergies, and a small hernia, all of which have caused his mother some concern. She has taken him to several doctors and allergists in the past few years.

Barry, the son who is in the institution, visits the home on week-ends. According to Mrs. D. he is very fond of Don and
follows him around, touching him. Don is very fearful of Barry and becomes quite upset by his visits.

Recently, since a little girl undressed herself in front of Don, he has exhibited behaviour which his mother thinks is quite unusual. He will not undress in front of her, and must wear his bathing suit in the bathtub. His mother fears he is becoming "emotionally disturbed."

At the Clinic, the psychologist reported that Don tested in the "average range of general intelligence," but it was thought his potential is higher. In the psychometric tests he showed much concern about growing up and being masculine and independent. He still sees himself as a baby in need of protection, who lacks satisfaction and is fearful of being hurt.

The psychiatrist reported that there were three main areas of concern. Firstly, his mother's need to see him as an infant; secondly, his father's going away which gives Don's destructive feelings toward father considerable force; and, thirdly, his mother's concentration on his hernia condition which has aroused castration fears in Don.
SCHEDULE $D_1, D_2, D_3$

The D. Family
## Schedule D₁ - Mr. D.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Dependency on her mother</td>
<td>Self-esteem</td>
<td>Since birth</td>
<td>Hostility, feelings of inadequacy (mother helps her with housework but makes her feel inferior)</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Husband's inability to give her adequate emotional and physical support plus her feelings of inadequacy</td>
<td>Self-esteem, security</td>
<td>Since marriage</td>
<td>Hostility, guilt</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Birth of mentally defective son Barry especially after doctor told her she should have no more children</td>
<td>Self-esteem, mother-image</td>
<td>16 years</td>
<td>Guilt—feels responsible for Barry's retardation</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Donald's allergies and hernia</td>
<td>Mother-image</td>
<td>2-3 years</td>
<td>Guilt—&quot;has hustled him around to a host of doctors and allergists&quot;</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Donald's temper tantrums, demanding behaviour, plus her guilt feelings, etc.</td>
<td>Emotional equilibrium</td>
<td>?</td>
<td>Application to Adult Clinic (psychosomatic symptoms, fears she will lose her temper—anxiety reaction</td>
<td>Mother</td>
<td>Son</td>
</tr>
</tbody>
</table>
### Schedule D₃ - Don D.

**Age 6 Years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's ambivalence toward him</td>
<td>Self-esteem, security</td>
<td>Since birth</td>
<td>Anxiety, anger, illness</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Early hospitalizations plus his insecurity, anxiety</td>
<td>Security</td>
<td>1 year</td>
<td>Fearfulness, hostility</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Barry's weekend visits plus his fearfulness, anxiety, etc.</td>
<td>Security</td>
<td>Since birth</td>
<td>Fearfulness</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Awareness mother wishes he were a girl and her concern over his hernia plus his fearfulness, anxiety, etc.</td>
<td>Masculinity</td>
<td>2-3 years</td>
<td>Additional fearfulness, regression, castration anxiety</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Little girl's exposure plus his fearfulness, castration fears</td>
<td>Masculinity</td>
<td>6 mos.</td>
<td>Additional castration anxiety (must wear bathing suit in bathtub)</td>
<td>Son</td>
<td>Mother</td>
</tr>
</tbody>
</table>
CASE 4
THE D. FAMILY

MR. D.
EMPLOYEE

COMMUNITY MEMBER

HUSBAND

FATHER

SON

PEER

DON. D.
STUDENT

MRS. D.
EMPLOYEE

COMMUNITY MEMBER

WIFE

MOTHER

SIBLING

LEGEND
Not Impaired — O
Slightly Impaired — ⊙
Moderately Impaired — ●
Extensively Impaired — ○
Severely Impaired — ◎
Not Performing Role — ×
Not Known — ©

FIG. 4: PERFORMANCE IN MAJOR SOCIAL ROLES.
Case IV

Donald D., a six-year-old boy, is moderately impaired in his roles of son and sibling. Little is known of his performances in other roles but he seems to be "settling down in kindergarten," according to his mother. His response to stress has been an effort to maintain the infantile relationship to his mother. He is concerned about growing up, and becoming independent. His fear of undressing even while in the bathtub indicates concern about his masculinity.

The sources of stress have been Mrs. D.'s ambivalence towards him and her consequent difficulty in helping him mature normally. Her ill-concealed desire for him to have been a girl, her concern over his hernia, and the little girl's exposure have aroused serious castration fears in the child. His father's inadequate performance in his roles as father, husband and employee, has aggravated the stress this child is experiencing.

The major area of intervention would seem to be required in the stress-producing area—the inadequate parental role performance of Mr. and Mrs. D. However, as Mr. D. is leaving town for some months (which will further intensify the stress) casework services might be provided for Donald to help him react to stress in a more positive way, and to strengthen his masculine identification. Casework services for Mrs. D. might be directed at achieving a more satisfactory relationship with her mother,
and could give her the emotional support lacking in her marital relationship so that she can allow Donald to move towards greater maturity.
CASE V - EVA E.

Parents

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. E.</td>
<td>47</td>
<td>Labourer</td>
</tr>
<tr>
<td>Mrs. E.</td>
<td>40</td>
<td>Housewife</td>
</tr>
</tbody>
</table>

Children

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ralph</td>
<td>19</td>
<td>Unemployed</td>
</tr>
<tr>
<td>Sue</td>
<td>18</td>
<td>Married, 1 child</td>
</tr>
<tr>
<td>Eva</td>
<td>11</td>
<td>Student, grade V</td>
</tr>
<tr>
<td>Harry</td>
<td>6</td>
<td>?</td>
</tr>
</tbody>
</table>

Referred by: Mother in 1952, at suggestion of worker at Gordon Neighborhood House, because of Eva's violence towards other children and again in 1960 because of Eva's last unsatisfactory school report.

Presenting Problems: Mrs. E. is most concerned about Eva's lack of interest in school. She tackles new subjects with enthusiasm but soon loses interest. According to Mrs. E., Eva is very sensitive and very lazy.

Case Summary:
This family has experienced a good deal of illness and financial insecurity. Mrs. E. was in hospital three times this past year and Mr. E. once, for a hernia operation. It was during her
father's illness that Eva's school marks fell so badly. She told the principal that she was afraid her father would never get out of the hospital.

Mrs. E. was perceived by the worker as the disciplinarian in the family. She described her husband as "too soft and too easy." He seldom scolds Eva and has spanked her only twice.

According to information given by Mrs. E., worry, sickness and insecurity have been predominant in this home. Both parents come from broken homes. Mr. E. the youngest of ten children, left school at fourteen, when his father died. He has no special skill or training and his work history has been erratic. Mrs. E. said her home life was very unhappy. Her father argued constantly with her mother, bullied the children and deserted them when she was eleven. Her mother subsequently entered into a common-law relationship, about which Mrs. E. is embarrassed.

Eva was a sickly baby, who was hospitalized four times in her first year for a bronchial condition. She had her tonsils removed at thirteen months, and afterwards had attacks of bronchitis, mumps, measles, whooping cough, infected ear drums. During this period, the family moved frequently and Mrs. E. recalled she was upset and confused. Her mother, who stayed with them frequently, was very strict with Eva.

Eva, at two and a half, was attacking other children with sticks
and stones at every opportunity. Her mother took her to a play group at Gordon House, but Eva hated this. The social worker at Gordon House referred Mrs. E. to the Clinic in 1952, because of Eva's violent behaviour.

Investigation at that time showed Eva was also belligerent and controlling at home, was smearing, swearing, and causing general disorder in the house. Mrs. E. felt she was beyond control.

The psychiatrist analyzed the problem as severe separation anxiety with the mother's own emotional problems complicating the situation. Eva then tested in the "superior range of general intelligence." The case was closed in 1954 eighteen months later, when some improvement was noted.

Eva is now in grade V, and has been having trouble with her school work for some time. According to the school principal, she seems unable to concentrate, and was given remedial courses which did not help her, and was finally placed in a slower group, which she resents. Her mother noted that she is quite tomboyish, and prefers to play with boys, but her parents are not concerned with this aspect of her behaviour.

At the Clinic, the psychologist reported Eva tested in the "average range of general intelligence." In psychometric tests she proved immature and insecure, dissatisfied with herself and with life in the family.
SCHEDULE $E_1$, $E_2$, $E_3$

The E. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father's early death, Mr. E.'s lack of education and training</td>
<td>Security</td>
<td>Since boyhood</td>
<td>Insecurity, withdrawal, frequent unemployment</td>
<td>Employee</td>
<td>Employer</td>
</tr>
<tr>
<td>Mrs. E.'s concern for achievement, social status, plus his feelings of insecurity</td>
<td>Self-esteem</td>
<td>Since marriage</td>
<td>Withdrawal, passivity (does not discipline children, set limits, or give them emotional support)</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Eva's behaviour--poor school performance</td>
<td>?</td>
<td>?</td>
<td>Involvement in treatment at Clinic</td>
<td>Father</td>
<td>Daughter</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Father's brutality and desertion, mother's common-law relationship</td>
<td>Self-esteem, security</td>
<td>Since early childhood</td>
<td>Feelings of insecurity, inadequacy, overconcern about what people think</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Mr. E.'s passive, withdrawn behaviour - failure to give her adequate emotional support plus her insecurity</td>
<td>Security</td>
<td>Since marriage</td>
<td>Hostility, additional insecurity, dominating behaviour</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Mr. E.'s failure to succeed plus her insecurity, hostility</td>
<td>Security</td>
<td>Since marriage</td>
<td>Determination that Eva will be successful</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
<tr>
<td>Eva's early illness and hospitalizations plus her insecurity, etc.</td>
<td>Child's life, Mother-image</td>
<td>2 years</td>
<td>Overconcern, overindulgence, inconsistent handling</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
<tr>
<td>Eva's violent behaviour at 2 1/2 years of age plus her insecurity, etc.</td>
<td>Mother-image</td>
<td>Few mos.</td>
<td>Took Eva to Gordon House play group followed by application to Clinic (1952)</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
<tr>
<td>Eva's poor school report</td>
<td>Achievement, success</td>
<td>Gradually intensifying over 5-year period</td>
<td>Application to Clinic (1960)</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
</tbody>
</table>
### Schedule E3 - Eva E.

**Age 11 Years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's emotional instability, inconsistent handling, overindulgence</td>
<td>Security</td>
<td>Since birth</td>
<td>Insecurity, hostility, demanding behaviour</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Early illnesses, plus her insecurity</td>
<td>Security</td>
<td>2 years</td>
<td>Fearfulness, hostility</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Grandmother's strictness and harshness</td>
<td>Security</td>
<td>?</td>
<td>Fearfulness, hostility</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Father's inability to set limits and give emotional support and mother's inconsistency</td>
<td>Femininity</td>
<td>7-8 years</td>
<td>Confusion regarding her identification—wears jeans, plays with boys, tomboyish behaviour</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Demands of teachers plus her mother's expectations plus Eva's insecurity</td>
<td>Achievement, Self-esteem</td>
<td>5 years</td>
<td>Underachieving in school, cannot concentrate</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>Parents' hospitalization (esp. father's) plus her insecurity</td>
<td>Security</td>
<td>Past few months</td>
<td>Regression, deterioration in academic work</td>
<td>Student</td>
<td>Teacher</td>
</tr>
</tbody>
</table>
CASE 5  THE E FAMILY

MR. E.
EMPLOYEE
COMMUNITY MEMBER
HUSBAND
FATHER
DAUGHTER
PEER
SIBLING

MRS. E.
EMPLOYEE
COMMUNITY MEMBER
WIFE
MOTHER
STUDENT

LEGEND
Not Impaired - O
Slightly Impaired - ☺
Moderately Impaired - ☻
Extensively Impaired - ☼
Severely Impaired - ☽
Not Performing Role - ☒
Not Known - ☐

FIG. 5. PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case V

Eva E., an eleven-year-old girl, is functioning at a moderately impaired level in her roles as daughter and peer, and at an extensively impaired level in her role as student. Her early reaction to stress was rebelliousness, but more recently she has become discouraged and apathetic and has expressed the desire to escape from her present environment. This reaction has particularly affected her student role. Nothing is known about her sibling relationships, although the generalized hostility with which she has responded to stress, in the past, has possibly impaired her performance in this area.

The major sources of stress have been her illnesses in the first two years of her life which necessitated frequent hospitalization and separation from her mother and her mother's inconsistency, occasioned by her own emotional problems, her husband's failure to provide for her physical and emotional needs, and Eva's illnesses.

Eva appears to be particularly resentful towards her mother (particularly because of her assumption of the husband's function of disciplinarian) and thus is experiencing some difficulty identifying with her.

The most modifiable factor in the family situation would appear to be Eva's reaction to stress. Both parents, however, may be
helped strengthen their performance in the parental roles through casework services. It is unlikely that Mr. E. will be able to meet his wife's requirements for success or to assume the role of dominant partner even if Mrs. E. could permit this. Little improvement may be expected in their performance of other roles. It would appear Eva could benefit most from individual casework services directed to strengthening her ego functioning and feminine identification.
CASE VI - FRANK F.

Parents  
Mr. F.  
Mrs. F.  

Children  
Frank  
Louise  

Age  
52  
46  
11  
9  

Occupation  
Professional  
Housewife  
Student, Grade VII  
Student, Grade V  

Referred by: Mother, in 1953, at the recommendation of the family doctor because of eneursis, masturbation and antagonizing behaviour; and again in 1955 because of Frank's poor grade I report, and again in 1960 because of his poor school performance. She is also concerned about Louise's phobias.

Presenting Problems: Mother fears Frank might lose control of himself and hurt someone.

Case Summary: Although Mr. F. has professional training, he has been unable to give his family much financial security. He has moved frequently from job to job, which has meant many changes of residence for the family and periods of little or no income. He is described by the worker as impatient and explosive. He voiced criticism of his wife's inconsistency, and indulgence with
the children. He said he is unable to make friends and is not interested in community affairs.

Both parents come from homes they describe as "unhappy." According to Mrs. F., her father, who was brutal and harsh, died when she was eleven. Her mother then operated a laundry where the children worked long hours. She beat the boys with her fists to elicit obedience, and at times lapsed into mental illness and threatened suicide. Mrs. F. stayed out of trouble by conforming. She still finds it difficult to assert herself, and gives in to the children to prevent quarreling. She has had rheumatism since she was fourteen and other illnesses. She feels ill and tired and finds it hard to cope with the children and the housework.

Although Mrs. F.'s mother is now remarried, Mrs. F. and her husband have stayed with her occasionally when Mr. F. has been away on a job or unemployed, and she is a frequent visitor in the F. home. According to Mrs. F., the grandmother prefers Louise to Frank, and has been harsh with the boy.

Mr. and Mrs. F. were staying with the grandmother when Frank was born. His mother recalled that he was always a "difficult baby" with eating and sleeping problems, colic, and frequent colds. He was hospitalized at four months to find a satisfactory formula. The family moved several times, returning to the grandmother's household when he was about two, because Mrs. F. was ill and Mr. F. away. The grandmother toilet-trained Frank. Following
Louise's birth, during this period, Frank started to wet his bed again, and had severe temper tantrums when he would hold his breath until he lost consciousness, and started masturbating.

In 1953, Frank was brought to the Clinic by his mother at the recommendation of her doctor. The presenting problems were enureses, masturbation and antagonism. The Clinic defined three problems:

1. The frequent presence in the home of the maternal grandmother who rejected Frank in favour of his sister Louise. Grandmother punished the boy and became very angry when she found him masturbating.

2. Mother's inability to break the hostile-dependent tie to her own mother.

3. Unsatisfactory marital relationship, in which both parents repress hostile feelings, are unable to achieve a satisfactory sexual adjustment, are unable to give the children the warmth and security they need, have conflicts about disciplining children.

Treatment at the Clinic continued through 1954 for parents and child.

In 1955, Mrs. F. again contacted the Clinic because Frank's grade I report noted his deterioration in work and behaviour. The teacher reported to the Clinic that Frank displayed increasing masturbation, restless and silly behaviour, resentment
towards other children, wetting, uncooperativeness, and did anything to get the teacher's attention. In his work, he was slow and messy, had difficulty printing and was regressing in his reading. Mrs. F. noted that at home Frank was defiant, swearing, masturbating, complaining of pains and sickness, increasingly enuritic, displayed temper tantrums, was dependent on his mother and hated going to school. Mrs. F. was most concerned about the school's criticism of Frank.

The case was closed again in 1957 when general improvement was noted.

In 1960, the third application was made. Louise was also showing signs of emotional disturbance and treatment is being provided for Frank, Louise, and both parents.
SCHEDULE $F_1$, $F_2$, $F_3$

The F. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor parental relationships, unhappy home life</td>
<td>Security, self-esteem</td>
<td>Since childhood</td>
<td>Feelings of inadequacy, hostility, dependency</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Demands of employers plus his inadequacy feelings</td>
<td>Self-esteem</td>
<td>Since adulthood</td>
<td>Frequently leaves job</td>
<td>Employee</td>
<td>Employer</td>
</tr>
<tr>
<td>Wife's dependency on her mother plus his feelings of inadequacy, dependency and hostility</td>
<td>Self-esteem</td>
<td>Since marriage</td>
<td>Feels neglected and rejected, &quot;she does not value his opinions;&quot; hostility, duodenal ulcers</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Wife's objections to his disciplinary measures plus his insecurity, etc.</td>
<td>Self-esteem, his position of authority</td>
<td>10 years ?</td>
<td>Hostility because &quot;she undermines his authority,&quot; &quot;protects when he punishes,&quot; frustration, temper outbursts</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Frank's behaviour plus his insecurity</td>
<td>Authority</td>
<td>7-8 years</td>
<td>Resentment towards child</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Mr. F.'s feelings of insecurity, hostility, marital conflict, job and residence changes</td>
<td>Self-esteem</td>
<td>?</td>
<td>Withdrawal from social relationships (inability to make friends, lack of interest in community activities and organizations)</td>
<td>Member of Community</td>
<td>Community</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Parents' brutality, father's early death, mother's mental illness</td>
<td>Life security</td>
<td>Since childhood</td>
<td>Conforming behaviour, hostility, guilt, feelings of inadequacy, fear of asserting herself, hostile dependency on mother, psychosomatic illnesses</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Husband's inability to provide physical and emotional support, plus her feelings of inadequacy, etc.</td>
<td>Security</td>
<td>Since marriage</td>
<td>Returned with family to live with mother at frequent intervals--additional illness, migraine headaches, hostility, depression, insecurity</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Frank's behaviour (pre-school) enureses, masturbation, temper tantrums, plus her feelings of inadequacy</td>
<td>Security, mother-image</td>
<td>2 years</td>
<td>Application to Clinic (1953)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Frank's poor school report in Grade I plus her feelings of inadequacy</td>
<td>Family ego</td>
<td>6 mos.</td>
<td>Application to Clinic (1955)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Frank's behaviour and her fear of losing control, Louise's phobias plus her feelings of inadequacy</td>
<td>Authority, self-esteem, family ego</td>
<td>?</td>
<td>Application to Clinic (1960)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Mother's anxiety, depression, illness</td>
<td>Security</td>
<td>Since birth</td>
<td>Anxiety, early eating problems, sleeping problems, overt dependency</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Grandmother's harshness during early years, especially in toilet training</td>
<td>Self-esteem, independence</td>
<td>Since birth</td>
<td>Anxiety, hostility, guilt</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Louise's birth, plus his insecurity, anxiety</td>
<td>Place in family</td>
<td>9 years</td>
<td>Anxiety, bedwetting, masturbation, temper tantrums</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Father's resentment, hostility, plus his insecurity, anxiety, etc.</td>
<td>Masculine identifi- dation</td>
<td>7-8 years</td>
<td>Confusion re identification, conforming, inhibited, excessively controlled behaviour</td>
<td>Son</td>
<td>Father</td>
</tr>
<tr>
<td>Grandmother's preference for Louise plus his insecurity, hostility</td>
<td>Self-esteem</td>
<td>9 years</td>
<td>Hostility towards Louise as well as grandparents (hits Louise with fists)</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Demands of teacher plus his insecurity</td>
<td>Self-esteem</td>
<td>6 years</td>
<td>Underachieving in school</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>His insecurity, etc.</td>
<td>Self-esteem, independence</td>
<td>7-8 years</td>
<td>Bosses other children, argues, fights</td>
<td>Peer</td>
<td>Peers</td>
</tr>
</tbody>
</table>
CASE 6  THE F. FAMILY

MR. F.
EMPLOYEE
COMMUNITY MEMBER
FATHER
PEER
FRANK, F.
EMPLOYEE
COMMUNITY MEMBER
WIFE
SON
SIBLING
STUDENT

MRS. F.

LEGEND
Not Impaired - O
Slightly Impaired - O
Moderately Impaired - O
Extensively Impaired - O
Severely Impaired - O
Not Performing Role X
Not Known - ?

FIG. 6  PERFORMANCE IN MAJOR SOCIAL ROLES.
assessment

Case VI
Frank F., an eleven-year-old boy has shown impairment since birth in his role of son (he was a difficult, nervous baby) and subsequently extensive impairment in his roles of sibling and peer, and moderate impairment in his role of student.

He has reacted to the stresses imposed on him by fearing and resisting the demands of growth, as evidenced by his bed-wetting, smearing, masturbating, over-dependency on his mother, and by expressing much jealousy and hostility towards his younger sister. His earlier symptoms of disturbance have been fairly well repressed, and now he is overly controlled and inhibited, but still dependent on his mother.

His major source of stress has been the failure of both parents to perform adequately in their parental roles, a condition which has been exacerbated by a poor marital relationship, conflict over authority, and Mrs. F.'s hostile-dependent relationship with her own mother. The birth of his sister, Louise, coming at the crucial time when he was being toilet-trained by his grandmother who was rejecting and harsh, was another major source of stress. The grandmother's continued rejection of the boy and her obvious preference for Louise, have added greatly to the stress. The father's impatient, resentful attitude towards Frank has made masculine identification even more difficult. In appearance he is overweight and slightly feminine.
The major area of intervention possibly should be in the area of the source of stress, the role impairment of Mr. and Mrs. F., with the goal of improving their marital relationship and strengthening their performance in their parental roles.

Frank might also benefit from casework services directed to strengthening his ego-functioning and his masculine identification.
CASE VII - GORDON G.

Parents | Age | Occupation
---|---|---
Mr. G. (step father) | ? | Professional (Government service)
Mrs. G. | ? | Housewife
Mr. A. - natural father (deceased) | | Logger

Children

Joe | 19 | ?
Jim | 17 | Student, Grade ?
Gordon | 15 | Student, Grade VIII (repeating)
Patsy | 14 | Student, Grade ?

Referred by: Mother, because Gordon stole money from newspaper route funds. Men from the newspaper company have been calling at the house, causing the parents much embarrassment.

Presenting Problems: Mrs. G. told the worker that Gordon is unreliable, and has been stealing and lying.

Case Summary:
Mr. and Mrs. G. with the children live in a large, comfortable home in a good neighborhood. Mrs. G. has high housekeeping standards. The family has relatively high status because of Mr. G.'s position and they are financially comfortable. Mr. and Mrs. G. were married in 1950, and Mr. G. has since adopted all the children. According to Mrs. G. he leaves the major
responsibilities and decisions to Mrs. G. which she resents.

Mrs. G. told the worker that her first marriage was an extremely unhappy one. She had trained as a nurse, primarily to escape from home and a tyrannical father. She could not become involved easily with single men, but instead went out with married men and formed an unhappy homosexual relationship. She extricated herself from this situation by marrying Mr. A. They lived in logging camps and drank heavily. Then they moved to a more settled area, where she returned to her occupation and found different friends. She became more dissatisfied with her husband, seeing him as crude, unkempt, of low status, keeping poor company. She was critical and resentful.

Gordon was born about this time. Mrs. G. said she did not want him either before or after his birth. While she was in hospital, her husband had an affair with the girl she had hired to care for Joe and Jim, and Mrs. G. was so upset she thought of poisoning the girl. She said she was not "normal" during this period, and she added that the extra-marital affairs were most humiliating to her.

Gordon was born with an extra toe on each foot and an extra finger on one hand, and this abnormality his mother found particularly repulsive. She never held or cuddled him, and slapped him when he cried. She said he wanted to be loved and would hang on to her neck, but she pushed him away.

Patsy was born when Gordon was only fourteen months old.
According to Mrs. G. she preferred the girl to the boys and always favoured her.

She was working during this period as was her husband, but they worked opposite shifts. When he was away on a job, she went out with the iceman to punish her husband and overcome her boredom. Shortly after Patsy's birth, Mr. A. was killed in an automobile accident while on a drinking party with another woman. Mrs. G. married her present husband about ten years ago. She told the worker he nags at the boys and he and Joe, the oldest boy, quarrel frequently.

In 1954, Joe then 13, was brought to the Clinic, by Mrs. G. He had been stealing money from his mother and guests at the home and bullying other children. He tested "high on the moron range of general intelligence."

In 1955, Jim, then 12, a huge obese boy, who whispered and cried, was assessed as very withdrawn, functioning in the "defective range of general intelligence." Two years ago, Gordon had been caught forging small cheques at the drug store and slashing car tires, but it was the embarrassment caused by the theft of newspaper funds which brought Mrs. G. to the Clinic.

At the Clinic, the psychologist reported that Gordon is functioning in the "borderline range of general intelligence," but this rating would seem to be minimal. In the psychometric tests he showed confusion about his sexual identity. He
100

expressed considerable discouragement about his relationships with his parents, his schooling, and his future.
SCHEDULE $G_1, G_2, G_3$

The G. Family
## Schedule G₁ - Mr. G. (step father)

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>?</td>
<td>?</td>
<td>Passiveness, withdrawal, leaves major responsibilities to wife</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Gordon's disturbed behaviour and poor scholastic achievements</td>
<td>Family ego, reputation</td>
<td>10 years (since marriage)</td>
<td>Nagging and belittling Gordon</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Gordon's theft of newspaper money</td>
<td>Reputation</td>
<td>A few days</td>
<td>Extreme embarrassment, attended Clinic</td>
<td>Father</td>
<td>Son</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhappy home environment, dictatorial father (unresolved oedipal conflict)</td>
<td>Self-esteem, femininity</td>
<td>Since childhood</td>
<td>Hostility to males, homosexual relationship, marriage to man of less status, education</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Cultural conflict, desire to be with people of her own social status and cultural group following their move to community from logging camps plus her hostility</td>
<td>Social status, self-esteem</td>
<td>1-2 years ?</td>
<td>Hostility to Mr. A., resentment, nagging</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Mr. A.'s extra-marital affairs plus her hostility</td>
<td>Self-esteem</td>
<td>2-3 years ?</td>
<td>Hostility, depression, revenge—went out with iceman</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Mr. G.'s passivity</td>
<td>Security</td>
<td>10 years</td>
<td>Hostility to Mr. G.</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Gordon's theft of newspaper money</td>
<td>Security, social status</td>
<td>Few days</td>
<td>Application to Clinic</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Marital conflict, her guilt, hostility, boys' behaviour</td>
<td>Self-esteem</td>
<td>?</td>
<td>Withdrawal from social relationships (she does not want to bother with anyone)</td>
<td>Community Member</td>
<td>Community Member</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Mother's emotional instability, rejection, revulsion towards his deformity</td>
<td>Life security, self-esteem</td>
<td>Since birth</td>
<td>Feelings of insecurity, fear, inadequacy, despair</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Patsy's birth when he was 14 mos. old</td>
<td>His place in family</td>
<td>?</td>
<td>Intensified these feelings</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Father's death</td>
<td>Security, male identification</td>
<td>14 years</td>
<td>Anxiety, confused identification</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Mother's preference for Patsy, stepfather's belittling attitude plus his anxiety, insecurity, etc.</td>
<td>Self-esteem</td>
<td>14 years 10 years</td>
<td>Hopelessness, sees being female more advantageous than male, additional confusion re identification, lying, stealing</td>
<td>Son</td>
<td>Mother</td>
</tr>
</tbody>
</table>

Employer  Employee
CASE 7. THE G. FAMILY

MR. G.

EMPLOYEE

COMMUNITY MEMBER

FATHER

GORDON, G.

STUDENT

MRS. G.

EMPLOYEE

COMMUNITY MEMBER

WIFE

MOTHER

SON

LEGEND

Not Impaired - O
Slightly Impaired - O
Moderately Impaired - O
Extensively Impaired - O
Severely Impaired - O
Not Performing Role - O
Not Known - O

FIG. 7. PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case VII

Gordon G., a fifteen-year-old boy has responded to the stress he has experienced by withdrawal and discouragement. He is despairing of gaining love and recognition from his parents, of passing in school, and of achieving his desire of becoming a mechanic. He is immature, generally confused regarding his sexual identity, and functioning under his intellectual potential, which would seem to be below average. His general despair, coupled with his low intellectual ability, has resulted in moderately impaired functioning in his role of son, and extensively impaired functioning in his roles of peer and student. Nothing is known of his sibling relationships.

The major source of stress has been the severe rejection by his mother from the time of his birth. She did not want this child, was seriously disturbed about her marital situation, and repulsed by Gordon's deformity (extra fingers and toes which have since been removed). The birth of a younger sister when he was fourteen months of age, and his mother's overt preference for her daughter, added to the stress. His father's death meant the loss of a male image and an unresolved oedipal conflict, with consequent confusion around his sexual identification. Although Mrs. G. remarried when Gordon was five or six, Mr. G. has been unable to give the boy much emotional support.
As the stress imposed on this boy has been severe and has endured since his birth, it is unlikely vast improvement can be expected in his social functioning. However, he could possibly benefit from casework services to bolster his feelings of self-worth and strengthen his masculine identification.

Mrs. G., too, has been subject to severe stress over a long period but has achieved some improvement in her social functioning. This would indicate she could benefit from casework services, directed particularly to strengthening her performance in the roles of wife and mother.
CASE VIII - HOWARD H.

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. H.</td>
<td>43</td>
<td>Labourer</td>
</tr>
<tr>
<td>Mrs. H.</td>
<td>35</td>
<td>Restaurant Worker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children (from Mr. H.'s first marriage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill, 20 yrs</td>
</tr>
<tr>
<td>Betty, 18 yrs</td>
</tr>
<tr>
<td>Howard, 9 yrs</td>
</tr>
<tr>
<td>Helen, 8 yrs</td>
</tr>
</tbody>
</table>

Referred by: Mother, first in 1958 because of Howard's failure in grade I, and again in 1960 because landlord had threatened them with eviction because of Howard's temper tantrums.

Presenting Problems: Mother is concerned about Howard's temper tantrums and finds him unmanageable. She also complained that he has been stealing things around the house.

Case Summary: Mr. and Mrs. H. separated in 1959 and are now divorced. Mrs. H. with Betty, Howard and Helen, have moved into a small suite. Mrs. H. is presently working twelve hours per day and has had a
series of housekeepers living in. Shortly after application, Mrs. H. sent Betty back to her natural mother, because she and Howard fought constantly.

According to Mrs. H., their ten years of married life were marred with arguments and fights. They seldom went out together or entertained. She said that her husband belittled her in company, was harsh with the children, and drank too much. He had also been in a special class at school. He worked as a labourer and was unable to provide well for the family. Mrs. H. bought the house which she rents, with her money when they were married and also bought the car.

Howard was born the year following their marriage. The pregnancy was difficult. Mrs. H. developed kidney infection and had to stay off her feet. She said Mr. H. was "miserable" to her, and did not seem to want the baby. The mother described Howard as an "unhappy baby from birth." He had constant diarrhea, and banged his head steadily against his crib. Mr. H. accused her of giving too much affection to Howard and neglecting his older children.

In 1958 Mrs. H., who had previously been to the Clinic with Bill and Betty, contacted the Clinic to ask for help with Howard because he had failed in Grade I.

By the time of the second application the parents were divorced but the arrangement had been made that Mr. H. would see the children. He has, according to Mrs. H., shown more interest
in Howard recently.

Mr. H. (described by the worker as an immature, dependent, person), thinks that Howard is too much like his mother. Mrs. H. (described by the worker as insecure, having had little affection and too high standards) thinks that Howard is like his father, with his father's red hair, temper and outlook on life. Although he pleases her by running errands, and helping her with housework, she is most displeased with his clinging, babyish manner. She complains Howard is spoiling her life.

At the Clinic, the psychologist reported that Howard tested in the "borderline range of general intelligence." Psychometric tests indicated he is immature, insecure and emotionally deprived. He seems fearful of losing all sources of satisfaction.
SCHEDULE $H_1, H_2, H_3$

The H. Family
### Schedule H₁ - Mr. H.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>?</td>
<td>?</td>
<td>Dependency, feelings of inadequacy and hostility</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Wife's superior intellectual ability, financial situation and her inability to meet his dependency needs</td>
<td>Self-esteem</td>
<td>Since marriage</td>
<td>Belittling his wife, drinking, harshness, paranoidal tendencies</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Howard's unwelcome birth</td>
<td>His place in wife's affections</td>
<td>Since Howard's birth</td>
<td>Ambivalence toward child, denial of Howard's needs, (he did not let her (mother) give the children the love they needed)</td>
<td>Father</td>
<td>Son</td>
</tr>
</tbody>
</table>
### Schedule H₂ - Mrs. H.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early emotional deprivation</td>
<td>Security, self-esteem</td>
<td>Since birth ?</td>
<td>Insecurity, inadequacy, marriage to man with less education, less money, poor employment prospects (she paid for home and car)</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Husband's inability to meet her physical and emotional needs plus her insecurity, etc.</td>
<td>Security, emotional stability, marriage</td>
<td>Since marriage</td>
<td>Hostility, psychosomatic disorders, (infections, headaches, sinus trouble)</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Husband's drinking, harshness, plus her insecurity, hostility</td>
<td>Self-esteem</td>
<td>Since marriage but intensifying</td>
<td>Divorce - 1959</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Marital conflict, husband's rejection of child plus her insecurity</td>
<td>?</td>
<td>Since Howard's birth</td>
<td>Ambivalent feelings toward Howard</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Howard's failure in Grade I plus her insecurity</td>
<td>Child's future, mother-image</td>
<td>6-7 mos.</td>
<td>Application to Clinic (1958)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Landlord's threats to remove them because of Howard's temper tantrums</td>
<td>Security</td>
<td>A few days ?</td>
<td>Application to Clinic (1960)</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Husband belittled her in front of others plus her insecurity, etc.</td>
<td>Self-esteem</td>
<td>Since marriage</td>
<td>Withdrawal from social relationships (they rarely went out--never entertained--she has no friends)</td>
<td>Community member</td>
<td>Community</td>
</tr>
</tbody>
</table>
### Schedule $H_3$ - Howard H.

**Age 9 Years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's anxiety, illness, ambivalent feeling towards him</td>
<td>Life security</td>
<td>Since birth</td>
<td>Anxiety, fearfulness, constant diarrhea, head banging, &quot;unhappy child from birth&quot;</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Parents' continual arguing and fighting—and final separation last year plus his anxiety, fearfulness</td>
<td>Security</td>
<td>Since birth</td>
<td>Fearfulness, hostility, depression, babyishness, dependency, temper tantrums, abdominal pains, headaches</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Demands of teacher plus Howard's &quot;borderline&quot; mentality plus his insecurity, fearfulness</td>
<td>Self-esteem</td>
<td>2 years</td>
<td>Failure in school last year, underachieving in special class this year</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>Fearfulness, anxiety, inferiority, depression</td>
<td>Self-esteem</td>
<td>Since birth but intensifying</td>
<td>Plays best with only one child at a time, cannot participate in group activities</td>
<td>Peer</td>
<td>Peer</td>
</tr>
</tbody>
</table>
Case VIII
Howard H., a nine-year-old boy, is performing at an extensively impaired level in his role of student, and at a moderately impaired level in his roles of son, sibling and peer. His reaction to stress has been to attempt to maintain his infantile relationship with his mother, as evidenced by his over-dependency, clinging, babyish behaviour, and hostility which erupts in temper tantrums. He reacts with abdominal pains and headaches when his mother becomes impatient with him and their relationship is threatened.

His sources of stress have been his mother's ambivalent feelings towards him from birth, a result of her emotional disturbance and serious marital conflict; the birth of his sister when he was one-year-old; his father's inability to give him affection and emotional support; the parents' separation and divorce last year; and his mother's present long working hours which deprives him of her care and attention. His fearfulness and dependency, together with his limited intellectual capacity, have resulted in his failure in school last year and underachievement in special class this year.

The most modifiable factor would seem to be Mrs. H.'s performance in the role of mother. But because she will also have the responsibility of supporting the family, an additional source of
stress for her, and will have little time to spend with Howard, much improvement cannot be expected in this area. As the other major stress factor, his parents' separation, cannot be modified, Howard might be helped, through casework service, to contend more effectively with the stress.
CASE IX - IKE I.

Parents  
Mr. I.  30  Carpenter
Mrs. I.  27  Housewife

Children  
Shirley  8  Student-grade III
Ike  6  Student-grade I
Rose (born one month after application to Clinic)

Referred by:  Mother, at the recommendation of the family doctor to whom she had gone because the school teacher told her Ike should be seen by a psychiatrist.

Presenting Problems:  
Mrs. I. told worker Ike is going poorly in school. He is epileptic and stutters and she finds him hard to manage.

Case Summary:  
This young couple live in an unfinished house in the outskirts of the city. Mr. I. works steadily and is finishing the house as he can afford to get material. They were married when she was seventeen and he, twenty.

According to Mrs. I., her early life was most unsatisfactory. Her mother was an alcoholic, her father a drug addict, and she and her
brother became wards of a child welfare agency while still very young. She was moved from foster home to foster home, so that she felt she did not belong anywhere. She was eventually placed in a convent, but rebelled at the discipline, and at sixteen, was asked to leave. She had worked for a summer the previous year at the farm owned by Mr. I.'s parents and she returned there at that time. She and Mr. I. were married the following year.

Both her parents are now dead, but prior to her death, her mother had visited in the home. Mrs. I. said the grandmother could not tolerate Ike, because he was shy, but liked Shirley. Mrs. I.'s brother, now a drug addict, who has been in and out of jail, stays at the house frequently, but Mr. I. does not approve of this. Recently, he arranged for his own brother, who is working on a contract with him, to board at the home so there is no longer room for Mrs. I.'s brother.

According to the school nurse, there is a history of epilepsy in Mrs. I.'s family, but Ike showed no symptoms of this disorder in his first few years. His mother has said he was a healthy, happy baby. When he was three, a bakery truck backed up on him while he was playing in the street. Mrs. I. saw him and screamed. The truck stopped but not before the tire had scraped the hair off one side of Ike's head. Although X-rays showed no permanent damage had been done, according to his mother, Ike started to stutter about this time and seemed more fearful.
When he was five, he had his first major seizure. Since then he has had ten to twelve major seizures and a number of minor, brief seizures. He is now on medication. Both parents expressed much concern about Ike's seizures, and hesitate to discipline him for fear of precipitating them.

Mrs. I. thinks that Ike is retarded but does not know exactly where he does fit in. He is hard to manage, his speech is difficult to understand and he can't think for himself. He has temper tantrums but mother says these are not too hard on her, because now she does not insist on obedience. He used to bawl and throw himself on the floor, but she "knocked that out of him." She describes him as a "little brat." He gets into trouble with the neighbours, lights fires, takes the neighbours' tools and children's toys. She feels he prefers his father to her.

Shirley, Ike's older sister, has always been expected to look after Ike. According to Mrs. I., she is more aggressive and has never been any trouble to her parents, but she and Ike quarrel. Other children pick on Ike, calling him a "dumbell" and "stupid" which hurts his feelings. He usually plays with younger children.

At the Clinic, Ike tested "high in the borderline range of general intelligence" but his potential is possibly in the average range. The psychologist reported that he seemed confused, insecure, unhappy and unsure of his own identification. In the
test, he gave evidence of angry feelings towards others, his parents, sister, and school authorities and seems to feel a general lack of acceptance for himself from others.
SCHEDULE $I_1$, $I_2$, $I_3$

The I. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ike's seizures</td>
<td>Son's future and health</td>
<td>1 1/2 years</td>
<td>Fearful of precipitating seizures--lack of firmness with Ike.</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Ike's poor school performance</td>
<td>Son's future family ego</td>
<td>4-5 mos.</td>
<td>Involvement in treatment at Clinic</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Early emotional deprivation, no consistent parent figures, lack of opportunity to learn mother role</td>
<td>Security, self-esteem</td>
<td>Since birth</td>
<td>Feelings of inadequacy, insecurity, lack of confidence, dependency</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Ike's seizures plus her lack of confidence</td>
<td>Child's life</td>
<td>1 1/2 years</td>
<td>Fearfulness, guilt, inconsistent handling, either &quot;trims him up&quot; or indulges him</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>Teacher's concern about Ike's poor progress, misbehaviour and her suggestion Ike see a psychiatrist, plus mother's insecurity</td>
<td>Mother-image (&quot;They don't think I am a very capable mother&quot;)</td>
<td>4-5 mos.</td>
<td>Visit to family doctor, application to Clinic</td>
<td>Mother</td>
<td>Son</td>
</tr>
</tbody>
</table>
### Schedule I₃ - Ike I.

**Age 6 Years**

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's insecurity, lack of confidence, inconsistency</td>
<td>Security</td>
<td>Since birth</td>
<td>Confusion, anxiety, hostility</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Truck accident</td>
<td>Security</td>
<td>-</td>
<td>Fearfulness, stuttering</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Epileptic seizures</td>
<td>Life</td>
<td>1 1/2 years</td>
<td>Additional fearfulness</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Mother's inconsistent handling because of her fear of seizures</td>
<td>Security</td>
<td>1 1/2 years</td>
<td>Hostility, stubbornness, temper tantrums, fire setting, stealing toys</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Grandmother's preference for Shirley, Shirley's aggressiveness and efforts at domination</td>
<td>Self-esteem, Independence, Place in family</td>
<td>3 1/4 years</td>
<td>Hostility to Shirley, quarreling, crying</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Teacher's demands plus Ike's fearfulness, hostility</td>
<td>Self-esteem</td>
<td>6 mos.</td>
<td>Functioning below potential, misbehaving</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>Children's teasing plus Ike's fearfulness, hostility</td>
<td>Self-esteem</td>
<td>6 mos.</td>
<td>Hits other children, won't cooperate in group play, plays with younger children</td>
<td>Peer</td>
<td>Peers</td>
</tr>
</tbody>
</table>
CASE 9.  THE I. FAMILY

MR. I.

EMPLOYEE

COMMUNITY MEMBER

FATHER

SON

IKE. I.

STUDENT

MRS. I.

EMPLOYEE

COMMUNITY MEMBER

WIFE

MOTHER

SIBLING

LEGEND
Not Impaired -0
Slightly Impaired ◦
Moderately Impaired ◆
Extensively Impaired ◈
Severely Impaired ◈
Not Performing Role X
Not Known - ②

FIG. 9. PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case IX
Ike I., is a six-year-old boy whose performance is severely impaired in the student role, extensively impaired in the son and peer roles, and moderately impaired in the sibling role. His response to stress has been to cling to his infantile relationship with his mother, as evidenced by his baby talk, over-dependency, temper tantrums, and by his way of taking what he wants when he wants it. His stuttering, and to some extent, his epileptic seizures, may also be a reaction to stress. Although his intellectual potential is average, he is functioning in the borderline range.

The major sources of stress seem to be his parents' inconsistent handling and his seizures. Shirley's aggressively dominant behaviour, the incident of the truck backing up on him, and the other children's response to his general impairment (they call him "stupid") have added to the stress.

Casework services might be primarily directed at strengthening both parents' performance in the parental roles. Ike, too, may benefit from casework services. A warm, consistent relationship would give him some of the emotional support and security necessary for an improvement in his social functioning.
CASE X - JEAN J.

Parents
Mr. J. ? Policeman
Mrs. J. 38 Housewife

Children
Donna 10 Student-grade V
Jean 8 Student-grade III

Referred by: Mother; at the recommendation of the family doctor, because Jean has been soiling every day for the past two months. This is the second episode in a year.

Presenting Problems: Mrs. J. reported Jean has been soiling, wetting herself occasionally, and seems unhappy and preoccupied. She is slow in school and is continually bickering with her sister, Donna.

Case Summary:
The J. family live in a small house in the City. Mr. J. whom the worker described as quiet and steady, has been in the police force for a considerable time and seems content with his job. Mrs. J., who seemed to the worker to be anxious and restrictive, was subsequently diagnosed at the Clinic as an "obsessive-compulsive type" of personality. In her childhood she was
physically and emotionally deprived. Her father was an alcoholic who abused his wife and children. Her mother was generally incapacitated with psychosomatic illnesses. Mrs. J. has had asthma most of her life. She left school after finishing Grade VIII, and did housework. Mr. and Mrs. J. were married during the War, when Mrs. J. was twenty-one. A few days later, Mr. J. left for overseas and was away for over two years.

Their first child, Donna, was born seven years after their marriage, and two years later, Jean was born. Just after Jean's birth, Mr. J.'s father came to stay with the family. He was dying of cancer and Mrs. J. said she was repelled by his illness and his appearance. The house was small, they were crowded together, and she did not want the children to be near him. This experience was quite upsetting to her.

Jean was a colicky baby for the first two or three months, and subsequently had various illnesses—colds, sore throat, inflammation of the bladder. Two years ago, both children had their tonsils and adenoids removed. Jean was quite ill and upset. Her mother could not visit her at the hospital because she, too, was ill.

According to both parents, Donna is outgoing, bright, feminine and the family favourite. Donna gets new clothes, but Jean gets clothes passed on from Donna and from a cousin. Jean is quieter than Donna, boyish, slow in school, untidy, prefers playing with boys and guns to doing housework and homework. Her father is most concerned about her tomboyishness.
At the Clinic, the psychologist reported that Jean tested "high on the average range of general intelligence" but appears to have a higher potential. She has a deep voice, boyish manner and walk. The psychologist noted that she seems generally immature, lacks controls, is very hostile, particularly towards her mother, and is moving towards masculine identification. She seems to crave acceptance from other children.
SCHEDULE $J_1, J_2, J_3$

The J. Family
### Schedule J\_1 - Mr. J.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>?</td>
<td>?</td>
<td>Criticizes wife's performance as mother, will not support her disciplinary efforts</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Jean's boyish behaviour, her preference for boys and guns to housework and schoolwork</td>
<td>Daughter's femininity</td>
<td>3(\frac{3}{4}) years</td>
<td>Involvement in treatment at Clinic</td>
<td>Father</td>
<td>Daughter</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Emotional and material deprivation in childhood</td>
<td>Security</td>
<td>Since birth</td>
<td>Feelings of inadequacy, insecurity, hostility &quot;obsessive-compulsive&quot; behaviour, asthma</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Lack of emotional support from husband: his criticism of her performance as mother; his expectation that 'good mother' always remains with children, his reluctance to help her with housework, he didn't help her in knowing how to deal with children, his defence of children when she sets limits</td>
<td>Self-esteem, freedom, independence, security, authority</td>
<td>Since children's births</td>
<td>Hostility, additional lack of confidence in herself, fears children will like father better than her because she has to discipline them</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Father-in-law's visit at time of Jean's birth</td>
<td>?</td>
<td>?</td>
<td>Additional anxiety, repulsed by his illness (cancer)</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
<tr>
<td>Jean's untidiness, inability to communicate, bickering with Donna, slowness in school</td>
<td>Mother-image, family ego</td>
<td>5-6 years</td>
<td>Hostility to Jean</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
<tr>
<td>Jean's soiling</td>
<td>Cleanliness</td>
<td>2 mos.</td>
<td>Visit to family doctor and application to Clinic</td>
<td>Mother</td>
<td>Daughter</td>
</tr>
</tbody>
</table>
## Schedule J₃ - Jean J.
### Age 8 Years

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's anxiety and insecurity</td>
<td>Life security</td>
<td>Since birth</td>
<td>Anxiety, illness, colicky for first 2-3 mos., head-colds, sore throat, inflammation of bladder, hostility to mother, withdrawal</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Parental conflict re authority</td>
<td>Security</td>
<td>Since birth</td>
<td>Additional anxiety, hostility, rebelliousness</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Unresolved oedipal conflict</td>
<td>Femininity</td>
<td>4-5 years</td>
<td>Boyish mannerisms, moving to masculine identity</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Parents' preference for Donna and Donna's teasing and aggressiveness plus Jean's insecurity, hostility</td>
<td>Self-esteem</td>
<td>4-5 years</td>
<td>Hostility to Donna, threatens to tear up her books, takes her money (and possibly further rebellion against femininity which parents prize in Donna)</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Demands of teacher plus Jean's insecurity</td>
<td>Achievement, self-esteem</td>
<td></td>
<td>Poor academic performance, untidiness, daydreaming</td>
<td>Student</td>
<td>Teacher</td>
</tr>
<tr>
<td>Insecurity, confusion re identity</td>
<td>?</td>
<td>4-5 years</td>
<td>Plays with boys a few years older than herself</td>
<td>Peer</td>
<td>Peers</td>
</tr>
</tbody>
</table>
CASE 10. THE J. FAMILY

MR. J.  

EMPLOYEE  

COMMUNITY MEMBER  

FATHER  

JEAN. J.  

STUDENT  

MRS. J.  

EMPLOYEE  

COMMUNITY MEMBER  

MOTHER  

SIBLING  

DAUGHTER  

LEGEND  
Not Impaired  - O  
Slightly Impaired  - @  
Moderately Impaired  - •  
Extensively Impaired  - ◦  
Severely Impaired  - ☆  
Not Performing Role  - X  
Not Known  - ?  

FIG. 10. PERFORMANCE IN MAJOR SOCIAL ROLES.
Case X

Jean J., an eight-year-old girl, is performing at the moderately impaired level in the roles of daughter, peer and student, and shows extensive impairment in her role as sibling. She has responded to stress by regressing to an earlier stage of matur- 
ation (anal from oedipal phase) and by moving towards masculine identification. She is quiet, withdrawn, slow and untidy, has reverted to soiling, and is acquiring some masculine traits, a deep voice, boyish manner and walk, and masculine interests.

The major source of stress which has affected this child since birth has been her mother's anxiety and insecurity, a result of her own emotional problems and her husband's inability to give her support in her role of mother. Another primary source of stress has been the overt preference of both parents for Donna, Jean's older sister. Jean's hostility for Donna would seem to have made her rebel against the characteristics which the parents admire in Donna. As Donna has become more feminine, neat and tidy, helpful and outgoing, Jean has become more masculine, untidy, resistant and withdrawn.

As the major source of stress stems from the parents' inadequacy in their roles of mother and father, this might be one area of intervention. Both parents could benefit from casework services, although treatment for Mrs. A. because of her greater degree of impairment, may be relatively long-term.
As the other source of stress is the unsatisfactory sibling relationship, casework services for Jean might help her establish her own sense of identity.
CASE XI - KEN K.

Parents  
Mr. K. 33  Millworker (unemployed)
Mrs. K. 31  Housewife

Children  
May 9  Student, grade III
Ken 6 1/2  Student, grade I
Peter 4

Referred by: Father, at the recommendation of the family doctor because of Ken's persistent coughing, for which there is no physical justification.

Presenting Problems: Father is afraid Ken has inherited mental illness. He coughs persistently, frequently wipes his hands on his face, and is doing poorly in school.

Case Summary: 
Mr. and Mrs. K. were married when he was twenty-two, she, twenty. He has not been regularly employed since their marriage. Mrs. K. has referred to him as "accident-prone" because of the many accidents he has had. Several years ago he suffered a back injury which has restricted his employability to some extent. Over the years the family has piled up many debts, a big worry for both parents.
There is a history of mental illness in the family. Mr. K.'s mother was admitted to the mental hospital when he was nine years old, and is still there. The diagnosis was "paranoid schizophrenia with suicidal tendencies." She had been ill for some time prior to her admission, and Mr. K. remembers this period of his life very vividly. He was referred to the Clinic when he was seventeen, because he was worried about becoming like his mother. He did not return for treatment.

Mrs. K.'s mother had also suffered from mental illness. Mrs. K. and her father had a close affectionate relationship. Mrs. K., like her husband, had been referred to the Clinic when she was seventeen. At that time she left school having become very disturbed by the death of her older brother of cancer. She had been nursing him for some time. Her brother and sisters went through University and she feels quite inferior to them because of her lack of education. She has since seen several psychiatrists because of frequent depressions but has found little relief. She was severely depressed at the time of Ken's birth, and remained in a depressed state for about a year afterwards.

Two years ago, Mrs. K. took an overdose of sleeping pills and was admitted to Crease Clinic for a few days. The parents feel that their neighbors have withdrawn from them since this incident, and they, in turn, have withdrawn from the neighbors. The children, too, are isolated, and play by themselves.

According to the parents, May the oldest child protects and mothers Ken. She takes him to his classroom and calls for him.
after school. She also bosses him around, and Ken teases her.

Mrs. K. was reluctant to come to the Clinic, but was persuaded by her husband. She believes Ken's problems are unavoidable because he is like her. She complains that her husband does not give her enough affection and wishes she had gone on to University and a career instead of marrying.

At the Clinic, the psychologist reported that Ken tested "low in the average range of general intelligence," but probably has higher potential. In psychometric tests he appeared fearful and immature with much repressed hostility he feared to express. There was evidence of a poor relationship with either parent, and concern about his relationships with other children particularly his sister, May.
SCHEDULE $K_1, K_2 \text{ and } K_3$

The K. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early emotional deprivation and mother's institutionalization</td>
<td>Security, self-esteem</td>
<td>Since childhood</td>
<td>Feelings of inadequacy, fearfulness of close relationships</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Wife's demands for affection, emotional support plus his feelings of inadequacy</td>
<td>Security</td>
<td>Since marriage</td>
<td>&quot;He can't compete with her father, afraid to give her too much affection—something always happens to people he is fond of&quot;—passivity (cannot argue with her, just walks away)</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Demands of employers plus his insecurity</td>
<td>Self-esteem</td>
<td>Since adulthood</td>
<td>Accident-proneness, frequent withdrawal from labor market</td>
<td>Employee</td>
<td>Employer</td>
</tr>
<tr>
<td>Fear of Ken's inheriting mental illness plus Mr. K.'s insecurity, inadequacy</td>
<td>Child's mental health, family ego</td>
<td>3-4 years</td>
<td>Application to Clinic</td>
<td>Father</td>
<td>Son</td>
</tr>
<tr>
<td>His wife's mental illness and attempted suicide, paranoidal tendencies plus his insecurity</td>
<td>Family reputation</td>
<td>2 years</td>
<td>Withdrawal from contacts with friends and neighbors</td>
<td>Community Member</td>
<td>Community Member</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Her mother's mental illness, her very close affectionate relationship with father (unresolved oedipal conflict), brother's death</td>
<td>Security</td>
<td>Since early childhood</td>
<td>Anxiety, &quot;neurotic-depressive reaction,&quot; additional anxiety, left school, feels inferior to siblings</td>
<td>Threatens all roles</td>
<td></td>
</tr>
<tr>
<td>Her husband's inability to show affection plus her anxiety, depression</td>
<td>Security, self-esteem</td>
<td>Since marriage</td>
<td>Hostility, resentment to Mr. K. (would prefer not to be married) symbiotic relationship with son (Kenneth)</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Her fears of being rejected by neighbors following her admission to Crease Clinic</td>
<td></td>
<td></td>
<td>Suspiciousness, distrust, withdrawal from social contacts</td>
<td>Community</td>
<td>Community Member</td>
</tr>
</tbody>
</table>

Schedule K₂ - Mrs. K.
### Schedule K₃ - Ken K.

<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's emotional disturbance, depression, her inability to allow him emotional independence</td>
<td>Security, self-esteem</td>
<td>Since birth</td>
<td>Fearfulness, anxiety, insecurity, repressed hostility, dependency, inhibited behaviour</td>
<td>Son</td>
<td>Mother</td>
</tr>
<tr>
<td>Father's inability to give him affection, emotional support, father's over-concern</td>
<td>Security, self-esteem</td>
<td>(Continual coughing, face-wiping, daydreaming, talking to himself, occasional bed-wetting)</td>
<td>Son</td>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Sister's overprotection plus his insecurity, dependency</td>
<td>Independence, self-esteem</td>
<td>Since birth</td>
<td>Dependency and submission to sister's domination, hostility (repressed)</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Family's isolation plus Ken's fearfulness, insecurity</td>
<td>Security</td>
<td>2 years</td>
<td>Does not play with other children, stays home after school</td>
<td>Peer</td>
<td>Peer</td>
</tr>
<tr>
<td>Demands of teacher plus Ken's fearfulness, insecurity, dependency</td>
<td>Security, self-esteem</td>
<td>Does not want to go to school, underachieving, short attention span, restlessness, dependency on teacher</td>
<td>Student</td>
<td>Teacher</td>
<td></td>
</tr>
</tbody>
</table>
CASE II. THE K. FAMILY

MR. K.

EMPLOYEE

COMMUNITY MEMBER

HUSBAND

FATHER

K. K.

STUDENT

MR. K.

EMPLOYEE

COMMUNITY MEMBER

WIFE

SON

MOTHER

LEGEND

Not Impaired - O
Slightly Impaired - O
Moderately Impaired - O
Extensively Impaired - O
Severely Impaired - O
Not Performing, Kohe - O
Not Known - O

FIG. 11. PERFORMANCE IN MAJOR SOCIAL ROLES.
Assessment

Case XI
Kenneth K., a six-year-old boy, is performing at a moderately impaired level in the role of son, extensively impaired level in the roles of sibling and student and severely impaired level in the role of peer. He has reacted to stress by attempting to maintain the infantile relationship with his mother. He is dependent, immature, fearful of new experiences, and imitates some of his mother's nervous mannerisms, such as the face-wiping routine. His desire to remain a baby is also evident in his submission to his sister's efforts at mothering and in his relationship with his teacher.

The main sources of stress have been his mother's emotional disturbance (and particularly her state of depression during his early years), which has seriously affected her performance in all roles. The father's anxiety and concern for the boy's mental health, along with his passivity and insecurity, has seriously impaired his role performance. Neither parent has been able to give the boy much affection and emotional support. The parents' reaction to their fear of rejection by their neighbors, has been another source of stress for Ken.

Based on this material, the major area of intervention might be in the stress-producing area rather than in the child's reaction to stress. The sources of stress may be modified by psychiatric treatment for Mrs. K. and casework services for
Mr. K. The Day Centre for Children may provide a substitute peer group for Kenneth until the neighborhood relationships improve and he has gained more sense of security.
CASE XII - LANA L.

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. L.</td>
<td>42</td>
<td>Self-employed</td>
</tr>
<tr>
<td>Mrs. L.</td>
<td>45</td>
<td>Housewife</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>9</td>
<td>Student, Grade ?</td>
</tr>
<tr>
<td>Betty</td>
<td>8</td>
<td>Student, Grade ?</td>
</tr>
<tr>
<td>Lana</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Referred by: Mrs. L.'s worker at Children's Clinic because of the difficulty of separating Lana from her mother at interview times. Mrs. L. and Bob were already attending the Clinic.

Presenting Problems: Mrs. L. wonders whether Lana will be able to separate from her when she starts school next September. Otherwise she believes Lana is the only healthy member of the family.

Case Summary:
According to Mrs. L., when she met her husband about ten years ago, he had separated from his wife and children, and was drinking quite heavily and not working steadily. After she went to live with him they worked together to build up his business. It was a hard struggle, for they had little money. They were just becoming established when the present recession commenced.
Now they fear bankruptcy and the loss of all they have worked for. There is also the worry of the pending divorce from his first wife. Mrs. L. feels that her husband may go to jail if he cannot pay the cost of the proceedings.

Shortly before Lana's birth, Mr. L. had left the family to return to his legal wife, who had threatened Court action to obtain support. Mrs. L. was quite ill and placed Bob and Betty in non-ward care. The records show that the children were placed in a "low-grade" foster home and remained there for about three years until the agency contacted Mrs. L. through a newspaper advertisement. Mr. L. had returned by this time, and the family was reunited. Mrs. L. describes her husband as an easy-going man who is exceptionally fond of his children. She said she and her husband have little in common, and cannot sit down and discuss family matters. She feels desperately entrapped by their marital and financial entanglements.

Mrs. L. describes herself as the "sickest member of the family." She broke off relationships with all her friends when she went to live with Mr. L., for fear of their rejection, and she disappeared following the placement of the two older children. She has been very upset by their behaviour since their return from the foster home. Bob, especially, she hates. She has kept Lana very close to her, seeing herself in this child, but feels that Lana is fonder of her father than of her mother. Lana has never played with other children, and Bob and Betty have been made to give in to her.
Lana is a fat little girl, with eczema, who is clinging and dependent on her mother. The psychologist reported that she tested in the "average range of general intelligence" and did not show signs of gross disturbance.
SCHEDULE $L_1, L_2, L_3$

The L. Family
<table>
<thead>
<tr>
<th>Source of Stress</th>
<th>Value Threatened</th>
<th>Duration of Stress</th>
<th>Response to Stress</th>
<th>Major Role Impaired</th>
<th>Reciprocal Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal wife's efforts to obtain financial support</td>
<td>Independence, security</td>
<td>10 years</td>
<td>Temporary desertion of Mrs. L. and children to return to first wife</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Financial difficulties (pending bankruptcy and divorce costs)</td>
<td>Independence, future</td>
<td>10 years</td>
<td>?</td>
<td>Father</td>
<td>Children</td>
</tr>
<tr>
<td>Wife's anxiety about children's behaviour</td>
<td>?</td>
<td>4 years</td>
<td>Hostility to wife (if she would stop yelling and not worry so much)</td>
<td>Husband</td>
<td>Wife</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value Threatened</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Common-law relationship</td>
<td>Self-esteem, social status</td>
<td>10 years</td>
<td>Fear that people will reject her--broke off with all her friends</td>
<td>Member of Community</td>
<td>Community</td>
</tr>
<tr>
<td>Efforts of husband's legal wife to obtain support and his temporary desertion</td>
<td>Marriage, financial security</td>
<td>10 years</td>
<td>Anxiety, hostility, further isolation, illness, guilt, placement of Bob and Betty with child welfare agency but clung to baby (Lana)</td>
<td>Mother</td>
<td>Children</td>
</tr>
<tr>
<td>Financial difficulties, (struggle to establish business, threatened bankruptcy, pending divorce costs)</td>
<td>Financial security, home, future</td>
<td>10 years</td>
<td>Resentment--feels trapped by circumstances and can do nothing about them, she is &quot;full of hatred&quot;</td>
<td>Mother</td>
<td>Children</td>
</tr>
<tr>
<td>Husband's lack of firmness with children</td>
<td>Security, authority</td>
<td></td>
<td>Hostility to husband, &quot;If he would take a firmer stand she would not have such a hard time&quot;</td>
<td>Wife</td>
<td>Husband</td>
</tr>
<tr>
<td>Children's disturbed behaviour plus her guilt feelings, hostility (she is &quot;sickest member of family&quot;)</td>
<td>Mother-image</td>
<td>4 years</td>
<td>Application to Clinic first for Bob, but all children eventually were treated</td>
<td>Mother</td>
<td>Children</td>
</tr>
<tr>
<td>Source of Stress</td>
<td>Value</td>
<td>Duration of Stress</td>
<td>Response to Stress</td>
<td>Major Role Impaired</td>
<td>Reciprocal Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Mother's withdrawal from social relationships, mother's unhappiness and anxiety (because of Mr. L.'s desertion), her insecurity, depression</td>
<td>Security</td>
<td>6 years</td>
<td>Insecurity, hostility, dependency on mother, (mother called it a &quot;strangling relationship&quot;), controlling, conforming behaviour, eczema</td>
<td>Daughter</td>
<td>Mother</td>
</tr>
<tr>
<td>Bob and Betty's return home from foster care when Lana was two or three plus her insecurity</td>
<td>Place in family</td>
<td>3-4 years</td>
<td>Hostility, pushes Bob down, and fights with Betty</td>
<td>Sibling</td>
<td>Sibling</td>
</tr>
<tr>
<td>Material deprivation plus her anxiety, insecurity</td>
<td>Security</td>
<td>Since birth</td>
<td>Acquisitiveness, refusal to share with other children</td>
<td>Peer</td>
<td>Peers</td>
</tr>
<tr>
<td>Being sent to Day Centre play group plus her insecurity, dependency</td>
<td>Security</td>
<td>A few weeks</td>
<td>Anxiety, hostility to other children (separated herself from them and played alone), refused to return after she had been attacked by another child</td>
<td>Peer</td>
<td>Peers</td>
</tr>
</tbody>
</table>
CASE 12.  THE L. FAMILY

MR. L.
- EMPLOYEE
- COMMUNITY MEMBER
- HUSBAND
- FATHER
- PEER
- LANAL.
- STUDENT

MRS. L.
- EMPLOYEE
- COMMUNITY MEMBER
- WIFE
- MOTHER
- SIBLING

LEGEND:
- Not Impaired - 0
- Slightly Impaired - 0
- Moderately Impaired - 0
- Extensively Impaired - 0
- Severely Impaired - 0
- Not Performing Role - 0
- Not Known - 0

FIG. 12. PERFORMANCE IN MAJOR SOCIAL ROLES
Assessment

Case XII

Lana L. is a six-year-old girl who is showing considerable impairment in social functioning. Her role as daughter is moderately impaired, as sibling and student, extensively impaired, and as peer, severely impaired. Her reaction to stress has been to cling more closely to her mother, in a relationship referred to by Mrs. L. as "strangling." She shows much hostility to her brother and sister, for she resents sharing her mother with them. She fears new experiences and cannot relate to other children.

The sources of stress have been the inadequate performance of both parents in their familial roles. At the time of her birth, her parents had separated and the two older children were placed in non-ward care. Mrs. L., who was depressed and ill and who had cut off all relationships with her friends, encouraged Lana's dependency. The return of Bob and Betty to the home was an additional source of stress for this child, for it threatened her complete possession of her mother.

Casework services appear to be required for the parents, the source of Lana's stress. Their degree of impairment would indicate long-term service, directed in the area of their marital and parental roles. As Lana's impairment in her peer role is so severe she cannot tolerate group activity, individual casework
services may provide her with a relationship in which she has more stimulation and freedom to move towards greater maturity and independence.
Chapter 4

THE SOCIAL ROLE THEORY - IS IT A USEFUL TOOL FOR ASSESSMENT?

Redefining the Purpose of this Thesis

The purpose of this thesis is to examine the implications of the social role theory by application to the assessment phase of casework practice. It is not the purpose to test the validity of the concepts of role and stress, but to attempt a practical application of these concepts, as suggested in the Curriculum Study, to the assessment phase of casework practice.

Limitations of the Study

Before an evaluation of the usefulness of the theory can be made, it is important to review some of the limitations of this study.

First, the case material had not been collected or recorded with a view to examining the social functioning of the client and of those in his immediate role network in terms of role performance. While some reference was made to the performance of the child and his parents in their major social roles, the primary focus was on those physical, psychological, mental and to a lesser degree, social factors which may have caused the emotional disturbance in the child, the primary client.

Any change in this focus at the Clinic may involve some difficulties. It is usually the mother who makes the
application to the Clinic for help with her child. If the problem is obviously a problem in marital relationships, or in some other area which is not considered appropriate to the function of the Clinic, the mother is referred to the Family Service Agency or some other community resource. The cases that are accepted, are those where the children are emotionally disturbed and at least one parent appears motivated to become involved in treatment. In the first few interviews, the focus is generally kept on the problem of the child because this is what the parents want to discuss, or at any rate, expect to discuss. This would seem to be in conformance with the social work principle of "starting where the client is." It has been the experience of the Clinic staff that many of the mothers who apply are the dominant marital partners. Their husbands, who tend to be passive and withdrawn, have been more difficult to involve in treatment. This may account for the fact that most of the early interviews are held with the mothers and there is a scarcity of information about the fathers. As the relationship between the mother and worker strengthens, the focus is gradually shifted to the parents' problems, marital relationships, and other areas of stress in the family role network.

The problem of changing the focus is not insurmountable, but careful, well-planned testing will have to be done to determine how more information regarding social functioning in terms of performance of major roles within the client's network can be obtained for assessment purposes. It may possibly
involve some revision of the social history outline, which emphasizes the child's developmental history. And most important of all, it will involve a change of focus on the part of the worker.

The Concept of Stress

An examination of the analysis of the material on the basis of the concept of stress reveals how much the project was limited by this focus in early interviews on the child and his general emotional reactions to stress. This emphasizes that a different approach will be necessary if this theory is put into practice.

The sources of stress were culled by the writer from the records, often from a remark made by one of the parents. In some instances it was impossible to gauge whether a certain situation, such as a child's early illness, had really caused stress, and this would be difficult to determine no matter what the orientation of the worker. In this regard, it was necessary for the writer to make some arbitrary decisions.

The reactions to stress were usually described in the records in terms of emotional responses. Many of these were rather abstract generalities--hostility, rejection, fearfulness, guilt--which terms were repeated again and again. In some instances, there was reference to psychosomatic illness, an emotional-physical response. In a few cases, particularly with the children, the assessment had been carried to the extent that
there was some explanation of how the child's behaviour was affected by these emotional reactions. The school reports, in the cases where these had been obtained, usually stated in a forthright manner how the child's behaviour was impairing his performance but of course did not explore the sources of stress. Particularly with respect to the adults, however, there was little clarification of how these emotional responses were really affecting the person's role performance. Neither was it clear how this reaction was helping the individual maintain the level of social functioning which existed prior to the occurrence of stress— an inherent feature of the concept of stress. A real effort was made to search out this information, but as is indicated by the analyses, the results were not too satisfactory.

**Concept of Role**

The analyses using the concept of role also show the limitations imposed by the material used. In several cases, nothing was known about the person's relationships outside the immediate family group. It is worth emphasizing that there are thirteen question marks on the charts for community member or peer role. Even within the family, little was known of the performance of the sibling in many cases. There was little to indicate the expectations of the parents with regard to their children, other than their complaints, which indicated their expectations were not being met. There was little, too, to indicate the parents' expectations of themselves or of each other. The emphasis was primarily on the mother-child relationship, and as noted previously, in some cases information about
the father was rather sketchy. Marital relationship was an unexplored area in some instances, in this early phase of treatment. This confirms the previous comment that if this theory is to be put into practice, a different approach must be utilized in the fact-finding process—an approach that will extend beyond the present emphasis on the child's developmental history, although, of course, this cannot be overlooked. Social functioning is the product of interaction among intrapsychic, somatic and social forces. Any assessment of social functioning therefore, must take all these factors into account.

The limitations of this study, primarily lack of sufficient information and the necessity of making arbitrary decisions, have been described in some detail because they must be considered if an objective evaluation is to be made.

Evaluation of the Applicability of Theory to Casework Practice

At the risk of overemphasizing the negative, it seems relevant to discuss some of the difficulties which emerged in the application of the concepts. Whether these problems represent limitations of, or areas of ambiguity in the theory, or limitations of knowledge and understanding on the part of the writer, it is hard to determine at this point in time. But if there were other ways of dealing with these problems, the writer was unable to discover them.

The first was the problem of tracing back the reaction to stress to some particular source of stress. As was mentioned
in Chapter 2, the reaction, in most instances, seemed to be a cumulative one. The mother's impairment in her role of mother, for example, seemed to stem from her earlier life experiences and her reaction to them, and then from an accumulation of various stresses. A child's temper tantrums, enuresis, poor school progress, seemed to be a general response to all the stresses imposed on him. This may have been due in part to deficiencies in records and the fact that the workers were not attempting to ascertain the information, which would point to the importance of a theoretical perspective to fact gathering. Whether this is the case, or whether it is possible to determine the particular source of stress which has caused a certain reaction, is a point that requires more clarification.

The second major problem was with regard to the role concept. The writer, whose orientation has been the holistic view, found it difficult to consider an individual in terms of various roles. At first it seemed to entail, theoretically at least, a surgical operation for each person—a cutting up on the whole into parts. Much of the difficulty was undoubtedly caused by the very general descriptions of reaction to stress, such as "hostility." It was difficult to determine what social roles were most affected, if, for that matter, they were affected at all. As the project developed and the writer became more orientated to the use of the concept, she realized that it did not conflict with the holistic view. The solution would seem to be to obtain from the client or others in his role
network, some clarification about how his performance in various roles is affected by stress.

A third problem, and this appears to be more complex, was with regard to the roles themselves. The specific roles, mother, son, husband, clearly fit the definition of role in social role theory (see p. 14). But so do the general roles, the role of student, or community member, or worker (which was labelled "employee" in this paper). General roles, however, have no one reciprocal role. In the case of role of student, the role of teacher is the one logical reciprocal role. The other students, however, are also in the picture for if a child cannot get along with his fellow students, or hits them, or distracts them, his role of student will be impaired. If a child is making little academic progress because of his low intellectual ability, this factor can be considered a determinant of role. (In one case, the teacher said the child was no problem and was doing well considering his limited intelligence. There was no impairment of the student-teacher relationship because of his poor academic progress, although his parents and society generally might consider his performance in the role of student impaired.) But if a child is doing poorly academically and has a superior intelligence rating, one cannot deny his role of student is impaired. This may or may not affect the student-teacher relationship. Therefore, the role of student must take into consideration more than the student-teacher relationship. In other words, for some roles there may not be a reciprocal
role, and reciprocal roles are a major feature of the concept of role. It is possible that the writer attempted to use the concept too broadly by combining many specific roles into one general role.

In the case of the self-employed husbands, at least two possible reciprocal roles, both including many individual relationships can be perceived. One is the role of customer or client, another is business affiliate. But an examination of performance in either of these roles may not give us a clear picture of the person's performance in his role of businessman.

It would seem that the role concept requires clarification in this regard if it is to be used by social workers.

This study has highlighted some of the problems that may be encountered when a serious effort is made to apply the theory to casework practice. The sources of stress, value threatened and reaction to stress in terms of role impairment will need to be clarified. And the focus must be on the client's social functioning in terms of performance of major roles and on the social functioning of those in his role network. This would indicate an extension of the fact-finding process to determine the adequacy of performance in all major roles. As was noted previously, some experimentation will be required to determine how this can best be done. This problem may vary somewhat in different settings. In a family service agency, where the presenting problem is often marital conflict, it may be easier
to obtain information about parents' total role performance, but more difficult to obtain information about the children. In a public welfare agency, where the clients are requesting financial assistance, the exploration of total social functioning may present some problems. In any setting, an exploration of the adequacy of performance in all major roles in the early fact-finding phase would not only necessitate a different focus on the part of the worker but may arouse additional resentment and resistance on the part of the client. This is a very real possibility that cannot be overlooked. Resistance may be minimized by an early clarification of role expectations between worker and client. Role confusion would thus be eliminated for the client would be aware of what was expected of him and what he could expect from the worker, representing the agency.

Evaluation on the Basis of Criteria

The second basis on which the theory is to be evaluated is whether it meets the criterion, mentioned in Chapter 1, of enabling caseworkers to help the client more effectively.

In this study the concepts of stress and role have been used in combination for assessment purposes. But let us first look at the concept of stress in relation to the small sample of case record material used in this thesis. In all cases, the application of this concept helped to identify the sources of stress. And even more important, it helped to clarify whether the stress was internal or external. The use of this concept,
therefore, suggests options in treatment—whether to work with the child in the area of reactions to stress or with the parents, in the area of their force as a stress factor. The duration of stress and modifiability of the stress factor help to determine the form of treatment and level of treatment.

There is one important feature that has been mentioned previously in this study, but bears repeating. The reaction to stress must be perceived by the worker in terms of whether or not it impairs social functioning. According to the Curriculum Study, social casework's purpose is to help the client achieve more effective role performance. Thus the interpretation of the reaction must be in terms of role performance, and not in terms of general emotional reactions, such as "fearfulness." The worker must go one step farther, and assess whether or not this reaction is impairing the client's role performance, and which roles are impaired and which threatened. The concept of stress used together with the concept of role would seem to provide a much broader, more comprehensive assessment of the client in relation to his problem than current practice usually provides.

In this study the approach was through the concept of stress to the concept of role. The client's inner self was examined first to determine how and where it had affected performance of his outer self. This was done because of the nature of the material used. The writer would suggest that a more fruitful and direct approach would be through the concept of role.
The first step would be to examine social functioning in major social roles and move on from this to an investigation of the sources of stress which have caused impairment.

A fuller understanding of the concept of role would lead the worker to look not only at the client's psychic structure, but first of all, at his whole role network. This focus on the role network might give the worker a better understanding of which member is most in need of help. A study of the chart depicting the role performance of the A. family indicates that Mr. A.'s poor performance in his marital and parental roles is indeed a source of stress to Mrs. A. and to Alan. While it is possible that Mr. A. may not become readily involved in treatment, an understanding of his performance would enable the worker to be of more help to Mrs. A. and the child.

Of particular interest, is the fact that the study highlights a role which is often neglected in assessment and treatment process--the role of sibling. This, in itself, could be the area of a good deal of study. In the small sample of cases used in this thesis, six of the total of twelve children exhibited severe impairment in their sibling role. The parents' differential treatment of their children was a factor in some cases, and this may be modified through casework service to the parents. There is some indication, however, that impairment in the reciprocal role of sibling may also be a source of
stress to the child-client. Unless there is some modification in this stress factor, treatment of the client may be impeded. The writer could find very little reference to sibling relationships in the literature. Dr. Alan Cashmore, child psychiatrist at the Clinic, confirmed that this vastly important area of relationship remains relatively unexplored.

Probably the most significant feature of the social role theory, and this is best indicated by the role performance charts, is that it would seem to be an excellent tool for family assessment. The profession has been aware of the need for diagnosing family groups, but until now, there have been no theories which have provided the key. Psychoanalytic theory provided a means for a better understanding of the dynamics of the individual—a necessary step in this development. Now the profession seems to be on the verge of the next great advance, a better understanding of family dynamics.

Resistance to new theories and new concepts would seem inevitable and some resistance by social workers to this new theory may be expected. Comments made to the writer by practising workers, however, have pointed out several specific areas of resistance. One is the concern that the psychoanalytic theories may be discarded. Another is that this theory provides nothing new but the jargon. This study indicates that the concepts of psychiatry, particularly the ones clustering around ego-psychology, are firmly maintained. The difference
is that they become part of a more encompassing and more cohesive whole.

The tremendous contribution of the social role theory is that it leads from an understanding of individual dynamics to an understanding of family, group and eventually community dynamics. While it utilizes psychoanalytic and ego psychology theories, it has integrated them with sociological theories, or in other words, has put our understanding of individual dynamics in a social context. Thus is provided a better balanced perspective of man in relation to society.
APPENDIX A

Diagnostic Conference

Alan A.

"Clinical findings—see copy of psychological report. Alan is described as an appealing child but more demanding than usual. He wants to show off, seeks a great deal of reassurance, is intensely insecure, and concerned about himself. His intelligence is very superior, his mental age being 7 years and 6 months on the Binet Test. He showed attention seeking and silly mannerisms as described by mother. He said he hated to go home and it was hard to get him to leave. He responds to firmness. He cited one of his bad dreams—describing a witch with two children. They fell through a hole and mother got one back, and the other was eaten up. He proved sensitive, tried to avoid looking at real feelings and became angry if encouraged to do so.

Tests revealed an extreme degree of sibling rivalry; that he feels left out and that all parents' attention and love go to Brian. He indicated that he is lonely and not deriving satisfaction from peer relationships.

It was considered that Alan's problems stem from the separation from his mother at age two and her earlier unhappiness, and from his succession of traumatic experiences: at age four, meningitis and returned from hospital to find the new baby; tonsilectomy and attendance at play school. It was considered that he would respond well to individual therapy and that he might be put on the list for Day Centre for Children. He will be assigned to a therapist as soon as one is available. During the interval, individual interviews will be carried on with the mother. It was considered that she would respond to help and be able to effect some amelioration in the family situation."

Bob B.

"The psychiatrist saw Bob as a reasonably average youngster. He expressed some rather fanciful material which it was difficult to tell whether it had any factual base or not. He was taken up with the idea of being a protector. He spoke of a tutor, a Chinese and Spanish lady. He emphasized punishment and strictness.

The psychologist found that Bob responded to her in an immature manner and though he cooperated fairly well, he became restless with increasing demands. He showed dependent,
coy and attention-seeking behaviour. He is functioning low in the average range of general intelligence. He was threatened and became self-conscious when presented with emotionally charged material. He generally fears relationships and is emotionally immature and dissatisfied. He sees his parents as fearsome people. There is a great deal of emphasis on spankings and punishment. He is especially hostile to mother whom he sees as a very directive and unhappy person.

**Treatment:** Child and parents both to be assigned to workers.

*Carl C.*

"Psychologist reported that Carl was cooperative and tried hard in doing psychological tests. His reading is exceedingly poor and brings down his rating. He is immature, shows lack of control and anxiety around mutilation. He tested in the low borderline group in some areas but generally should be rated as slow normal. Psychologist considered he would best be treated in an institutional setting over a long period of time, as his amount of inner strength is in question. He has a minimal amount of control over his impulses. He showed difficulty accepting male identification.

Psychiatrist questioned the possibility of his having post-encephalitic damage of his temporal lobe and suggested an E.E.G. It was noted that his history was traumatic and his disturbance considerable. Clinical diagnoses is 'character disorder.' A certain amount of transvesticism is normal for adolescence. Further conference will be held when results of E.E.G. are obtained. It could be questioned whether Carl has a personality disorder or a transient perversion tied up with temporal lobe abnormality."

Subsequently an E.E.G. was done and the psychiatrist accepted Carl for treatment at the Clinic.

*Don D.*

"Social worker and psychiatrist outlined progress to date with Don and mother. Don was seen as an appealing, bright child, who has a lot of problems around his relationships with both parents. He seems to have a lot of conflict in the anal area and the psychiatrist suggested that mother's attitude towards this be explored.

Mrs. D. was seen as quite an intelligent woman with a passive-aggressive type of adjustment, with many psychosomatic symptoms. Social worker expressed some concern about much intense exploration of Mrs. D.'s feelings, which are not readily available because of her tendency to react through
illness when under too much pressure, but felt mother could benefit from support and acceptance of herself, as well as some exploration of her relationship with Don and suggestions re handling. The case was seen as fairly short-term and will be reassessed in three months."

Eva E.

"The psychiatrist reported her interview with Mrs. E. She thought that Mrs. E. was very ambivalent about coming to the Clinic. She spoke of Eva as being a very sensitive child. Mrs. E. also stated that her husband is too soft with the children and leaves the disciplining to her. The psychiatrist felt Mrs. E. had a great need for the children to be successful since she did not find the father successful in his work.

The psychologist reported that Eva was superficially friendly and has a tomboyish manner. She tries to appear casual and at ease but is quite an anxious girl and became more and more evasive. She became threatened when things were difficult to do and she was reluctant to express herself verbally. She is functioning in the average range of general intelligence. There was difficulty in visual motor coordination and Eva became confused and disorganized and discouraged when presented by such material. She was seen to be an immature and insecure girl. She is dissatisfied with herself and with life in the family. There is evidence of hostility to others and she resents their restrictions and controls, especially maternal. There was also evidence of vague apprehension which may be related to concern about her feminine role. Relationships with people have offered very little satisfaction and Eva is denying her affectional needs. Eva was resentful and did not want to recognize problems. She is not highly motivated to seek change for herself. Her reading was within the normal range but she had a problem in concentrating.

The psychiatrist saw Eva and found that her relationships were not satisfying to her. Eva wants to get away and look after animals in a remote rural area. She tends to be hypochondrical. She told the psychiatrist she was not worried about school or home. She mentioned that she liked to play with a boy in the neighborhood but her parents discouraged it as the boy was effeminate. She tends to be interested in gang activities.

Discussion: The psychiatrist felt that Eva was either bored, preoccupied with fantasy or depressed. It was noted that most of her hostility is directed towards her mother. Intra-familial conflicts cause her to want to escape. The psychiatrist wondered if Eva had started to menstruate and worker was not sure about this.
Recommendations: It was recommended that Mr. and Mrs. E. be seen by present worker and that Eva also be seen for treatment if she can be engaged in treatment. It was thought she might respond better to a male."

Frank F.

"Discussion was held around parent's physical symptoms and the psychiatrist suggested it might be helpful to go into what precipitated Mrs. F.'s migraine headaches (repressed hostility often the cause). If she understands what causes them she may be able to delay them. Regarding Mr. F.'s duodenal ulcers, dependency and frustrated ambition are said to be prominent personality traits of people suffering from this condition. The social worker felt that he needs occasionally to "explode" and that Mrs. F. and Frank might be helped to understand this.

Regarding Frank, the psychologist found him to be much more subdued and unproductive than the average eleven-year-old. He evidenced anxiety in relation to both parents and confusion in his identification. He uses projection and denial a good deal and compared to Louise, would take longer to help. Psychologist said he showed excessive control and lack of spontaneity. Social worker wondered whether the mother's fears of Frank losing control and seriously hurting someone were realistic and psychologist thought it would take a lot to lose control to this extent, although Frank is fearful of close relationships and of what he might do.

Intellectually, Frank tested low bright normal (minimal rating). The psychologist said Frank seems sensitive to people and can relate.

Recommendations:

1. Frank to be seen by a male worker for supportive therapy and limited aims for one year. Case to be assessed re termination or continuation at that time.

2. Louise to be seen by new resident psychiatrist. It was felt that she is a bright responsive child who will respond well to treatment.

3. Parents to continue joint interviews for the present with the possibility of individual sessions if indicated.

4. In view of the fact that three people and the psychiatrist will be working on this case, monthly conferences were suggested."
Gordon G.

"The social worker reviewed the case and team members added their findings. The psychiatrist said that Gordon had not been communicative with him. He did not see Gordon as a seriously disturbed boy. He saw him to be a very large, awkward boy who saw his mother as punitive and controlling. Gordon was near tears as he spoke of his poor progress in school. He said that he wanted to be a mechanic but he feels hopeless about getting the academic requirements. The psychiatrist saw Gordon as an unmasculine, sexually passive boy.

The psychologist stated Gordon was anxious but tried to control his anxiety. He did become less anxious in the second interview. He was cooperative and anxious to please and needed support to continue. Gordon was completely unable to draw the female figure at all and showed great anxiety with regard to this, being near tears. Gordon tested in the borderline range of general intelligence and this rating would seem to be minimal as anxiety is interfering with his functioning. His verbal rating was in the dull normal range of general intelligence and his performance was in the defective range. His reading is at the Grade 4 level. The psychologist assessed Gordon as immature and inadequate, evasive and flattened. He is very discouraged and is confused about his identity. He sees being female as more advantageous than being masculine. He is lacking in satisfying relationships. He sees his mother as critical and depriving. He does have an awareness of values.

It was felt that Gordon and Jim both need masculine identification and that this could be given to them through a male person in their environment. If no suitable male can be found the psychiatrist suggested that possibly one therapist could take on Gordon and Jim together for interviews and possibly Joe could be included in this. The team felt that remedial academic work would be helpful at some point. It was also suggested that Gordon might get into Vocational School even if he does not have Grade X standing."

Howard H.

"The psychologist reported Howard tested in the borderline range of general intelligence. He is unable to read through a paragraph but can make out some of the words, is not doing as well as he should. He is immature, insecure and emotionally deprived.

Howard shows positive feelings towards male figures, does not get satisfaction out of relationships, is pre-occupied with death and fear of loss of all sources of satisfaction. Howard expressed anxiety about parental relationships."
The psychiatrist found Howard fearful, anxious, depressed. The mother appeared tense, talked of tranquillizers. Says she cannot get cross with Howard or he reacts with abdominal pains and headaches.

Too much change in mother cannot be anticipated. A supportive level of treatment was recommended.

The school should be advised they are doing well with Howard and should not be too permissive. They could be advised that the child is unhappy and should improve in his work as his family relationships improve under treatment."

Ike I.

"The psychiatrist found Ike to be a hard child to get through to. He showed a lot of testing, controlling and passively aggressive behaviour. He was very active but there was a looseness and disorganization about his play. He played by himself and did not include the therapist. He had a pronounced stutter, regressive speech, reverted to baby talk.

The psychologist found that in a structured interview Ike tended to be quite cooperative but if anything was too hard to do, he tended to be evasive. When pressured to talk about feelings, he stuttered a great deal. He tested high in the borderline range of general intelligence and is possibly potentially of average intelligence. He is confused, mixed-up, unhappy, unsure of his own identification and insecure. He seems to be trying to deny his need for affection and acceptance from others but does show some ability to respond and to look for a warmer relationship with a maternal figure.

It was decided before we determine what treatment to offer, the psychiatrist would check with the family doctor re epilepsy and medication."

Jean J.

"Much of the discussion in this case centred around the problem of mother, Mrs. J. In discussing Jean, the psychiatrist said she is an emotionally deprived child who has had poor relationships with both parents, but mother especially. In view of Mrs. J.'s inability to give to Jean and in view of Jean's early history of disturbances, e.g., colic, method of weaning, illness--there was some question as to Jean's ability to respond to treatment. However, both psychiatrist and psychologist noted a rich fantasy life in Jean, and much surface hostility, and it was felt that these were favorable indications of treatability."
Jean appears to have much sexual concern and curiosity regarding relationships between men and women and is confused about her own sexual identification. The psychiatrist stated that it was difficult to speculate on Jean's soiling until more is known about the mother's problem. However, he felt the soiling did appear to represent a regression from the oedipal conflict.

Regarding Mrs. J., the general feeling was that she will be difficult to treat as her problems seem to be largely those of the obsessive-compulsive. She is displaying a classic symptom of the obsessive's inability to talk about problems in that her speech is halting and hesitant and she does not even finish sentences at times. The psychiatrist felt that her asthma and stammering are related. Further, Mrs. G.'s concern over Jean's tomboyishness is likely a result of her own confusion re sexual identification. It was felt by those present that the best approach to take with Mrs. J. at present was a supportive one, rather than a deeper method of treatment, as she is at present incapable of discussing her own problems because of her ambivalence and conflict."

Ken K.

"The psychiatrist suggested that if the mother is left untreated she could have another psychotic episode. She shows schizophrenic tendencies and has insidious paranoia. He suggested to mother that she attend Day Hospital in the Adult Clinic and at same time, boys can attend Day Centre for Children. Mother sees her own destruction and that of the family as inevitable and seems to be working toward that end. She is dissatisfied with married life and may eventually want to leave home.

The psychologist found Ken exceedingly inhibited and frightened. He proved cooperative. His reading is poor. He measured low in the average range of intelligence. He showed a lack of good relationship with May. Psychiatrist mentioned Ken's relationship with mother is a symbiotic one. It was agreed that Ken should be accepted for treatment and should be considered for Day Centre. The psychiatrist will see mother and social worker, the father.

Ken is a six-year-old emotionally disturbed child of average intelligence who has parents and grandparents on both sides who have suffered or are suffering emotional disturbances. His behaviour is in response to his father's over-concern and to mother's similar habits and his identification with her. The family's withdrawal from the community and May's overprotection enter the situational picture. There was evidence of hostility turned inward and of guilt. There are pregenital neuroses factors present."
"Very little is known about Lana's early developmental history as mother has not considered Lana a problem and dismisses inquiries by stating that Lana does not really need treatment. Lana started at Day Centre originally, partly because of our need for more girls in the program and partly because of the problem of interviewing mother when Lana was along. She was having difficulty in separating from mother and would not sit in the waiting room by herself. Mother has never really considered her much of a problem. It was felt by the psychologist that Lana does not show too much disturbance. The psychiatrist pointed out that the mother seemed to feel that our interest in Lana might dilute our interest in Bob. It was felt that we should continue with Lana, at least to see her through the starting of school. Lana will, therefore, be seen for another three months and mother will be assured that our principal interest is in Bob and in herself."
### APPENDIX B

Rating Scale for Measuring Performance in Peer Role (if child) and Member of Community Role (if adult)

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td>Friend</td>
<td>Makes friends with relative ease and maintains friendships. Does not force his opinions upon others and respects their opinions.</td>
</tr>
<tr>
<td>Neighbour</td>
<td>Friendly, considerate and cooperative. Neither imposes on neighbours nor allows himself to be imposed on by them.</td>
</tr>
<tr>
<td>Participating</td>
<td>Enjoys companionship of others. Takes some responsibility as a member of society by contributing time and talent to at least one community organization. If a child, enjoys one or two group activities appropriate for age.</td>
</tr>
<tr>
<td>Member of Community Groups</td>
<td></td>
</tr>
</tbody>
</table>
### Rating Scale for Measuring Performance in Employee Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td>Relationship with Employer</td>
<td>Respects employer and is respected by him; loyal; not fearful of expressing himself but is not antagonistic.</td>
</tr>
<tr>
<td>Training and Skill</td>
<td>University or high school and good vocational or in-service training. Finds opportunities to improve his knowledge and skills.</td>
</tr>
<tr>
<td>Interest in Vocation</td>
<td>Finds job satisfying and challenging. Contributors new ideas and new techniques to improve standard or quantity of work.</td>
</tr>
</tbody>
</table>
### Rating Scale for Measuring Performance in Husband Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source of Emotional Support</strong></td>
<td><strong>Not Impaired</strong></td>
</tr>
<tr>
<td></td>
<td>Expresses affection for wife. Gives her security and freedom from anxiety. Shows an interest in her activities, her creativity, her work and her needs, both emotional and physical. Has selected wife with good feminine identification and accepts her more dependent role.</td>
</tr>
<tr>
<td>Social Partner</td>
<td>Communicates easily with wife; shares some interests and activities; treats her with respect when alone and in presence of others.</td>
</tr>
<tr>
<td>Provider</td>
<td>Provides well for the family's economic needs beyond the subsistence level.</td>
</tr>
</tbody>
</table>
### Rating Scale for Measuring Performance in Father Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td><strong>Source of Emotional Support and Guidance</strong></td>
<td></td>
</tr>
<tr>
<td>Shows affection and understanding. Acts as counsellor and encourages child with school and other interests suitable to age and sex. Can place child's needs before his own. Provides a good pattern of masculine behaviour.</td>
<td>Shows little affection or understanding. Spends little time with child and does not help him develop special interests. Some competition with wife over child.</td>
</tr>
<tr>
<td>Provides consistent discipline; is firm but kindly.</td>
<td>Inconsistent in dealing with child, or gives in too much and is generally ineffective or is too severe. Some conflict with wife over authority.</td>
</tr>
<tr>
<td>Respected member of community with good community relationships.</td>
<td>Displays some socially unacceptable behaviour. Has few friends or community interests.</td>
</tr>
</tbody>
</table>
### Rating Scale for Measuring Performance in Wife Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source of Emotional Support</strong></td>
<td>Not Impaired</td>
</tr>
<tr>
<td>Gives husband affection and encouragement. Shows concern for his needs, physical and emotional. Has selected a husband with good masculine identification and accepts his more dominant role.</td>
<td>Expresses little affection for husband and gives little encouragement. Not much ability to perceive husband's needs and no ability to put them before her own. Struggles with him for authority or is overly dependent.</td>
</tr>
<tr>
<td><strong>Social Partner</strong></td>
<td>Communicates easily with husband; enjoys his company and shows pride in his social accomplishments. Performs required social tasks, such as entertaining with goodwill.</td>
</tr>
<tr>
<td><strong>Homemaker</strong></td>
<td>Keeps home moderately clean and attractive. Usually limits expenses to budgeted amount; prepares adequate meals; keeps family's clothing presentable.</td>
</tr>
</tbody>
</table>
## Rating Scale for Measuring Performance in Mother Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td><strong>Source of Maternal Love</strong></td>
<td></td>
</tr>
<tr>
<td>Has given consistent love and warmth to child since birth.</td>
<td>Has marked ambivalent feelings toward child; is inconsistent, overly anxious, or apathetic.</td>
</tr>
<tr>
<td>Source of Emotional Support</td>
<td>Encourages child to develop own individuality; guides him through developmental phases; encourages extrafamilial activities.</td>
</tr>
<tr>
<td><strong>Provider of Physical Care</strong></td>
<td>Provides adequate food; is interested in child's health and appearance; and provides for these as well as circumstances permit.</td>
</tr>
</tbody>
</table>
### Rating Scale for Measuring Performance in Student Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td><strong>Relationship with Teacher</strong></td>
<td>Likes and respects teacher; feels secure; neither overly timid nor overly aggressive</td>
</tr>
<tr>
<td><strong>Academic Progress</strong></td>
<td>Rates average or above average in class; keeps up with school work.</td>
</tr>
<tr>
<td><strong>Relationship with other Students</strong></td>
<td>Friendly, cooperative, secure</td>
</tr>
</tbody>
</table>
## Rating Scale for Measuring Performance in Sibling Role

<table>
<thead>
<tr>
<th>Role Criteria</th>
<th>Social Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td><strong>Ability to Maintain, and Allow Sibling to Maintain Individuality</strong></td>
<td>Occasionally domineering or dominated by sibling, but maintains own individuality and allows sibling to maintain his.</td>
</tr>
<tr>
<td><strong>Ability to Establish Positive Relationship with Sibling</strong></td>
<td>Involved in some bickering and arguing but can share toys and play; shares some consideration for sibling.</td>
</tr>
<tr>
<td><strong>Ability to Establish His Place in Family</strong></td>
<td>Has integrated into family with relation to other children; feels reasonably secure.</td>
</tr>
<tr>
<td>Role Criteria</td>
<td>Social Functioning</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Not Impaired</td>
</tr>
<tr>
<td>Mental Development</td>
<td>Average or higher intelligence</td>
</tr>
<tr>
<td>Physical Development</td>
<td>Good health; normal development with no crippling diseases or physical handicaps and few illnesses.</td>
</tr>
<tr>
<td>Emotional Development</td>
<td>Loving, happy, secure, with growing acceptance of own identity. Successfully mastered developmental phases to date.</td>
</tr>
<tr>
<td>Sexual Development</td>
<td>Has good conception of own sexual identity.</td>
</tr>
<tr>
<td>Social Development</td>
<td>Outgoing and friendly, relates to children and adults. Relatively independent. Can handle new experiences.</td>
</tr>
</tbody>
</table>
## APPENDIX C

### Measurement of Role Performance

<table>
<thead>
<tr>
<th>Roles</th>
<th>Case I</th>
<th>Case II</th>
<th>Case III</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY MEMBER</td>
<td>extensive</td>
<td>severe</td>
<td>-</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not impaired</td>
<td>extensive</td>
<td>-</td>
</tr>
<tr>
<td>HUSBAND</td>
<td>extensive</td>
<td>severe</td>
<td>-</td>
</tr>
<tr>
<td>FATHER</td>
<td>extensive</td>
<td>severe</td>
<td>-</td>
</tr>
<tr>
<td>COMMUNITY MEMBER</td>
<td>extensive</td>
<td>extensive</td>
<td>?</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not performing</td>
<td>not performing</td>
<td>not impaired</td>
</tr>
<tr>
<td>WIFE</td>
<td>moderate</td>
<td>moderate</td>
<td>not performing</td>
</tr>
<tr>
<td>MOTHER</td>
<td>extensive</td>
<td>moderate</td>
<td>moderate</td>
</tr>
<tr>
<td>PEER</td>
<td>extensive</td>
<td>extensive</td>
<td>?</td>
</tr>
<tr>
<td>STUDENT</td>
<td>extensive</td>
<td>severe</td>
<td>moderate</td>
</tr>
<tr>
<td>SIBLING</td>
<td>severe</td>
<td>extensive</td>
<td>moderate</td>
</tr>
<tr>
<td>SON OR DAUGHTER</td>
<td>moderate</td>
<td>extensive</td>
<td>extensive</td>
</tr>
</tbody>
</table>
### Measurement of Role Performance

<table>
<thead>
<tr>
<th>Roles</th>
<th>Case IV</th>
<th>Case V</th>
<th>Case VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY MEMBER</td>
<td>?</td>
<td>?</td>
<td>severe</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>severe</td>
<td>severe</td>
<td>extensive</td>
</tr>
<tr>
<td>HUSBAND</td>
<td>extensive</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td>FATHER</td>
<td>moderate</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMMUNITY MEMBER</td>
<td>?</td>
<td>?</td>
<td>not impaired</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not performing</td>
<td>not performing</td>
<td>not performing</td>
</tr>
<tr>
<td>WIFE</td>
<td>moderate</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>MOTHER</td>
<td>extensive</td>
<td>moderate</td>
<td>moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEER</td>
<td>?</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>STUDENT</td>
<td>not performing</td>
<td>extensive</td>
<td>moderate</td>
</tr>
<tr>
<td>SIBLING</td>
<td>moderate</td>
<td>?</td>
<td>extensive</td>
</tr>
<tr>
<td>SON OR DAUGHTER</td>
<td>moderate</td>
<td>moderate</td>
<td>extensive</td>
</tr>
</tbody>
</table>
Measurement of Role Performance

<table>
<thead>
<tr>
<th>Roles</th>
<th>Case VII</th>
<th>Case VIII</th>
<th>Case IX</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY MEMBER</td>
<td>?</td>
<td>severe</td>
<td>?</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>slight</td>
<td>severe</td>
<td>not impaired</td>
</tr>
<tr>
<td>HUSBAND</td>
<td>slight</td>
<td>not performing</td>
<td>slight</td>
</tr>
<tr>
<td>FATHER</td>
<td>moderate</td>
<td>extensive</td>
<td>slight</td>
</tr>
<tr>
<td>COMMUNITY MEMBER</td>
<td>extensive</td>
<td>severe</td>
<td>moderate</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not performing</td>
<td>?</td>
<td>not performing</td>
</tr>
<tr>
<td>WIFE</td>
<td>moderate</td>
<td>not performing</td>
<td>slight</td>
</tr>
<tr>
<td>MOTHER</td>
<td>extensive</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>PEER</td>
<td>extensive</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>STUDENT</td>
<td>extensive</td>
<td>extensive</td>
<td>severe</td>
</tr>
<tr>
<td>SIBLING</td>
<td>?</td>
<td>moderate</td>
<td>moderate</td>
</tr>
<tr>
<td>SON OR DAUGHTER</td>
<td>moderate</td>
<td>moderate</td>
<td>extensive</td>
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</tbody>
</table>
### Measurement of Role Performance

<table>
<thead>
<tr>
<th>Roles</th>
<th>Case X</th>
<th>Case XI</th>
<th>Case XII</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY MEMBER</td>
<td>?</td>
<td>severe</td>
<td>?</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not impaired</td>
<td>severe</td>
<td>slight</td>
</tr>
<tr>
<td>HUSBAND</td>
<td>slight</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td>FATHER</td>
<td>moderate</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td>COMMUNITY MEMBER</td>
<td>?</td>
<td>severe</td>
<td>severe</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>not performing</td>
<td>not performing</td>
<td>not performing</td>
</tr>
<tr>
<td>WIFE</td>
<td>moderate</td>
<td>extensive</td>
<td>moderate</td>
</tr>
<tr>
<td>MOTHER</td>
<td>extensive</td>
<td>extensive</td>
<td>moderate</td>
</tr>
<tr>
<td>PEER</td>
<td>moderate</td>
<td>severe</td>
<td>severe</td>
</tr>
<tr>
<td>STUDENT</td>
<td>moderate</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td>SIBLING</td>
<td>extensive</td>
<td>extensive</td>
<td>extensive</td>
</tr>
<tr>
<td>SON OR DAUGHTER</td>
<td>moderate</td>
<td>moderate</td>
<td>moderate</td>
</tr>
</tbody>
</table>
"Psychiatric history taking is not merely a process of collecting data. It is a means of getting acquainted with the person who presents the data. It is not a cut and dried 'technique' but a thrilling experience had by two people." This is the way that Dr. Leo Kanner* describes the report which the referror submits in his attempt to convey his understanding of the child, his family, and their problem. It is an organized record of the story which the family pours out to one who, having offered to help, listens in a warm and encouraging manner. From this 'thrilling experience' comes the family's willingness to use the resources of the Children's Clinic.

The intrinsic value of a written case history is determined neither by its volume nor by the mass of detail which it contains, but by its orienting function! Two foolscap size pages of digested data is of more value than three or four such pages of unrelated detail. The rambling story given by the parents can be reduced to a concise, graphic account of the problem as it faces the child, his family, and his community.

The attached social-psychiatric history outline is a suggested means of organizing and focusing data. For the novice it is an instrument in learning of what type of facts to be aware, and for the experienced person it simply serves to suggest the four broad areas of interest basic to a psychiatric diagnosis--the problem, family background, personal history, and the referrer's evaluation and plan. The novice may lean upon this outline as a guide to content, but never as a questionnaire or as a means of interviewing. These four headings should follow in this sequence, providing a universal order to the writer as well as to the reader. If one section is more important than the others, it is the problem; all other data should be relevant to the reason for referral.

* Kanner, Leo -- 'Child Psychiatry'; this is the textbook in this field of medicine.
SOCIAL HISTORY OUTLINE

A guide to preparation of Social Histories for the Children's Clinic of the Mental Health Centre.

DATE WRITTEN:
DATE OF EXAMINATION:

NAME:
BIRTHDATE: STATUS: (Ward, non-ward, etc.)

PARENTS: (FATHER) BIRTHDATE: (MOTHER) BIRTHDATE: (MAIDEN NAME) S.S. INDEX:

TELEPHONE: ADDRESS:

SOURCE OF REFERRAL: (By whom and how)

PROBLEM: (1) As stated and seen by parents, child, and any other closely involved persons.
What help are they asking for?
How long have parents, child, or others been aware of the problem(s)?
How do they feel about receiving help?

(2) Social worker's/public health nurse's general picture of problem.
Estimate client's awareness of the presenting problem and other problems seen by the social worker/public health nurse.
Reason for referral to Clinic at this time.
What specific help is desired by social worker/public health nurse.

DATE OF PREVIOUS EXAMINATION AT CHILDREN'S CLINIC (formerly Child Guidance Clinic), P.M.H., ETC. (Child or relatives).

FAMILY HISTORY

HOME SETTING: Pertinent and brief descriptive material of present home setting --
economic and community status; housing; persons in home.

FATHER: (1) Identifying information -- name; present age; place of birth; religion.

(2) Social and cultural background -- others in family, ages; father's
description of paternal grandparents; father's estimate of his adjust-
ment to family, school, religion, and social groups; extent of education;
work record, health; any serious illnesses or operations.

(3) Family relationships -- father's feelings about and relationship to
child, to wife, to others in family.
Father's attitude and contribution with regard to problem(s); How does he handle it?
FAMILY HISTORY: (cont'd)

(4) Paternal relatives -- information pertinent to child and parents' adjustment.

MOTHER: Information as for father (1), (2) and (3).

(4) Maternal relatives -- information pertinent to child and parents' adjustment.

MARITAL ADJUSTMENT:
When, where and how did parents meet? Courtship; sexual adjustment.

STEP-PARENTS OR FOSTER HOMES:
As above with dates child was with them and reasons for leaving.
Indicate and evaluate relationships, adjustment, and the meaning of the experience to the child. (In chronological order)

SIBLINGS: Identifying information -- name; date and place of birth; religion.
How do they fit into the family, inter-personal relationships?

PERSONAL HISTORY

DEVELOPMENTAL FACTS:

Date, place of birth: Age weaned: Bladder control at:
Toilet training began: Bowel control at:
Teethed at: Walked at:
Talked at (words): (sentence formation):

DESCRIPTION OF DEVELOPMENT TO DATE: Mother's health, attitudes and feelings about child during pregnancy; method of delivery; length of labour; birth injuries.

(1) Eating: Method of early feeding.
Method of weaning, any early feeding, or present eating difficulties.
Food fads or fussiness.
Indigestion or any indication of gastro-intestinal disorder.

(2) Elimination: Method and attitudes in training child.
Difficulties.
Any indications of frequent constipation or diarrhea.
Any incidents of enuresis.
Soiling.
Smearing.
Any present unusual attitudes or habits regarding elimination.

(3) Sexual development: Interest in sexual information.
Any incidents of exhibitionism.
Sex play.
Masturbation or intercourse (describe, including age and frequency, of such incidents).
Extent of sexual knowledge.
From whom obtained.
Evidence of development.
PERSONAL HISTORY (cont'd):

Age of puberty.
Attitude toward it.
If menses established is it regular? Painful?
Has someone discussed puberty and sexual role with child?
Any indication of abnormal sexual behaviour?

(4) Physical development:
Has physical growth been normal?
Give incidents of illness, disease (ages) sequelae (disability, etc.)
Reactions of child and parents to serious illnesses.
Disabilities.
Operations and preparation of child for these (age).
Child’s attitude to and estimate of present health.
Any over-compensation or over-concern.

PERSONALITY AND APPEARANCE:
Physical description — any indications of nervous habits; fears; disturbances of sleep; recurrent or significant dreams.
General picture of the child’s outstanding relationships and how he (she) uses these.
How does he (she) handle feelings and need such as anger, affection, dependency in relation to his (her) closest relationships.
Attitudes to school, teachers, people in authority.

Interest and Recreation; adjustment to social groups, employment, particular friends of both sexes.
Ambitions and goals.
Estimate of child’s insight, intelligence, humour.

SCHOOL RECORD: Grade and teacher’s report. Bureau of Measurements record if in Vancouver.

EVALUATION AND PLAN

Social worker’s/public health nurse’s evaluation of case from work done by the presenting agency.
What has been done? How frequent are the contacts? How strong is the worker-child relation?
What methods have been tried in working with child and parent(s)?
What has been tried by family members in dealing with problems? How successful?
What possible resources are there in family or community to help meet child’s needs?
What are worker’s/nurse’s suggestions for carrying on from the point?
Questions around which social worker/public health nurse would like discussion.

ALL HISTORIES SHOULD BE SIGNED BY THE SOCIAL WORKER OR PUBLIC HEALTH NURSE AND FOUR COPIES SUBMITTED TO THIS CLINIC.
APPENDIX E

BIBLIOGRAPHY

A. General

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