SOCIAL PROBLEMS OF A GROUP OF PATIENTS
WITH PSYCHOGENIC ILLNESS

by

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The social problems of a group of fifty-three patients with psychogenic illness are analyzed and interpreted in this study. The patients were all those with at least one somatic complaint referred to the Social Service Department of the Royal Alexandra Hospital, Edmonton, Alberta, during the period from October 1944 to July 1946.

The patients were found to have two main types of problems, those associated with their environment, and those associated with their emotional condition. The environmental problems were those associated with employment, finances, war, school, immigration, housing, and miscellaneous conditions. The emotional problems were those associated with the patients' attitude to illness; relationships with other persons; with their own emotional development; with their feelings about matters pertaining to sex; and with a number of miscellaneous feelings.

In all these groups, there were forty-six different problems studied. There was a total of 550 individual problems among all the patients, with an average of 10.37 problems per patient. Of these, 126 were environmental problems, with an average of 2.7 environmental problems per patient. The average number of emotional problems per patient was 7.3, with a total of 424 such problems.

There were thirteen groups of problems among the environmental and emotional problems. The most frequent problems were those associated with illness. These were found in all patients. The next most frequent
group was of problems associated with the patients' relationships with others, 98.11% of the patients having problems here. 88.68% of the patients had problems associated with their emotional development. 64.15% of the patients had problems associated with employment. The same number of patients had problems arising from their attitude to matters pertaining to sex. 43.39% of the patients had problems associated with finances; 30.19%, with war; 26.41%, with school; 26.41%, with immigration; 11.32%, with housing; 41.52%, with miscellaneous situations; and 35.81%, with miscellaneous feelings. The large numbers of problems among the patients emphasixes the need for medical casework treatment for hospital patients.

A brief description of the nature of medical social work and of the setting in which these problems arose, is given. Descriptive and statistical material being summarized in 9 tables. Interpretation of social work and medical terminology is given whenever the meaning of these terms appeared obscure. An example of the type of social history, from which information for this study was obtained, and a table summarizing all the problems are given in the appendices. Reading material used in the study is listed in the bibliography.
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CHAPTER I
PURPOSE, SCOPE AND METHOD

Purpose

The purpose of this study is to analyze and interpret the social problems of fifty-three general hospital patients who suffered from physical ailments which were primarily psychogenic. This type of illness is one which has a high degree of environmental and emotional factors in its initial development and progress, and as such, requires particular diagnosis and treatment. With the intense specialization of modern medical practice it has become difficult for the doctor to have the time and training to study this aspect of the patient's problems and assist in solving them. He can, however, refer the patient to a person specially trained for this, i.e., the medical social worker.

The importance of the role of the medical social worker has been described by the American physician, Dr. H.M. Margolis, as follows:

With greater recognition of the social and emotional factors in illness, there came naturally greater acceptance of the social worker and her help.... We depend on her largely for an objective picture of the patient's social setting, his relationship with the family group, its socio-economic as well as its emotional resources. We recognize that she often has the equipment and the inclination to help the patient to understand the early emotional conflicts that are a basis for existing emotional illnesses. 1.

As a result of this growing awareness of the value of medical social

work, hospitals in western Canada have shown an interest in the establishment of such departments. Prior to 1945, pioneer work had already been done in this direction in six hospitals in British Columbia, namely, the tuberculosis sanitarium in Vancouver, Victoria and Tranquille, 2 the Crippled Children's and General Hospitals in Vancouver, and the Royal Jubilee Hospital in Victoria. 3 In Alberta, however, the only work of that nature was carried out in the Royal Alexandra Hospital where the information for this study was obtained.

The Social Service Department in this hospital has been considered outstanding due to the skill of its social worker. It is felt, therefore, that the material contained in this study may be of interest and assistance to administrators and staffs of newly formed departments by indicating what types of environmental and emotional problems may be expected among patients with psychogenic disorders. Although some of the social problems studied here are peculiar to the locality and time most of the problems are representative of all hospital patients suffering from illnesses of this type.

Scope

This study covers the social problems of fifty-three patients at the Royal Alexandra Hospital, Edmonton, Alberta, who were referred to the Social Service Department from October 1944, at which time the department was established, to July 1946, when the data for this paper was gathered. This group includes all patients with at least one somatic complaint, referred by their physician for study and social treatment because they

considered the patients' environmental and emotional problems influential in the development of their illness and deterrent factors in their recovery.

Method

Most of the material for this study was obtained from the psychosomatic or social histories compiled by the social worker at the Royal Alexandra Hospital following her interviews with patients, and in some instances members of their families. These histories described the patient's childhood and cultural background, his present family relationships and living conditions, and his feelings and attitudes. This enabled her to direct attention to what she judged to be the chief disturbing factors. Obviously the information varied considerably with each case and there was no standardization in the form of these records, an example of which may be found in Appendix A. Psychosomatic histories and accompanying face-sheets, containing brief data such as the patient's age, sex, birthdate, nationality, symptoms and diagnosis were virtually the only case-records kept by the department. Lack of any clerical staff prevented the social worker from recording each interview in detail which is preferable in this type of work.

For ease in analyzing the above material it has been felt necessary to make some sort of division and the problems have been separated arbitrarily into those which are predominantly (a) environmental and (b) emotional. Difficulty has been encountered in achieving this since both are inter-related. However, those which appeared to arise principally out of external circumstances were included in the first group: those principally due to the patient's attitude, in the second.
Medical social work is carried on in a hospital as a service to the patient, the physician, the hospital administration and the community. Its purpose is to help meet the problems of the patient which aggravate his medical condition. These problems fall roughly into two groups, those of an environmental nature such as poor housing or prolonged poverty and those of an emotional nature associated with the individuals' feelings and attitudes, as, for instance, a sense of insecurity or unsatisfactory relationship with parents.

The problems of a patient are met by a social worker by a variety of methods, dealing directly with the sick person or indirectly through others working toward his recovery. The American Association of Social Workers has outlined the means by which this is done in its description of the total functions of medical social service departments. They are as follows:

1. The practice of medical social casework.
2. The development of the medical social program within the medical institution.
3. Participation in the development of the medical social program in the community.
4. Participation in the educational program for professional personnel.
5. Medical social research.

4. A Statement of Standards to be Met by Medical Social Service Departments in Hospitals and Clinics. The American Association of Medical Social Workers, New York, 1940.
The first of the above, the practice of medical social casework, was carried on to the greatest extent at the Royal Alexandra Hospital. In general, this branch of the work involves dealing directly with the patient and his problems and requires first of all, a thorough study of the situation in which the patient lives or has lived, i.e., his work, housing, family relationships and emotional development. The social worker (in future referred to as "her" to distinguish from the patient referred to as "him") may achieve this by being, first of all, truly understanding and sympathetic to the patient who comes to rely on the worker as a person he can trust with his innermost thoughts and feelings. Once he has found that these, no matter how reprehensible they may seem, will be met without shock or censure, he is able to unburden himself. His treatment begins as he talks and unravels his tangled memories and emotions. Once the medical social worker has a clear picture of the patient's problems, she can start to help him with the most pressing of them. For example, a patient who has just developed some alarming symptoms and has been admitted to hospital might find his confusion about the nature of his illness particularly disturbing. After the social worker has discussed with him his concern about such things as -- what his diagnosis is, how the symptoms came about, and what kind of treatment he may expect, she may proceed to help him with his other worries. This may be achieved by making him aware of the causes of his anxiety and offering concrete suggestions as to how to effect a solution of problems concerning the financial state of his family during his illness, his work, his relationship with his wife, or feeling of insecurity in his daily contacts.

To work out these difficulties may take varying lengths of time depending on the seriousness of the problem, the response of the patient
to treatment, the skill of the social worker, and the frequency and length of interviews between the patient and social worker. In some cases a patient may be greatly helped by two or three interviews: in others he may require assistance for a year or more: occasionally he may require supportive treatment indefinitely.

Although at the Royal Alexandra Hospital, most attention was paid to social casework treatment, the other functions listed by the American Association of Medical Social Workers, and noted in reference 4, were also carried out as time and facilities permitted. For example, there was an encouraging development of the medical social work program in the hospital. Firstly, the social worker demonstrated her usefulness to the patients with the most obvious social problems. As she did this, she heightened the awareness of the physicians and hospital staff of the patients' problems. As requests for social work assistance are made through the physicians and the hospital staff the broadening of such a program can only be achieved by a growth in this understanding of the social problems.

The social worker took part, too, in the development of social and health programs in the community. This often involved initiating as well as continuing with an active part in certain public projects such as the better co-ordination of social agency functions, slum clearance or cancer fund campaigns.

To some extent, she carried on an educational program for professional personnel, i.e. social workers, physicians and nurses. She supervised social work students placed in her department by a school of social work, participated in clinics for internes and gave lectures to student nurses.

Medical social research was not done to any extent. Although this
study is an example of medical social research and was done in that department, it was done extraneously, and not as part of the responsibility of that office.

The Setting of the Problems

The Royal Alexandra Hospital is a 500 bed hospital situated near downtown Edmonton. It is owned by the city, controlled by a board of directors and administered by a superintendent who is a physician himself. Serving as a teaching hospital for the University of Alberta, it is staffed by graduate resident physicians and undergraduate interns. The hospital also has a training school for nurses. The institution offers no free hospitalization or treatment. The only care given there for which patients do not pay, is maternity care which is paid for by the province, and indigent care, paid for by the municipalities who place their patients there. Daily rates for hospitalization range from $3.00 to $6.00.

The Social Service Department was set up in the fall of 1944. Its office, located on the first floor of the hospital near the main entrance and admitting office, is easily accessible to doctors and patients. The services of the social worker are free and available to all patients on referral from their physician, nurse or intern. As there was only one social worker in this hospital to deal with the many problems among the patients, there was little opportunity for the social worker to continue contact with the patient after his discharge. In a few cases the contact was continued for a short time by means of home visits, but the majority of city patients needing continued casework treatment after discharge were referred to the Edmonton Family Welfare Bureau. Patients from the
country districts received no further help, as there are no agencies offering casework services in Alberta outside the cities of Edmonton and Calgary.

In order to secure a clearer view of the social problems discussed in this study, it is of value to know a little of the patients and where they lived. They were all residents of the province of Alberta whose geographical location makes it particularly suitable for grain growing, mixed farming, stock raising, lumbering, mining and the fur trade. Much of the prairie land was taken by early settlers for homesteading. During the latter part of the nineteenth century and the beginning of the twentieth century, immigrants from all parts of continental Europe and Great Britain came out to this land of promise, so much publicized by the Canadian railway companies. In addition to those coming from Europe, people from the United States and eastern Canada moved out to "sunny Alberta". The population of the province is thus made up chiefly of people of British, French, German, Ukrainian and western Slavic descent.

Edmonton, the capital city of the province, with a population of over 100,000 and situated on the banks of the northern branch of the Saskatchewan River, is a trading centre for northern and central Alberta. During the war years there was a large influx of population. In the city and the surrounding country were numerous Royal Canadian Air Force training stations. The United States Army Air Force base and that for the construction of the Alaska Highway were both in Edmonton. About a half of the patients covered in this study lived in this city, and the remainder were from the small towns and country districts of the province.

Of the group of patients, twenty-seven were women, and twenty-five, men. A large number of the women were housewives. The remainder were
clerks, domestics, students and unemployed. Details of the patients' occupations are given in Chapter 3, section 2.

The age distribution ranged from eight to sixty years, with the largest group of the patients, fourteen, in the 31-40 year group, which also was the mean age group. The following table indicates the distribution according to age.

Table 1
The Distribution of the Patients According to Age Groups.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 10 years</td>
<td>2</td>
</tr>
<tr>
<td>11 - 20 years</td>
<td>7</td>
</tr>
<tr>
<td>21 - 30 years</td>
<td>11</td>
</tr>
<tr>
<td>31 - 40 years</td>
<td>14</td>
</tr>
<tr>
<td>41 - 50 years</td>
<td>9</td>
</tr>
<tr>
<td>51 - 60 years</td>
<td>4</td>
</tr>
<tr>
<td>61 - 70 years</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

The illnesses, which were all predominantly psychogenic, were diagnosed as follows; psychoneurosis, 18 patients; mucous colitis, 4 patients; abdominal pain (ulcer symptoms), 3 patients; 2 patients with each of the following, neurosis, anxiety state, nervous exhaustion,
rheumatic heart disease, anorexia nervosa, scleroderma, Reynaud's disease, diabetes mellitus; one patient with each of involutional melancholia, globus hystericus, reactive depression, conversion hysteria, anxiety neurosis, simple syncope, hysterical state, pruritus ani, arthritis, auricullar fibrillation, duodenal ulcer, irritable bowel and skin condition.

Most of the patients complained of symptoms associated with organ-system. A knowledge of the symptoms helps to give a more complete picture of the patients' physical conditions. The table below indicates the number of patients who complained of symptoms in the various organ-systems.

Table 2

The Incidence of Complaints with Reference to the Various Organ-systems

<table>
<thead>
<tr>
<th>Organ-systems</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastro-intestinal</td>
<td>23</td>
</tr>
<tr>
<td>Central nervous</td>
<td>18</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>10</td>
</tr>
<tr>
<td>Locomotor</td>
<td>10</td>
</tr>
<tr>
<td>Genito-urinary</td>
<td>9</td>
</tr>
<tr>
<td>Endocrine</td>
<td>4</td>
</tr>
<tr>
<td>Respiratory</td>
<td>2</td>
</tr>
<tr>
<td>Skin</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>
It may be noted that a large number of patients had symptoms with reference to the gastro-intestinal tract. Among patients whose illness is so closely tied up with their emotions this can be expected since the abdomen, due to its sensitivity to nervous strain, has come to be called "the sounding board of the emotions". Complaints in the central nervous system were also frequent. This is to be expected, as disorders affecting this part of the body, such as fainting, headache, dizziness and feelings of weakness, if without organic cause, are an expression of the patient's anxiety.5

CHAPTER III

ENVIRONMENTAL PROBLEMS

It is interesting to note that of the fifty-three patients studied in the Royal Alexandra Hospital, all were disturbed by some environmental situation, either of the past or present. For purposes of analysis, the problems arising out of these circumstances were considered as follows: those associated with employment, finances, war, school, immigration, housing and miscellaneous conditions. The number and percentage of patients having problems in each one of these groupings is given below.

Table 3

The Number and Percentage of Patients with Problems Associated with Certain Environmental Conditions

<table>
<thead>
<tr>
<th>Environmental Condition</th>
<th>Number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>34</td>
<td>64.1</td>
</tr>
<tr>
<td>Finances</td>
<td>23</td>
<td>43.4</td>
</tr>
<tr>
<td>War</td>
<td>16</td>
<td>30.2</td>
</tr>
<tr>
<td>School</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>Immigration</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>Housing</td>
<td>6</td>
<td>11.3</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>21</td>
<td>39.6</td>
</tr>
</tbody>
</table>
There was a total of 126 problems associated with environmental situations, making an average of 2.7 such problems per patient. Certain of these situations were unalterable since they had occurred in the past or were a result of circumstances beyond the control of the patient and the social worker; as, for example, prolonged periods of financial insecurity during the depression, years of heavy farm work, loss of a member of the family in the war, an unsatisfactory school life and disappointment on immigration to Canada. By the time a patient is hospitalized, conditions such as those described above have already exacted their toll on his physical and mental health. Here the social worker may assist him to make these occurrences less harrassing. She is prepared to be a sympathetic listener to his resentment and self-pity at continued deprivation. This may be the first opportunity he has ever had to unburden his troubles. Merely talking about his bitterness may help a patient to rid himself of it. If the social worker is able to help him understand how these hardships and worries have been affecting him he may come to realize that his attacks of stomach pain coincided with strenuous farm labor or that he really has never been happy since leaving his home in Europe and his illness has run parallel to this. He might then find it possible to develop a new philosophy of meeting difficult situations.

Other environmental problems were the result of situations which may be altered, such as, unsuitable employment, debt, confusion over the ways of the adopted country, poor housing or absence of a member of the family in the army. As an example of the problem there is the case of unsuitable employment, where the well-trained mechanic doing unskilled labor on a railway section gang and as a consequence suffering from a sense of
frustration. With encouragement and the active assistance of the social worker he may find work for which he has greater aptitude. Here the social worker is of real value indeed.

1. Problems Associated with Employment

Problems associated with employment were encountered in thirty-four or 64.2% of the patients. The problem faced by the largest group, seventeen in number, was that their work was either too heavy physically or involved more responsibility than they were able to assume. This was particularly noticeable among housewives, fourteen of the twenty-five studied belonging to this category. The other three patients were a farmer and two men engaged in aeronautics. Six patients found the occupations in which they were engaged unsuitable for other reasons such as having been trained for work with more prestige and higher wages, or lacking training and inclination for their work. The amelioration of such situations is of particular importance because the mental and physical strain of dissatisfaction, heavy work, and too much responsibility cause a vicious circle which may go on until the victim finally collapses.

Lack of stable employment during the difficult depression years were found to have an effect on five patients and repeated farm losses through fire, flood, crop failure and poor markets, on seven. These were events of the past and, as such, were unalterable. In these cases however, as mentioned before, it is the job of the social worker to attempt a satisfactory adjustment of the patient’s attitude towards them.

A sense of failure in connection with their work was found to have worried six patients, four of whom felt their military service rejection
intensely. The other two patients who thought they had failed were a clerk who was transferred to a lesser position and a man who was retired after a series of positions each one of decreasing importance.

It is interesting to examine the types of employment of those having occupational difficulties, although the sample is too small to draw any conclusions about the relationship between occupations and problems therein. As is illustrated in the table below, all those who were engaged in aeronautics, domestic service or who were unemployed had problems connected with their work. Five of the six farmers, two of the three clerks, seventeen (68%) of the twenty-five housewives, both of those in aeronautics and the music teacher also fell in this category.

Table 4

The Number and Percentage of Patients with Problems in Each Occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Total number of patients</th>
<th>Patients with problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Housewife</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Student</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Farmer</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Clerk</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Aeronautics</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Railway section-man</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mechanic</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>School teacher</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domestic</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>
2. Problems Associated with Finances

Certain of the problems associated with finances were connected with lack of employment and repeated farm losses, principally the result of the depression years. Of the twenty-three patients having serious past or present financial difficulties, twelve had undergone at least prolonged periods of financial insecurity, and three extreme poverty and hardship. It can quite easily be understood that the patient's present illness is linked to these problems because physical deprivation and mental strain are bound to have an effect on the health and happiness of a patient. It was concluded that this was certainly a factor in the instance of a fifty-nine year old Polish housewife who underwent much hardship in Europe during the first World War. Soon after she and her husband came to Canada to live on a homestead, drought and depression struck and eventually resulted in actual want for this family. This woman began to have stomach pain whenever she worked hard or was faced with additional trouble and a short time before she came into hospital experienced abdominal pain and symptoms simulating a heart attack while she was worrying about a crop failure. These physical manifestations were felt to be a result of her prolonged struggle with difficulties and were diagnosed as reactive depression. (Case 15.)

Only nine patients were deeply concerned with the effect of their illness on their financial situation; six because of the loss of income through illness, and three because of debts incurred for farm machinery and medical treatment. This number is small because the study was made during the war years when there was full employment and good returns
for farm produce. Also, less than half of the patients were bread-winners and six of those were farmers whose families could continue to operate the farm while the man was in hospital.

At this time immediate financial problems were not noticeable with this group of patients, but they can be expected to be more important in ordinary times. Naturally the seriousness of the illness and the length of hospitalization may be expected to influence them to a considerable degree. If there is provision for it in a state or hospital, assistance to the patient with financial problems is in the scope of the medical social worker. This may relieve to some extent the anxiety and physical deprivation which can easily prevent the recovery of a patient from a psychogenic illness. If such help is given by a social worker who is sensitive to the feelings of the person who becomes financially dependent, she can make the acceptance of assistance much less disturbing to him. She is aware, too, of the need to prevent him from becoming overly dependent and bring him gradually to become self-sufficient as soon as his condition permits.

3. Problems Associated with School

Fourteen of the patients had some problems which were a result of their school life. Ten patients had found school either too difficult, or unpleasant for other reasons. Feeling this way, some commenced to avoid regular attendance by frequent illness at an early age. For example, a twenty-six year old man, who was diagnosed as having diabetes mellitus, found school difficult at the early age of six years. He avoided it by being ill. He was sick first, with rheumatism, which was followed by
a series of injuries through accidents, and in his early twenties, hyperglycoemia, and finally diabetes. (Case 19.)

Two of these ten patients who found school difficult were attending high school when they became ill and it was felt by their physician that the worry and strain resulting from this situation were contributing factors to their sickness. One, a sixteen year old boy under considerable tension felt unable to cope with the work and to live up to his parents' wish that he should be a brilliant scholar. Unable to face failure, he began to avoid examinations by being ill and eventually developed duodenal ulcers. (Case 34.) The other patient, a girl of seventeen, was worried and doing poor school work. It was felt that this was not because of innate ability but because of her concern over the home situation. This resulted in truancy, further anxiety, and finally, fainting attacks in school. In addition, she complained of headaches, dizziness and backache. (Case 20.) These are disorders of the central nervous system and are regarded as being expressions of anxiety.

Because of illness, four patients had been forced to leave school permanently and two of them, children with rheumatic heart disease. Two more had been unable to attend school as long as they wished because of the distance from their home to the school and because they were needed to help with work at home. Both felt this lack of education keenly, particularly one who had a responsible civilian position with the Air Force and was professionally and socially in the company of people to whom he felt inferior. Among other factors, this was felt to contribute to the development of this symptoms which were diagnosed as irritable bowel. (Case 46.)

Approximately one-quarter of those studied had problems associated with school, which were as keen as those connected with employment and finances. Where the patient's school life was a thing of the past, the social worker could only attempt to change his attitude to it; where he was still a student, she could do much more. He might be made to understand how he is reacting to the situation, why it is unpleasant for him and what can be changed in it. She might also interpret the student's difficulties to his teachers and parents. For example, in Case 34, where the parents were urging the boy to become a brilliant scholar, an important part of the social worker's task lay in bringing to the realization of the parents that they were setting an impossibly high scholastic standard for the boy and that it would be wiser for him not to concentrate all his energies on his studies.

4. **Problems Associated with War**

As the patients studied were ill during the years 1944, 1945 and 1946, they had certain problems associated with the war which would not have been as numerous or as prominent in peacetime. Sixteen, or about 30% of the patients were troubled by some events brought about by the war. Nine persons were affected by the absence of a member of a family in the services, both through anxiety about him, and the increased responsibility for the home and family. For example, the onset of symptoms of a heart disorder in one patient was thought by the doctor to result from her inability to accept the responsibility of managing the home, and caring for the children after her husband went overseas. This situation, together with anxiety about his safety,
contributed to this illness which provided her with an acceptable reason to request the return of her husband on compassionate grounds. (Case 38.)

The loss of a member of the family as a result of the war was a disturbing factor to four patients. Case 20, for example, describes a young woman suffering from nervous exhaustion which manifest itself in headache, dizziness and fainting. She became noticeably more ill after receiving news of the overseas death of her brother to whom she was closely attached. This also served to arouse still more antagonism toward her father whom she held responsible for the enlistment of this brother.

Three patients expressed concern over relatives living in war zones in Europe, namely, Yugoslavia, Italy and the Ukraine. Although it might be expected that the number of patients with such problems might be a little higher in Alberta, where immigrants from Europe make up such a large percentage of the population, the emergence of such a problem can be anticipated in any part of Canada during wartime.

5. Problems Associated with Immigration

Fourteen of the twenty patients of European descent had difficulties associated with immigration. Eight had difficulty in speaking English and felt themselves to be foreigners. Learning an entirely new way of life, doing work they thought to be menial or mingling with people who were, in their opinion, social inferiors resulted in unhappiness which was felt by the physician to be an important contributory cause to the illness of three patients. One of them was a woman from a wealthy Italian family which had retired in South Africa after living in a rich
farming area in Italy, where the father had been a road building contractor. Leaving this life, she came to Canada and married a homesteader in northern Alberta. She was unable to adjust to the heavy farm work, cold climate and the separation from her parents and developed abdominal and genito-urinary symptoms which have continued for fifteen years. (Case 18.)

Children of immigrants had some problems associated with their adjustment to Canadian life and the resultant conflict with their families' cultural patterns. There were two such patients, both young girls. The Hungarian father of one of them demanded old world servitude and hard work from her which was not in keeping with the freedom allowed her fellow students. This made her self-conscious and fearful of appearing different from them. (Case 42.)

6. Problems Associated with Housing

Problems arising out of poor and overcrowded housing were of significance to six patients. They resulted from the shortage of accommodation rather than the inability to pay for better housing. Two of the patients were living with their husbands' parents and feeling the effect of crowding and strain. The others were living in small, inconvenient suites and rooms.

Since the population of the city where this study was made swelled markedly, with subsequent overcrowding, during the war years, it is at first glance surprising that the number of patients affected was so small. This is explained, however, by the fact that only one half of the patients were city residents. Of the remaining twenty-six patients living
on farms and small towns in Alberta, none spoke of inadequate housing as being one of the problems.

7. Other Problems

Twenty-one patients were bothered by other individual situations and occurrences. Four of them were unhappy because of physical defects, one being lame, the second overweight, the third, short of stature, and the fourth, a 'stammerer'. Other situations disturbing the patients were as follows: change in religious affiliations, sterile marriage, impending legal action, daughter's running away from home, a sister's marriage to a best friend, son's marriage, quarrel with a friend, sister's rape, visit to the city, leaving home for the first time, childbirth, abortion, lack of knowledge about sex relations and reproduction, absence of a husband while he worked evenings, the marriage of a friend, VE Day celebrations, and the observation of a post-mortem. As most of these situations are not remediable, it is with the problems and attitudes which they bring out in the minds of the patients that the social worker would have to deal.
CHAPTER IV

EMOTIONAL PROBLEMS

It appears, from the psychosomatic histories of the Royal Alexandra Hospital that problems of an emotional nature were larger in number than those related to environment. The resultant maladjustments caused fears, anxieties and dissatisfactions which, expressing themselves through the autonomic nervous system, contributed to the dysfunction of certain organs. Everyone has experienced at one time or another the physical manifestations of emotional strain, has had "goose pimples" at a movie "thriller", upset digestion or urinary frequency before examinations, or heart pounding from fright. With psychogenically ill people, the anxiety and fear have been so constant as to have established such symptoms permanently and have even, in prolonged cases, led to actual structural change of certain organs.

The problems arising from the above have been divided, for ease in handling, into the five following groups: those associated with the patients' attitudes to illness, their relationships with other persons, their own state of emotional development, their feelings regarding sex, and those of miscellaneous character.

All the patients had difficulties which could be included in two or more of the above classifications. Seven patients had problems in two groups only but the largest number of patients, (twenty-one) had problems in four. See Table 5.
Table 5

Number of Patients According to the Number of Groups of Problems

<table>
<thead>
<tr>
<th>Number of Patients</th>
<th>Number of Problems per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

The number and percentage of patients having problems associated with each group is shown in the following table.

Table 6

The Number and Percentage of Patients with Problems Associated with Each Group with Emotional Conditions

<table>
<thead>
<tr>
<th>Emotional Conditions</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Attitude to illness</td>
<td>53</td>
</tr>
<tr>
<td>Feelings associated with relationships</td>
<td>52</td>
</tr>
<tr>
<td>Emotional development</td>
<td>47</td>
</tr>
<tr>
<td>Feelings about sex</td>
<td>33</td>
</tr>
<tr>
<td>Miscellaneous feelings</td>
<td>19</td>
</tr>
</tbody>
</table>
The total number of problems associated with emotions among all the patients was 424. The smallest number of difficulties per patient was two, with only one patient having this number. The largest number of emotional problems per patient was thirteen, two patients having this number. The average number of problems associated with emotions was 7.3 per patient. This is an interesting and possibly a significant figure as compared with the average of 2.7 environmental problems found in the previous chapter.

1. Problems Associated with Attitudes towards Illness

Illness itself was naturally a complicating factor for all the patients and a part of the cycle of cause and effect, being the end result of the problems and the source of further difficulties. However, attitudes associated with poor health which the patients had acquired were contributing factors to their present ailments or hindrances to their recovery. These feelings had frequently been built up over many years and sometimes were the result of the patients' own physical reactions in the past or of the disabilities of members of their families. The social worker found that all patients had disturbed thoughts in this regard or very strongly established patterns of reaction to illness. Much of her assistance in such situations lay in the discussion with the patients of what their real feelings were toward illness and how these caused their symptoms and prevented their amelioration.

Each and every one of the patients was perplexed by his misunderstanding and incorrect conception of his illness. Many of them had gone from doctor to doctor, receiving varied and hurried explanations of their disability and numerous kinds of treatment and drugs. In the strange
surroundings of the hospital they had, perhaps, undergone further extensive examinations to be finally told there was no apparent physical cause for their complaint.

In the rush of the complicated system of a modern hospital it is difficult for a physician to find the time to talk over in detail the diagnosis and possible reason for the illness and until they have an opportunity to see the social worker, patients often lie in bed picturing every sort of imaginable horror conjured up by snatches of conversation overheard in the examining room, stories of other patients and of visitors and "old wives tales" heard in childhood. With the guidance of the doctor the social worker is able to explain first, the exact physical findings, then attempt to help the patient see how his various problems and anxieties operate to cause the physical dysfunctions of which he complains. This frequently requires some time as it is necessary for the patient himself to come to the conclusion that his problems were causing physical disturbances, which is difficult for anyone to do.

Thirty-three patients were particularly disturbed by fears of their symptoms and of death. With most of them, it was a case of panic at the onset of such disorders as sudden abdominal pain, heart palpitations or shortness of breath. Several patients disclosed to the social worker that they were terrified that such manifestations might be the result of cancer or heart disease. Sometimes this fear was suggested by the fact that they had seen someone else with such a diagnosis. In case 3, for example, a thirty-eight year old man suffering from abdominal and prostate pain was obsessed by the idea that he might have cancer, partly because a neighbor with similar complaints had died from that illness a short time before.
Closely associated with such reactions to symptoms was the fear of death which was expressed by several patients. In Case 53, which has been mentioned previously, the woman was afraid she would die before she was able to rid herself of her sins.

In some instances the illness was complicated by the patient's resentment at its manifestations or the medical treatment required. For example, the irritating and embarrassing symptoms of pruritus ani and neurodermatitis caused such feeling in the sixty year old mechanic who suffered from it. (Case 14.) In Case 32, the patient, a thirty-five year old housewife complaining of severe backache had undergone a spinal tap as part of the medical examination. Probably because there had been insufficient explanation of the importance and mechanism of the operation before it was carried out, she was extremely upset by it.

Twenty-three patients had damaging attitudes to illness because of prolonged poor health, to which they built up certain resultant reactions. In some cases this was a firmly entrenched pattern of meeting difficult situations by illness. This led to tenacious clinging to their physical disorder in seventeen patients who really did not wish their symptoms removed and consequently were almost untreatable. In Case 8, for example, the social worker felt that the young woman suffering from anorexia nervosa did not wish to have removed the escape which this provided her. She had been unwell most of her life and found more satisfaction in this sheltered situation than in facing life with its uncertainties.

In twenty-five instances, illness or bereavement in the family led to certain disturbing conditions. With some patients the loss of a parent in childhood had naturally affected their personality development and attitude to sickness and death. For example, it was felt that some
of the factors influencing the formation of anorexia nervosa in a seventeen year old girl were her father's repeated digestive disorders and interest in various special diets. The girl was very close to her father so there was naturally some identification with him. (Case 6.) Her disorder, which involved an inability to eat to the extent that she lost an alarming amount of weight was considered to be associated with family concentration on foods and the patient's identification with the father. 7

In another instance, the fact that the patient had seen another person with a partial paralysis had led to her sudden inability to move one side. She was in hospital only two days, the symptom being completely removed the morning following the discussion of her problems and how they contributed to her disability, which was diagnosed as conversion hysteria.

Fear that their illness might effect their family relationships was expressed by three women patients. The twenty-eight year old woman in Case 7, for example, was unduly concerned that her poor health, which caused her to be irritable, would eventually spoil the happy relationship she had with her husband. Part of her psychoneurosis was expressed by a severe pre-menstrual tension which found its outlet in quarrels with her husband and scolding of the children.


Problems disturbing an almost equal number of patients were those which were associated with their relationships with other persons. Fifty-two, or 98.11% of the patients had problems of this kind. Some of these were results of relationships in the past such as with parents in childhood and others were aroused by existing relationships, as between husband and wife.

The five types of relationships in which there were difficulties were those between the patient and his parents, between the patient and spouse, between the patient and siblings, between the patient and his children and between the patient and other persons. The number and percentage of patients having problems associated with each type of relationship is indicated in the following table.

<table>
<thead>
<tr>
<th>Type of Relationship</th>
<th>Number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient and parents</td>
<td>46</td>
<td>86.7</td>
</tr>
<tr>
<td>b. Patient and spouse</td>
<td>18</td>
<td>33.9</td>
</tr>
<tr>
<td>c. Patient and siblings</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>d. Patient and children</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>e. Patient and others</td>
<td>8</td>
<td>15.1</td>
</tr>
</tbody>
</table>
a. Relationship with Parents.

Forty-six patients had problems resulting from unsatisfactory relationships with parents. It is understandable that this group was large because of the tremendous influence of the child-parent bond on subsequent personality development. Where this was faulty, as with those patients whose maladjustment found its expression in psychogenic illness, it is natural to find a high proportion (86.7%) of them who had a poor relationship. The most frequent complaint the patients made to the social worker was that they were not wanted or loved by one or both parents. This rejection made them antagonistic to their parents, and guilty and anxious about that feeling which they could not express. The anxiety, together with other problems they had, appeared in many cases to contribute to the formation of physical symptoms.

Case 35 is an example of a lack of parental affection and its results. Mrs. M. was a thirty seven year old housewife with three children, living in a lumber camp where she cooked for her husband's twenty-five employees. She was one of five children, repeating often that she was an "unwanted child" rejected by all the family. At the age of fifteen years she was forced by her family to marry a man much older than herself in order that they might be rid of her. She said that her husband had attempted to kill her several times, which, she felt, did not worry her parents. However, she finally divorced him and married a man of her own choice. She had had almost a lifetime of illness, somewhat exaggerated by her, as the hospital records did not always agree with her statements. During the present hospitalization she
complained of arthritis in all the joints, diagnosed as a "psychoneurotic state".

Recently much has been written in medical literature of the importance of emotional factors in the development of arthritic symptoms. Dr. James L. Halliday states that psychoneurotics often develop a symptom complex of aches, pains, and stiffness and that the nature of the problem cannot be properly understood without psychological investigation to supplement the physical findings. He says that people with "psychoneurotic rheumatism" are sore and stiff symbolically, as they are "sore" about things and "stiff" with aggression turned inward. Mrs. M's stiffness and soreness appeared to have developed in such a way.

When parental rejection was accompanied by discord between the mother and father, further conflict was aroused because of the division of loyalty to both parents. The following case is given as an illustration of the effect of such a situation. Frances was an eight year old girl hospitalized for rheumatic heart disease. She was the eldest of three children born in quick succession during the depression years. There was much discord between the parents which resulted in the mother planning to divorce the father on his return from overseas. She never had wanted Frances, and alternately spoiled and scolded the child. When the child was removed from this tense situation and placed in a foster home, her physical condition improved but deteriorated whenever the child went home for weekends.

Situations where the patients felt their parents had been strict rather than rejecting were frequent. For example, Case 24 describes a thirty-nine year old woman patient who had grown up in a highly religious and rigid home atmosphere. As a result, she overstressed the value of "goodness" and gentility, and when she was faced with unpleasant responsibilities she expressed her revulsion by developing diarrhea.

In some cases the patients remained too strongly attached to a parent of the opposite sex. This hindered them from reaching emotional maturity and independence. Sometimes this was accompanied by a desire to be like that parent and this further hindered their functioning in the role of their own sex. A 30 year old woman patient, who was very attached to her father, had considerable conflict between acting like a boy, to please her father, or a domesticated daughter, to please her mother. This led to physical disturbances which prevented her from functioning adequately as a wife and mother. (Case 52.)

Some patients tried to rid themselves of this too strong tie by running away from home at an early age. Case 17 describes a sixty-five year old man who in youth had run away from home and, as a consequence, was experiencing a feeling of guilt which was a part of his symptoms of involutional melancholia.

b. Relationship with Spouse.

Eighteen patients (33.9%) had problems associated with their relationship with their husband or wife. It is interesting to note that fourteen of them also had poor relationships with their parents, making
.78 the coefficient of correlation between the incidence of marital problems and poor relations with parents in childhood.

Fear of losing the affection of the marital partner was expressed by several patients. A man emotionally upset when his wife became friendly with other men developed ulcer symptoms. As he was not sure of her affection for him he became fearful of losing her altogether. His symptoms were similar to those he had had at the time of his divorce from his first wife. (Case 4.)

Quarrels, lack of understanding and resentment toward the husband or wife were the bulk of the problems of the patients in this category. An example of such a condition was that of a thirty-eight year old man, (Case 3), who resented what he felt to be his wife's exploitation of him and her failure to give him emotional support he needed for his inward security. His resentment was further intensified by the fact that she was more sexually demanding than he. As a result of his anxiety he suffered from abdominal and prostate pain.

In Case 25, a woman patient was irked by her husband's inefficiency in his work while she herself was very quick and meticulous. This irritation no doubt contributed to the development of mucous colitis, from which she suffered.

c. Relationship between Patient and Siblings

Fourteen patients had problems associated with their relationship with their siblings. The disturbing feelings of antagonism and jealousy conflicted with those of affection toward the sibling. For example, a forty-one year old woman patient spoke of much antagonism toward a sister
who was the favourite of the family and was more beautiful than she. Even when this sister was fatally injured and her death mourned by all the family, she felt jealous of the attention paid her. Also, less robust than her brothers and sisters, the patient remembered the teasing and ridicule to which they had subjected her. (Case 5.)

Another patient noticed that the onset of her symptoms usually coincided with the arrival of her sister from another city. She was envious of this sister's carefree life and resentful of her sister's intolerant attitude to her illness, which consisted of severe headaches, fainting spells, fatigue and backache. (Case 32.)

d. **Relationship with Children.**

Feelings about relationship with their children caused difficulties for fourteen patients. Most of these feelings were associated with the parents' rejection of their children. This basic rejection aroused anxiety and conflict between the real attitude toward the child and the sense that they should have more affection toward it. Fear, resulting from a lack of knowledge about the care of their children, disturbed several mothers. For example, a forty year old woman patient with a three year old daughter, born after many years of marriage, had ambivalent feelings toward the child, based on the fact that she had never wanted to have a child. The anxiety reaction manifested itself in backache and ringing in the left ear. (Case 26.) In Case 11, a young woman of eighteen was disturbed because she had ambivalent feelings toward her child and felt she lacked sufficient knowledge about the care of it.
With some patients, it was an over-attachment to their child which caused their difficulties. For example, a woman’s feeling that her daughter should stay with her and had no right to a life of her own, resulted in emotional disturbance and finally illness when the girl ran away from home. (Case 42.) In Case 15, a woman patient was very upset by the oncoming marriage of her son, to whom she was overly attached. Shortly after he told her of his plans she developed symptoms simulating a heart attack which had no organic basis.

e. Relationship with Other Persons

Eight patients had problems associated with their relationship with other persons. Five of them had difficulty in establishing a close relationship with anyone and for the most part were lonely and without friends. A thirty-nine year old farmer who lived alone was unable to relate to others and had almost no friends. He had half-heartedly advertised for a wife in a newspaper and was unsuccessful in his endeavour. (Case 47.)

An inability to relate to members of the opposite sex caused problems to three patients. In Case 6, for instance, the patient, a seventeen year old girl, was unable to establish normal relationships with boys her own age. This feeling toward members of the opposite sex was one of her many problems which led to the anorexia nervosa from which she suffered.
3. Problems Associated with the Patients' Emotional Development.

The term "emotional development" is used here to denote the usual attitudes, feeling tone and reaction patterns of a patient. These patterns are a result of the sum total of the person's environmental and hereditary influence. Many problems among the individuals referred to the social worker at the Royal Alexandra Hospital were associated with the degree of the patient's emotional growth.

Forty-seven patients (88.7%) had problems associated with their emotional development. Since this is a part of all the disturbing factors in the patient's life it is interesting to examine the correlation. Forty of the forty-seven patients having inadequacies in their emotional development also had difficulties associated with their relationships to their parents. Thus, in this group of patients, the coefficient of correlation between poor relationships with parents and disturbing emotional development is .85. The coefficient of correlation between faulty emotional development and unhappy relationship with the marital partner is .89.

The largest number of patients had difficulties associated with their feelings of insecurity, guilt and inadequacy. A sense of dependency, resentment and inability to assume responsibility aroused anxiety in a smaller number of patients. The number of patients having problems associated with various emotional conditions are given in the table which follows.
Table 8

The Number of Patients Having Problems Associated with Various Emotional Conditions

<table>
<thead>
<tr>
<th>Emotional Conditions</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Insecurity</td>
<td>16</td>
</tr>
<tr>
<td>b. Guilt</td>
<td>15</td>
</tr>
<tr>
<td>c. Inadequacy</td>
<td>12</td>
</tr>
<tr>
<td>d. Dependency</td>
<td>11</td>
</tr>
<tr>
<td>e. Resentment</td>
<td>8</td>
</tr>
<tr>
<td>f. Inability to assume responsibility</td>
<td>8</td>
</tr>
<tr>
<td>g. Perfectionist tendencies</td>
<td>7</td>
</tr>
<tr>
<td>h. Over-conscientiousness</td>
<td>6</td>
</tr>
<tr>
<td>i. Emotional immaturity</td>
<td>6</td>
</tr>
<tr>
<td>j. Emotional flattening</td>
<td>6</td>
</tr>
<tr>
<td>k. Feeling against authority</td>
<td>4</td>
</tr>
<tr>
<td>l. Emotional rigidity</td>
<td>4</td>
</tr>
<tr>
<td>m. Meticulousness</td>
<td>4</td>
</tr>
<tr>
<td>n. Aggression</td>
<td>3</td>
</tr>
<tr>
<td>Total problems</td>
<td>110</td>
</tr>
</tbody>
</table>
Many of the above feelings are experienced in varying degrees by everyone. It is only when they become too acute, numerous and disturbing to the person's normal functioning in society that they become problems. They may then result in anxiety and physical dysfunction over which the patient has no control.

a. Insecurity

The term "insecurity" is used here to denote the patient's feeling of unsureness, particularly in relation to the esteem and affection held for him by others. Fifteen patients had problems arising from this source. A forty-one year old man had symptoms which were associated with his extreme fear of losing his wife, this fear growing out of his own feeling of insecurity. (Case 4). Another patient, a thirty year old woman, was very unsure of her husband's affection for her because of her own insecurity. This feeling was actually a carry-over from her unsureness in regard to her parents' affection for her, and was a contributing factor to her psychoneurotic anxiety state which expressed itself in nervousness, dizziness and fainting. (Case 22).

b. Guilt

Guilt feelings are those which make the person uncomfortable because he feels he has done wrong, either in thought or action. Fifteen patients discussed such feelings with the social worker. Most of them were associated with their attitude toward other persons, religious beliefs or sex behaviour. In Case 25, for example, a twenty-nine year old housewife had not been loved by her mother as a child. For this reason she experienced much guilty resentment toward the mother and her expression of this resulted in mucous colitis. Another woman patient's chief worry was
her feeling that she had sinned against the teachings of her church by using contraceptives. Her illness she considered to be a punishment for her sins, perhaps to be followed by death and eternal damnation. (Case 53).

An example of guilt associated with sexual behaviour was that of a nineteen year old boy who was anxious over masturbation, imagining that indulgence in it would lead to impotence. This was associated with a speech blocking which he referred to as "speech impotence." (Case 31).

c. Inadequacy

Although a sense of inadequacy is often associated with emotional insecurity, it is used here as a feeling of inability to cope with some particular task. Some of this may be real, as in the case of a person lacking aptitude and training for a job; some of it may be imaginary, particularly where it is the result of inward insecurity and lack of confidence. For example, a man employed as a civilian flying instructor felt that he was not able to do the job properly. This was further intensified by the fact that he lacked the formal education of his associates. His anxiety state was expressed in dizziness and headache, diagnosed as hyperventilation. (Case 50).

Case 48 illustrates the situation of inner insecurity engendering a sense of inadequacy. The patient, a young woman of twenty-eight, felt unable to cope adequately with the care of her home and family. Prior to her marriage, she was employed in a store where she suffered from the fear of making errors. When under pressure she suffered from palpitation, dyspnoea and numbness of the hands and wrists.
d. **Dependency**

Dependency leads to problems in a patient when it is so strong that it hinders his normal functioning as a self-sufficient person or arouses strong conflicts through his desire to be free of the bond. Eleven patients had such difficulties. In Case 39, for example, a twenty-one year old girl was overly-dependent on her family. As a result, she was very disturbed when she left home to take a position in another city and subsequently became ill, complaining of vision blur, nausea and headache. In another patient, a sixteen year old high school boy, the conflict was between his dependence on his parents and the need to assert himself as an independent adult. This contributed to the development of his duodenal ulcer symptoms. (Case 34).

e. **Resentment**

By the term "resentment" we mean feelings of antagonism, whether expressed or not, and some of the problems studied here stemmed from the inability of the patient to express his resentment toward persons or situations. There were eight such cases. One individual had suffered much through his own illness and those of his family. He had worked extremely hard on his farm and lost much through drought, crop failure and fire. He was resentful of a fate which had exposed him to such hardship but instead of expressing this feeling, he kept it within himself for years with a resulting martyr-like attitude to life culminating in bronchial asthma and gastric ulcers. (Case 27).
f. Inability to Assume Responsibility

The inability to assume a large amount of responsibility in regard to work or actions was a disturbing factor to eight patients. This was a source of worry to one young farmer who had grown up without having to shoulder responsibility for any of his actions. He married a girl who had become pregnant by him before marriage. When he became badly in debt on the farm which his parents had given him, he deserted his wife and family suddenly and remained away for several months. Troubled by the feeling that he would never be able to assume adequately the responsibilities expected of him, he suffered from abdominal pain similar to ulcer symptoms.

g. Perfectionist Tendencies

In this paper the term, "perfectionist tendencies" is used to denote that feeling which makes a person demand of himself and others an unattainable standard of performance and behaviour. The struggle for such perfection resulted in problems for seven patients. For example, an elderly man wanted to have everything in life clean and orderly. Employed for a time as a hotel detective, he was disturbed by the conduct of many of the hotel guests, and began to suffer from irritable bowel symptoms about this time. (Case 28)

h. Over-conscientiousness

Persons whose conscience, or sense of duty, drove them to do, chiefly for others, more than was normally expected of them are classed here as being "over-conscientious." This is closely related to the perfectionist
tendencies already described. Six patients had problems as a result of this striving. Case 7 is an example. The patient, a young woman of a warm and affectionate nature, became extremely upset when she was unable to meet the material or emotional needs of others. She suffered from menstrual disorders, palpitation, weakness, dyspnoea and vision blur as a consequence.

i. Emotional Immaturity

Emotional immaturity includes feelings of over-dependence, insecurity, inability to assume responsibility, to relate to persons of the opposite sex, to work under persons in authority and all those feelings which hinder the person's functioning as a balanced adult. Most of the patients had some of these difficulties, which are actually indications of degrees of emotional immaturity. However, it was not until they appeared to have almost all the symptoms of immaturity that they were included in this group. There were six such patients. One was a woman of twenty-one years. She became very unhappy and ill when she left her parents to move, together with her husband and child, to another city. She was very dependent, insecure, unable to assume responsibility for the care of her child and to have satisfactory sexual relations with her husband. Her condition was diagnosed as a chronic anxiety state which found expression in abdominal pain, headaches, dizzy spells, dysmenorrhia and dyspareunia. (Case 43).

j. Emotional Flattening

The term "emotional flattening" is used here to indicate the inability to show an emotional response where it would ordinarily be expected. Sometimes this is the result of fear of being hurt through responding
emotionally. An extreme reaction of this sort is associated with a schizoid personality.

There were six patients with varying degrees of emotional flattening. One of them, for example, was a bachelor of thirty-nine who came to Canada alone. He lacked the ability to relate in a friendly manner to others and showed no feeling when talking of his friends, his work of his family in Europe. Because of his inability to respond to anyone the social worker was unable to help this man. (Case 47).

k. Feeling Against Authority

The feeling of resentment toward persons in authority and the inability to accept instructions from such persons was found to cause difficulty for four patients. This attitude toward authority was, in most cases, in conflict with the patients' needs for dependence. For instance, an elderly man exhibited this attitude to a marked degree with regard to the government, the doctors and his employers. At the same time he was rather dependent and needed someone to lean on. (Case 40). Such feelings are described by Flanders Dunbar to be a part of the personality pattern of the diabetic patient.

1. Emotional Rigidity

An inability to have any depth of feeling toward anyone or anything

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is the interpretation given here to "emotional rigidity." There were four patients with problems of this sort. For example, in Case 45 as a result of emotional rigidity, a sixty-one-year spinster had few friends and was unable to relate to people. It further contributed to her arthritic symptoms which were an expression of her tension. She was akin to the type of person Halliday describes as likely to develop the symptoms - emotionally restricted, set in his or her ways and ideas and with a high sense of duty.

m. Meticulousness

A very strong need for neatness and order in their surroundings resulted in anxiety for four patients. One of them was a fifty-seven year old housewife whose meticulousness in regard to the details of her surroundings drove her to fear of involuntary soiling while she suffered from mucous colitis. Associated with her neurotic desire for cleanliness was her attitude toward sex, which she considered degrading. (Case 1.)

n. Aggression

A markedly disturbing amount of overt hostility in a patient is referred to her as "aggression." There were three patients with pronounced feelings of this sort. One particularly aggressive farmer of thirty-eight, who was also very impulsive, had, in the past, been quick to engage in fights. At the time of his hospitalisation for abdominal pain he was

remorseful over having severely beaten an Indian. (Case 3).

4. Problems Associated with the Patients' Feelings about Sex

The feelings of a person with regard to sex are related to his emotional development. These feelings are discussed in a separate section, however, because of the large number of patients having a conflict in regard to sexual matters. A total of thirty-three patients had problems in this field.

Twenty-nine of the patients had what was classified as a "sex conflict," which means the existence of a problem in connection with his functioning in the role of an adult person of his own sex. This was expressed in impotence, frigidity, dyspareunia and other maladjustments in sexual relations. Case 29 illustrates such a situation. The patient was a thirty-eight year old housewife who was shy and immature in discussing sexual matters. She was frigid and used malaise as an excuse to avoid sexual relations. It was felt that her complaints of headache and pains were the result of this conflict.

A further example is that of a middle-aged man who was psychogenically impotent and had a deep sex conflict. He had outstanding physical strength and was very disturbed by his lack of sexual prowess. He suffered from prostate and abdominal pain. (Case 29.) Another patient, a forty-five year old woman, during twenty years of marriage, vomitted after each act of intercourse. This reaction regarded as symbolic of feelings of revulsion felt by the patient.

In a few cases there seemed to be sexual conflict in the patient because of his complete repression in matters pertaining to sex. (Case 47, which was mentioned previously, illustrates this. The patient was a man of thirty-nine who showed considerable emotional flattening and appeared to have repressed everything to do with sex.

Some of the patients' conflicts were centred around the use of contraceptives. For example, a thirty-nine year old woman who stressed her wishes for "gentility" and ladylike things was very upset over the use of contraceptives, considering them "not nice." (Case 24).

Ten patients' problems were associated with their fear of pregnancy. The patient in Case 43, for example, was so fearful of pregnancy that she avoided sexual intercourse altogether. This fear of conception was an expression of her sexual immaturity which was a part of the emotional immaturity discussed in Section 3.

There were two patients who told the social worker they were disturbed by the conflict between their religious teachings and the use of contraceptives. Case 26 illustrates this situation. The patient was a forty year old woman who felt guilty because she had practised a form of contraception against the teachings of her church. Being very fearful of child-bearing, she was frigid and complained of backache, which was diagnosed as anxiety state.

5. Problems Associated with Other Feelings

Nineteen patients had problems associated with other feelings, none of which were of primary importance to the patients or in the development of their symptoms. Six patients were very lonely. Ten had fears of such things as wind, thunderstorms, loud noises, water and ridicule. One of
the others felt unwanted by her husband's family, another was very worried about her mother's health and another was upset because so few souls were saved to go to Heaven.
The analysis of the problems of this relatively small group of patients has brought to light several outstanding features, which, it is felt, may also appear among other hospital patients with psychogenic illness. These features are brought out in the summarizing table in Appendix B. In examining this table, a particularly significant fact is that all the patients lacked an understanding of their illness. Linked closely with this were the fears, associated with illness, expressed by 62.27\%, and destructive attitudes resulting from previous illness expressed by 43.39\%. These facts alone indicate the urgent need for a skilled social worker to discuss with sick people their diagnosis, treatment and the factors contributing to their symptom formation. This is required not only by those with psychogenic illness, but by all hospital patients who do not have a clear conception of their diagnosis and medical treatment.

Poor relationships with parents, the second item in the table, was revealed by all but 14\% of the patients. About 86\% complained of this. Nothing could point more clearly to the necessity of assisting parents to give their children the affectional security so essential to their development into adequately functioning adults. Without this, like these patients, it is possible that they will develop into ailing psychoneurotics who find their satisfaction and escape in aches, pains and dysfunctions. When they are in hospital, disabled by the manifestations of their malad-
justment, they cannot recover until their anxiety has appreciably diminished. Here there is need for a skilled social worker to deal with the maladjustments herself, or point out the need for psychiatric treatment. The need for assistance is further indicated by the large proportion of patients having poor relationships with their marital partner, and the still larger proportion (over half) of patients with a sex conflict.

The large aggregate of patient-problems (550) in this group of fifty-three patients again demonstrates the indispensability of social treatment for hospitalized persons. Since all such problems are felt to be causes contributing to psychogenic illness, the patients cannot fully recover until the difficulties are solved in a satisfactory manner. If the anxieties are not recognized or resolved and the patient is told by the doctor that there is nothing organically wrong with him — that his illness is "just nerves", and he had better stop worrying — he is left with no alternative but to go from doctor to doctor in search of an answer. The numbers of such patients are large, some doctors estimating them to be one half of their total clientele. It seems reasonable to believe that the maintenance of social service departments in hospitals would be a financial economy to the patient and the community at large, shortening the period of hospitalization and reducing income loss.

Although many of the patients with these types of problems may be helped by social work treatment in a hospital, there are many who will also require occasional after-discharge help when they are confronted with difficulties. This makes apparent the need for social agencies which give such services. In many instances, they could assist in preventing the recurrence of the patient's breakdown and hospitalization.
When a person has developed the physical symptoms of a psychogenic disorder, his emotional difficulties are already acute. Intensive remedial therapy is then necessary. But if his emotional maladjustment can be diagnosed and treated, on a preventive level, before the crisis has developed, not only can the patient be spared unnecessary mental and physical suffering, but an economy in case work services can be effected. These preventive services should begin in childhood before the seeds of future disturbances have sprouted. With this end in view, the importance of adequate child welfare and family case work services in the community cannot be over-stressed.

Although an awareness of the inter-relation of social problems and physical health is growing among the medical profession and the general public, it is the duty of medical social workers to quicken that awareness through their community contacts and educational programs. As the overwhelming consequence and costs of ignoring the problems which result in illness are grasped by the general public, there is bound to be a demand for more family and medical casework services in the community. With the increasing number of social workers being trained in both fields there is reasonable assurance that this need can be met.
APPENDIX A

Psychosomatic History

Social Service Notes: Re: Mr. M.B. Age 41
(Address)

Service of Dr. S.
Referred: July 5, 1946.

Mr. B. was admitted to Hospital 28/6/46 suffering from pains suggestive of stomach ulcers. Medical findings, including x-ray, were negative for organic damage, and he was referred to social service for psychosomatic history, and assistance with social and emotional problems upsetting him.

History:

Mr. B. was born in Hungary, (a part which then became Jugoslavia, and then later was incorporated into Roumania) in 1905. He has told me nothing of childhood, but he gives the impression of having had good education and other opportunities of the more privileged classes in that country. His father died of gas poisoning in the First Great War, and his mother of some gynecological condition, when she was 48. He has 1 brother and 3 sisters alive, and fairly well, as far as he knows. They were in the old country during the past War, and suffered acutely. The brother, he understands from the guarded communication he has had within the last month or so, was in a concentration camp, as were also some of his other relatives, and his wife's aunt and her Jewish husband. He has worried considerably about them, during the years of silence, when unable to get word of them, but is greatly relieved to know that they are still alive and well, since he has had letters from them all during the last couple of months. It was not possible to judge the emotional relationship with these siblings in our limited conversation about them.
The patient came to Canada in 1928, at 23 years, — a step for which he gave me no reasons. He did farm work for about one month, did not like it, and began wandering in search of more congenial work. He got a job as section labourer with a railway company and did very well for the first couple of years, but with the depression, work became more and more irregular. He married in 1932, and shortly after lost his regular job. There were constant fights over finances with the necessarily reduced income, and his wife did not seem to be able to adjust herself to this reduction. It was in 1932 that we have record of his first illness. He was in Hospital for appendectomy and adhesions to intestines. He was well for some months following surgery but in 1933-4 had symptoms diagnosed as duodenal ulcers, and was told by Dr. S. that this was a result of anxiety. He was not willing to believe that such real pain could result from worry, and went down to Mayo Clinic, where a diagnosis of 'nervous indigestion' was given, but no explanation of how 'nerves' could cause such pain and disability. His symptoms seem to have commenced about the time his wife became pregnant of the child, a son, born in 1934. He was not earning much, and was worried about the added expenses and lessened income, and his wife became more and more demanding. There were frequent fights, and the year following the birth of the child she began to go out occasionally with other men. He secured a divorce (I think in 1936 or 37) on grounds of adultery, he retaining custody of the child, whom he placed in a foster home. He had difficulty financing the divorce, foster home charges, and trying to pay on medical and hospital bills, but nevertheless managed to save enough for a trip back to Jugoslavia in the spring of 1939.

While back among his own people he met and married his present wife,
15 years younger than he. She was the niece of some friends, living
with them and caring for a youngster about the age of his son, and he
felt she would make an admirable substitute mother for the child, then
5 years old. They were married rather hurriedly as they had been
warned by the British Consul to get out of the country immediately, and
just got out before the outbreak of the war. Communication with both
his relatives and hers was cut off almost immediately, and she, who had
grown up in a large city, among relatives and in comparatively cultured
surroundings, found herself in a small Alberta mining town, married to an
intelligent but rather domineering man many years her senior, with a ready-
made family of one for her to look after. She and the youngster, now 12,
get along smoothly and seem fond of each other. Mr. B. says she has been
an excellent mother, and very good housekeeper. He also says "she is not
dumb. She learned English very quickly and learns other languages just as
easily", and she seems to be well liked in their community.

He feels, I think, that she is too well liked, and that she likes
everyone and is too friendly. She loves music and dancing, and wants to
go to every party in the town. She also wants pretty clothes and other
expensive frivolities, and for everything she wants, she won't take no
for an answer, but coaxes and cajoles until her husband finally gives in,
hating himself for being such a weakling, knowing that he is making a
mistake, but unable to put up with her wheedling. He does not like to go
to some of the 'rough parties' at the local dance hall, but goes with her
once or twice a month, while she wants to go frequently. He resents seeing
her dance with some of the tough customers there, and is extremely jealous
of her popularity among the group in town which he does not approve. He
says "she comes of good family, and should not enjoy being with such
people. There are only half a dozen families in the town fit for us to
associate with". He is still just a section worker on the railroad, but does not like to have to associate socially with his fellow workers, and thinks himself above them.

After considerable digging, the patient finally admitted to me (and to himself) that his present symptoms began when his wife went off for the week-end to Lake View with another girl of questionable reputation, and some sailors. He tried to think it just a girlish prank, a mistake in judgment and discretion that could be overlooked, but others began to talk and say "Oh, if I were her husband, I'd just throw her out". She said she was sorry, and wheedled him into forgiveness, but, he says, "If she says she is sorry, why doesn't she act it? Why does she have to continue to want to go out, and dance, and have good times? Perhaps I'm not good enough for her, eh?" There has been no repetition of the week-end, but he lives in daily terror of something happening which will force him again, in order to save his pride, to break up his home. He does not want to do this, and frets continually about how he can force her to his way of life, without making her kick over the traces completely. To some extent, I felt that his illness actually had a purpose in it, as a weapon to bring her to heel.

The similarity to the picture of about 10 years ago, when he had ulcer symptoms first, and when he was worried about his first wife's infidelity - which she blamed on her desire to have a good time which he could not then afford to give her because of irregularity of employment - has been heightened by the fact that he has been unemployed now for about 5 months, a result of an accident in which he hurt his right arm and shoulder. While he recounted the story of his treatment, prolonged convalescence, and the puzzlement of the doctors that his arm did not
respond to treatment, I felt that again his non-recovery perhaps had a purpose, even if almost unconscious. While he was in hospital his stomach symptoms cleared up, except for flare-ups when his wife came to visit him and did not arrive at the exact moment specified. I believe he was also on compensation, as long as the arm incapacitated him. But compensation is not equal to earnings, and his wife began to complain of their reduced income, and the things she could not have, and his old conflict of whether to say all the things he wanted to say to her, and run the risk of losing her, or to bottle them up, and lose his own self respect, and the respect of the community for letting her get away with things, again became acute. I have advised him to get back to work as soon as possible, to lessen the financial strain, and get him busy so that he will not be hanging around home all day, building up a wall of little resentments to add to his present oversupply.

Mr. B. asked me to see his wife and explain to her, as I had to him, the cause of his symptoms. He also wanted me to tell her that she must not annoy him so that he would not have to develop real ulcers. I said that I would be glad to see his wife, and try to get her side of the picture, so that it might be possible to help them towards better mutual understanding and co-operation. He wired her, asking her to come into town, but then did not tell her to keep the appointment made with this department. I felt that he had lost his courage, for fear she presented too unfavorable opinion of him to us, and that he could not face that possibility. He blamed this failure to keep the appointment on our department, at first, although we had no way of seeing her unless he gave her word of the appointment, but was later able to see something of why this occurred. He has never been able to accept blame himself readily
and finds it hard to believe that it is often more painful to have resentment poison your system, than to admit yourself in error.

Mr. B. has a deep lying feeling of inferiority and insecurity which has made him a bit aggressive, impulsive, and belligerent. He has, however, an underlying sense of justice and the ability to see other people's point of view if this is explained sufficiently objectively to rouse his interest, without immediate emotional blocking. It is not going to be easy for him to change his way of meeting life, but his intelligence has accepted the cause of most of his difficulties, and he is willing to attempt the change. He has dogged determination in his make-up, and it is possible that in our interviews he got enough insight into himself and his problems to help him for some time to come. I wish it had been possible to talk with his wife, as that might have been of value both to her and to him.

(Signed)

9/7/46.
### Table 9. The number and percentage of patients with each problem

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of understanding of the illness</td>
<td>53</td>
<td>100</td>
</tr>
<tr>
<td>2. Relationship with parents</td>
<td>46</td>
<td>86.66</td>
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<tr>
<td>3. Fears associated with illness</td>
<td>33</td>
<td>62.27</td>
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<tr>
<td>4. Sex conflict</td>
<td>29</td>
<td>56.60</td>
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<tr>
<td>5. Illness or death in the family</td>
<td>25</td>
<td>47.17</td>
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<tr>
<td>6. Attitudes from previous illness</td>
<td>23</td>
<td>43.39</td>
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<tr>
<td>7. Miscellaneous situations</td>
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<td>47.52</td>
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<td>8. Miscellaneous feelings</td>
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<td>35.81</td>
</tr>
<tr>
<td>9. Relationship with marital partner</td>
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<td>33.96</td>
</tr>
<tr>
<td>10. Too heavy and responsible work</td>
<td>17</td>
<td>32.07</td>
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<tr>
<td>11. Emotional insecurity</td>
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<td>30.19</td>
</tr>
<tr>
<td>12. Guilt</td>
<td>15</td>
<td>28.50</td>
</tr>
<tr>
<td>13. Relationship with siblings</td>
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<td>26.41</td>
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<tr>
<td>14. Relationship with children</td>
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<td>26.41</td>
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<tr>
<td>15. Sense of inadequacy</td>
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<td>22.64</td>
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<td>16. Prolonged financial insecurity</td>
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<td>22.64</td>
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<tr>
<td>17. Immigration</td>
<td>11</td>
<td>20.75</td>
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<tr>
<td>18. Emotional dependency</td>
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<td>20.75</td>
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<td>19. Difficult school life</td>
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<td>18.87</td>
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<tr>
<td>20. Fear of pregnancy</td>
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<tr>
<td>21. Absence of family member in war</td>
<td>9</td>
<td>16.98</td>
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<tr>
<td>22. Feeling of resentment</td>
<td>8</td>
<td>15.09</td>
</tr>
<tr>
<td>23. Inability to assume responsibility</td>
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<td>15.09</td>
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<td>24. Relationship with other persons</td>
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<td>25. Perfectionist tendencies</td>
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<td>13.21</td>
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<td>26. Repeated farm losses</td>
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<td>13.21</td>
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<td>27. Income loss through illness</td>
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<td>28. Unsuitable employment</td>
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<td>29. Failure in employment</td>
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<td>30. Poor and overcrowded housing</td>
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<td>31. Over-consciousiousness</td>
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<td>32. Emotional immaturity</td>
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<td>33. Emotional flattening</td>
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<td>34. Lack of stable employment</td>
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<td>35. Illness interfered with school attendance</td>
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<td>36. Loss in war</td>
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<td>7.54</td>
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<td>37. Feelings against authority</td>
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<tr>
<td>38. Emotional rigidity</td>
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<td>39. Meticulousness</td>
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<td>40. Debt</td>
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<td>41. Relatives in war zones</td>
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<td>42. Fear of illness affecting relationship</td>
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<td>5.56</td>
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<td>43. Aggression</td>
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<td>5.56</td>
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<td>44. Children of immigrants</td>
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<td>45. Sudden income loss</td>
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<td>46. Religious teaching vs. contraception</td>
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