Order Number 9119678

Fathers of schizophrenic sons: A psychological portrait

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City University of New York, 1991

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FATHERS OF SCHIZOPHRENIC SONS:

A PSYCHOLOGICAL PORTRAIT

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, the City University of New York.

1991

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Jan 31, 1991
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Abstract

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by

Irwin Allen Schatz

Adviser: Professor Louis J. Gerstman

Because little is known about the fathers of schizophrenics, I decided to study them in order to determine whether they show consistent personality patterns or family roles. I wanted to know whether they play a part in the pathogenesis of their children's schizophrenia.

I selected 15 middle class, working fathers of schizophrenic sons who were interviewed to collect data regarding their personality and family roles. The fathers were all from intact families. The fathers ranged in age from 42 to 59 years and were from a variety of religious and racial backgrounds.

During several pilot interviews it was observed that the fathers' avoidant styles made a direct interpersonal interview arduously long. It was decided to obtain the desired data through the use of a computerized interview.

The instrument used was the Giannetti On-Line Psychosocial History (GOLPH), a Response-Contingent Data Acquisition and Reporting program that collects data in nine areas of a person's psychosocial past and present.

These fathers had a traumatic childhood and adolescent experiences that led them, as youngsters, to adopt avoidant styles of interacting with their world. They also avoid their wives physically, emotionally and sexually, and have shown little interest in their schizophrenic sons and child rearing in general. They are loners who often have no friends.

Despite the somewhat restricted sample, I concluded that they experience a life style that meets the criteria for the diagnosis of schizoid personality (DSM III-R). They also manifest a passive manipulative style that enables them to avoid interpersonal contacts. They covertly manipulate their wives, sons, and others. These fathers play a role that has not previously been described by those authors who have focused on the so-called schizophrenogenic mother.

Further research is indicated to confirm these findings in a wider sample of schizophrenic children. Among the suggestions for future work are treatment stratagems for the family of the schizophrenic that focus on the father of the schizophrenic and put less treatment emphasis on the schizophrenic and the schizophrenic's mother.

Dedication

This work is dedicated to Professor Louis J. Gerstman without whose guidance this dissertation would not have been finished.

From the beginning to its completion, I received his support, encouragement, inspiration, and wisdom. He believed in me even when I didn't.

First he was my teacher and then my friend. Lou Gerstman is what a mentor should be. He is in every way a true "mensch."

ACKNOWLEDGEMENTS

In the process of earning a doctorate in clinical psychology, one begins to feel like a lonely runner. However, in reality, I was running in a crowd, surrounded by people whom I love and who love me. Some old and dear friends and family, and some new friends who joined the run in the last mile, and supported me over the finish line. I will always be nurtured by my memories of their generous support, endless loyalty, and unconditional love. I would like to take the time and space to thank them.

Robert Wesner.--A friend who evolved to be my brother. Bob and I go back a long way, since 1971. Together we laugh, diet, walk, share, and sometimes cry. During many walks around the Central Park Reservoir, Bob continually encouraged my work and often helped me shape my ideas; he's so exceptionally bright. One of my fantasies is to become president of a university and award him an honorary doctorate.

Florence L. Denmark, Ph.D., Robert Scott Pace Professor of Psychology--First a professor and then a friend. In the earliest days of my work, Professor Denmark was enthusiastic and supportive. She was never afraid of a theoretical dissertation, and as a member

of my committee she was demanding, creative, supportive, and always available. Her humility was so disarming that I had to constantly remind myself that this giving woman is one of the world's leading psychologists. Not only has she served as president of the American Psychological Association, but she is also a member of the Board of Governors of the New York Academy of Sciences and her brilliant research and writing was a criterion of excellence for my own work (I hope I'm not embarrassing her). Her warmth and support to this student will always be the standard by which I will treat my own students and clients. Thank you, Dr. Denmark.

Wayne Hening, M.D., Ph.D., Scholar, Scientist, Humanist.--I was honored to have another distinguished scientist on my committee. With his grants, labs, writing, and publishing, I was gratified that Dr. Hening took such an enthusiastic interest in my work. He was always available and always supportive. Dr. Hening trained as a neurology resident and research fellow at Columbia University Hospital and is currently a clinical investigator in neurology in the Department of Veteran's Affairs, Career Development Program, where he is Principal Investigator on a grand studying

Parkinson's disease. Thank you, Dr. Hening, for showing interest in my work and being there for me.

Vita Carulli Rabinowitz, Ph.D., Graduate Faculty CUNY, Professor of Psychology, Social/Personality at Hunter College.--Professor Rabinowitz was supportive, creative and articulate, she kept me on my scholarly toes. Thank you, Dr. Rabinowitz for being there when I needed you. You were wonderful!

Vera Paster, Ph.D., Professor of Clinical Psychology, CCNY.--Dr. Paster, a clinician, saved the day by stepping in for a retired colleague and was rewarded by having to read a five pound, 250 page dissertation with two weeks' notice. She was gracious, understanding, and supportive. Thank you, Dr. Paster, for your participation.

Gisela Zabriskie, Typist, Editor, and finally a friend.--Gisela, who lives and works in Massapequa, New York, is a state-of-the-art typist and desk-top publisher. Additionally, her perfect knowledge of AA publishing rules was an important asset to my work. Thank you, Gisela, for an excellent job.

Ronald R. Giannetti, Ph.D., Creator of the GOLPH.--Many thanks to Dr. Giannetti for his generous telephone conversations between my office in New Hyde

Park, New York and the Fielding Institute, where he is Chairman of the Department of Psychology. His support of this project was appreciated.

Bob Ciforelli--for his help with and maintaining of the often highly technical equipment used in my research.

The National Computer Systems Corporation, publishers of the GOLPH, and knowledgeable technical support staff.

My friends, Ethel Jackson, Marvin Melnyk, Eleanor Hening--for their constant support.

Finally, I want to thank my wonderful children Andrea, Linda, my son-in-law Verne, and Sasha, and Conrad, all of whom waited (except Conrad, he's new!) with hope, love and encouragement for me to complete my doctorate.

Table of Contents

List of Tables

Chapter 1

Introduction

This dissertation developed from observations I made over a three-year period while doing individual and family therapy with schizophrenic inpatients and their families.

During my internship at Hillside Hospital/Long Island Jewish Medical Center, and a two-year post-internship position at South Beach Psychiatric Center, I had the experience of treating approximately 25 patients who had been diagnosed as schizophrenic-paranoid type. All of those cases were young adult males whose relationships with their mothers were unusually intense, manifesting symbiotic[1] patterns. Their relationships with their fathers appeared, at best, to be casual.

My treatment approach, although flexible for each individual case, was to do family therapy with the goal of changing the patient's outside (the hospital) support system. During the post-internship position at South Beach Psychiatric Center, I observed an

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[1]The term symbiotic is used to describe a mutually intense emotional dependency between two people. It often appears to be parasitic in quality, e.g., each needs the other to "feed off" of emotionally.

increasingly good rate of success with schizophrenic patients. This was indicated by both a high discharge rate and a low rate of recidivism.

The results appeared to be the products of a major change in my conceptualization of the family processes of my schizophrenic patients which resulted in a rather different treatment approach to schizophrenics and their families.

In my earlier work, I had perceived the mother and patient as a symbiotic duo who in some way had to be separated to allow the patient the opportunity to learn the skills of individuation. That treatment approach consisted of a combination of family therapy and individual therapy with the mother. In the family therapy sessions, I attempted to use an apparently well-intending father as a wedge between the mother and patient. The father, on some occasions, might be encouraged to attend a ball game or other activity alone with the son, or else the father might be prodded to take the mother out on a date. The focus of the individual therapy was always with the mother. It was supportive and directed at helping her to deal with her own anxiety surrounding her emotional separation from the patient. My perceptions of the fathers,

invariably, were that they were overburdened, hard working, often weak men who were pushed out of their marriage and deprived of their wives' love and attention, as well as the opportunity of being fathers to the patient, by a symbiotic relationship that was too overwhelming for them to cope with. The results of this approach was a constant and painful tug-of-war between the therapist and the family that yielded minimal results which were often completely lost with the first attack of anxiety by either the patient or his mother, often resulting in the patient's return to the hospital.

Towards the end of my internship year, a significant incident took place during a family therapy session. It was an initial interview with a twenty-two year old schizophrenic patient, his mother, father, and older sister. I had asked the family if they would be willing to continue with subsequent family sessions. In response to my request, the patient's mother became quite upset and blurted out (paraphrased), "Sure, why not, let's go--I know the game. I'm the bad one, I'm the overbearing, symbiotic . . . what's the other name--schizophrenogenic mother. I made my son sick, you're the 20th therapist we had, I know the whole

story.--But I'm telling you, I want you to listen, I carry the whole burden alone. He (pointing to her husband) is never around to help me. I've never had a husband, and Larry (the patient) has never had a father. I'm the bad one, he's the good one--I'm always blamed--but what about him?"

The woman's complaint about my pre-set theoretical biases were well taken; she was correct. I had to accept both her accusation and her apparent pain as being very real. However, most provocative of all was her question regarding her husband--"What about him?"

For some time I had been puzzled by several observations and problems that I encountered in family therapy with my schizophrenic patients. They were in relation to the behavior of the patients' fathers. I often encountered major contradictions between the fathers' avowed desire to be helpful and their actual behavior. For example, I never experienced difficulty in involving a mother in family therapy, but I often met with direct resistance from the fathers that was often so blatant, that their behavior often manifested a "sabotage-the-therapy quality." To elaborate the type of behavior that I am speaking of, I offer a short

vignette from a typical family session that might take place during the second or third meeting.

Therapist: (Attempting to use the father as a wedge between the symbiotic mother/son) Larry (pt.), last week you said that you'd like to go to a baseball game with your dad.

Patient: Yeah, we never did that. (Pt. is staring at the floor.)

Therapist: How about it, dad, will you be able to take Larry out this weekend during his home visit?

Father: Wonderful, wonderful, we'll go to the ball game and then we'll go out to eat. It's time that we spend some time together. (Father is enthusiastic and apparently sincere. The patient is obviously happy with the plan.)

Therapist: Well, mother, what do you think of your husband and son going to the ball game this Saturday, and what will you do during that time?

Mother: (anxious and somewhat depressed) Don't worry, I have plenty to do, it will be good for them to spend time together. (The

mother appears impressed by her husband's enthusiasm.)

Therapist: (reiterates and outlines the agreement between the family members and the session ends).

One week later, the family arrives for their next family therapy session. They are all somewhat glum and uneasy.

Therapist: How was the ball game?

Patient: (no verbal response. He stares to the floor, family members are silent, therapist turns to the father.)

Father: (with an inappropriate grin) Well, my wife had a lot of work in the house and I felt that it was more important that Larry help her. Besides, you know I hold two jobs, and I was tired on Saturday and figured there's no rush. (Mother and son anxiously look at each other.)

It was further observed, in one way or another, that the fathers would attempt to passively manipulate and impede the family therapy sessions. These tactics were often discernible even at initial meetings. I would often encounter a glibly smiling father posturing

himself as my co-therapist rather than behaving as a member of the family. His message seemed to be, "Those two (the mother and patient) are the sick ones and I'm just a helpless, innocent victim." Another, quite consistent, series of behaviors were manifest by the fathers when the mother and patient demonstrated signs of separating. The fathers would often announce that their job demands had increased and that they could no longer attend family sessions, or else might attempt to impede the interviews by going into long superfluous harangues.

As I began to perceive the fathers of schizophrenics as men who were quite different from the passive victims described in the literature, I began to change my treatment approach. Instead of seeing the family as one unit and the mother individually, I continued to see the family as a unit and saw the mother and father as a unit in couple therapy. When the parents began to communicate with each other and share some of their thoughts and feelings, the patient began to improve. Therapeutic strategies are discussed more fully in chapter 5.

In search of a theoretical framework for my new approach, I went to the literature and found that very

little work had been done regarding fathers of schizophrenics. However, it was apparent that the journals were rich with reams of theory and research publications about the mothers of schizophrenics. Since Fromm-Reichmann (1948) coined, almost as an aside, the concept of the "schizophrenogenic mother" to identify the mother of her schizophrenic patients, the catch-phrase and the concept it represented became popular and dominated research and theoretical thinking for the next forty years.

In answer to my own need for a theoretical frame of reference, as well as a need to understand my observations of these fathers, I have undertaken this dissertation to sketch a psychological portrait of a group of fathers of schizophrenic sons with the goal of provoking questions and formulating suggestions for research that can be tested in future formal research studies.

Chapter 2

Related Literature

The goal of this research is to describe the psychological profile, and to evaluate the role of the father in the family dynamics of schizophrenic young adult men. The available information about these men is sparse. Therefore, it was decided to review the important theory and research on healthy and malignant fathering to use as a frame of reference against which we may discuss the collected data. For a comprehensive review of the father's role in child development, one should refer to Lamb, Pleck, and Levine (1985), and Lamb, Pleck, Charnov, and Levine (1985, 1987).

Additionally, according to R. A. Giannetti (personal communication, May 3, 1990), this dissertation is the first to utilize his computerized on-line response-contingent psychosocial history (described in the method chapter) to collect data for research purposes. Therefore, a brief review by Giannetti of the psychosocial history and of computerized assessment is also presented in Appendix D.

Infancy and Childhood

Since the early 1970's there has been an increasing awareness of the father's contribution to infant development (Pacella, 1989). Prior to this new research interest in fathers, most writers perceived the mother-infant dyad as the most important and even a necessary prerequisite to healthy development (Bowlby, 1969, 1973; Freud, 1940; Macoby & Masters, 1970; Parsons, 1958; Sears, 1957; Winnicott, 1965). Freud and Bowlby both described the infant's relationship with the mother as the basis of healthy emotional development and all future emotional relationships.

It was suggested that the ongoing positive association of need gratification is the seed for future effective relationships (Dollard & Miller, 1950). This concept of "secondary drive" was challenged by, first, the "drive reduction" model (Hull, 1943), and later by Harlow (1961), who demonstrated that infant monkeys choose to attach themselves to soft, soothing, and comforting cloth mother surrogates rather than wire surrogates that feed them. Harlow's work is supported by studies that demonstrate infant's develop attachments to persons who

are not involved in their primary caretaking needs (Schaffer & Emerson, 1964).

The research that has attempted to demonstrate a reliable relationship between infant gratification and dependency behavior, has failed to do so (Sears, Macoby, & Levin, 1957). Schaffer (1971) questions whether an infant's initial relationship is the model for ". . . all future relationships we do not know; the clinical material bearing on this point is hardly convincing" (p. 151).

Bowlby (1958, 1969) offers a theory of attachment that accents the species' survival aspect of a mother-infant bond that guides the infant to maintain close proximity to the protective mother.

As noted, prior to the 1970's the major theorists presumed that the mother is exclusively important in the infant's and child's development. This posture appears reasonable because of the mother's primary caretaking role and the amount of time she spends with the infant. However, research on the subject has not supported this impression. Additionally, in studies of father-infant interactions, fathers spent time with their infants and were playful, affectionate, and attentive when alone with them (Belsky, 1979; Pederson,

Anderson, & Cain, 1980). The amount of time a mother spends with the infant is a questionable predictor of the quality of the infant's relationship with either parent (Feldman, 1974; Pederson & Robson, 1969; Schaffer & Emerson, 1964). Long periods of daily day-care separations do not appear to affect the bonding between the mother and infant (Belsky & Steinberg, 1978; Bronfenbrenner, 1975a; Doyle, 1975; Doyle & Somers, 1975; Ramey & Mills, 1975; Roopnarine & Lamb, 1978; Kagan, Kearsley, & Zelazo, 1978). Lamb (1981) suggests that there is ". . . no reason that the daily separations from a working father need be more disruptive" (p. 5).

Several workers have emphasized the quality of the interactions as being more significant than the quantity of time spent with the infant (Bossard & Boll, 1966; Pederson & Robson, 1969; Schaffer & Emerson, 1964). The adult's cognizance of, and sensitivity to an infant's communications (Schaffer & Emerson, 1964) and brief periods of gentle interactions with either parent may be more important to forming secure and healthy attachments than long periods of unstimulating interactions with an unhappy and distressed mother

(Birmbaum, 1971; Yarrow, Scott, Deleeuw, & Heinig, 1962).

Fathers seem to generate different types of responses than do mothers. The father does this by bringing a different set of affectmotor stimulus patterns to the infant's environment. His body movements and his voice are more aggressive, louder and different than those of the mother. The infant responds with ". . . quicker arousal--a shorter 'plateau' and briefer disengagement" (Yogman, 1982, p. 110). Mahler, Pine, and Bergman (1975) suggest that these stimuli are preparing the infant for greater options for self-expression and object-relatedness during and after separation-individuation.

Research by Lamb (1975b, 1975c) and previous work by Pederson and Robson (1969) indicate that most infants have good interactions with their fathers and that both infant and child appear to have positive feelings. Lamb (1976) suggests that this may be "critical" in the development of strong father-infant relationships. He further offers that mother-infant interactions are less extensive than has been suggested and that the quality of the interactions are the critical variable for forming attachments to mothers

and fathers. Many fathers do not interact extensively or sensitively. However, insecure mother-infant attachments due to insensitive interactions are also very common (Ainsworth & Wittig, 1969).

Parent Roles and Family Interaction

Recent literature reveals a new emphasis on the role of the father in child development (Abelin, 1980; Biller, 1974d; Biller & Meredith, 1974; Cath, 1989; Gilbert, 1975; Lamb, 1975a, 1986; Meredith, 1985; Pacella, 1989; Pederson, 1980; Russell, 1983; Shedd, 1975; Solnit, 1989; Stafford, 1978; Stoller, 1979; Tessman, 1989). It indicates that mothers and fathers are both fundamental to the healthy development of their infants. Each parent has a separate functional role in the socialization of older children. Earlier studies presumed fathers had no direct role in early infancy. Hence, maternal and paternal roles in infancy were not differentiated (Lamb, 1975a).

Research by Parke, Power, Tinsley, & Hymel (1979) suggested that the birth of the first child shifts even egalitarian couples toward individualized differentiation in parental roles rather than similar ones.

The literature that focuses on differential parental roles is limited. However, additional support for the concept of separate parental roles is supported within the framework of family process theory.

Family therapists and family theorists have described the effects of the family system and family processes on both the family unit and on its individual members since the late 1950's (Ackerman, 1958; Bateson, 1959; Bowen, 1956; Haley, 1962; Jackson 1957, 1959, 1961, 1974; Jackson & Satir, 1961). Investigation of the clinicians' observations and theories reveals considerable support for the concept that family social systems and processes have formidable effects on both infant and child development (Lewis, Feiring, & Weintraub, 1981; Parke & Tinsley, 1987; Muir, 1989; Pruett, 1989).

In one study of family processes, Parke & O'Leary (1976) observed that parents' interactions with their children increase from the dyadic to triadic situations. They report that both fathers and mothers smiled more at their infants and that mothers, specifically, displayed greater exploratory behavior. They suggested that parents verbally stimulate each other by focusing their partner's attention on aspects

of the infant's behavior and/or appearance, and this in turn generates the partner to explore, touch, and smile at the infant more than when either parent is alone. Gunsberg (1989) suggested that paternal nurturing can originate and grow in father-child family interactions. Parke et al. (1979) summarized the importance of studying parent-child interactions in the context of family processes as follows:

> The importance of the findings (largely from parent-infant interaction research) is clear: in order to understand the father-infant relationship and its effects on the infant's development, the total set of relationships among the members of the family need to be assessed. Only in this way will the complex nature of such influences be understood. (p. 31)

Biller (1974c) observed one behavior in which fathers and mothers interact differently with their infants. He observed that fathers supported their babies' curiosity and motivate them to accept to solve motoric and cognitive challenges, whereas mothers appeared to inhibit the child's exploration. He proposes that these interactions encouraged the

children's abilities to learn to master their environment.

In a detailed observational study (Lamb, 1974) reported that while mothers engage in more conventional and toy-mediated types of play, fathers initiate rough-and-tumble type and idiosyncratic types of play. In a follow-up study, Lamb (1976) reported that infants apparently prefer to play with their fathers. They responded less positively to their mothers' attempt at play than to their fathers' initiated play. The fathers more readily picked them up for play, while the mothers picked them up for caretaking activities. Research by Lynn and Cross (1974) further confirms the prominence of play in the infant-father interactions. They report that boys of two years and older prefer to play with their fathers rather than their mothers. Radin (1982) suggests that ". . . fathers behave differently when their wives are present" (p. 391). Fagot (1974) reported that the parents of two-year-old boys accept the view that the father's role involves playing with, and being a role model for their sons.

Secure mother-infant relationships enhance the skills necessary to relate positively to others, while warm and sensitive fathering is the basis for secure

father-infant attachment relationships (Lamb, Frodi, Hwang, & Frodi, 1982).

Thompson (1986) suggests that "As children grow older and fathers become more intimately involved in the child's life, the paternal role becomes more complex and multifaceted" (p. 73). Fathers also support individuation-type behaviors more than do mothers (Cantor, Wood, & Gelfand, 1977). Additionally, fathers give more reinforcement for sex-typed behaviors than do mothers (Langlois & Downs, 1980). Block (1983) suggested that fathers use different teaching styles, set higher standards, focus on cognitive aspects of the task, and stress task performance with their sons. With their daughters, they stress the interpersonal perspective and try to make it fun.

Unavailable Fathers

The term "unavailable" is used in this section to imply limited psychological and physical accessibility. The men, in the present study, had fathers who lived at home. However, the question of father absence becomes relevant to the present study when one observes that sons in two-parent households, whose fathers are emotionally unavailable to them, often exhibit low identification with their fathers. Furthermore,

Hoffman (1971) found "the effects of low identification with fathers who are present are quite similar though somewhat less pronounced than the effects of father absence" (p. 404). Therefore, a look at some of the relevant literature of father absence is indicated.

Father absence in infancy and early childhood is associated with greater difficulties in the areas of self-concept, attainment of masculine identity, cognitive development, and scholastic achievement (Santrock, 1970a; Blanchard & Biller, 1971; Radin, 1976; Thompson, 1978; Michaels, 1989). Many studies report that father absence has its most negative effect on children who are separated from their fathers at an early age (Blaine, 1963; Hetherington & Deur, 1971; Leichty, 1960; Michaels, 1989; Santrock, 1970b; Siegler, 1982).

Boys who were raised by their mothers, without a father present, are reported to be less masculine in their sex-role behavior and preferences (Altus, 1958; Biller & Bahm, 1971; Burton & Whiting, 1960; Stoltz, et al., 1954). Other boys tend to display "compensatory masculinity" (Bartlett & Harrocks, 1958; Lynn & Sawrey, 1959; Pettigrew, 1964; Tiller, 1958, 1961). These boys tend to manifest "feminine" (i.e., nonanalytic)

cognitive styles (Altus, 1958; Barclay & Cusumano, 1967; Carlsmith, 1964, 1973; Wohlford & Liberman, 1974).

In girls, father absence is related to problems with relationships with men (Jacobson & Ryder, 1969). It is interesting that father absence has its observable effects on girls in adolescence, even though, as with boys, early father absence is more devastating. Possibly, girls are spared the harsher damages from father absence because they have their mothers as role models (Mussen & Parker, 1965).

The Father and Academic Achievement

The parental influences on intellectual development and achievement need further research (Freeberg & Payne, 1967). However, much of the available research suggests that fathers probably influence their sons' intellectual development and performance more than has previously been realized (Brenton, 1966; Lederer, 1964; Palmeri, 1989). Girls and boys who have highly involved fathers present increased cognitive abilities (Radin & Sagi, 1982; Pruett, 1983; Carlson, 1984; Easterbrook & Goldberg, 1984; Palmeri, 1989). In a correlation study, fathers, who were highly motivated, spent more time trying to

stimulate their children's cognitive growth, however, they also spent more time with their sons. Positive correlations were noted between verbal scores for both boys and girls and the degree of father involvement (Radin, 1982). Biller (1974a) suggested that fathers may facilitate cognitive development in their children, from their infancy.

Academic achievement is, apparently, effected by paternal involvement. Boys who underachieve have poor father-son relationships and they perceive their fathers as rejecting, angry, and aloof (Grunebaum, Hurwitz, Prentice, & Sperry, 1962; Hurley, 1967; Kimball, 1952), while boys who are high achievers seek their fathers' companionship more than low achievers (Mutimer, Loughlin, & Powell, 1966). Shaw et al. (1965) found that high achiever sons also perceive themselves more like their fathers than do low achievers. In a correlational study, fathers who were encouraging, tended to have sons who were high achievers (Solomon, 1969; Katz, 1967). However, this may not be consistent in all social groups (Kahl, 1953). Boys are less susceptible to pressures by their mothers to achieve than to pressures from their mothers to achieve (Kagan & Freeman, 1963). Close father-son

relationships (Bieri, 1960; Dyk & Witkin, 1965) and outgoing fathers (Dreyer, 1975) are related to their sons' taking on a "masculine" cognitive style. Several investigators reported that a supportive father-child relationship with a father who is both dominant but fair is associated with boys and girls who have a high motivation to achieve (Bordua, 1960; Hoffman, 1961; Kahl, 1957). These findings were more pronounced with boys than girls (Norman, 1966; Werts, 1966).

Interpersonal and Social Competence

Several researchers have noted that the presence of a warm and supportive father is associated with psychological adjustment and adult heterosexual relationships (Barclay, Stilwell, & Barclay, 1972; Hetherington, 1972; Holman, 1959; Palmer, 1960; Seplin, 1952; Winch, 1950). A warm father-son relationship has also been reported to be associated with good personality adjustment (Mussen et al., 1963; Reuter & Biller, 1973; Slater, 1962). Fathers who are warm, supportive, and emotionally available to their sons tend to have boys with good self-esteem (Coopersmith, 1967; Rosenberg, 1965; Sears, 1970).

Several observational studies have reported that social competence is associated with the warmth of the

father-son relationship (Cox, 1962; Howells, 1969; Rutherford & Mussen, 1968).

On the one hand, boys who manifest the ability to establish good peer relationships have experienced warm father-son relationships. These boys had fathers who spent time with and communicated with (i.e., play, talk, go places) with their sons (Leiderman, 1959; Lynn & Sawrey, 1959; Stoltz, et al., 1954; Tiller, 1957; Barclay, Stilwell, & Barclay, 1972; Hetherington, 1972; Holman, 1959; Palmer, 1960; Seplin, 1952; Winch, 1959), while, on the other hand, boys from mother-dominated homes have more trouble being accepted by their peers (Hoffman, 1961).

Chapter 3

Method

The goal of this research is descriptive. It is an hypothesis-generating study. The approach was to evaluate a sample of 15 fathers of schizophrenic, young adult sons from a multiplicity of viewpoints, and then to present the psychological, psychosocial, and family process characteristics of these men, as a group, for evaluation and conceptualization of new hypotheses for further research.

The present level of understanding of the fathers of schizophrenics is sparse, and warrants a case study methodology. The characteristics of these men have not been defined and further exploration is needed.

Sundberg and Tyler (1972) stress the importance of "clinical exploration." They emphasize the contributions that have been made by researchers who have studied a few individuals in detail, thereby generating hypotheses to be tested on larger samples of the population. They state that such investigation, although not a formal research design, falls well within the framework of respected inquiry.

The Handbook of Clinical Psychology (Wolman, 1965) has an entire chapter on the case study method by

Bolgar. It is, again, emphasized that ideographic studies primarily discover and generate hypotheses rather than producing conclusive and widely generalizable results. It is also noted that much of the knowledge clinicians have was discovered by the method of case study. A critical issue that Bolgar confronts is that of discovery versus proof, pointing out that the experimental design is concerned with proof and rarely leads to discovery and in the orthodox concentration on hypothesis testing, the researcher often ignores unexpected results that might be discoveries. However, she notes there is universal agreement that the case study method is the ideal technique to generate hunches, hypotheses and important discoveries, and is the procedure of choice in an area where little information is available in the literature.

Subjects

The subjects were the fathers of hospitalized or previously hospitalized schizophrenic males. These men were between the ages of 42 and 59, and their sons, the identified patients (IDP's) ranged in age from 17 to 31 years and had no schizophrenic siblings. The subjects were also married or had been married to the IDP's

mother, with no separation or divorce, at least until the IDP's initial psychotic episode and hospitalization.

A liaison was arranged on each of five treatment units at South Beach Psychiatric Center, Staten Island, New York. When a unit case manager had a father to refer for the interview process, the unit team leader (supervisor) was notified. The IDP's hospital and/or clinic record was then reviewed to ascertain the diagnosis of schizophrenia, paranoid type (DSM III 295.3). If the diagnosis was confirmed, the team leader, who was either a psychiatrist or a clinical psychologist, and the case manager, who was either a clinical psychologist or a social worker, evaluated the family's history and demographics. If both agreed that the father met the research criteria, the author was contacted and supplied with the father's telephone number for an initial contact.

The father was called and told that he had been ". . . picked as a potential participant in a research project that was studying the families of patients like your son." If he was interested in learning more about the study, he was invited to a 30-minute interview. During this first interview, he was told the study was

an attempt to learn about the families of patients like his son. However, he was also informed that the present study would not directly benefit his family or his son, but that it might benefit patients like his son and their families in the future. Additionally, the father was informed that, if he did wish to participate in the study, it would involve two additional interviews that would include a three-hour interview in approximately one week, followed by a final one to one and one-half hour interview three to five days later. He was told that his involvement with the research would be concluded within two weeks from the time of the initial interview.

Finally, the father was informed the research was not a facility study but part of a doctoral dissertation. He was, at this time, given the option of not continuing as a subject and reassured that if he chose not to participate it would in no way affect his son's or his family's relationship with the treatment facility. If the father chose to continue as a subject in the study, the second appointment was arranged and he was, once more, asked to allow three half-hours for the interview. It is noteworthy that all of the first 15 fathers who were called by telephone agreed to come

to the initial meeting and all 15 agreed to participate as subjects in the study.

Apparatus

The Giannetti On-Line Psychosocial History (GOLPH), was chosen for the research. The GOLPH is a computer software program distributed by National Computer Services (NCS) of Minneapolis, Minnesota. The distribution of NCS's assessment software is under the supervision of the American Psychological Association. The supervising psychologist for the use of the GOLPH in this research was the dissertation chairman.

The computer hardware necessary to administer the GOLPH consists of an IBM or IBM-compatible microcomputer (PC) with a minimum 512K (RAM), a monitor, an IBM-compatible printer and an NCS scorebox interface. The scorebox is a small peripheral that contains the algorithms that organize the data and prepare the psychosocial report for printing. The PC used in this research was a Hewlett Packard 286 with a separate numeric keypad. The additional keypad, with the basic numbers 1, 2, 3, . . . through o, and an "enter" key was used in place of the more standard and more complicated computer keyboard.

The software consists of two floppy discs: a utilities diskette that allows one to install the NCS assessment software, and the GOLPH diskette that contains the programmed questions for the psychosocial history.

The GOLPH is an on-line, Response-contingent Data acquisition and reporting interview that collected information in 10 areas of the subjects' past and present functioning and generated a six- to eight-page psychosocial history report. The areas investigated in this study, by the GOLPH, were:

1. Demographics and current living situation
2. Family of origin
3. Client development
4. Educational history
5. Marital history and current family functioning
6. Occupational history and current financial circumstances
7. Military history
8. Legal and criminal history
9. Physical illness and current somatic symptoms
10. Psychological symptoms and treatments.

As noted, the GOLPH is a response-contingent program. The excellent branching capacity of the GOLPH

makes it a uniquely efficient instrument of inquiry. Questions were presented on the computer monitor and the subject selected and entered his response by pressing the appropriate key on the numeric keypad. If the response indicated that further inquiry was necessary, the program branched to one or multiple questions that collected further information. Additionally, the GOLPH holds branching inquiries for later use in the interview. For example, an indication of substance abuse in adolescence would be followed-up much later in the GOLPH during the marital history and/or the psychological symptoms and treatments categories.

The GOLPH has a data bank of approximately 700 questions. However, the number of questions presented to an individual would be a function of a multiplicity of variables, e.g., sex, developmental history, educational history, marital status history, and present living conditions--to cite a few, as well as the amount of branching necessary to elicit information from an individual subject. Additional information about research for item construction, sample GOLPH frames, and samples of branching is available in Appendix A.

Procedure

The first of the two data gathering interviews took place on Saturdays and Sundays over a four-week period at South Beach Psychiatric Center in Staten Island, New York. The weekend days were utilized because they were both convenient for the fathers and the same comfortable, quiet, well-lit and private room was available on weekends. Additionally, South Beach was accessible and afforded free and convenient parking for the fathers, all of whom drove cars.

When a father arrived, he was greeted with a handshake and invited to sit in a comfortable chair at a table on which the computer equipment was in place. The computer, monitor, scorebox, and printer were all turned on.

The fathers were told they were going to be presented with a series of questions that would appear on the computer monitor. At this time, a sample question was displayed on the screen (sample frame 5, in Appendix A), and he was asked to read it out loud and decide which one of the six available choices best describes his answer. He was then asked to press the number of his choice on the numeric keypad and then to press the key marked "enter." When this was done,

another question appeared on the screen (sample frame 6, Appendix A), and the instructions were repeated. In most cases, the fathers had no difficulty with the second sample frame. Three fathers needed an additional practice frame, and sample frame 5 was repeated.

The men were told they were not being tested or scored. They were told the computer was gathering information about families of patients like their sons. They were also told that their anonymity would be protected by the use of the first name only and an identification number that would be assigned and secured by the researcher.

It is noted that this was the first time that the fathers were informed they were to be involved in a computerized interview. This was done to avoid pre-interview computer anxiety. They were asked, at this time, "Do you feel comfortable answering computerized questions?" All of the men said yes; however, two expressed concern that they might need some extra time to get the idea of using the keypad. They were informed that there was no time limit and that they could take all the time they needed.

After approximately one hour, about halfway through, when the legal history category of the GOLPH was completed, the fathers were given a 15 minute rest period. The remaining categories of inquiry were completed in a second one-hour to one and one-quarter hour segment.

When the programmed interview was completed, the fathers were thanked for their participation. At this time, the researcher shared the fact that the men who participated in the study were the first people to give a computerized psychosocial history as part of a research study. The fathers were asked about their feelings regarding the computerized interview and were offered the opportunity to make suggestions that might improve the GOLPH program. Their feedback is discussed in the summary chapter of this work. The fathers were told they would be contacted for a final one and one-half hour noncomputerized interview in three to five days.

The last interview was utilized to clarify issues that arose from the fathers' responses to the GOLPH and to collect additional information, not queried by the GOLPH, regarding their relationships with their sons,

the IDP's. When the interview ended, the men were thanked for participating in the research project.

Chapter 4

Results

In this chapter, the data collected by the Giannetti On-line Psychosocial History (GOLPH) and the follow-up inquiry is presented. The data is presented by category of inquiry in the same order as it was collected on the GOLPH. The complete psychosocial reports for each of the 15 fathers is available in Appendix C.

In most categories, the results are stated in tables showing the data in ratios. In most statements, the number of subjects is 15 (n = 15). The ratio, 11/15, for example, will be expressed as 11, followed by the percentage in parentheses, and will be stated as 11 (73%). If the n is less than 15, then the full ratio is stated (for example, 11/14 or 9/13) or, if an entire table has an n that is less than 15, it will be stated at the top of the table (e.g., n = 14).

As stated in the method section, a follow-up interview took place within three days after the computerized psychosocial history was completed. The purpose was to make inquiries to clarify what the father meant with a particular response, and to collect information regarding his relationship with his wife

and son (the IDP). For example, one of the GOLPH frames offered the father the choice of describing his mother as being "bothersomely attentive." If that choice was selected, then an inquiry was made in the follow-up to clarify what the father intended to communicate. In the above case, all of the men described their understanding of the term "bothersomely attentive" as intrusive and/or having no privacy. When this writer, therefore, wishes to add information gained from the interview, the comment will be enclosed in square ([]) brackets.

Demographics

The fathers were never late, never changed an appointment, and never complained. It is notable that of the first 15 fathers who were referred as potential subjects in the study, all agreed to participate. Indeed, they were all exceptionally compliant.

The subjects in this study ranged from 44 to 59 years of age. Two were black and 13 were white. One was Buddhist, five were Catholic, one was Christian (fundamentalist), one was Greek Orthodox, four were Jewish, and three were Protestant. Fourteen of the 15 men were married and living with their first wife, the schizophrenic son's (IDP's) mother, during the time

that this study was conducted. One had separated from his second wife, the IDP's mother, three months before his interview, and several years after his son's initial psychotic episode. Eleven of the couples had 1 son only (the IDP), and 14 of the couples had their first-born within 18 months of their wedding date. Twelve of the men reported that their first-born was a planned child.

A more detailed table of demographics is available in Appendix B. However, it is worth noting, at this point, that 13 of the fathers have consistently worked unusually long hours (between 55 and 70), and that 13 (87%) work at trades that require minimal interaction with other people, i.e., night watchman, truck driver, postal worker, pattern maker, taxi driver, house painter, and bookkeeper.

Subjects' Family of Origin

The data regarding the subjects' family of origin presents both their recall of information about the personality of their own parents (the IDPs' grandparents), and their recall of their interpersonal relationship with their own parents.

Subjects' mothers (the IDP's grandmother). The data describing the psychological profile of the

subjects' own mothers is presented in Table 1. It strongly suggests that, as a group, the mothers described by these men were both unhappy and/or depressed women. Each of the 15 women are described by the subjects as having manifested one or both of the symptoms of unhappiness or depression. One must consider the fact that the subjects were not trained mental health workers and that their reports of depression as well as other psychiatric symptoms must be accepted with some qualification. Therefore, one must note that of the 14 (93%) who recalled their mothers as having been unhappy, 11 (73%) stated that their mothers were also depressed. Six (40%) of the women were reported to have adopted a posture of {an unusually high degree of] rigidity. As a group, the mothers of the subjects appear to have had a notable incidence of mental illness (6 = 40%) and suicide attempts (4 = 27%), while presenting a low rate of substance abuse (1 = 7%). Five (33%) of the women appear to have each manifested multiple symptoms of schizophrenia (i.e., high levels of anxiety, delusions, hallucinations, flat effect, and impairment of personal hygiene). The mothers of the subjects present a large

Table 1

The Subjects' Recall of the Psychological Histories of Their Own Mothers (Ms)--the IDP's Grandmother

N = 15

Report their Ms [usually] unhappy and/or depressed	14[a]	(93%)
Report their Ms were [usually] rigid [inflexible]	6	(40%)
Report their Ms were mentally ill [were diagnosed]	6[b]	(40%)
Report their Ms hospitalized for emotional illness	4[b]	(27%)
Report their Ms attempted suicide	4	(27%)
Report their Ms were alcohol abusers	1	(7%)

Note: [a]Eleven Ss reported their mothers as being both unhappy and depressed for "long periods of time" and "for years," three unhappy only. [b]Four of the six that were diagnosed were hospitalized.

rise in psychopathology. There is both a large amount of reported depression and psychosis.

The data reporting the interpersonal relationships between the subjects and their mothers (female caretakers) is presented in Table 2.

A clarification of two terms is in order. First, physical abuse is defined as violent punishment, e.g., biting, punching, kicking, choking, hair pulling, attacking with a dangerous weapon or other object. Spanking and shoving was not considered abuse. Second, verbal abuse is defined as threatening to kill, maim, abandon, vulgar name calling and/or other threats of violence, and the consistent use of terms such as moron, idiot, stupid.

In reviewing the data regarding the subjects' mothers, a striking aspect is noted, i.e., that all 15 (100%) subjects perceived their mothers as "impatient, hard, and cold." The subjects defined these terms as meaning aloof and distant. However, 13 (87%) reported that their mothers cared for them by preparing meals for them, clothing them and showing concern for such matters as school attendance and homework assignments. Additionally, as shown in Table 2, nine (60%) subjects also perceived their mothers as giving no physical

Table 2

The Subjects' Recall of their Relationships with Their Own Mothers (Ms)--the IDP's Grandmother

N - 15

Felt their Ms were impatient, hard, cold	15	(100%)
Felt their Ms fed, clothed, and cared for them	13	(87%)
Felt their Ms were bothersomely attentive [intrusive]	12	(80%)
Felt their Ms were never physically affectionate	9	(60%)
Felt their Ms hated them and/or didn't love them	8	(53%)
Felt their Ms ignored/demeaned their accomplishments	6	(40%)
Felt their Ms verbally abused them	5	(33%)
Felt their Ms were unusually strict disciplinarians	5	(33%)
Felt their Ms physically abused them	3	(20%)

affection, and 8 (53%) subjects reported feeling not loved and/or hated by their mothers. At the same time, twelve (80%) of the men recalled their mothers as having been "bothersomely attentive"--having constantly questioned them, searched their personal belongings and even followed them. As already noted, "bothersomely attentive" (the third item in Table 2) was perceived as intrusion. There appears to be a discrepancy in the data. On the one hand, 53% of the subjects recalled being unloved, 60% felt totally deprived of physical affection, and 100% perceived their mothers as being aloof and cold, while on the other hand twelve of the subjects (80%) reported that their mothers were too attentive. To their credit, an interesting piece of insight on the part of the fathers was observed during the follow-up inquiry. When they were asked about a possible contradiction in their selections, all twelve of the subjects stated in their own terms that there was a great difference between affection and intrusion.

The incidence of physical abuse, verbal abuse, and extreme strictness is also notable. Each of these factors was selected by three (20%) subjects--two (13%) subjects reported all three, and one (7%) subject reported extreme strictness and verbal abuse.

Subjects' fathers (the IDP's grandfather).

Fourteen of the 15 men in the study agreed to provide information concerning their own fathers (male caretakers). One of them, John M. (Case Study 2, Appendix C), was raped by his stepfather at age 10. The sexual abuse continued for months [two years]. When the theme of his male caretaker was raised, he became markedly agitated and stated that he considered his stepfather " . . . a low-life human being," and he refused to deal with questions relating to him. The matter was apparently very painful to Mr. M., and it would have been both poor taste and unethical to pursue information regarding Mr. M.'s stepfather. He was given some time to relax and vent his feelings with the writer. He was also offered the option of not continuing with the GOLPH, however, he chose to continue with the other categories of inquiry. Therefore, because only 14 subjects gave information on their male caretakers, Tables 3 and 4 have an n of 14.

The data concerning the psychological profile of the subjects' own fathers is presented in Table 3. Again, as in Table 1, the responses to the queries concerning unhappiness and depression are merged. Ten (71%) subjects reported that their fathers were both

Table 3

The Subjects' Recall of the Psychological Histories of Their Own Fathers (Fs)--the IDP's Grandfathers

N = 14

Report their Fs [usually] unhappy and/or depressed	10[a]	(71%)
Report their Fs were rigid [were usually stubborn]	8	(57%)
Report their Fs were alcohol and/or drug abusers	6[b]	(43%)
Report their Fs were mentally ill {were diagnosed]	3[c]	(21%)
Report their Fs hospitalized for emotional illness	2[c]	(14%)
Report their Fs attempted suicide	1	(7%)

Note. Fourteen of the fifteen subjects responded to questions regarding their male caretakers.

[a]Eight Ss reported their fathers as being both unhappy and depressed for "long periods of time" and "for years," and two unhappy only. [b]All 6 substance abusers were alcoholics, and 1 of the 6 was cross-addicted and also used drugs. [c]Two of the three mentally ill fathers of the subjects has psychiatric hospitalizations and 1 of the 2 attempted suicide.

Table 4

The Subjects' Recall of Their Relationships with Their Own Fathers (Fs)--the IDP's Grandfathers

N = 14

Felt their Fs spent almost no time with them	14	(100%)
Felt their Fs hated them and/or didn't love them	12	(86%)
Felt their Fs ignored/demeaned their accomplishments	12	(86%)
Felt their Fs were impatient, hard, cold	10	(72%)
Felt their Fs were never physically affectionate	9	(64%)
Report their Fs physically abused them	8	(57%)
Felt their Fs were unusually strict disciplinarians	7	(50%)
Report their Fs verbally abused them	5	(36%)
Report sexual abuse by their father/ male caretaker/non-relative	5[a]	(36%)

Note. Fourteen of the fifteen subjects responded to questions regarding their male caretakers. Fourteen of 15 subjects responded to these queries.
[a]The 5 cases of sexual abuse were by 3 male caretakers (1 natural and 2 stepfathers); a 10 year-old, male cousin, baby-sitter [who was trusted by the 10 year-old]; and a stranger who had befriended the 12 year-old in the park (cases 2, 3, 6, 10, and 14; Appendix C).

unhappy and/or depressed. Eight (57%) subjects stated that their fathers were both depressed and unhappy, and two (14%) reported that their fathers were unhappy. In Table 3, one notes that three (21%) of the subjects' fathers were reported to have been mentally ill, all of whom manifested multiple symptoms of schizophrenia, i.e., flat affect, high levels of anxiety, delusions, hallucinations, paranoid ideation, and impairment of personal hygiene. Nine (64%) of the subjects' own fathers were alcoholics, two were both alcoholics and mentally ill.

The data regarding the subjects' recall of their relationship with their own fathers is shown in Table 4. A striking 14 (100%) of the responding subjects recall their fathers as having spent very little to no time with them. Several of the subjects could not remember being alone or going somewhere alone, even once, with their fathers.

In Table 4, there is a large number of subjects, 12 (86%) who reported their fathers, as well, as having been "impatient, hard, and cold." Twelve subjects (86%) perceived their fathers as having ignored and/or demeaned [felt that their fathers were in competition with them, and belittled . . .] their accomplishments.

Nine of the 12 subjects who reported not feeling loved by their fathers stated that they received no physical affection. It is interesting to note that 12 (86%) of the subjects reported receiving no love from their fathers, in contract to eight (53%) who reported feeling no love from their mothers. Another bit of data, conspicuous by its absence. is with regard to the fact that none of the subjects reported that their fathers were bothersomely attentive [intrusive].

The incidence of physical abuse is also quite high. Eight subjects (57%) reported [some very violent] physical abuse.

Five cases (33%) of sexual abuse were reported by the subjects (n = 15, Mr. M. was included). Three were with their male caretakers (1 natural father and 2 stepfathers), and one was with a 19 year-old male cousin who was trusted by the subject when he was a child. The sexual abuse in this case began when the subject was 10 years old, and continued for two years. In the three cases involving the fathers, the sexual abuse began when the subjects were 7, 10, and 11 years of age and all were multiple incidents over a protracted period of time. The fifth case was when the subject was 12 and involved a non-relative [whom the

child met in a park]. The abuse occurred twice. All the cases of sexual abuse are included in this section even though two of the offenders were not parents. This is done to present the data in an organized way.

Subjects' parents' marital relationship. The data describing the IDPs' grandparents is presented in Table 5. Thirteen (87%) of subjects reported that their own parents displayed mutual affection, i.e., touching, hugging, kissing. Twelve (80%) of them reported that their own parents spent much time talking to each other, that their fathers initiated the affection, and that their parents appeared to have an ongoing sexual relationship. Eleven (73%) reported that their fathers also initiated conversation with their mothers. Five (33%) of their fathers worked more than fifty hours a week, and two of the five held extra jobs, i.e., weekends and/or evenings. Three (20%) physically and/or verbally abused their wives.

Developmental History

Subjects' childhood. The data concerning the subjects' own childhood is presented in Table 6. A striking aspect of the early childhood behavior of the subjects is that 14 (93%) of them reported a history of antisocial behaviors before the age of twelve, i.e.,

Table 5

The Subjects' Recall of Their Own Parent's (IDP's Grandparents') Marital Relationships

N = 15

Report their parents displayed mutual affection, e.g., touching, hugging, kissing	13	(87%)
Report their Fs often initiated the affection	12	(80%)
Felt their parents had an ongoing sexual relationship	12	(80%)
Report their parents spent much time talking together	12	(80%)
Report their Fs often initiated conversation	11	(73%)
Report their Fs worked more than 50 hours a week	5	(33%)
Report parents abused each other verbally/physically	3	(20%)
Report Fs held extra jobs, e.g., evenings or weekends	2	(13%)

Table 6

The Subjects' Recall of Their Early Childhood Developmental History

N = 15

Recall multiple acts of antisocial behavior	14[a]	(93%)
Recall themselves as being, generally, moody children	12	(80%)
Recall their childhood as being, generally, unhappy	11	(73%)
Recall enuresis, nailbiting, stuttering	11[b]	(73%)
Recall having experienced many nightmares	10	(67%)
Recall having experienced many daytime fears	10	(67%)
Recall difficulty with tasks involving coordination	9	(60%)

Note. [a]Each of fourteen subjects reported multiple acts of 2 or more of behaviors considered antisocial, i.e., deliberate setting of fired, stealing, deliberate vandalism, repeated fighting, and chronic lying. [b]Five subjects reported all three symptoms, 2 reported enuresis and stuttering, 2 reported enuresis and nailbiting, 1 reported nailbiting and stuttering, and 1 reported enuresis.

fighting with other children, stealing, setting fires. Twelve (80%) of the subjects also reported being very moody [angry, sad, volatile] during their elementary school years. Eleven (73%) of the twelve recalled themselves as having been generally unhappy children.

Twelve (80%) also experienced nightmares and/or daytime fears. Eleven subjects (73%) reported nailbiting, enuresis, and stuttering after age four. Nine (60%) recalled difficulty with tasks involving coordination.

Subjects' preadolescence and adolescence. In their preadolescence and adolescence, the subjects recalled themselves as unhappy, lonely, and friendless teenagers who didn't "fit in" with other teens. The data concerning the subjects' own adolescence is presented in Table 7. One observes that thirteen (87%) recalled themselves as having been a loner. Eleven (73%) reported not "fitting in" with other teenagers and that they did not have even one close friend. One subject (Case 5, Appendix C) confided that not having even one friend wasn't too bad ["I didn't like them and they didn't like me--it was fine with me."]. Others reported feeling more comfortable by themselves. The total number of subjects who reported being shy, or not

Table 7

The Subjects' Recall of Their Preadolescent and Adolescent Psychological Histories

N = 15

Recall being very shy and tending to be a loner	13	(87%)
Recall having negative body image (hair, weight,etc.)	12	(80%)
Recall feeling they did not "fit in" with other teens	11	(73%)
Recall they had not one close friend to talk with	11	(73%)
Recall being very unhappy as a teenager	9	(60%)
Recall multiple episodes of suicidal ideation	7	(47%)
Report adolescent alcohol and/or drug abuse	5[a]	(33%)
Report multiple incidents of sexual abuse	5[b]	(33%)
Report frequent fights with other teens	3	(20%)
Report serious suicide attempt(s)	3	(20%)
Report running from home and staying out overnight	2	(13%)

Note. [a]All Ss were alcoholics, however, 3 of them were cross-abusers and also drug users. [b]All sexual abuse cases are included in this table; the ages of the subjects at the time of initial abuse ranged between 7 and 12 years.

"fitting in," or not having a friend is 14 (93%). Nine subjects reported all three, one reported not "fitting in" and not having a friend, one reported being shy and not having a friend, two reported being only shy, and one reported being shy and "not fitting in." Their isolation and depression took its toll. We note that 7 subjects (47%) had suicidal preoccupation as a teenager, three (20%) of whom made serious suicide attempts. Suicidal preoccupation is noted in this study if a subject recalled having fantasies how he would actually commit suicide and/or if he fantasized and/or planned the suicide. Isolated and infrequent thoughts such as "I'd probably be better of dead" were not counted in the data.

Subjects' educational history. The educational screening resulted in some interesting data. With all of the apparent problems that these men endured in their adolescence, 11 (80%) managed to graduate high school, 2 (13%) graduated college, and 2 (13%) dropped out of high school.

Subjects' occupational history. As noted earlier, the subjects in this study worked at jobs that required very little interaction with other people and they worked unusually long hours. They also had

interpersonal problems on the job, i.e., conflicts with authority, not "getting along" with fellow workers, and alcohol abuse on the job. A more detailed report of the subjects' trade and work histories is available in Appendices B and C.

Subjects' military history. Thirteen subjects were neither drafted nor did they try to enlist. Two served in Viet Nam where one saw active duty and witnessed civilian and military casualties and deaths, and one was discharged for drug abuse.

Subjects' legal history. All fifteen subjects denied any history or legal conflicts. However, two admitted to minor disability claims for injury on the job.

Subjects' Adult Life.

Present mental status. The data concerning the subjects' adult psychological profile is presented in Table 8. Thirteen (87%) subjects were depressed and 12 (80%) were moderately to markedly anxious, i.e., wringing hands, twitching shoulders, hyper-vigilant, and obsequious. They also manifested symptoms that may be associated with depression and anxiety, i.e., sleep disturbances 12 (80%); sexual dysfunction 11 (73%); suicidal ideation 9 (60%), and suicide attempts 3

Table 8

Total Number of Subjects (Ss) Manifesting Symptoms for Each of the Following Psychological Disorders

N = 15

Ss who manifest marked depression	13	(87%)
Ss who manifest high levels of anxiety	12	(80%)
Ss with sleep disturbances associated with depression	12	(80%)
Ss who reported multiple acts of antisocial behavior	11	(73%)
Ss who manifest sexual dysfunction with no apparent organic etiology	11	(73%)
Ss who have had multiple episodes of suicidal ideation	9	(60%)
Ss who report chronic alcohol and/or drug abusers	8[a]	(53%)
Ss who have had one or more suicide attempt(s)	3	(20%)
Ss who manifest psychotic symptoms	2	(13%)

Note. [a]The 8 subjects were all alcohol abusers, however, 4 were cross-addicted and also abused drugs.

(20%). Eleven (73%) subjects avoided eye contact and 8 (53%) reported alcohol and/or drug abuse. Eleven (73%) reported multiple acts of antisocial behavior associated with substance abuse and domestic violence (Appendix B). Two (13%) reported psychotic symptoms, i.e., hallucinations, delusional ideation, marked levels of anxiety, and paranoid ideation.

Subjects' wives. The data concerning the subjects' perception of their own wives is presented in Table 9. One observes that 14 (93%) of the subjects describe their wives as impatient, hard, cold and [very] unhappy. Twelve (80%) state their wives are unrealistic [all 11 subjects suggested that their wives were not realistic because the women expected that family life would improve and the possibly their son's mental illness would be cured. Additionally, they hoped that their husbands, the subjects, would become more involved as a husband and father].

Ten subjects gave their wives credit for being hard working, emotionally strong, and adding money to the family income by working on a job, in addition to her job as a homemaker.

Subjects' marital relationships. In Table 10 one notes that 13 (87%) subjects reported having difficulty

Table 9

The Subjects' Description of their Wives' Personalities --the IDP's Mother)

N = 15

Feel their wives are impatient, hard, cold	14	(93%)
Feel their wives are [very] unhappy	14	(93%)
Feel their wives are energetic, outgoing, talkative	12	(80%)
Feel their wives are unrealistic	12	(80%)
Feel wives are hard working and strong [emotionally]	11	(73%)
Report their wives work and add to family income	10	(67%)
Feel excluded by the mother/son relationship	2	(13%)

Note: Additional information from the follow-up interview, regard the subject's wives is shown in Table 12.

Table 10

The Subjects' Evaluations of their Relationships with Their Wives--the IDP's Mother

N = 15

Feel they have difficulty showing affection	13	(87%)
Feel they do not try to talk to their wives	13	(87%)
Report they rarely take wives out (movies, dinner, etc.)	13	(87%)
Report they encourage wives' relationship with IDPs	11	(73%)
Feel sexual problems are due to their lack of interest	10	(67%)
Feel they avoid spending time at home with their wives	9	(60%)
Report physical and/or verbal abuse against wives	9[a]	(60%)
Feel they are responsible for the couple having very few or no friends	9[b]	(60%)

Note. [a]Physical abuse and verbal abuse were 2 separate queries; however, 5 subjects reported practicing both abuses, and 3 subjects used verbal abuse only.

showing affection toward their wives, talking to their wives and spending time with their wives [most of the subjects said that they felt clumsy and uncomfortable; they had nothing important to say]. Actually, 14 subjects (93%) reported difficulty with showing affection and/or talking to their wives. Ten (67%) admit that they are having personal difficulty with their sexual relationship, and 9 (60%) report that they avoid spending time at home with their wives [and when they are at home, they avoid contact with their wives, i.e., stay in another part of the house]. Additionally, 9 (60%) state that they shove and/or verbally abuse their wives [when they are drunk or angry], and that they are responsible for the couple having no friends.

Subjects and their sons (IDPs). Data concerning the subjects' recall of their sons' (IDPs') developmental histories and of their relationship with their sons is shown in Table 11. The 15 subjects were all presented with dozens of questions regarding their children's medical, developmental, educational, and psychological histories and 14 (93%) of the fathers were unable to answer more than just a few of the questions. During the follow-up interview, they were

Table 11

The Subjects' (Ss) Reports of Involvement With IDPs

N = 15

Ss who recalled little to no data regarding IDP's developmental milestones	14	(93%)
Ss who recalled little to no data regarding IDP's medical history	13	(87%)
Ss who recalled little to no data regarding IDP's academic history	12	(80%)
Ss who were uncomfortable and/or not interested in "handling" their infant son (IDP)	12	(80%)
Ss who encourage sons to spend time with mothers	11	(73%)
Ss who reported never going out with IDP, i.e., ball game	5[a]	(33%)
Ss who reported going out with IDP 2 to 3 times	3[a]	(20%)
Ss who reported going out with IDP 3 to 5 times	3[a]	(20%)
Ss who state they would like more time with their sons	3	(20%)
Ss who reported going out with IDP on a steady basis	1	(7%)

Note. [a]This data was collected by the GOLPH, all other data on this Table was collected during follow-up interview. [b]Eleven (73%) reported taking them out to ball games, movies, walks, etc., 5 times or less.

queried about their dearth of information regarding their children's histories. It became apparent that these men were somehow unaware of many of the most apparent and often important details of their sons' developmental history.

Eleven (73%) of the subjects stated that they never took their son out more than five times, i.e., ball games, movies, and other father/child types of excursions, and five of those never took their son out even once. Only 1 (7%) had an ongoing relationship with his son (Case 7, Appendix C). Twelve of the fathers admitted that they were [uncomfortable touching, fondling, and holding] their infant son. Finally, 11 (73%) of the subjects state that they encourage their sons to spend time with their mothers.

The Follow-up Interview

Data obtained during the follow-up interview with the subjects is presented in Table 12. All 15 (100%) of the fathers were unusually compliant. Their compliance was noted during the early selection process and continued through the follow-up interview. Ten (67%) were obsequious, i.e., complimentary, overly polite, and conspicuously congenial. An intriguing bit of data collected during the follow-up interview was

Table 12

Data from Follow-Up Interview with Subjects

N = 15

Ss who were unusually compliant	15	(100%)
Ss who feel their wives are bothersomely attentive (intrusive) with their son (IDP)	14	(93%)
Ss who feel child rearing is the mother's responsibility	13	(87%)
Ss who feel that housework is a wife's responsibility	12[a]	(80%)
Ss whose wives want a closer marital relationship	12	(80%)
Ss who admit they use "indirect" and "manipulative" ways of avoiding intimacy	12	(80%)
Ss who are "satisfied" and "comfortable" with the mother/son (IDP) relationship	12	(80%)
Ss who are highly obsequious (ingratiating, patronizing)	10	(67%)
Ss who avoid eye contact during interview	10	(67%)
Ss who admitted they are most comfortable when alone	9	(60%)
Ss who feel excluded by the mother/son relationship	2	(13%)

Note. Terms in quotation marks were clarified and defined for subjects. [a]Eleven report never having helped their wives with the housework, i.e., making beds, washing dishes, or shopping.

that 14 of the fathers reported perceiving their wives as being bothersomely attentive (intrusive) towards their sons (IDPs), while 12 of the 14 also stated they were "satisfied" and "comfortable" with the mother/son relationships. Further, 2 (13%) of the aforementioned fourteen reported feeling "excluded" from the mother/son relationship.

The fathers in this group were quite blunt in their attitudes regarding their wives' responsibilities in the marital relationship. Thirteen (87%) felt that child rearing was the mother's responsibility, and twelve of the same group did not feel that housework is a man's work. On the one hand, 12 (80%) admit that they use "indirect" ways of avoiding intimacy, i.e., working long hours, not responding to their wives' attempted conversation (Case 6, Appendix C: "I just don't hear her.") and being generally unavailable, while on the other hand 12 (80%) stated that their wives sought a closer marital relationship (11 of them were in the group who reported that they indirectly avoided intimacy).

Finally, 10 (67%) tended to avoid eye contact during the interview and 9 (60%) revealed, in different

ways, that they were more comfortable when alone by themselves.

Chapter 5

Discussion

The goal of this study was to sketch a psychological portrait of the fathers of schizophrenic sons and to generate suggestions for future, more formal research. To that end, I will begin the discussion chapter by briefly summarizing the results and reviewing the implications of the research. Following that, I will discuss causation and close the thesis with suggestions for future research.

However, before beginning, I must underline the remarkable part that the GOLPH has played as a data collection instrument with this unique group of subjects. During the preliminary stages of this study, I ran several pilot conferences with subjects (who were not used in the final research) in attempts to develop a comprehensive, interpersonal, psychosocial interview. I quickly encountered difficulty with the interview process. I found that, although I was able to establish a pleasant, usually friendly rapport with the fathers, that it was extremely difficult to interview them. They were withdrawn, shy, cryptic, and verbally sparse. Their answers were in the forms of grunts,

nods, short answers, or they went into long harangues in an apparent attempt to manipulate the interview.

Gathering the extensive amount of information that was required for the research seemed to be a hopeless task. It became clear that this particular group of men would require ten to twelve hours of interview time to accumulate the data necessary to obtain a psychosocial history. During this frustrating period, I learned that Ronald A. Giannetti was working with the National Computer Service Laboratories developing the GOLPH. After several personal communications with Giannetti, and reviewing the research used in the development of the GOLPH, I decided, with his encouragement, to try it with the fathers in this research.

At first, I was concerned that the fathers would reject a computerized interview. However, I was surprised when they accepted the suggestion of answering questions that were to be presented on a television monitor which required a keyboard response. The fathers were apparently very pleased with the idea of a computerized interview.

Now that the research is completed, I realize that

the use of an instrument like the GOLPH was the only reasonable, in terms of emotional and time demands on subjects, technique to interview the uncommon subjects in this study. The men, because of their avoidant personality style, were able to deal with computer questions much more easily than with an interviewer. They allowed the computer access to their history, feelings, and fears. They admitted information regarding their sexual dysfunctions, substance abuse, and other perceptions of personal inadequacies--information that I feel would not have been shared during many long hours of interpersonal interviews. In short, they were able to trust and confide in the computer, a trust they felt that they were unable to have with people. These avoidant qualities of the fathers will be defined as the discussion chapter evolves.

Summary of Findings

As shown in Tables 2 and 4, large percentages of the fathers studied recalled their parents as having been unloving, rigid, cold, intrusive, and abusive. They experienced their childhood, preadolescence and adolescence as having been unhappy, lonely, and

anxiety-laden (Tables 6 and 7).

The term that the fathers universally used to describe themselves as children was "frightened." As young children, an unusually large number of subjects suffered with enuresis and stuttering (11/73%) as well as nightmares and daytime fears (10/67%). The American Psychiatric Association (APA) surveys report much lower rates in the population. The APA reports that the prevalence of recurrent nightmares in four to twelve year-olds is between one and four percent, enuresis at age five is seven percent in boys and three percent in girls, stuttering in boys is three times greater than in girls, with from five to ten percent of elementary school children affected (DSM III-R, 1987).

In preadolescence and adolescence the fathers reported what appears to have been an evolving posture of withdrawal and isolation combined with feelings of marked unhappiness and of not "fitting-in" with other teenagers. Eleven (73%) of the fathers stated that as children and adolescents they had not one close friend to talk with (Table 7). An exceptional number of fathers reported serious suicidal ideation (7/47%) during their adolescence, and three of them made

suicide attempts as adolescents. In a recent study of suicidal ideation in normal adolescents (those who did not present psychiatric symptoms), Pfeffer (1988) found that between 8.9 and 17.9 percent manifested "suicidal ideation."

During the final interview, I attempted to get a "feel" for what it was like to be a child and an adolescent in their parents' homes. The sense that one gets was of a home in which the adults were perceived as unpredictable, frightening, invasive, and at times blatantly dangerous. Their homes were affected by a high incidence of parental mental illness and alcohol abuse (7/47% of the families had at least one parent who manifested psychotic type symptoms, and 7/47% had at least one parent who abused alcohol; in only one family was the same person both psychotic and alcoholic). There was also a high incidence of depression (14/93% of the subjects described their parent(s) as being usually depressed and/or unhappy). The incidence of schizophrenia in the general population is 0.7% to 1% (Gottersman & Shields, 1982). The prevalence of depressive disorders in women in the United States ranges from 9% to 26% for those women

with a history of depression, and 4.5% to 9.3% for those who currently manifest depression. The prevalence in the United States for depressive disorders in men ranges from 5% to 12% for those men with a history of depression, and 2.3% to 3.2% for those men who currently manifest depression (DSM III-R, 1987). The National Clearing House for Alcohol Information (personal communication, November, 1990) reports that the national incidence of alcohol abuse in the period from 1945 to 1955, when most of the subjects in our study were living with their parents, was between 2.5% and 3%. The present rate of alcohol abuse in the United States is between 4.7% and 7.2%.

One father (Case 7, Appendix C), in an attempt to describe life as a child with his caretakers, offered ["I learned the art of being there and not being there at the same time, that's how I stayed alive.], and another (Case 15, Appendix C) stated, ["No matter what I said or did, I couldn't be right . . . somehow I was always wrong."]. Several others described themselves as [having felt markedly hopeless, helpless, unhappy and depressed]. None of the fathers remembered their childhood and adolescent home environment as having

been secure, consistent, or happy. However, several 98/53%) credited their mothers as having been good caretakers [prepared meals, prepared clean clothing, and encouraged religious training].

One observes the toll that early psychological trauma has taken on the fathers in this study. On the one hand, the typical subject in this study has survived an often horrendous childhood and adolescence. He has sought out a female partner, courted and married her, fathered at least one son, worked steadily at a good paying job, and remained in the marriage without separation or divorce for about 20 years. However, on the other hand, as adults they present a cluster of psychological problems in relation to both their wives and their sons (IDPs) that strongly suggest a less than adequate psychological adjustment to family life (Tables 8, 9, and 10).

Their marriages are far from happy relationships. As noted, 13 (87%) admitted to being unable to show affection towards their wives, talk to their wives, or spend time with their wives. Many of the men have found ways to be unavailable husbands and fathers by working unusually long hours (9/60% work over 60 hours

a week), often at multiple jobs, when their family expenses do not indicate the need for additional income. The percentage of adult males who work more than 45 hours a week in the United States is eight percent (United States Census Report, 1980).

The high incidence of sexual dysfunction presented by the men in this study is conspicuous. A prominent number (11/73%) reported a variety of sexual difficulties (i.e., diminished arousal, erectile failure, premature ejaculation, and ten of the men acknowledged [just not being interested in sex]. The estimate of the prevalence of nonorganic sexual dysfunction in the normal population ranges from approximately 8 to 30 percent for adult males (Kaplan, 1974; DSM III-R, 1987). The subjects have clearly been both physically and emotionally unavailable and non-supportive husbands.

As shown in Tables 5 and 10, an important bit of data must be highlighted at this time. While the subjects have portrayed themselves as being conspicuously absent from their marriage, they also reported that their own fathers (IDPs' grandfathers) were intimately involved with their own mothers (IDPs'

grandmothers). The intimacy that the subjects' own fathers initiated and generated in the subjects' parents' marriages contrasts strongly with the subjects' own marriages.

The data that were collected on the GOLPHs and during the final interview (Table 11) strongly indicate that the subjects have been "live in" absentee fathers to their sons (IDPs). They have shown minimal interest in their sons' developmental milestones, i.e., physical, psychological, or academic. Further, they have been emotionally and physically unavailable to their sons from the time of their earliest cuddling needs, through their developmental stages, and into their present young adult life. Eleven (73%) acknowledge that they encourage their sons to spend more time with their mothers.

During the first interview, the fathers were asked to clarify what they meant when they reported that their wives wanted a "closer marital relationship" (Table 9). Their answers were quite surprising. All 12 men who indicated that their wives wanted a closer relationship specified that their wives wanted more time together, better communication, more tenderness,

and a more active sexual relationship. They also stated that their wives wanted them to spend more time with their sons (IDPs) and to be more involved in the day-to-day care of the IDPs.

Implications of Research

Avoidant style. The first implication to be made concerns the fathers' striking consistency in their personalities (see Tables 2, 4, 6, 7, 8, 10, and 12). One observes their avoidant coping style evolving since early childhood.

Horney (1937) suggested three possible personality styles that a child might develop. The first she described as "moving toward people" which she considered the most desirable. The children who develop this style feel comfortable with other people and do not perceive the adults in their world as invasive and dangerous. These children have a healthy sense of self and are able to take the risks necessary for emotional growth. The second style, that a child might develop, she described as "moving against people." This style of interacting is observed in the children who blatantly refuse to obey, who are rebels. These children as adults might manifest anti-

authoritarian behavior. Quite often a child or adolescent will adopt aspects of the first two styles only to find that a less dangerous course of behavior is to move towards the third style which Horney called "moving away from people." Arieti (1974) suggested that children who adopt this third style of moving away from people have adopted an avoidant protective character armor to defend and protect themselves in a world in which the adults are experienced as being both unreliable protectors and dangerous. He also offered that the adjustment to an avoidant personality posture is a preschizophrenic condition. However, it is well known that not all preschizophrenics develop schizophrenia.

The schizoid personality. I am going to suggest a diagnostic category that, based on the data, best describes the fathers who were studied. The data that were collected, both from the GOLPH and the personal interactive interviews, strongly suggest that they embrace the criteria for the diagnosis of schizoid personality disorder as defined in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R). The diagnostic criteria for

schizoid personality are presented in Table 13. As is apparent, the man who was once the frigid child, preadolescent, or adolescent, and who adopted a "moving away from people" posture to protect his psychological integrity, has evolved to a preschizophrenic condition, the schizoid personality. Within the framework of this diagnosis, the father's behavior in the family system is more readily evaluated.

Passive manipulative. I have formulated the term "passive manipulative" to help sketch my portrait of the fathers of schizophrenic sons. The passive manipulative personality, as I perceive him, is an individual who appears to be a helpless victim in his environment. Yet, he is actually, with passive and subtle skills, manipulating his environment. For example, the husband who withholds emotional and/or sexual support from his wife and thereby pushes her to find emotional support from a child is passive manipulative. For the subject in this study, such a mechanism works well to defend a fragile avoidant ego.

Perhaps I understood the "passive manipulative" quality of these men most clearly when one (Case 8, Appendix C) winked his eye, leaned forward and

Table 13

The Diagnostic Criteria for Schizoid Personality Disorder (DSM-III-R, 301.21) Requires That a Person Manifests Any Four of the Following Symptoms (p. 340).

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1. Neither desires nor enjoys close relationships, including being part of a family.

2. Almost always chooses solitary activities.

3. Rarely, if ever, claims or appears to exhibit strong emotions such as anger or joy.

4. Indicates little, if any, desire to have sexual experiences with another person (age taken into account).

5) Is indifferent to the praise and criticism of others.

6) Has no close friends or confidants (or only one) other than first degree relatives.

7) Displays constricted affect, e.g., is aloof, cold, rarely reciprocates gestures or facial expression, such as smiles or nods.

Note. From The Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised) (p. 340), Washington, D.C.: The American Psychiatric Association. Copyright 1987 by The American Psychiatric Association. Adapted by permission.

whispered, "I think the only reason I knocked her up was to give her a kid and get her off my back." This manipulativeness is employed mainly to support their protective shield and is not the same as passive aggressive. Their need to defend their avoidant style is so strong that they will rise to the occasion and play the role of the "friendly nice guy," when necessary. I encountered this type of manipulation, quite routinely, in my family therapy work with schizophrenic patients and their families. However, I was always led to believe (or just assumed) that the fathers were somehow the unfortunate victims of others and/or circumstance. Hindsight in this case could be a helpful teacher. I recall the many apparently "easy-going" fathers who so obligingly jumped at the opportunity to begin family therapy only to embark upon a series of personal no-shows that were supported by creative accounts of unforeseen woe. One father (not a subject in this study), after five minutes with his family and myself, was told that I perceived the family system as the patient, and not his son. I asked the family members if they would all agree to a series of family sessions. The father was the first to agree,

""Sure, 'Irv' (I was wearing a badge that stated, "Irwin Schatz, Clinical Psychology"), it's a great idea, it'll really help them . . . 'Irv'." (The seduction had begun.) On the way out of my office, he put his arm on my shoulder and offered, "You're the best therapist they've ever had." I was an inexperienced intern and responded too quickly, "I can understand you feeling that way, you've known me all of five minutes." I realize now, as my research has developed, that what I was sensing was an annoying and obsequious manipulativeness. This type of behavior was often manifest during the present study. As noted earlier, all of the first 15 fathers who were referred as subjects agreed to be a part of the study, almost without question, and they continued to be too ready to please throughout the interview process.

Causation

The schizophrenogenic mother. This work has sketched a picture of the fathers as having distinctive psychopathology and of playing an important role in family dysfunction. As noted, Fromm-Reichmann (1948) introduced the unfortunate term "schizophrenogenic mother" to describe some observations she had made of

some mothers of her schizophrenogenic patients. Fromm-Reichmann described these mothers as neurotic, overprotective, highly anxious women who are over-involved in the lives and care of their schizophrenogenic children. The introduction of the term "schizophrenogenic mother" opened a Pandora's box that seems to have signaled permission to assail the mothers of schizophrenics for the next forty years.. Rosen (1962) rose to the occasion and described these overburdened women as "perverse." Sullivan (1953, 1964); Rosen (1962, 1963); Hill (1955); Bateson et al., (1956); Lu (1961); and Lidz et al. (1965) all described the mothers as malevolent, sick women who have an investment in maintaining their children's illness and, in some unexplained way, receive symbiotic nurturing from their schizophrenic children. Further, the so-called schizophrenogenic mother has been perceived as being emotionally married to the schizophrenic, and of pushing her husband out of the marriage and depriving him of access to the schizophrenic for the purpose of maintaining a symbiotic relationship with her child (Rosen, 1962). Some of the mothers of the schizophrenic sons in this study have been described as

presenting an array of problems. However, at the same time, many of them appear to be both caring wives and mothers who apparently work by themselves to hold the marriage together and care for their sick sons and other children. Several of the women work at responsible part-time jobs in addition to their burdensome home responsibilities. A study of the mothers of schizophrenic sons is not the scope of this work. However, the GOLPH did collect quite a bit of data regarding the mothers (Tables 9 and 11, and Appendix C). When one reviews this information in relation to the data regarding the fathers in this study, the validity of a concept of the "schizophrenogenic mother" quickly disintegrates. As we have been taught by the sample of fathers in this research, the writers on the subject of the schizophrenogenic mothers have been overlooking an important variable in the world of schizophrenia . . . the schizophrenic's father.

Double-Bind theory. The fathers and their families have apparently experienced what Bateson et al. (1956) described as the Double-Bind theory of schizophrenia. As the reader will recall, the Double-

Bind concept suggests that in the family of the schizophrenic or preschizophrenic the individual has, during childhood and/or adolescence, repeatedly experienced what can be described, colloquially, as a "damned if you do and damned if you don't" family system. The necessary components for a double-bind situation are:

1. Two or more persons.

2. Repeated experience. We assume that the double-bind is a recurrent theme in the experience of the victim.

3. A primary negative injunction. . . . either of two forms: (a) "Do not do so and so or I will punish you," or (b) "If you do not do so and so I will punish you."

4. A secondary injunction conflicting with the first at a more abstract level, and like the first enforced by punishments or signals which threaten survival. This secondary injunction is more difficult to describe . . . by nonverbal means. Posture, gesture, tone of voice, meaningful action and the implications concealed in verbal comment may all be used to convey this more abstract message.

5. A tertiary negative injunction prohibiting the victim from escaping from the field.

(p. 258)

Bateson further suggested that once the individual learns to perceive the world in double-bind patterns, "almost any part of a double-bind sequence

may then be sufficient to precipitate panic or rage" (p. 259).

An important aspect of the Double-Bind theory has apparently been overlooked by most mental health writers. Bateson and his associates noted that they did not assume that double binding was only by the schizophrenic's mother. They suggested that is was part of a family process involving different combinations of the father, the mother, and possibly other siblings.

The fathers in this study have apparently experienced the double-bind process both as child and adolescent victims in their own parents' homes, and again as an adult component of their own pathogenic family system. I hasten to add that I am using the term "pathogenic" In place of "schizophrenogenic." Firstly, because the term "pathogenic" is somewhat vague as is knowledge of the etiology of schizophrenia at this stage. Secondly, the label "schizophrenogenic" is an imprecise term that, through overuse, misuse and abuse has been given the appearance of being a proven concept. I must acknowledge that in the past, whenever I heard the label "schizophrenogenic," it conjured up

images such as mother, bad mother, symbiotic, as well as the mother being the source of schizophrenia. It would be productive if mental health workers forfeited the label in their work and their writing; it would allow us to observe the schizophrenic and his family from a fresh, unbiased perspective.

The findings of this study propose that the fathers of schizophrenic sons, contrary to the preponderance of the literature, are not the passive, weak, relatively healthy victims of a markedly pathological wife who is symbiotically fused to their schizophrenic child. On the contrary, the fathers who were interviewed present a cumulative profile of marked individual psychopathology and manipulativeness. They are apparently active participants in their present families' pathogenic system.

Limitations of Findings

One limitation of these findings is that the data collected by the GOLPH is based on the fathers' recall. I have no independent means of verifying the information provided. At this stage in the development of the GOLPH, we do not know the extent to which this instrument steers the respondents to particular

responses nor do we know the extent to which the shared pathologies of these fathers lead to the shared distortions in recall.

A second limitation is that no attempt to sample the universe of fathers of schizophrenic sons was made. Since the fathers were recruited through a family therapy program, intact families are over-represented. Additionally, the fathers were of working and middle-class status. I did not interview fathers of poor and/or broken families and, therefore, my results may be less applicable to these groups.

Finally, the study focused on the fathers of schizophrenic sons and may not be applicable to the fathers of schizophrenic daughters.

Suggestions for Further Research

The outcome of this study suggests that further, more formal inquiry is indicated to evaluate both the fathers' personality and his role in the schizophrenic's pathogenic family.

As noted, the fathers of schizophrenic sons, in this study, meet the criteria for the diagnosis of schizoid personality. This is a compelling finding, and a controlled investigation with a larger

representative random sample is indicated.

The fathers of schizophrenic sons apparently have unique and significant roles in their family processes, and again further, more formal qualitative research to evaluate the exact nature and nuances of their roles is important.

As the reader is aware, the usual psychotherapeutic stratagem with the schizophrenic and his family has been to (1) treat the schizophrenic in individual psychotherapy and/or treat the patient's mother in individual psychotherapy, (2) involve the entire family in family therapy and see the mother and/or patient in individual therapy. These approaches, or some variation, is directed at helping the "schizophrenogenic" mother to release her hold on the patient. The results are usually poor.

The high rate of success, that I noted earlier, in my work came about when I changed the above techniques and directed the therapy at the fathers of my patients. I began to treat the fathers in individual supportive therapy, and the family as a unit; or I treated the father in individual supportive therapy, and the couple as a unit.

The rationale for the change in my therapeutic stratagem was to finally put the therapeutic focus on the father's individual pathology, while treating the family's pathological system of communicating with each other, and additionally, to take the therapeutic emphasis away from the mother and the schizophrenic son.

I strongly feel that the fathers of schizophrenic daughters are a group of men who must be studied. During the four-year period that I worked as a psychologist in both inpatient and outpatient facilities, I had the experience of observing several families of young schizophrenic women. I was struck with the conspicuous styles of the fathers of these patients. They were usually much "too close" to their daughters, i.e., hugging them during interviews, touching their legs and/or arms during interviews, using them as confidants, and generally burdening the women with too much "closeness." In short, they appeared to fit the description of the "schizophrenogenic" parent much more so than did the mothers in those families. In fact, the mothers of the schizophrenic daughters presented themselves as being

generally well integrated, less anxious, and less intrusive than their husbands. However, I hasten to add, research to study the fathers of schizophrenic daughters is strongly indicated and my statements are based on observations that I made while working as a therapist with the families of several young schizophrenic women.

Finally, the "passive manipulative" style of the fathers in this research must be evaluated. Firstly, they are obviously much more influential in their family systems than the literature suggests; and secondly, they are apparently so skillful in their ability to "passively manipulate" their world, that they have successfully kept the focus on their wives and sons and kept themselves out of the psychological literature for the past fifty years.

APPENDIX A

Sample GOLPH Frames

Sample GOLPH Frames

Some sample frames from the Giannetti on-line Psychosocial History (GOLPH)

1. Dash lines are used to separate the GOLPH frames.
2. Editorial comments will appear in brackets.
3. The numbers assigned to the sample frames are not necessarily in the same order as presented to subject.

---------- SAMPLE FRAME 1 ----------

Using the numeric keypad, enter the number(s) of those sections which you do NOT wish to administer, then enter +.
If you wish to administer, all sections, press 10.

01. Family of origin
02. Developmental History
03. Educational History
04. Marital History
05. Occupational History
06. Military History
07. Legal History
08. Symptom Screen - Physical
09. Symptom Screen - Psychological
10. Administer all sections

---------- SAMPLE FRAME 2 ----------

Which of the following best describes your religion?

01. Catholic or Eastern Orthodox
02. Protestant, non-denominational
03. Protestant or other Christian denomination
04. Jewish
05. Religion other than Christian or Jewish
06. Agnostic
07. Atheist
08. No religious preference

[If 01 is chosen in frame 2, then the next frame will be]

---------- SAMPLE FRAME 3 ----------

Are you

01. Catholic
02. Greek Rite Catholic
03. Russian Orthodox
04. Greek Orthodox
05. Armenian Orthodox
06. None of the above

[However, if 04 is chosen on frame 2, the next frame will be]

---------- SAMPLE FRAME 4 ----------

Are you

01. Orthodox Jewish
02. Conservative Jewish
03. Reformed Jewish
04. Other Jewish denomination

---------- SAMPLE FRAME 5 ----------

Which of the following best describes your marital status at this time?

01. Never married
02. Annulled marriage
03. Married (including common law)
04. Married but separated because of marital problems
05. Divorced
06. Widowed

---------- SAMPLE FRAME 6 ----------

Have you had any children (including any that may have died)? Press all that apply.

01. Natural child(ren)
02. Adopted child(ren)
03. Stepchild(ren)
04. Foster child(ren)
05. I have had no children

[If 01 is chosen in frame 6, than the next frame will be sample frame 7. However, if more than 1 choice was indicated, for example, if the subject pressed 01, 02 and 04, then the next series of frames would be sample frames 7, 8 and 9.]

---------- SAMPLE FRAME 7 ----------

How many natural children have you had? Type in number.

---------- SAMPLE FRAME 8 ----------

How many children have you adopted? Type in number.

---------- SAMPLE FRAME 9 ----------

How many foster children have you had? Type in number.

SAMPLE FRAME 10

Which of the following best describes where you live?

01. Household (home, apartment, trailer, hotel, etc.)
02. Military base barracks
03. In a hospital, nursing home, or other health care facility
04. At school, even if school is not your permanent address
05. At my place of work (for example, domestic worker living in)
06. In a camp (migrant, construction, convict)
07. On a boat or vessel
08. In a residence for members of a religious order
09. Other

SAMPLE FRAME 11

Who lives there with you? Press all that apply.

01. Your spouse
02. Parent(s)
03. Your natural child(ren)
04. Brother(s) or sister(s)
05. Other child(ren)
06. Living with my boyfriend
07. Living with my girlfriend
08. Other relatives - either yours or your spouse's
09. Other non-relatives
10. None of the above

SAMPLE FRAME 12

Have you ever had any previous outpatient mental health services or counseling of any kind?

01. Yes 02. No

[If 01 is selected in frame 12 then frame 13 is presented]

SAMPLE FRAME 13

Have you ever been hospitalized in the past for emotional troubles or a nervous breakdown? Do not count hospitalizations that were for alcohol or drug detoxification only.

01. No
02. Yes, once
03. Yes, twice
04. Yes, three times
05. Yes, four times
06. Yes, more than four times

---------- SAMPLE FRAME 14 ----------

Have you ever been hospitalized in the past for alcohol or drug detoxification?
01. No 02. Yes

[If 02 is selected in frame 14, then the next frame is]

---------- SAMPLE FRAME 15 ----------

How many times have you been hospitalized for alcohol and/or drug abuse? Type in number.

[If, for example, after a series of questions, the subject's responses suggest possible drug abuse, then frames 16 through 22 are just a few of the possible branching questions that might be presented to evaluate his or her level of addiction].

---------- SAMPLE FRAME 16 ----------

Are you currently (Press all that apply)

01. Under a doctor's care for a physical problem, actual or suspected?
02. Using any prescribed medications
03. Using any medications available without a prescription
04. None of the above

---------- SAMPLE FRAME 17 ----------

Press all of the following drugs that you have used even if you used them without a prescription.
[Followed by an extensive list of legal and illegal drugs]

---------- SAMPLE FRAME 18 ----------

What age were you when you started taking drugs? Type in age.

---------- SAMPLE FRAME 19 ----------

How often do you take drugs now?
[Followed by several choices]

---------- SAMPLE FRAME 20 ----------

Have any of the following happened to you because of drug use? Press all that apply.

01. Missed work
02. Trouble at work
03. Trouble with family/friends
04. Lost friends
05. Trouble with the law
06. Became violent
07. Lost interest
08. Suicidal thoughts
09. None of the above

---------- SAMPLE FRAME 21 ----------

Compared to when you first started using drugs, do you have to use more now to get the same effect?

01. Yes 02. No

---------- SAMPLE FRAME 22 ----------

Have any of the following happened to you if you stopped using narcotics for a while? [Followed by a list of psychological and physical symptoms]

---------- SAMPLE FRAME 23 ----------

As a child or teenager did you ever (press all that apply)

01. Get sexually molested
02. Run away from home
03. Hurt yourself on purpose, but were not trying to kill yourself
04. Seriously think about killing yourself
05. Try to kill yourself
06. None of the above

[If, for example, one of the subject's choices on frame 23 was 01, then the GOLPH program would branch to the follow-up question in frame 24].

---------- SAMPLE FRAME 24 ----------

Who sexually molested you?

01. The man who was raising me
02. The woman who was raising me
03. A relative
04. A non-relative

---------- SAMPLE FRAME 25 ----------

Did he [your father] ever use physical punishment on you?

01. Yes 02. No

---------- SAMPLE FRAME 26 ----------

I felt that my father

01. Loved me too much
02. Loved me about right
03. Liked me, but didn't really love me
04. Put up with me
05. Disliked me, but didn't really hate me
06. Hated me

SAMPLE FRAME 27

He [my father] was

01. Too affectionate, hugged or kissed me so much that it bothered me
02. Affectionate enough, but not too much
03. Affectionate now and then
04. Not affectionate enough
05. Never affectionate

SAMPLE FRAME 28

Choose up to three adjectives from those below. Do not choose two from the same line.

01. Warm	02. Cold
03. Patient	04. Impatient
05. Gentle	06. Hard
07. Honest	08. Dishonest
09. Generous	10. Stingy

11. None of the above

SAMPLE FRAME 29

Again, choose up to three from those below that describe him the best.

01. Responsible	02. Weak
03. Realistic	04. Immature
05. Hardworking	06. Mostly unhappy
07. A good money manager	08. Insecure
09. A success	10. A failure

11. None of the above

SAMPLE FRAME 30

Parents usually tell children, or show them by example, that certain things in life are very important. BEING TOLERANT, for example, (being fair and not judging other people because they are different in color, religion, background or have opinions different than yours), indicate if it was

01. Overly important	03. Not stressed
02. Very important	04. Discouraged

05. Disagreement

SAMPLE FRAME 31

The following questions are about your marital relationship.

Not talking about feelings

01. Not a problem	03. My partner's problem
02. My problem	04. Both of our problem

APPENDIX B

Demographics for Fifteen Subjects

Appendix B

Demographics For Fifteen Subjects

S	AGE	RACE/ CREED	MARITAL STATUS	CHILD #	TRADE	HOURS WEEK	GROSS/ ANNUAL
1	46	JE WH	MARRIED	1 S	HOME REPAIRS	70	39,000
2	44	BA BL	MARRIED	1 S	COMPUTOR DESIGNER	60	43,200 WIFE:PT 16,800
3	44	CA WH	MARRIED	2 S	NIGHT WATCH-MAN	55	24,000 WIFE:PT 4,800
4	50	JE WH	MARRIED	1 S	OWNS & DRIVES TAXI	60	18,000 WIFE:PT 9,600
5	52	CA WH	MARRIED	1 S	OWNS MUSIC	65	38,400
6	51	PR WH	MARRIED	1 S	HOUSE PAINTER	50	19,200
7	53	GK OR WH	MARRIED	1 S	CHEF	60	26,400
8	57	BU CV WH	MARRIED 2X, SEP IDP'S M	1 S	MOVIE EDITOR	60	60,000

S	AGE	RACE/ CREED	MARITAL STATUS	CHILD #	TRADE	HOURS WEEK	GROSS/ ANNUAL
9	54	EP WH	MARRIED	1 S	BOOK-KEEPER	55	34,800 WIFE:PT 6,000
10	48	JE WH	MARRIED	1 S	PATTERN MAKER	60	42,000
11	59	CA WH	MARRIED	3 D 2 S	OWNS CAR WRECKING BUSINESS	62	48,000
12	57	BA BL	MARRIED	1 S 1 D	DAIRY DRIVER	56	21,600 WIFE: 10,200
13	42	CA WH	MARRIED	2 S	TRUCK DRIVER	61	30,000
14	59	JE WH	MARRIED	1 S	TILE MAN	60	30,000 WIFE: 12,000
15	48	CA WH	MARRIED	3 S	POSTAL WORKER	40	32,400

Note. The following abbreviations were used in the presentation of the data, Baptist(BA), Buddhist(BU), Catholic(CA), Episcopalian(EP), Greek Orthodox(GK,OR), Jewish(JE), converted(CV), times(x), separated(SEP), Identified Patient(IDP), Mother(M), full-time(FT), and part-time(PT), daughter(D), son(S), and children(CHILD).

APPENDIX C

Complete GOLPH Reports for Fifteen Subjects

Case 1: Allen C.

Identifying Data

Allen C, is a 46 year-old white Reformed Jewish male. He is employed full-time working 70 hours per week as a carpenter and performing general repairs and taking home $3,250 per month. The client is married and has had one natural child. He resides in a multiple family dwelling, which he owns, and has lived there for about 19 years. He lives with his spouse and one natural child from his current spouse. He has had no previous psychiatric hospitalizations, two hospitalizations for alcohol detoxification, and no previous outpatient mental health services. [His son, diagnosed schizophrenic, is 21 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother is still living. The natural father died in an accident when the client was 27 years old.

He has one older sister. The natural mother is reported to have suffered from depression, acted hyperenergetic at times, had problems with headaches, and visited a physician frequently. The natural father is reported to have had back/neck pain. His sibling is reported to have suffered from depression and acted hyperenergetic at times. When the client was born, his mother was 25 years old. He describes his mother as being confident, energetic, talkative, and generous, yet also impatient and hard. She was viewed as hardworking and a good money manager, but unrealistic, immature, mostly unhappy, and short-tempered. The client perceives his mother as having liked, but not loved, him. The mother reportedly was not physically affectionate enough but was bothersomely attentive. The client could not talk to her about problems. She is said to have been overly fault-finding, but sometimes accepting. His mother is seen as having invaded his privacy and demeaned his accomplishments. She is reported to have been an extremely strict disciplinarian who always wanted to know where the client was going or what he would be doing. When they disagreed, the client could not persuade her to change her mind. If the client misbehaved, punishment was inevitable. To punish the client psychologically, the mother would ignore him, yell at him, tell him that she was ashamed of him, make him feel that she had been hurt, embarrass him, and take away privileges. She never used corporal punishment.

When the client was born, his father was 27 years old. He describes his father as being shy, cautious, quiet, cold, dishonest,

and stingy. He was viewed as responsible and hardworking, but a failure, weak, immature, and mostly unhappy. The client perceives his father as having liked, but not loved him. The father reportedly was intermittently affectionate and gave very little time and attention, The client could talk to him about very few problems. He is said to have been accepting, but appropriately critical. His father is seen as having ignored most of the client's activities but occasionally praised him for his accomplishments. He is reported to have been not very strict and gave the client unrestricted freedom of action. When they disagreed, the client could usually get him to give in. If the client misbehaved, punishment was infrequent. To punish the client psychologically, the father would yell at him and tell him that he was ashamed of him. Typical corporate punishments were hand-spanking and shoving.

The client's family strongly valued being religious and being married.

He thinks that being ambitious, working hard and trying your best, being responsible, being self-disciplined, obeying authority, and having a close family were overemphasized to the point of being bothersome. Being self-reliant, asserting your beliefs, appreciating art/culture, and openly expressing feelings were discouraged. There was disagreement in the family over the importance of getting an education.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He had problems learning to dress himself. Before age 13, he considers himself to have been neither happy nor unhappy. He reports thumb sucking after age 5, nail biting after age 5, stuttering after age 5, and enuresis after age 4. He recalls being very afraid of monsters. He had difficulty with learning activities requiring coordination, short-temperedness, excitability, and moodiness. He recalls frequent lying. He was ill no more often than peers.

As a child and teenager, he denies sexual molestation, running away from home, deliberate self-injury, suicidal preoccupation, and attempted suicide.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself too short and unattractive. He describes himself as talkative, hardworking, and a conservative, yet also awkward, unhappy, and felt like he didn't fit with others. His caretakers were strict about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 15, later than most of the boys he knew. He first learned about sex from a book and received a reasonably accurate

explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 21. On the average, he dated every week. His parents objected to and tried to interfere with the people he dated. He dated one person only. He first had heterosexual intercourse at age 22 and reports feeling nervous and guilty. He reports having had one sex partner. Currently, he would rather avoid sex. He denies having had homosexual experience before age 18 or afterwards. Before age 18, he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed high school in 1960.

The client attended one public high school. His academic performance was in the C range. He denies major antisocial behavior. He describes himself as being neither shy nor outgoing, not popular nor unpopular with other students, and having mixed feelings about high school much of the time.

Marital History

The client's current marriage began when he was 22 years old, and his spouse was 24 years old. He was not married prior to his current marriage.

The client's partner is a 48 year-old white Jewish female. She is a homemaker. She had a high school education. He describes his partner as being outgoing, energetic, talkative, and warm, yet also impatient and hard. He states his partner is irresponsible, unrealistic, a failure, immature, mostly unhappy, and insecure.

In their relationship he reports that they both have problems with talking about feelings, the sexual relationship, and friends. The client admits to problems with the amount of time spent together and showing affection. Arguments occur once or twice a year. Child rearing has been problematic because extreme nervousness or fear and an attempted suicide occurred with his schizophrenic son.

Occupational History/Financial Status

The client is self-employed in his own business and is paid in profits. He has had this job for 20 years, is very happy with it, and is not thinking about changing jobs. The positive aspects of the job are the compensation and interesting work. He has had two previous jobs in the same occupation. He has never quit a job.

Income supports three people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities.

Primary responsibility for money management resides with the client.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other legal conflicts.

Physical Symptom Screen

Last physical exam occurred within the last year and the physician did not say that problems were detected. Within the last year he visited a dentist, and he is having no dental or gum problems. He has never had surgery. Current physical health is rated as good. He reports having blood relatives with cancer. He has no known allergies. Recently, he has had abdominal pain. As to sexual intercourse, he complains of inhibited arousal/interest.

Psychological Symptom Screen

He began drinking alcohol at age 23 and now drinks once or twice a month. He usually drinks hard liquor. He denies usual diagnostic signs of pathological alcohol use and psychosocial impairment. He reports no increase in tolerance over time. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood and diminished energy level accompanied by difficulty concentrating, loss of interest in sex, social withdrawal, and irritability. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/ hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, and feeling unrefreshed by sleep.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
Alcohol
Pathological Use:
Tolerance/Withdrawal
hospitalized for detoxification
None endorsed

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives.)
None endorsed

Mood Symptoms (290.xx; 293.83; 292.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives.)
Depression
depressed mood
loss of interest in sex
difficulty concentrating
social withdrawal
diminished energy
irritability

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
None endorsed

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
Gastrointestinal
abdominal pain
Pain
abdominal pain
Psychosexual symptoms
not interested in sex or can't become aroused

Psychosexual Problems (302.xx; 306.51)
not interested in sex or can't become aroused

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia
early awakening
nonrestorative sleep

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
persistent lying (age less than 13)

Other Potential Adult Problems/Stressors
Domestic
child with anxiety problems before age of 12
child attempted suicide

Case 2: John M.

Identifying Data

John M. is a 44 year-old black Baptist male. He is employed full-time working 60 hours per week as a computer programmer and taking home $3,600 per month. Income of approximately $1,400 per month comes from his spouse's employment. The client is married and has had one natural child. He resides in a single family home, which he owns, and has lived there for about 14 years. He lives with his spouse and one natural child from his current spouse and 1 other relative (his wife's mother). He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. [His son, diagnosed as schizophrenic/paranoid type, is 17 years of age.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and two stepfathers. The natural father lived with the client only when he was very young because he died in an accident when the client was four years old.

The natural mother died from illness when the client was 43 years old.

He has had no siblings. The natural mother is reported to have suffered from a serious medical condition.

He considers himself to have been raised primarily by his natural mother and no particular man. When the client was born, his mother was 18 years old. He describes his mother as being outgoing, confident, and honest, yet also quiet, cold, and impatient. She was viewed as responsible, hardworking, a good money manager, and strong, but mostly unhappy and short-tempered. The client perceives his mother as having loved him overly much. The mother reportedly smothered him with physical affection but made him feel she would have been better off without him. The client could not talk to her about problems. She is said to have been accepting, but appropriately critical. His mother is seen as having invaded his privacy but praised him for his accomplishments. She is reported to have been an extremely strict disciplinarian who always wanted to know where the client was going or what he would be doing. When they disagreed, the client could get a hearing, but it rarely changed anything. If the client misbehaved, punishment was usually forthcoming. To punish the client psychologically, the mother would yell at him and tell him that she was ashamed of him. The client was also threatened with abandonment. Typical corporal punishments were hand spanking, slapping, ear pulling, and hair pulling. The client reports that the mother punched him, kicked him, and hit him

with a solid object.

The client's family strongly valued being religious, getting an education, being patriotic, being ambitious, working hard and trying your best, being responsible, being self-disciplined, and obeying authority.

He thinks that having a close family was overemphasized to the point of being bothersome. Being self-reliant, openly expressing feelings, and being married were discouraged.

Developmental History.

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He reports thumb sucking after age 5, stuttering after age 5, enuresis after age 4, and frequent nightmares. He recalls being very afraid of the dark, certain animals, monsters, being kidnapped, and dying. He had difficulty with learning activities requiring coordination and sitting still. He recalls being a roughneck, being a daredevil, and getting in many fights. He was rarely ill.

As a child and teenager, he reports sexual molestation and suicidal preoccupations and denies running away from home, deliberate self-injury, and attempted suicide. He was sexually molested by his male caretaker [his second stepfather]. The first incident occurred at age 10 and reoccurred many times over a period of months [two years]. He reports three episodes of serious suicidal preoccupations beginning at age 11.

As a teenager, he was very healthy, had no unusual eating habits and considered himself unattractive. He describes himself as shy, awkward, unhappy, nervous, short-tempered, and hardworking. His caretakers were strict about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 12, at roughly the same time as most of the boys he knew. He first learned about sex from a relative and received an incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 24. On the average he dated less than once per month. His parents did not comment upon the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 25 and reports feeling sad, nervous, and guilty. He reports having had 2 sex partners. Currently, he can take sex or leave it. He had homosexual experience before age 18 but not afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed elementary school in 1959, junior high school in 1961, high school in 1963, and college in 1970.

He completed his elementary education in one public school. He reports that his performance was usually good. He reports problems in learning to do arithmetic, but took no special classes for learning problems. He admits to provoking fights, but took no special classes for behavioral problems. Socially, he describes himself as shy, not liked by most schoolmates, and as having no close friends. In general, he liked elementary school much of the time.

The client attended one junior high and one public high school. His academic performance was typically high B's. Extracurricular activities consisted of music. He had difficulty with school due to problems at home. He describes himself as being shy, somewhat unpopular with other students, and having mixed feelings about high school much of the time.

Marital History

The client's current marriage began when he was 25 years old, and his spouse was 17 years old. He was not married prior to his current marriage.

The client's partner is a 36 year-old black Christian female. She is employed and works full-time for 35 hours per week as a bank teller. She has a high school education. He describes his partner as being shy, cautious, cold, impatient, and hard, yet also energetic. His partner is responsible, realistic, and hardworking, but immature, mostly unhappy, and short-tempered.

In their relationship he reports that they both have problems with the sexual relationship and in-laws. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, and friends. Arguments occur at least weekly and have resulted in physical attack to the partner. The primary caretaker of the children in the home is his partner. Child rearing has been problematic because attempted suicide occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in regular salary. He is a union member. He has had this job for 18 years, is very happy with it, and is not thinking about changing jobs. The positive aspects of the job are the compensation, benefits,

interesting work, security, and personal fulfillment of it. He has been neither promoted nor demoted on this job. He has had 5 previous jobs in 3 different occupations. He has quit previous jobs because of opportunity for a better job and a return to school.

Income supports 3 people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse.

Military History

The client was drafted and served on active duty in the Army. He entered the service at age 19. Upon entering the service he had some college education. He attained the rank of E-11 and completed 9 months of active duty. He received an honorable discharge. While in the service, he was involved in wartime face-to-face combat. He witnessed American and civilian casualties and was not personally wounded. Events experienced in the service are currently distressing him.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and other legal conflicts.

Physical Symptoms Screen

Last physical exam occurred more than one year ago and the physician did say that problems were detected. Within the last year he visited a dentist, and he is having problems with his gums. He has had one surgery. Current physical health is rated as good. He reports having blood relatives with diabetes and cardiovascular disease/stroke. He has no known allergies. He has a history of high blood sugar. He has had frequent bronchitis. He has a history of hemorrhoids. He reports recent back pain.

Psychological Symptom Screen

He began drinking alcohol at age 17 and now drinks daily. He usually drinks vodka. He denies usual diagnostic signs of pathological alcohol use and psychosocial impairment. He reports no increase in tolerance over time. He denies use of unprescribed psychoactive drugs. He reports an episode of suicidal ideation accompanied by depressed mood, diminished energy level, and sleep disturbance. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory

distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. He reports having experienced a highly stressful event with prolonged consequences including intrusive memories, recurrent dreams about the event, experiencing the event as reoccurring, feelings of guilt about what happened, and sleep disturbance. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, excessive daytime somnolence, and awakening from nightmares.

Summary and Findings

Adult Problems

Note; *The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.*

Substance Use
- Alcohol (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
  - Daily drinking (a pint or more)

- Drugs
- None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - SUICIDAL IDEATION

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Traumatic stress
  - frightening situation followed by:
    - unwanted memories
    - repetitive dreams
    - flashbacks
    - guilt
    - sleep problems
- Other
  - obsessions

Somatoform Symptoms (300.xx; 307.80; 316.00)
(Of R/O physical etiology, somatization disorder requires 13 symptoms)
Pain
back pain

Psychosexual Problems (302.xx; 306.51)
None endorsed

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia
early awakening
nonrestorative sleep
daytime somnolence
awakened by nightmares

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
frequent fights (age less than 13)
started fights (elementary school)
frequent fights (high school)

Other Potential Adult Problems/Stressors
Loss
Domestic
frequent arguments with spouse
domestic violence
child attempted suicide

Case 3: Robert C

Identifying Data

Robert C. is a 44 year old white Catholic male. He is employed full-time working 55 hours per week as a night watchman and taking home $2,000 per month. Income of approximately $400 per month comes from his spouses employment. The client is married and has two natural children. He resides in an apartment, which he rents, and has lived there for about 14 years. He lives with his spouse and two natural children, a son and a daughter, from his current spouse. He has had no previous psychiatric hospitalizations and has had previous outpatient mental health services. [His son, diagnosed schizophrenic, is 18 years old, and the older child, a daugher, is 20 years old, with no apparent emotional disturbances.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

Both natural parents are still living.

He has one older brother and one older sister. The natural mother is reported to have suffered from depression. The natural father is reported to have had a nervous condition, required hospitalization for emotional problems, suffered from depression, attempted suicide, acted peculiarly at times, and visited a physician frequently. His siblings are reported to have had an emotional condition, required hospitalization for emotional problems, suffered from depression, attempted suicide, drank excessively, used drugs excessively, and acted peculiar at times. When the client was born, his mother was 25 years old. He describes his mother as being confident, warm, and honest, yet also shy, quiet, and impatient. She was viewed as responsible, hardworking, and strong, but unrealistic, mostly unhappy, and insecure. The client perceives his mother as having loved him. The mother reportedly was intermittently affectionate and gave him insufficient time and attention. The client could talk to her about very few problems. She is said to have been overly fault-finding, but sometimes accepting. His mother is seen as having been disinterested in most of the client's activities but occasionally praised him for his accomplishments. She is reported to have been not very strict and gave the client more freedom of action than desirable. When they disagreed, the client could usually get a hearing and a change of heart when it was reasonable. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the mother would yell at him, tell him that she was ashamed of him, and make him feel that she had been hurt. She never used corporal punishment.

When the client was born, his father was 26 years old. He describes his father as being awkward, not energetic, quiet, cold, hard, and stingy. He was viewed as irresponsible, unrealistic, a failure, weak, mostly unhappy, and insecure. The client perceives his father as having only put up with him. The father reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have criticized the client over almost everything. His father is seen as having ignored most of the client's activities and ignored his accomplishments. He is reported to have been a very lenient disciplinarian who gave the client unrestricted freedom of action. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the father would ignore him, yell at him, make him feel that he had been hurt, embarrass him, and take away privileges. The client was also locked in a room for more than an hour, abandoned, threatened with a dangerous object, threatened with his life, threatened with damage to his sex organs, threatened with police intervention, and given threats to his safety and well-being. Typical corporal punishments were hand-spanking, slapping, pinching, ear pulling, hair pulling, and shoving. The client reports that the father punched him, kicked him, bit him, hit him with a solid object, cut him, tried to smother him, attacked him with a weapon, and attempted to seriously injure or kill him.

He thinks that being responsible, being self-disciplined, obeying authority, and having a close family were overemphasized to the point of being bothersome. Being involved with sports, being self-reliant, asserting your beliefs, being socially active, and openly expressing feelings were discouraged.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been neither happy nor unhappy. He reports nail biting after age five, stuttering after age five, and frequent nightmares. He recalls being very afraid of the dark, monsters, and dying. He denies difficulties with coordination, excitability, and overactivity. He recalls being a roughneck, being a daredevil, repetitive stealing, setting fires, frequent lying, getting in many fights, and deliberate vandalism. He was ill no more often than peers.

As a child and teenager, he reports sexual molestation, running away from home, and suicidal preoccupations and denies deliberate self-injury and attempted suicide. He was sexually molested by his

[natural father] male caretaker. The first incident occurred at age 11 and reoccurred twice. He first ran away from home at age 12, repeated this once and once stayed away overnight. He reports two episodes of serious suicidal preoccupations beginning at age 12.

As a teenager, he was as healthy as others, and he had no unusual eating habits. He describes himself as outgoing, active, hardworking, and felt like he fit in with others, yet also unhappy and short-tempered. His caretakers were lax about rules and acted as if the client's judgment could be trusted only a little. He began to physically mature at about age 12, at roughly the same time as most of the boys he knew. He first learned about sex from a friend and received a somewhat incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 22. On the average he dated every week. His parents did not comment upon the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 23 and reports feeling satisfied. He reports having had one sex partner. Currently, he usually enjoys sex. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims to have had one very close friend with whom he could discuss nearly anything. He has one such friend now.

Educational History

The client completed high school in 1963.

The client attended one parochial high school. His academic performance was in the B range and included being put on probation. He had difficulty with school due to problems at home and having to work. He admits to repeated trouble with school authorities, repeated truancy, frequent fighting, and behavior resulting in referral to a counselor. He describes himself as being, shy not outgoing, not popular nor unpopular with other students, and having mixed feelings about high school much of the time.

Marital History

The client's current marriage began when he was 23 years old, and his spouse was 23 years old. He was not married prior to his current marriage.

The client's partner is a 44 year-old white Catholic female. She is employed and works part-time for 15 hours per week as a typist. She has some college education. He describes his partner as being shy, awkward, quiet, impatient, and hard, yet also warm. His partner is unrealistic, immature, mostly unhappy, and insecure, but responsible and hardworking.

In their relationship he reports that they both have problems

with the amount of time spent together. The client admits to problems with talking about feelings, showing affection, feeling jealous, and fidelity. Arguments occur once or twice a year. The primary caretaker of the children in the home is his partner. Child rearing has been problematic because extreme nervousness or fear and attempted suicide occurred with his offspring.

Occupational History/Financial Status

The client is working in his uncle's business and is paid in hourly wages and commissions. He has had this job for 12 years, is neither pleased nor displeased with it, and is not thinking about changing jobs. The positive aspect of the job is the interesting work. The negative aspects of the job are the compensation, benefit level, lack of future prospects, bad hours, and relationships with co-workers. He has had three previous jobs in two different occupations. He has never quit a job. He has been laid off twice.

Income supports four people, has increased somewhat over the past year, yet is insufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. He is having debt problems, but is not concerned about bankruptcy.

Military History

The client was drafted and served on active duty in the Army. He entered the service at age 18. When entering the service he had a high school education. He attained the rank of E-11 and completed two months of active duty. He was discharged early for medical reasons. He received a general medical discharge under honorable conditions. While in the service, he was involved in wartime face-to-face combat and ambushes. He witnessed American, allied, enemy, and civilian casualties and was not personally wounded. He was treated for emotional problems.

Legal History

The client denies having been picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other local conflicts.

Physical Symptom Screen

Last physical exam occurred more than one year ago and the physician did not say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with his teeth. He has never had surgery. Current physical health is rated as good. He reports having blood relatives with diabetes. He has also known allergies. The client reports recent problems with being

overweight. Since age 18, he admits to having engaged in self-induced vomiting, binge eating, crash dieting, and use of laxatives to control weight. He has had gonorrhea twice. He reports recent back pain, joint pain, and muscle cramps. He reports having had gout.

Psychological Symptom Screen

He has never used alcohol. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, anorexia, sleep disturbance, and suicidal ideation accompanied by a significant weight change, stomach/bowel problems, difficulty concentrating, loss of interest in sex, social withdrawal, agitation, and irritability. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, and excessive daytime somnolence.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
Alcohol

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems for pathology in first degree relatives)
Depression
depressed mood
loss of interest in sex

weight change
stomach/bowel problems
sleep disturbance
difficulty concentrating
agitation
social withdrawal
loss of appetite
diminished energy
irritability
suicidal ideation

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
Possible anxiety-related somatic symptoms, if physical etiology ruled out.
Muscle cramps.

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
Pain
back pain
joint pain

Psychosexual Problems (302.xx; 306.51)
None endorsed

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia
early awakening
nonrestorative sleep
daytime somnolence

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
truance (high school)
ran away from home overnight
frequent fights (age less than 13)
frequent fights (high school)
persistent lying (age less than 13)
theft (age less than 13)
vandalism (age less than 13)
repeated trouble with school authorities (high school)

Other Potential Adult Problems/Stressors
Domestic
child with anxiety problem(s) before age of 12
child attempted suicide
child diagnosed schizophrenic: paranoid type.

Case 4: Leonard S.

Identifying Data

Leonard S. is a 50 year-old white Reformed Jewish male. He is employed full-time working 60 hours per week as a cab driver and taking home $1,500 per month. Income of approximately $800 per month comes from his spouse's employment. The client is married and has two natural children. He resides in an apartment which he rents, and has lived there for about 22 years. He lives with his spouse and 1 natural child from his current spouse. He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. [His son, diagnosed as schizophrenic, is 23 years old, and his daughter, who lives and works on her own, is 25 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother is still living. The natural father died from illness when the client was 19 years old.

He has one older sister and one younger brother. The natural mother is reported to have acted hyperenergetic at times, had problems with headaches, and had back/neck pain. His younger brother is reported to have had a nervous condition and suffered from depression. When the client was born, his mother was 25 years old. He describes his mother as being outgoing, confident, and energetic, yet also cold, impatient, and hard. She was viewed as responsible, hardworking, and strong, but unrealistic, mostly unhappy, and short-tempered. The client perceives his mother as having only put up with him. The mother reportedly was never physically affectionate but was bothersomely attentive. The client could not talk to her about problems. She is said to have criticized the client over almost everything. His mother is seen as having invaded his privacy and demeaned his accomplishments. She is reported to have been very strict, although reasonable in some areas, and gave the client little freedom of action. When they disagreed, the client could not persuade her to change her mind. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the mother would yell at him, tell him that she was ashamed of him, and make him feel that she had been hurt. She never used corporal punishment.

When the client was born, his father was 35 years old. He describes his father as being warm and generous, yet also shy, cautious, quiet, and dishonest. He was viewed as responsible,

realistic, hardworking, strong, and mature, but short-tempered. The client perceives his father as having only put up with him. The father reportedly was not physically affectionate enough and gave very little time and attention. The client could not talk to him about problems. He is said to have been accepting, but appropriately critical. His father is seen as having been disinterested in most of the client's activities but occasionally praised him for his accomplishments. He is reported to have been reasonably strict but gave the client more freedom of action than desirable. When they disagreed, the client could get a hearing, but it rarely changed anything. If the client misbehaved, punishment was infrequent. To punish the client psychologically, the father would yell at him. Typical corporate punishment was hand spanking.

He thinks that being responsible, being self-disciplined, obeying authority, being married, and having a close family were overemphasized to the point of being bothersome. being self-reliant, asserting your beliefs, being socially active, appreciating art/culture, and openly expressing feelings were discouraged. There was disagreement in the family over the importance of being involved with sports, being ambitious, working hard and trying your best, and being 'manly' and tough.

Developmental History

At birth he was delivered normally. He had no birth defects. He is not aware with problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He reports thumb sucking after age 5, nail biting after age 5, stuttering after age 5, enuresis after age 4, insomnia, and frequent nightmares. He denies persistent childhood fears or phobias. He had difficulty with sitting still, completing tasks requiring concentration, short-temperedness, excitability, moodiness, showing off, and bragging. He recalls being a roughneck, being a daredevil, repetitive stealing, frequent lying, and getting in many fights. He was ill no more often than peers.

As a child and teenager, he denies sexual molestation, running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide.

As a teenager, he was as healthy as others, and he had no unusual eating habits. He described himself as shy, awkward, unhappy, nervous, a rebel, and felt like he didn't fit in with others. His caretakers were strict about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at age 13, later than most of the boys he knew. He first learned about sex from a friend and received an incorrect explanation. He felt that he could discuss nothing about sex with

his parents. He did not date by age 18, but began at age 20. On the average, he dated less than once per month. His parents did not comment upon the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 21 and reports feeling sad, nervous, guilty. He reports having had two sex partners. Currently, he has little interest in sex. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims to have had one very close friend with whom he could discuss nearly anything. He has one such friend now.

Educational History

The client completed high school in 1956.

The client attended two public high schools. His academic performance was in the C range. He denies major antisocial behaviors. He describes himself as being shy, somewhat unpopular with other students, and being usually unhappy in high school much of the time.

Marital History

The client's current marriage began when he was 23 years old, and his spouse was 21 years old. He was not married prior to his current marriage.

The client's partner is a 49 year-old white Jewish female. She is employed and works full-time for 35 hours per week as a travel agent, She has a high school education. He describes his partner as being cautious, cold, impatient, and hard, yet also energetic and talkative. His partner is unrealistic, mostly unhappy, insecure, and short-tempered, but hardworking and a good money manager.

In their relationship he reports that they both have problems with friends. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, the sexual relationship, managing money, alcohol use, and drug use. Arguments occur every day and have resulted in physical attack to the partner. The primary caretaker of the children in the home is his partner. Child rearing has been problematic because extreme nervousness or fear occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages, commissions, and tips. He has had his job for 25 years, is very unhappy in it, but is not thinking about changing jobs. The negative aspects of the job are the compensation, benefit level, lack of stimulating work, lack of future prospects, bad hours, management, relationships with co-workers, and lack of fulfillment

in it. He has been neither promoted nor demoted on this job. Complaints have been made about him regarding his alcohol abuse and he has had a formal complaint filed against him and been threatened with dismissal. He has had 10 previous jobs in the same occupation. He has never quit a job. He has been fired 5 times.

Income supports three people, has remained about the same over the past year, and is insufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. He is having debt problems, but is not concerned about bankruptcy. He has gambling debts. [He also admits that his daily alcohol and drug abuse take a hold on the family budget.]

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and other legal conflicts.

Physical Symptoms Screen

Last physical exam occurred more than one year ago and the physician did say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with both teeth and gums. He has had three surgeries. Current physical health is rated as poor. He has no known allergies. He reports having had recent coughing-up of blood. He has a history of liver disease/problems, jaundice, and ulcer. As to sexual intercourse, he complains of erectile difficulty and inhibited arousal and interest.

Psychological Symptom Screen

He began drinking alcohol at age 16 and now drinks daily. He usually drinks beer, wine, and hard liquor. He reports attempts to control his intake, difficulty controlling intake, having drunk throughout the day for more than a day, and drinking despite a contraindicating physical condition. Drinking has resulted in missed work, trouble in the job, arguments over drinking with significant others, traffic accidents, trouble with the law, and suicidal ideation. He reports some increase in tolerance over time. Upon discontinuation of drinking, he has experienced tremulousness, anxiety/tension, depression, and D.T.'s. He has attended AA meetings for his alcohol problem. He has used cocaine, hallucinogens, and cannabis. He began taking drugs at age 18, and uses them three or four times a month now. He reports using drugs

nearly every day for a month or more. Drug use has resulted in missed work, trouble on the job, and arguments over drug use with significant others. Compared to when he started using them, he reports an increase in the amount of drugs necessary to produce the same effect. Discontinuation of cocaine has produced depression, anxiety/tension, and agitation. He has received treatment for drug use. He reports that he has experienced the unrelated occurrence of persistent depressed mood and sleep disturbance. He reports no history of suicide attempts. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, excessive daytime somnolence, awakening from nightmares, and general sleeplessness.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol
  - Pathological Use
    - attempts to control drinking
    - difficulty cutting down or stopping
    - drank all day, more than one day
    - drinks despite physical problem
  - Psychosocial Impairment
    - missed work
    - trouble on job
    - arguments with family/friends about drinking
    - traffic accident
    - trouble with law
    - suicidal ideation
  - Tolerance Withdrawal
    - needs more for same effect
    - tremulousness
    - anxiety/tension
    - depression
    - D.T.'s
  - Previous Treatment:
    - AA meetings

Drugs
Types
cocaine
hallucinogens
cannabis
Pathological Use
used every day for at least a month
Psychosocial Impairment
missed work
trouble on job
arguments with family/friends over drug use
Tolerance/Withdrawal
needs more for same effect
cocaine
depression
anxiety/tension
Agitation
Previous Treatment:
yes

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
Depression
depressed mood
sleep disturbance

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
None endorsed

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
Sickly
current health rated poor
Psychosexual symptoms
not interested in sex or can't become aroused
erectile difficulty

Psychosexual Problems (302.xx; 306.51)
not interested in sex or can't become aroused
failure to attain erection

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia

early awakening
nonrestorative sleep
daytime somnolence
awakened by nightmares
general sleeplessness

Antisocial Personality (301.70)
(Also note findings in Substance Use above.)
frequent fights (age less than 13)
persistent lying (age less than 13)
theft (age less than 13)
fired from more than 2 jobs

Other Potential Adult Problems/Stressors
Domestic
frequent arguments with spouse/partner
domestic violence
child with anxiety problem before age of 12

Case 5: Tom C.

Identifying Data

Tom C. is a 52 year-old white Catholic male. He is employed full-time working 65 hours per week as a store owner and musician and taking home $3,200 per month. The client is married and has had one natural child. He resides in a single family home, which he owns, and has lived there for about 22 years. He lives with his spouse and one natural child from his current spouse. He has had no previous psychiatric hospitalizations and has had previous outpatient mental health services. [His only child, a son diagnosed schizophrenic, is 20 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother died from illness when the client was 34 years old. The natural father died from illness when the client was 10 years old.

He has two older sisters. The natural mother is reported to have suffered from depression, acted peculiarly at times, had problems with headaches, had back/neck pain, had gastrointestinal problems, suffered from a serious medical condition, and visited a physician frequently. His siblings are reported to have suffered from depression and acted hyperenergetic at times. When the client was born, his mother was 28 years old. He describes his mother as being energetic and warm, yet also shy, quiet, impatient, and hard. She was viewed as responsible, but unrealistic, immature, mostly unhappy, and insecure. The client perceives his mother as having loved him very much. The mother reportedly smothered him with physical affection and was bothersomely attentive. The client could not talk to her about problems. She is said to have criticized the client over almost everything. His mother is seen as having invaded his privacy and ignored his accomplishments. She is reported to have been an extremely strict disciplinarian who always wanted to know where the client was going or what he would be doing. When they disagreed, the client could not persuade her to change her mind. If the client misbehaved, punishment never occurred.

When the client was born, his father was 40 years old. He describes his father as being shy, not energetic, quiet, impatient, and stingy. He was viewed as responsible and hardworking, but weak and insecure. The client perceives his father as having only put up with him. The father reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have

been accepting even of poor behavior. His father is seen as having ignored most of the client's activities and resented his accomplishments as if they were in competition. He is reported to have been a very lenient disciplinarian who gave the client unrestricted freedom of action. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment never occurred.

The client's family strongly valued being religious, being ambitious, working hard and trying your best, being married, and having a close family.

He thinks that obeying authority was overemphasized to the point of being bothersome. Being self-reliant, asserting your beliefs, being socially active, and appreciating art/culture were discouraged.

Developmental History

At birth he was delivered normally and was premature and underweight. He had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been somewhat unhappy. He reports nailbiting after age 5, enuresis after age 4, and frequent nightmares. He recalls being very afraid of the dark. He had difficulty with awkwardness/ clumsiness, learning activities requiring coordination, sitting still, short-temperedness, and moodiness. He recalls getting into many fights. He was ill no more often than peers.

As a child and teenager, he reports suicidal preoccupations and denies sexual molestation, running away from home, deliberate self-injury, and attempted suicide. He reports one episode of serious suicidal preoccupations at age 10.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself too fat. He describes himself as shy, awkward, unhappy, nervous, short-tempered, and a rebel. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 12, at roughly the same time as most of the boys he knew. He first learned about sex from a book and received a reasonably accurate explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 28. On the average, he dated once or twice per month. His parents objected to and tried to interfere with the people he dated. He dated one person only. He first had heterosexual intercourse at age 30 and reports feeling nervous. He reports having had two sex partners. Currently, he can take sex or leave it. He denies having homosexual experience before age 18 or

afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has one such friend now.

Educational History

The client completed junior college in 1957.

Marital History

The client's current marriage began when he was 30 years old. He was not married prior to his current marriage.

The client's partner is a 40 year-old white Catholic female. She is a homemaker. She has some high school education. He describes his partner as being confident, energetic, talkative, and warm, yet also impatient and hard. His partner is unrealistic, mostly unhappy, and insecure, but responsible and strong.

In their relationship he reports that they both have problems with friends. The client admits to problems with the sexual relationship and household chores, He states that his partner has problems with the amount of time spent together, talking about feelings, and showing affection. Arguments never occur. Child rearing has been problematic because extreme nervousness or fear occurred with his offspring.

Occupational History/Financial Status

The client is self-employed in his own business and is paid in profits. He has had this job for 20 years, is very happy with it, and is not thinking about changing jobs. The positive aspects of the job are the compensation, interesting work, security, and occupations. He has never quit a job.

Income supports three people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities. Primary responsibility for money management resides with the client.

Military History

The client was neither drafted nor did he enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other legal conflicts.

Physical Symptoms Screen

Last physical exam occurred within the last year and the physician did not say that problems were detected. Within the last six months he visited a dentist, and he is having no dental or gum problems. He has never had surgery. Current physical health is rated as excellent. He reports having blood relatives with cancer. He has no known allergies. He is far-sighted. Since age 18, he admits to having engaged in binge eating and crash dieting. As to sexual intercourse, he complains of loss of erection and inhibited arousal/interest.

Psychological Symptom Screen

He began drinking alcohol at age 18 and now drinks once or twice a year. He usually drinks wine. He denies unusual diagnostic signs of pathological alcohol use and psychosocial impairment, He reports no increase in tolerance over time. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, and sleep disturbance accompanied by a significant weight change, loss of interest in sex, social withdrawal, and agitation. He reports no history of suicide attempts. He indicates that he has experienced repeated episodes of persistent elated mood, racing thoughts, and uncontrollable talkativeness. He admits to having experienced grandiose beliefs but not feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations and persecutory beliefs. He reports having experienced multiple anxiety/panic attacks that were situation-specific. He reports unreasonable fear of crowds (but not when performing or with musicians). He denies having had repetitive thoughts and denies having performed repetitive acts. He reports having experienced a highly stressful event with prolonged consequences including intrusive memories and recurrent dreams about the event. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, and awakening from nightmares.

Summary and Findings

Adult Problems

Note; The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use
Alcohol

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- grandiose beliefs

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - depressed mood
  - loss of interest in sex
  - weight change
  - sleep disturbance
  - agitation
  - social withdrawal
  - diminished energy
- Elation
  - elated mood
  - uncontrollable talkativeness
  - racing thoughts

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Fears/Phobias
  - fear/phobia of crowds
- Traumatic stress
  - frightening situation followed by:
    - unwanted memories
    - repetitive dreams
- Other
  - panic attack(s)

Somatoform Symptoms (300.xx; 307.80; 316.00)
(Of R/O physical etiology, somatization disorder requires 13 symptoms)
- Psychosexual symptoms
  - not interested in sex or can't become aroused
  - erectile difficulty

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused
- failure to maintain erection

Sleep and Arousal (307.4x; 780.5x)
- sleep onset insomnia
- early awakening
- awakened by nightmares

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
frequent fights (age less than 13)

Other Potential Adult Problems/Stressors
Domestic
child with anxiety problem before age of 12

Case 6: Bill H.

Identifying Data

Bill H. is a 51 year-old white nondenominational Protestant male. He is employed full-time working 50 hours per week as a house painter and taking home $1,600 per month. Income of approximately $500 per month comes from his wife's employment. The client is married and has one natural child. The resides in an apartment, which he rents, and has lived there for about 21 years. He lives with his spouse and one natural child from his current spouse. He has no previous psychiatric hospitalizations, one hospitalization for alcohol detoxification, and previous outpatient mental health services. [His only child, a son, diagnosed schizophrenic, is 25 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother is still living. The natural father died in an accident when the client was 40 years old.

He has had no siblings. The natural mother is reported to have had a nervous condition, suffered from depression, acted peculiarly at times, had problems with headaches, had back/neck pain, had gastrointestinal problems, and visited a physician frequently. The natural father is reported to have suffered from depression, drank excessively, and had back/neck pain. When the client was born, his mother was 20 years old. He describes his mother as being shy, cautious, quiet, cold, impatient, and hard. She was viewed as hardworking, but unrealistic, a failure, weak, mostly unhappy, and short-tempered. The client perceives his mother as having hated him. The mother reportedly was never physically affectionate but was bothersomely attentive. The client could talk to her about very few problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy and demeaned his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his father was 26 years old. He describes his father as being confident, energetic, and adventurous, yet also cold, impatient, and hard. He was viewed as responsible, hardworking, and a good money manager, but weak, mostly unhappy, and short-tempered. The client perceives his father as having disliked him. The father reportedly was never physically affectionate and

made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have been overly fault-finding, but sometimes accepting. His father is seen as having ignored most of the client's activities and demeaned his accomplishments. he is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client could not persuade him to change his mind. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the father would yell at him and embarrass him. The client was also threatened with a dangerous object, threatened with his life, and given threats to his safety and well-being. Typical corporal punishments were hand spanking, slapping, pinching, ear pulling, hair pulling, and shoving. The client reports that the father punched him, kicked him, hit him with a solid object, cut him, tried to smother him, attacked him with a weapon, and attempted to seriously injure or kill him.

The client's family strongly valued being married.

He thinks that being religious, being self-disciplined, obeying authority, having a close family, and being "manly" and tough were being overemphasized to the point of being bothersome. Being self-reliant, asserting your beliefs, being socially active, appreciating art/culture, being tolerant to others, and openly expressing feelings were discouraged.

Developmental History

At birth he was delivered normally and was underweight. He was not put in an incubator and had a birth defect. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been somewhat happy. He reports thumb sucking after age 5, nail biting after age 5, enuresis after age 4, and encopresis after age 4. He denies persistent childhood fears or phobias. He had difficulty with sitting still, completing tasks requiring concentration, short-temperedness, showing off, bragging, and bothering other children. He recalls being a roughneck, being a daredevil, repetitive stealing, setting fires, frequent lying, getting in many fights, and deliberate vandalism. He was ill no more often than peers.

As a child and teenager, he reports sexual molestation and denies running away from him, deliberate self-injury, suicidal preoccupations, and attempted suicide. He was sexually molested by a relative [a 19 year-old male cousin]. The first incident occurred at age 10 and reoccurred many times over a period of months [three years].

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself unattractive. He described himself as awkward, unhappy, quiet, short-tempered, a rebel, and felt like he didn't fit in with others. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 14, later than most of the boys he knew. He first learned about sex from first-hand experience. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 22. On the average he dated less than once per month. His parents objected to, but did not interfere with, the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 22 and reports feeling sad, nervous, guilty, ashamed, and unsatisfied. He reports having had three sex partners. Currently, he would rather avoid sex. He denies having homosexual experience before age 18 or afterwards. Before age 18, he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friend now.

Educational History

The client completed high school in 1957.

The client attended one public high school. His academic performance was in the C range and included being put on probation. He admits to repeated trouble with school authorities, frequent fighting, and behavior resulting in referral to a counselor. He describes himself as being shy, very unpopular with other students, and being usually unhappy in high school much of the time.

Marital History

The client's current marriage began when he was 24 years old, and his spouse was 24 years old. He was not married prior to his current marriage.

The client's partner is a 51 year-old white Protestant female. She is employed and works part-time for 20 hours per week. She has a grade school education. He describes his partner as being shy, cautious, quiet, impatient, hard, and stingy. His partner is responsible, hardworking, and a good money manager, but immature, insecure, and short-tempered.

In their relationship he reports that they both have problems with friends. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, having trust in each other, feeling jealous, the sexual relationship, managing money, and alcohol use. Arguments occur at least monthly and have resulted in physical attack to the partner. The primary caretaker of the child in the home is his partner. Child rearing has been problematic because attempted suicide, drug use, and alcohol abuse occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages. He is a union member. He has had his job for 21 years, is very unhappy with it, but is not thinking about changing jobs. The negative aspects of the job are the compensation, lack of stimulating work, lack of future prospects, bad hours, management, relationships with co-workers, and lack of fulfillment in it. He has been neither promoted nor demoted in this job. Complaints have been made about him regarding conflicts with others, and he has been threatened with dismissal. He believes these complaints are due to misunderstanding, politics, personal conflicts, personal problems, and deliberate attempts to create problems for him. He had had three previous jobs in three different occupations. He has quit previous jobs because of dissatisfaction with an entire line of work. On one occasion he has simply quit a job for no pressing reason and with no new job to go to. He has been laid off once.

Income supports three people, has increased somewhat over the past year, yet is barely sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. He is having debt problems but is not concerned about bankruptcy.

Military History

The client was excluded due to alcoholism.

Legal History

The client denies disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and other legal conflicts. He has been picked up as a juvenile for drunken driving.

Physical Symptom Screen

The last physical exam occurred more than one year ago and the physician did say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with both teeth and gums. He has had one surgery. Current physical health is rated as fair. He has no known allergies. The client reports recent problems with being overweight. He is far-sighted. Recently, he has experienced swollen ankles and awakenings with leg cramps. Also recently, he has had abdominal bloating and diarrhea. Since age 18, he admits to having engaged in self-induced vomiting, binge eating, crash dieting, and use of laxatives to control weight. He has a history of liver disease/problems. As to sexual intercourse, he complains of erectile difficulty, loss of erection, ejaculatory difficulties, and inhibited arousal/interest. He reports recent neck pain, back pain, joint pain, and swollen/tender muscle. He reports having had gout.

Psychological Symptom Screen

He began drinking alcohol at age 18 and now drinks daily. He usually drinks beer and hard liquor. He reports a need to drink daily, attempts to control his intake, difficulty controlling intake, having drunk throughout the day for more than a day, having drunk a fifth or equivalent in one day on more than one occasion, and drinking despite a contraindicating physical condition. Drinking has resulted in missed work, trouble on the job, arguments over drinking with significant others, traffic accidents, trouble with the law, and violence. He reports some increase in tolerance over time. Upon discontinuation of drinking, he has experienced tremulousness, nausea, sweating, anxiety/tension, depression, insomnia, and D.T.'s. He has had outpatient therapy and attended AA meetings for his alcohol problem. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, and sleep disturbance accompanied by a significant weight change, difficulty concentrating, loss of interest in sex, social withdrawal, and irritability. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, and excessive daytime somnolence.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol
  - Pathological Use:
    - needs every day
    - attempts to control drinking
    - difficulty cutting down or stopping
    - drank all day, more than one day
    - drank fifth or equivalent per day, more than once
    - drinks despite physical problem

Psychosocial Impairment:
missed work
trouble on job
arguments with family/friends about drinking
traffic accident
trouble with law
became violent
Tolerance/Withdrawal:
needs more for same effect
tremulousness
nausea
sweating
anxiety/tension
depression
insomnia
D.T.'s
hospitalized for detoxification
Previous Treatment:
outpatient treatment
AA meetings

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 292.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
Depression
depressed mood
loss of interest in sex
weight change
sleep disturbance
difficulty concentrating
social withdrawal
diminished energy
irritability

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
Possible anxiety-related somatic symptoms, if physical etiology ruled out:
diarrhea

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)

- Gastrointestinal:
  - abdominal bloating
  - diarrhea
- Pain:
  - back pain
  - joint pain
  - neck pain
- Psychosexual symptoms:
  - not interested in sex or can't become aroused
  - erectile difficulty

Psychosexual Problems (302.xx; 306.51)

- not interested in sex or can't become aroused
- failure to attain erection
- failure to maintain erection
- inhibited orgasm

Sleep Arousal (307.4x; 780.5x)

- sleep onset insomnia
- early awakening
- nonrestorative sleep
- daytime somnolence

Antisocial Personality (301.70)
(Also note findings in Substance Use above)

- frequent fights (age less than 13)
- frequent fights (high school)
- persistent lying (age less than 13)
- theft (age less than 13)
- vandalism (age less than 13)
- repeated trouble with school authorities (high school)

Other Potential Adult Problems/Stressors

- Domestic
  - Domestic violence:
  - wife beating
  - child attempted suicide
  - child abuses drugs
  - child abuses alcohol

Case 7: John P.

Identifying Data

John P. is a 53 year-old white Greek Orthodox male. He is employed full-time working 60 hours per week as a Chef and taking home $2,200 per month. He client is married and has had one natural child. He resides in a multiple family dwelling, which he owns, and he has lived there for about 15 years. He lives with his spouse, spouse's mother, and one natural child from his current spouse. He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. [His son, diagnosed as schizophrenic, is 17 years of age.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

Both natural parents are still living.

He has one older sister. The natural mother is reported to have had a nervous condition, required hospitalization for nervous problems, suffered from depression, attempted suicide, acted peculiar at times, suffered from a serious medical condition, and visited a physician frequently. His sibling is reported to have had a nervous condition, required hospitalization for nervous problems, acted peculiar at times, and visited a physician frequently. When the client was born, his mother was 22 years old. He describes his mother as being energetic and talkative, yet also cautious, cold, impatient, and hard. She was viewed as hardworking, but irresponsible, unrealistic, immature, mostly unhappy, and insecure. The client perceives his mother as having hated him. The mother reportedly was never physically affectionate and made him feel neglected. The client could not talk to her about problems. She is said to have criticized the client over almost everything. His mother is seen as having ignored most of the client's activities but occasionally praised him for his accomplishments. She is reported to have been a very lenient disciplinarian who gave the client unrestricted freedom of action. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment was usually forthcoming. She never used corporal punishment.

When the client was born, his father was 23 years old. He describes his father as being confident, energetic, patient, and generous, yet also shy and cold. He was viewed as responsible, realistic, hardworking, strong, and secure, but mostly unhappy. The client perceives his father as having loved him. The father reportedly was intermittently affectionate and gave very little time and attention. The client could talk to him about very few problems. He is said to have been accepting, but appropriately

critical. His father is seen as having been disinterested in most of the client's activities and ignored his accomplishments. He is reported to have been very strict, although reasonable in some areas, and gave the client more freedom of action than desirable. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was usually forthcoming. To punish the client psychologically, the father would yell at him. The client was also threatened with a dangerous object and threatened with his life. Typical corporal punishments were slapping, ear pulling, hair pulling, and shoving. The client reports that the father punched him, kicked him, hit him with a solid object, tried to choke him, and attacked him with a weapon.

He thinks that being religious, being self-reliant, obeying authority, being married, having a close family, and being 'manly' and tough were overemphasized to the point of being bothersome. Getting an education, asserting your beliefs, being socially active, appreciating art/culture, being tolerant of others, and openly expressing feelings were discouraged. There was disagreement in the family over the importance of being involved with sports and being ambitious.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He recalls being very afraid of the dark, certain animals, monsters, and dying. He had difficulty with awkwardness/clumsiness, sitting still, completing tasks requiring concentration, short-temperedness, moodiness, and showing off. He recalls being a roughneck, repetitive stealing, frequent lying, and getting in many fights. He was ill no more often than peers.

As a child and teenager, he denies sexual molestation, running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself unattractive. He describes himself as shy, awkward, inactive, short-tempered, a rebel, and hardworking. His caretakers were strict about rules and acted as if the client's judgment could be trusted only a little. He began to physically mature at about 13, later than most of the boys he knew. He first learned about sex from a friend and received a reasonably accurate explanation. He felt that he could discuss nothing about sex with his parents. He began dating at age 18. On the average he dated once or twice per month. His parents objected to and tried to interfere with the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 27 and reports feeling nervous, guilty, and unsatisfied.

He reports having had three sex partners. Currently, he had problems with sexual enjoyment. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed elementary school in 1950 and high school in 1954.

He completed his elementary education in one school, parochial. He reports that his performance was about average. He was held back 2 semesters. He reports problems in learning to read and speak correctly, but took no special classes for learning problems. He admits ro repeated trouble with school authorities, but took no special classes for behavioral problems. Socially, he describes himself as shy, disliked by most schoolmates, and as having no close friends. In general, he disliked elementary school much of the time.

The client attended one high school, parochial. His academic performance was in the B range. He denies major antisocial behaviors. He describes himself as being shy, very unpopular with other students, and having a difficult experience in high school much of the time.

Marital History

The client's current marriage began when he was 30 years old, and his spouse was 18 years old. He was not married prior to his current marriage.

The client's partner is a 41 year-old white Eastern Orthodox female. She is a homemaker. She has a grade school education and 2 years of high school. He describes his partner as being outgoing, confident, talkative, and warm, yet also impatient and hard. His partner is irresponsible, unrealistic, mostly unhappy, and insecure, but hardworking and strong.

In their relationship he reports that they both have problems with the amount of time spent together, talking about feelings, and friends. The client admits to problems with showing affection, the sexual relationship, and managing money. Arguments occur at least weekly and have resulted in physical attack to the partner. The primary caretaker of the child in the home is his partner. Child rearing has been problematic because extreme nervousness or fear, antisocial behavior, attempted suicide, and chronic illness occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in regular salary. He has had this job for eight years, is neither pleased nor displeased with it, and is not thinking about changing jobs. He has been neither promoted nor demoted on this job. He's had five previous jobs in the same occupation. He has quit previous jobs because of opportunity for a better job. He has been laid off three times.

Income supports three people, has remained about the same over the past year, and is barely sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. He is having debt problems, but is not concerned about bankruptcy. He has gambling debts.

He has never used alcohol. He denies use of unprescribed psychoactive drugs. He reports no episodes of depressed mood, diminished energy, anorexia, sleep disturbance, or suicidal ideation lasting two or more weeks. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/ panic attacks. He denies specific phobias.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, and civile commitments. He has been granted a claim for disability.

Physical Symptom Screen

His last physical exam occurred more than 3 years ago and the physician did not say that problems were detected. It's been over 5 years since he visited a dentist, and he is having problems with his gums. He has had no surgeries. Current physical health is rated as good. He reports having blood relatives with cardiovascular disease/stroke, hypertension, and cancer. He is allergic to certain medication. Recently, he has experienced memory difficulty. He is nearsighted. Recently, he has experienced awakenings from leg cramps. He reports having had recent wheezing/whistling sounds while breathing. He has had frequent bronchitis. He reports recent swollen/tender muscle and swollen/tender joint/back pains.

Psychological Symptom Screen

He has never used alcohol. He denies use of unprescribed psychoactive drugs. He reports no episodes of depressed mood, diminished energy, anorexia, sleep disturbance, or suicidal ideation lasting two or more weeks. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
Alcohol

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Anxiety Related Symptoms (294.80; 300.xx; 309.89)
None endorsed

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
None endorsed

Psychosexual Problems (302.xx; 306.51)
None endorsed

Sleep and Arousal (307.4x; 780.5x)
None endorsed

Antisocial Personality (301.70)
(Also, note findings in Substance Use above)
frequent fights (age less than 13)
persistent lying (age less than 13)
theft (age less than 13)

Other Potential Adult Problems/Stressors
Domestic
frequent arguments with spouse/partner
domestic violence
child with anxiety problems before age of 12
child with behavior problems before age of 12
child with attempted suicide
child with chronic disease

Case 8: Dave K.

Identifying Data

Dave K. is a 57 year-old white Buddhist male. He is employed full-time working 60 hours per week as a movie projectionist and taking home $5,000 per month. The client is separated from his second wife and has has one natural child with her, a son who is the schizophrenic patient. He resides in an apartment, which he rents, and has lived there for about four years. He has had no previous psychiatric hospitalizations and no previous outpatient mental heath services. [His son, diagnosed schizophrenic/paranoid type, is 28 years old, and is living with his mother, the subject's second wife.]

Family of Origin

During childhood an adolescence, the client was raised by his natural mother and his natural father.

The natural mother died from illness when the client was 50 years old. The natural father died from illness when the client was 54 years old.

He has had no siblings. The natural mother is reported to have had a nervous condition, suffered from depression, acted hyper-energetic at times, acted peculiar at times,. and had problems with headaches. When the client was born, his mother was 26 years old. He describes his mother as being outgoing, energetic, and talkative, yet also cold, impatient, and dishonest. She was viewed as hardworking, but unrealistic, a failure, weak, mostly unhappy, and short-tempered. The client perceives his mother as having only put up with him. The mother reportedly was intermittently affectionate but was bothersomely attentive. The client could talk to her about very few problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy but occasionally praised him for his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his father was 28 years old. He describes his father as being outgoing, confident, energetic, warm, and generous, yet also dishonest. He was viewed as hardworking, but irresponsible, a poor money manager, weak, mostly unhappy, and short-tempered. The client perceives his father as having only put up with him. The father reportedly was intermittently affectionate but made him feel neglected. The client could talk to him about very few problems. He is said to have been overly fault-finding,

but sometimes accepting. His father is seen as having ignored most of the client's activities and demeaned his accomplishments. He is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client could usually get a hearing and a change of heart when it was reasonable. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the father would yell at him and embarrass him. Typical corporal punishments were hand-spanking and slapping. The client reports that the father punched him.

The client's family strongly valued getting an education, working hard and trying your best, asserting your beliefs, being self-disciplined, obeying authority, and having good health habits.

He thinks that being responsible, being self-reliant, and being married were overemphasized to the point of being bothersome. Appreciating art/culture, openly expressing feelings, and being 'manly' and tough were discouraged.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He had problems learning to stand, walk, talk, and feed himself. Before age 13, he considers himself to have been neither happy nor unhappy. He denies persistent childhood fears or phobias. He had difficulty with sitting still and moodiness. He recalls getting in many fights. He was ill no more often than peers.

As a child and teenager, he reports suicidal preoccupations and denies sexual molestation, running away from home, deliberate self-injury, and attempted suicide. He reports three episodes of serious suicidal preoccupations beginning at age 14.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself too short. He describes himself as outgoing, confident, active, good-tempered, and hardworking, yet also a rebel. His caretakers were reasonable about rules and acted as if the client's judgment could be trusted somewhat. He began to physically mature at about age 10, earlier than most of the boys he knew. He first learned about sex from a book and received a somewhat incorrect explanation. He felt that he could discuss nothing about sex with his parents. He began dating at age 15. On the average, he dated once or twice per month. His parents did not comment upon the people he dated. He tended to play the field. He first had heterosexual intercourse at age 15 and reports feeling ashamed and satisfied. He reports having had 50 sex partners. Currently, he usually enjoys sex. He denies having homosexual experience before age 18 or afterwards. Before age 18 he

claims to have had two very close friends with whom he could discuss nearly anything. He has two such friends now.

Educational History

The client completed college in 1954.

Marital History

The client's current marriage began when he was 25 years old, and his spouse was 27 years old. They have been separated more than two years, and he thinks that divorce or reconciliation are equally possible. While separated, the client has been dating others. He was previously married once. The previous marriage began when he was 20 years old and his former spouse was 25. The marriage ended in divorce when he was age 23. They had no children.

The client's partner is a 59 year-old white Jewish female. She is employed and works part-time for 25 hours per week as a bookkeeper. She has a high school education. He describes his partner as being energetic. talkative, and warm, yet also cautious, impatient, and stingy. His partner is unrealistic, a failure, immature, mostly unhappy, and short-tempered. He and his present wife had one natural child.

In their relationship, he reports, that they both have problems with managing money. The client admits to problems with the amount of time spent together, talking about feelings, and fidelity. He states that his partner has problems with showing affection, having trust in each other, feeling jealous, the sexual relationship, and religion. Arguments occur every day and have resulted in physical attack to the partner, He reports having had three ongoing extramarital affairs with different women, when living with the second wife. They have been separated for about 4 years.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages. He is a union member. He has had his job for 30 years, is very happy with it, and is not thinking about changing jobs. The positive aspects of the job are the interesting work, relationships with co-workers, and personal fulfillment of it. The negative aspects of the job are the compensation, benefit level, and lack of security. He has been neither promoted nor demoted on this job. He has had 15 previous jobs in the same occupation. He has never quit a job. He has been laid off ten times, which is common in his field of work.

Income supports three people, has remained about the same over the past year, and is sufficient to pay for basic necessities.

Primary responsibility for money management resides with the client. He is having debt problems, but is not concerned about bankruptcy.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other legal conflicts.

Physical Symptom Screen

Last physical exam occurred more than one year ago and the physician did not say that problems were detected. It's been over a year since he visited a dentist, and he is having no dental or gum problems. He has had three surgeries. Current physical health is rated as fair. He has no known allergies. He is far-sighted. Recently, he has experienced chest discomfort/pain. Since age 18, he admits to having engaged in crash dieting. He has a history of hemorrhoids. He has had gonorrhea three times. He has a history of hay fever. He reports recent back pain and stiff neck/joints. He reports having had gout.

Psychological Symptom Screen

He began drinking alcohol at age 19 and now drinks once or twice a week. He usually drinks liquor. He denies usual diagnostic signs of pathological alcohol use and psychosocial impairment. He reports no increase in tolerance over time. He has attended AA meetings for his alcohol problem. He has used cannabis. He began taking drugs at age 16, and uses them three or four times a week now. He denies usual diagnostic signs of pathological drug use and psychosocial impairment. Compared to when he started using them, he reports no increase in the amount of drugs necessary to produce the same effect. He has not received treatment for drug use. He reports no episodes of depressed mood, diminished energy, anorexia, sleep disturbance, or suicidal ideation lasting two or more weeks. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol
  - Previous Treatment
    - AA meetings
- Drugs
  - Type(s)
    - Cannabis

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Possible anxiety-related somatic symptoms, if physical etiology ruled out.
  - chest pain or discomfort.

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
- Pain
  - back pain
- Cardiopulmonary
  - chest pain

Psychosexual Problems (302.xx; 306.51)
- None endorsed

Sleep and Arousal (307.4x; 780.5x)
- None endorsed

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
- frequent fights (age less than 13)
- precocious age first intercourse
- fifty sex partners
- extramarital affairs

Other Potential Adult Problems/Stressors
- Domestic
  - divorce
  - marital separation
  - frequent arguments with spouse/partner
  - domestic violence
  - extramarital affairs

Case 9: Michael A.

Identifying Data

Michael A. is a 54 year-old white Episcopalian male. He is employed full-time working 55 hours per week as a bookkeeper and part-time tax preparer and taking home $2,900 per month. Income of approximately $500 per month comes from his spouse's employment. The client is married and has had one natural child. He resides in a single family home, which he owns, and has lived therefore about 17 years. He lives with his spouse and one natural child from his current spouse. He has had one previous psychiatric hospitalization and has had previous outpatient mental health services. Currently, he is using prescription medication. [His son, diagnosed schizophrenic, is 30 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother died by suicide when the client was 25 years old. The natural father is still living.

He has had no siblings. The natural mother is reported to have had a nervous condition, required hospitalization for nervous problems, suffered from depression, attempted suicide, acted hyperenergetic at times, acted peculiar at times, had problems with headaches, and visited a physician frequently. The natural father is reported to have suffered from depression. When the client was born, his mother was 20 years old. He describes his mother as being awkward, not energetic, cautious, cold, hard, and stingy. She was viewed as irresponsible, unrealistic, a failure, weak, mostly unhappy, and insecure. The client perceives his mother as having hated him. The mother reportedly was never physically affectionate but was bothersomely attentive. The client could not talk to her about problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy and resented his accomplishments as if they were in competition. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the mother would ignore him, yell at him, tell him that she was ashamed of him, make him feel that she had been hurt, and embarrass him. The client was also locked in a room for more than one hour, threatened with abandonment, abandoned, threatened with a dangerous object, threatened with his life, threatened with police intervention, and given threats to his safety and well-being. Typical corporal

punishments were pinching, ear pulling, and hair pulling. The client reports that the mother bit him, hit him with a solid object, and cut him.

When the client was born, his father was 19 years old. He describes his father as being energetic and honest, yet also shy, quiet, cold, and stingy. He was viewed as responsible and hardworking, but unrealistic, weak, mostly unhappy, and insecure. The client perceives his father as having only put up with him. The father reportedly was intermittently affectionate but made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have been overly fault-finding, but sometimes accepting. His father is seen as having ignored most of the client's activities and ignored his accomplishments. He is reported to have been not very strict and gave the client unrestricted freedom of action. When they disagreed, the client could get a hearing, but it rarely changed anything. If the client misbehaved, punishment was infrequent. To punish the client psychologically, the father would ignore him, yell at him, tell him that he was ashamed of him, make him feel that he had been hurt, and embarrass him. He never used corporal punishment.

Developmental History

At birth he was delivered normally and was underweight. He was not put in an incubator and had no birth defects. He had problems learning to stand and talk. Before age 13, he considers himself to have been somewhat unhappy. He reports thumb sucking after age five, nail biting after age five, stuttering after age five, enuresis after age four, insomnia, and frequent nightmares. He recalls being very afraid of the dark, monsters, separation from his caretakers, and dying. He had difficulty with awkwardness/ clumsiness, frequent accidents, learning activities requiring coordination, sitting still, completing tasks requiring concentration, short-temperedness, and moodiness. He recalls frequent lying and getting in many fights. He was ill more frequently than his peers.

As a child and teenager, he denies sexual molestation, running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide.

As a teenager, he was as healthy as others, and he had no unusual eating habits. He describes himself as shy, unhappy, short-tempered, and felt like he didn't fit with others, was talkative and hardworking. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 14, later than most of the boys he knew. He first learned about sex from a book and received a

somewhat incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 20. On the average he dated every week. His parents objected to, but didn't interfere with, the people he dated. He dated one person only. He first had heterosexual intercourse at age 20 and reports feeling nervous and guilty. He reports having had one sex partner. Currently, he has problems with sexual enjoyment. He denies having homosexual experience before age 18 or afterwards. Before age 18, he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Eduational History

The client completed his school in 1952.

The client attended two public high schools. His academic performance was in the B range. He had difficulty with school due to problems at home. He denies major antisocial behavior. He describes himself as being shy, somewhat unpopular with other students, and having mixed feelings about high school much of the time.

Marital History

The client's current marriage began when he was 20 years old, and his spouse was 21 years old. He was not married prior to his current marriage.

The client's partner is a 55 year-old white Protestant female. She is employed and works part-time for 20 hours per week as an assistant librarian. She is a homemaker. She has some college education. He describes his partner as being outgoing, confident, energetic, and warm, yet also impatient and hard. His partner is responsible, hardworking, a good money manager, strong, and mature, but mostly unhappy.

In their relationship he reports that they both have problems with the amount of time spent together and the sexual relationship. The client admits to problems with talking about feelings, feeling jealous, and friends. He states that his partner has problems with in-laws and relatives. Arguments occur several times a year. The primary caretaker of the children in the home is his partner. Child rearing has been problematic because extreme nervousness or fear occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and has a part-time tax preparation business of his own. He is paid in hourly wages and profits. He has had his day job for 13 years, is very happy with

it, and is not thinking about changing jobs. The positive aspect of the job is the compensation. The negative aspect of the job is the relationships with co-workers. He has been promoted in this job. He has had three previous jobs in the same occupation. He has never quit a job. He has been laid off twice.

Income supports three people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities. Primary responsibility for money management resides with the client.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies having been picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and/or legal conflicts.

Physical Symptom Screen

Last physical exam occurred within the last year and the physician did not say that problems were detected. Within the last six months he visited a dentist, and he is having no dental or gum problems. He has never had surgery. Current physical health is rated as good. He is allergic to pollen. The client reports recent problems with being overweight. He has a history of low blood sugar. He is near-sighted. Since age 18, he admits to having engaged in self-induced vomiting, binge eating, crash dieting, and use of laxatives to control weight. He has a history of hemorrhoids. He has recently had pain/burning while urinating, difficulty starting his urine, urinary urgency, and a weakened urine stream. He has a history of prostate trouble and bladder infection. As to sexual intercourse, he complains of loss of erection, ejaculatory difficulties, and inhibited arousal/interest. He has a history of hay fever. He reports recent back pain, muscle cramps, muscle weakness, swollen/tender muscle, and swollen/tender joint. He reports having had gout.

Psychological Symptom Screen

He has never used alcohol. He has used minor tranquilizers. Compared to when he started using them, he reports no increase in the amount of drugs necessary to produce the same effect. Discontinuing minor tranquilizers has produced depression and irritability. He has not received treatment for drug use. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, anorexia, sleep

disturbance, and suicidal ideation accompanied by a significant weight change, difficulty concentrating, loss of interest in sex, social withdrawal, and irritability. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/ hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced multiple anxiety/panic attacks that were situation-specific. He reports unreasonable fears of being alone and traveling, denies having had repetitive thoughts and denies having performed repetitive acts. His current sleep patterns is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, excessive daytime somnolence, and awakening from nightmares.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the content of occurrence.

Substance Use (191.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol

- Drugs
  - none endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - depressed mood
  - loss of interest in sex
  - weight change
  - sleep disturbance
  - difficulty concentrating
  - social withdrawal
  - loss of appetite
  - diminished energy
  - irritability
  - suicidal ideation

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Fears/Phobias
  - being alone
  - traveling
- Other
  - panic attack(s)
- Possible anxiety-related somatic symptoms, if physical etiology ruled out.
  - muscle cramps

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
- Sickly
  - sick often as a child
- Pain
  - back pain
  - pain on urination
- Conversion/pseudoneurological
  - muscle weakness
  - trouble urinating
- Psychosexual symptoms
  - not interested in sex or can't become aroused
  - erectile difficulty

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused
- failure to maintain erection
- inhibited orgasm

Sleep and Arousal (307.4x; 780.5x)
- sleep onset insomnia
- early awakening
- nonrestorative sleep
- daytime somnolence
- awakened by nightmares

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
- frequent fights (age less than 13)
- persistent lying (age less than 13)

Other Potential Adult Problems/Stressors
- Domestic
  - child with anxiety problem(s) before age of 12

Case 10: Larry F.

Identifying Data

Larry F. is a 48 year-old white Reformed Jewish male. He is employed full-time working 60 hours per week as a Patternmaker and weekend salesman and earning $3,500 per month. The client is married and has two natural children. He resides in a condominium, which he owns, and has lived there for about 10 years. He lives with his spouse and one natural child from his current spouse. He has no previous psychiatric hospitalizations and has had previous outpatient mental health services. Currently, he is using prescription medication. [His oldest child, a son, diagnosed as schizophrenic/paranoid type, is 24 years old and lives at home. His daughter is 21 years old and goes to college in Boston.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

Both natural parents are still living.

He has one older brother. The natural mother is reported to have had a nervous condition, suffered from depression, acted peculiarly at times, and visited a physician frequently. The natural father is reported to have suffered from depression and drank excessively. His sibling is reported to have had a nervous condition, suffered from depression, and used drugs excessively. When the client was born, his mother was 20 years old. He describes his mother as being shy, cautious, quiet, cold, impatient, and hard. She was viewed as responsible and hardworking, but unrealistic, immature, mostly unhappy, and insecure. The client perceived his mother as having disliked him. The mother reportedly was never physically affectionate but was bothersomely attentive. The client could not talk to her about problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy and demeaned his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going and what he would be doing. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his father was 22 years old. He describes his father as being shy, not energetic, quiet, impatient, hard, and dishonest. He was viewed as responsible, realistic, and hardworking, but weak, mostly unhappy, and short-tempered. The client perceives his father as having hated him. The father reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have criticized the client over almost everything. His father is seen as having ignored most

of the client's activities and resented his accomplishments as if they were in competition. He is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was usually forthcoming. To punish the client psychologically, the father would yell at him. The client was also threatened with a dangerous object, threatened with his life, and threatened with damage to his sex organs. Typical corporal punishments were hand spanking, slapping, ear pulling, hair pulling, and shoving. The client reports that the father punched him, kicked him, hit him with a solid object, cut him, tried to smother him, attacked him with a weapon, and attempted to seriously injure or kill him.

The client's family strongly valued being responsible.

He thinks that being ambitious, working hard and trying your best, obeying authority, being married, having a close family, and being 'manly' and tough were overemphasized to the point of being bothersome. Being involved with sports, being self-reliant, asserting your beliefs, being socially active, appreciating art/culture, and openly expressing feelings were discouraged. There was disagreement in the family over the importance of being religious and getting an education.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He reports thumb sucking after age 5, stuttering after age 5, enuresis after age 4, and frequent nightmares. He admits to worries about being underweight. He recalls being very afraid of the dark, leaving home, separation from his caretakers, and dying. He had difficulty with awkwardness/clumsiness, learning activities requiring coordination, sitting still, short-temperedness, and moodiness. He admits to no antisocial or daredevil behavior. He was ill no more often than peers.

As a child and teenager, he reports sexual molestation and denies running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide. He was sexually molested by a non-relative. The first incident occurred at age 12 and reoccurred once.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself too thin. He describes himself as shy, awkward, unhappy, nervous, short-tempered, and felt like he didn't fit with others. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 12, at roughly the same time

as most of the boys he knew. He first learned about sex from an adult and received an incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 21. On the average, he dated every week. His parents objected to and tried to interfere with the people he dated. He dated one person only. He first had heterosexual intercourse at age 22 and reports feeling sad, nervous, guilty, and ashamed. He reports having had one sex partner. Currently, he would rather avoid sex. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

He attended three years of high school before dropping out. He has attended trade school.

The client attended two public high schools. His academic performance was in the C range. He had difficulty with school due to problems at home. He denies major antisocial behaviors. He describes himself as being shy, somewhat unpopular with other students, and having a difficult experience in high school much of the time.

Marital History

The client's current marriage began when he was 23 years old, and his spouse was 21 years old. He was not married prior to his current marriage.

The client's partner is a 46 year-old white Jewish female. She is a homemaker and has a grade school education. He describes his partner as being shy, cautious, quiet, cold, impatient, and hard. His partner is unrealistic, immature, mostly unhappy, and short-tempered, but responsible and hardworking.

In their relationship he reports that they both have problems with talking about feelings and friends. The client admits to problems with showing affection and the sexual relationship. He states that his partner has problems with the amount of time spent together. Arguments occur several times a year. The primary caretaker of the child in the home is his partner.

Occupational History/Financial Status

The client works for an employer during the week and sells his own merchandise at a flea market on weekends. He is paid in hourly wages and profits. He is a union member. He has had his day job for 14 years, is very unhappy with it, but is not thinking about changing jobs. The negative aspects of the job are the compensation, management, relationships with co-workers, and lack of

fulfillment in it. He has been neither promoted nor demoted on this job. He has had two previous jobs in two different occupations. He has never quit a job. He has been laid off once.

Income supports four people, has increased somewhat over the past year, yet is barely sufficient to pay for basic necessities. Primary responsibility for money management resides with the client.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other legal conflicts.

Physical Symptom Screen

Last physical exam occurred more than one year ago and the physician did not say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with both teeth and gums. He has had two surgeries. Current physical health is rated as good. He is allergic to pollen and dust. As to sexual intercourse, he complains of inhibited arousal and interest.

Psychological Symptom Screen

He has never used alcohol or drugs. He has not received treatment for drug use. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, sleep disturbance, and suicidal ideation accompanied by a significant weight change, difficulty concentrating, guilt feelings, loss of interest in sex, social withdrawal, and irritability. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/ hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He reports unreasonable fears of confined spaces, open areas, being alone, and certain social situations, denies having had repetitive thoughts and denies having performed repetitive acts. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, awakening from nightmares.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol

- Drugs
  - None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - depressed mood
  - loss of interest in sex
  - weight change
  - sleep disturbance
  - difficulty concentrating
  - social withdrawal
  - diminished energy
  - guilt
  - irritability
  - suicidal ideation

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Fears/Phobias
  - confined spaces
  - open areas
  - being alone
  - certain social situations

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
- Psychosexual symptoms
  - not interested in sex or can't become aroused

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia
early awakening
nonrestorative sleep
awakened by nightmares
other sleep problems

Antisocial Personality (301.70)
(Also note findings in Substance Use above)

Other Potential Adult Problems/Stressors
None endorsed

Case 11: Joseph S.

Identifying Data

Joseph S. is a 59 year-old white Catholic male. He is employed full-time working 62 hours per week as an Auto Wrecker and taking home $3,000 per month. Income of approximately $1,000 per month comes from investments. The client is married and has had five natural children, four of whom are married. He resides in a single family home, which he owns, and has lived there for about 22 years. He lives with his spouse and one natural child from his current spouse. He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. [The sun, diagnosed as schizophrenic, is 31 years old. He has 3 daughters, ages 38, 36, and 35, and the youngest son who is 29 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

The natural mother died from illness when the client was 32 years old. The natural father died from illness when the client was 36 years old.

He has one older brother and one younger brother. The natural mother is reported to have drunk excessively, had problems with headaches, suffered from a serious medical condition, and visited a physician frequently. The natural father is reported to have suffered from depression. His siblings are reported to have had an emotional condition, required hospitalization for emotional problems, suffered from depression, attempted suicide, drank excessively, and used drugs excessively. When the client was born, his mother was 21 years old. He describes his mother as being honest, yet also shy, awkward, cautious, impatient, and hard. She was viewed as responsible, realistic, and hardworking, but weak, mostly unhappy, and insecure. The client perceives his mother as having only put up with him, The mother reportedly was never physically affectionate but was bothersomely attentive. The client could not talk to her about problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy and demeaned his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his father was 23 years old. He describes his father as being outgoing, confident, and energetic, yet also impatient, hard, and dishonest. He was viewed as

hardworking, but irresponsible, a failure, immature, mostly unhappy, and short-tempered. The client perceives his father as having disliked him. The father reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have been overly fault-finding, but sometimes accepting. His father is seen as having ignored most of the client's activities and demeaned his accomplishments. He is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the father would ignore him, yell at him, tell him that he was ashamed of him, make him feel that he had been hurt, and embarrass him. The client was also locked in a room for more than one hour, abandoned, threatened with a dangerous object, and threatened with his life. Typical corporal punishments were slapping and shoving. The client reports that the father punched him, kicked him, hit him with a solid object, cut him, and attacked him with a weapon.

The client's family strongly valued being married.

He thinks that working hard and trying your best, obeying authority, having a close family, and being 'manly' and tough were overemphasized to the point of being bothersome. Getting an education, being ambitious, being self-reliant, asserting your beliefs, being socially active, appreciating art/culture, and being tolerant of others were discouraged. There was disagreement in the family over the importance of openly expressing feelings.

Developmental History

At birth he was delivered normally and was premature. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been somewhat unhappy. He reports nail biting after age five, stuttering after age five, and enuresis after age four. He denies persistent childhood fears or phobias. He had difficulty with awkwardness/clumsiness, frequent accidents, learning activities requiring coordination, sitting still, completing tasks requiring concentration, short-temperedness, moodiness, showing off, and bragging. He recalls being a roughneck, being a daredevil, repetitive stealing, frequent lying, and getting in many fights. He was ill no more often than peers.

As a child and teenager, he denies sexual molestation, running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself too tall. He describes himself as shy, unhappy, short-tempered, a rebel, confident and hardworking. His caretakers were lax about rules and acted as if the client's judgment could be trusted somewhat. He began to physically mature at about age 11, earlier than most of the boys he knew. He first learned about sex from a book and received a reasonably accurate explanation. He felt that he could discuss nothing about sex with his parents. He began dating at age 16. On the average, he dated less than once per month. His parents did not comment upon the people he dated. He dated one person at a time. He first had heterosexual intercourse at age 17 and reports feeling nervous and satisfied. He reports having had three sex partners. Currently, he has problems with sexual enjoyment. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims to have had one very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client attended three years of high school before dropping out.

He attended one public high school. His academic performance was in the C range and included taking remedial classes, getting held back, and being put on probation. Extracurricular activity consisted of music. He had difficulty with school due to problems at home and having to work. He admits to repeated trouble with school authorities, repeated truancy, frequent fighting, and behavior resulting in referral to a counselor. He describes himself as being outgoing, not popular nor unpopular with other students, and having mixed feelings about high school much of the time.

Marital History

The client's current marriage began when he was 20 years old, and his spouse was 19 years old. He was not married prior to his current marriage.

The client's partner is a 58 year-old white Catholic female. She is a homemaker. She has a high school education. He describes his partner as being shy, cautious, impatient, and hard, yet also confident and warm. His partner is irresponsible, unrealistic, mostly unhappy, insecure, and short-tempered, but hardworking. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, feeling jealous, friends, and the sexual relationship. Arguments occur once or twice a year and have resulted in physical attack to the partner. The primary caretaker of the children in the home is his partner. Child

rearing has been problematic because frequent illnesses, trouble with the law, drug use, and alcohol abuse occurred with his offspring, including the psychosis with his son.

Occupational History/Financial Status

The client is self-employed in his own auto-wrecking business and is paid in regular salary and profits. He has had this job for 35 years, is neither pleased nor displeased with it, and is not thinking about changing jobs. It is a family business that was started by his father. The positive aspects of the job are the compensation, benefits, and security. The negative aspects of the job are the lack of stimulating work and bad hours.

Income supports three people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse.

Military History

The client was neither drafted nor has he tried to enlist.

Legal History

The client denies disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and other legal conflicts. He has been picked up as a juvenile for delinquency.

Physical Symptom Screen

Last physical exam occurred more than one year ago and the physician did say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with both teeth and gums. He has had four surgeries. Current physical health is rated as poor. He is allergic to certain medication. He is far-sighted. He has had pneumonia, frequent bronchitis, and emphysema. As to sexual intercourse, he complains of erectile difficulty, premature ejaculation, and inhibited arousal/interest.

Psychological Symptom Screen

He began drinking alcohol at age 15 and now does not drink. He has attended AA meetings for his alcohol problem. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood and diminished energy level. He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory

distortions and/or hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced multiple anxiety and panic attacks that were questionably situation-specific. He reports unreasonable fears of leaving home, confined spaces, traveling, and certain social situations, denies having had repetitive thoughts and denies having performed repetitive acts. He reports having experienced a highly stressful event with prolonged consequences including intrusive memories, recurrent dreams about the event, sleep disturbance, and avoidance of certain situations. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, excessive daytime somnolence, and awakening from nightmares.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use
- Alcohol
  - Previous Treatment
    - AA meetings
- Drugs
  - None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Development Problems/Stressors below for pathology in first degree relatives)
- None endorsed

Mood Symptoms (29.xx; 293.83; 296.xx; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - depressed mood
  - diminished energy

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Fears/Phobias
  - leaving home
  - confined spaces
  - traveling
  - certain social situations

Traumatic stress
frightening situations followed By:
unwanted memories
repetitive dreams
sleep problems
avoidance of situations
Other
panic attack(s)

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
Sickly
current health rated poor
Psychosexual symptoms
not interested in sex or can't become aroused
erectile difficulty

Psychosexual Problems (302.xx; 306.51)
not interested in sex or can't become aroused
failure to attain erection
premature ejaculation

Sleep and Arousal (307.4x; 780.5x)
sleep onset insomnia
early awakening
nonrestorative sleep
daytime somnolence
awakened by nightmares

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
truancy (high school)
picked up for delinquency as a juvenile
frequent fights (age less than 13)
frequent fights (high school)
persistent lying (age less than 13)
theft (age less than 13)
repeated trouble with school authorities (high school)

Other Potential Adult Problems/Stressors
Domestic
domestic violence
child frequently ill
child in trouble with law
child abuses drugs
child abuses alcohol
child diagnosed schizophrenic: paranoid type

Case 12: Horace G

Identifying Data

Horace G. is a 57 year-old black Christian male. He is employed full-time working 56 hours per week as a a Dairy Man and taking home $1,800 per month. Income of approximately $850 per month comes from his spouse's employment. The client is married and has had two natural children. He resides in an apartment, which he rents, and has lived there for about 23 years. He lives with his spouse and one natural child from his current spouse. His oldest child, a daughter, 30 years old, is married and on her own. He has had one previous psychiatric hospitalization, two hospitalizations for alcohol detoxification, and previous outpatient mental health services. Currently, he is under a physician's care for a health problem. [His youngest child, a son of 28, is diagnosed as schizophrenic/paranoid type.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother, his natural father, and a maternal grandmother.

The natural mother died from illness when the client was 47 years old. The natural father is still living.

He has 2 older brothers, 1 older sister, 1 younger brother, and 1 sibling died before the client was 18. The natural mother is reported to have had a nervous condition, suffered from depression, acted hyperenergetic at times, acted peculiarly at times, and suffered from a serious medical condition. The natural father is reported to have required hospitalization for nervous problems, suffered from depression, drank excessively, acted peculiarly at times, and suffered from a serious medical condition. His siblings are reported to have drunk excessively. When the client was born, his mother was 19 years old. He describes his mother as being shy, cautious, quiet, cold, hard, and stingy. She was viewed as irresponsible, unrealistic, a failure, weak, immature, and mostly unhappy. The client perceives his mother as having hated him. The mother reportedly was never physically affectionate and made him feel she would have been better off without him. The client could not talk to her about problems. She is said to have criticized the client over almost everything. His mother is seen as having invaded his privacy and ignored his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was inevitable. To punish the client psychologically, the mother would ignore him, yell at him, tell him that she was ashamed of him, make him feel that she had been hurt,

embarrass him, put him in 'time out,' and take away privileges. The client was also locked in a room for more than one hour, threatened with abandonment, threatened with a dangerous object, threatened with his life, and threatened with police intervention. Typical corporal punishments were hand spanking, slapping, pinching, ear pulling, and hair pulling. The client reports that the mother kicked him and hit him with a solid object.

When the client was born, his father was 20 years old. He describes his father as being shy, awkward, quiet, cold, hard, and stingy. He was viewed as a good money manager and strong, but irresponsible, unrealistic, immature, and mostly unhappy. The client perceives his father as having hated him. The father reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have been accepting even of poor behavior. His father is seen as having ignored most of the client's activities and resented his accomplishments as if they were in competition. He is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client didn't dare to voice it. If the client misbehaved, punishment was inevitable. To punish the client psychologically, the father would yell at him, tell him that he was ashamed of him, and embarrass him. The client was also threatened with a dangerous object, threatened with his life, threatened with damage to his sex organs, threatened with police intervention, and given threats to his safety and well-being. Typical corporal punishments were hand-spanking, slapping, pinching, ear pulling, hair pulling, and shoving. The client reports that the father punched him, kicked him, hit him with a solid object, cut him, tried to smother him, and attacked him with a weapon.

The client's family strongly valued being ambitious, working hard and trying your best, being responsible, self-disciplined, being married, and having a close family.

He thinks that being religious, obeying authority, and being 'manly' and tough were overemphasized to the point of being bothersome. Being self-reliant, being socially active, and openly expressing feelings were discouraged.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He had problems learning to talk. Before age 13, he considers himself to have been very unhappy. He reports thumb sucking after age 5 and enuresis after age 4. He recalls being very afraid of the dark, certain animals, monsters, leaving home, and separation from his caretakers. He had difficulty with moodiness. He admits to no antisocial or daredevil

behavior. He was ill no more often than peers.

As a child and teenager, he reports suicidal preoccupations and attempted suicide and denies sexual molestation, running away from home, and deliberate self-injury. He reports two episodes of serious suicidal preoccupations beginning at age 14. At age 15 he attempted suicide.

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself unattractive. He describes himself as shy, unhappy, quiet, nervous, and felt like he didn't fit with others a conservative. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 12, at roughly the same time as most of the boys he knew, He first learned about sex from a parent and received a somewhat incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 23. On the average he dated less than once per month. His parents did not comment upon the people he dated. He dated one person only. He first had heterosexual intercourse at age 25 and reported feeling sad, nervous, guilty, and ashamed. He reports having had one sex partner. Currently, he would do anything to avoid sex. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed high school in 1952.

The client attended 3 public high schools. His academic performance was in the C range. He had difficulty with school due to problems at home and poor relationships with other students. He denies major antisocial behaviors. He describes himself as being shy, very unpopular with other students, and being usually unhappy in high school much of the time.

Marital History

The client's current marriage began when he was 25 years old, and his spouse was 30 years old. He was not married prior to his current marriage.

The client's partner is a 62 year-old black Christian female. She is employed and works part-time for 25 hours per week as a dress operator. She has some junior high/high school education. He describes his partner as being shy, cold, hard, and stingy, yet also energetic and talkative. His partner is irresponsible, unrealistic, immature, mostly unhappy, and short-tempered, but hardworking. The

client admits to problems with the amount of time spent together, talking about feelings, showing affection, having trust in each other, the sexual relationship, alcohol use, and friends. Arguments occur several times a year and have resulted in physical attack to the partner. The primary caretaker of the children in the home is his partner.

Occupational History/Financial Status

The client works for an employer and is paid in regular salary. He has had this job for 30 years, is very unhappy with it, but is not thinking about changing jobs. The positive aspects of the job are the compensation and benefits. The negative aspects of the job are the management and relationships with co-workers. He has been neither promoted nor demoted on this job. Complaints have been made about him regarding tardiness and conflicts with others, and he has been threatened with dismissal, He believes these complaints are due to a misunderstanding, politics, personality conflicts, and deliberate attempts to create problems for him. He has had 2 previous jobs in 2 different occupations. He has never quit a job. He has been laid off once.

Income supports 3 people, has remained about the same over the past year, and is barely sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse.

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and other legal conflicts.

Physical Symptoms Screen

Last physical exam occurred more than one year ago and the physician did say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with his gums. He had never had surgery. Current physical health is rated as fair. He reports having blood relatives with cardiovascular disease/stroke and hypertension. He has no known allergies. Recently, he has experienced tremulousness. He reports having had recent wheezing/whistling sounds while breathing and frequent sighing. Recently, he has had abdominal pain. He has a history of liver disease/problems and jaundice. As to sexual intercourse he complains of erectile difficulty, loss of erection, ejaculatory difficulties, and inhibited arousal/interest. He reports recent

neck pain, back pain, muscle cramps, swollen/tender muscle, swollen/tender joint, and stiff neck/joints. He reports having had gout.

Psychological Symptom Screen

He began drinking alcohol at age 19 and now drinks daily. He usually drinks beer, wine, and hard liquor. He reports a need to drink daily, attempts to control his intake, difficulty controlling intake, having drunk a fifth or equivalent in one day on more than one occasion, and drinking despite a contraindicating physical condition. Drinking has resulted in missed work, trouble on the job, arguments over drinking with significant others, traffic accidents, and suicidal ideation. He reports some increase in tolerance over time. Upon discontinuation of drinking, he has experienced tremulousness, feeling weak/sick, sweating, anxiety/tension, depression, and D.T.'s. He denies use of unprescribed psychoactive drugs. He reports that he has experienced the unrelated occurrence of persistent depressed mood, diminished energy level, anorexia, sleep disturbance, and suicidal ideation. He reports one suicide attempt. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/ hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, and feeling unrefreshed by sleep.

Summary and Findings

Adult Problems

Note; The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol
  - Pathological Use
    - needs every day
    - attempts to control drinking
    - difficulty cutting down or stopping
    - drank fifth or equivalent per day, more than once
    - drinks despite physical problem
  - Psychosocial impairment
    - missed work
    - trouble on job
    - arguments with family/friends about drinking

traffic accident
SUICIDAL IDEATION
Tolerance/Withdrawal
needs more for same effect
tremulousness
felt weak/sick
sweating
anxiety/tension
depression
D.T.'s
hospitalized for detox

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
Depression
depressed mood
sleep disturbance
loss of appetite
diminished energy
SUICIDAL IDEATION
SUICIDE ATTEMPT

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
Possible anxiety related somatic symptoms, if Physical etiology ruled out.
shakiness
muscle cramps

Somatoform Symptoms (300.xx; 307.80; 316.00)
(Of R/O physical etiology, somatization disorder requires 13 symptoms)
Gastrointestinal
abdominal pain
Pain
back pain
abdominal pain
neck pain
Psychosexual symptoms
not interested in sex or can't become aroused
erectile difficulty

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused
- failure to attain erection
- failure to maintain erection
- inhibited orgasm

Sleep and Arousal (307.4x; 780.5x)
- sleep onset insomnia
- early awakening
- nonrestorative sleep

Antisocial Personality (301.70)
(Also note findings in Substance Use above)

Other Potential Adult Problems/Stressors
- Domestic
  - domestic violence

Case 13: Joseph C.

Identifying Data

Joseph C. is a 42 year-old white Catholic male. He is employed full-time working 61 hours per week as a truck driver and taking home $2,500 per month. The client is married and had two natural children (one is deceased). He resides in an apartment, which he rents, and has lived there for about 5 years. He lives with his spouse and one natural child from his current spouse. He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. Currently, he is under a physician's care for a health problem. [His son, diagnosed schizophrenic/paranoid type, is 18 years old.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

Both natural parents are still living.

He has one older sister. The natural mother is reported to have suffered from depression, suffered from a serious medical condition, and visited a physician frequently. The natural father is reported to have drunk excessively. His sibling is reported to have suffered from depression. When the client was born, his mother was 21 years old. He describes his mother as being energetic and talkative, yet also cautious, cold, impatient, and dishonest. She was viewed as irresponsible, unrealistic, a failure, weak, immature, and mostly unhappy. The client perceives his mother as having only put up with him. The mother reportedly was never physically affectionate but was bothersomely attentive. The client could talk to her about very few problems. She is said to have criticized the client over almost everything. His mother is seen as having invaded his privacy and ignored his accomplishments. She is reported to have been not very strict and gave the client unrestricted freedom of action. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the mother would ignore him, yell at him, tell him that she was ashamed of him, and make him feel that she had been hurt. She never used corporal punishment.

When the client was born, his father was 23 years old. He describes his father as being confident and energetic, yet also cautious, impatient, hard, and stingy. He was viewed as hardworking, but irresponsible, a poor money manager, weak, immature, and mostly unhappy. The client perceives his father as having disliked him. The father reportedly was not physically

affectionate enough and made him feel neglected. The client could not talk to him about problems. He is said to have been accepting even of poor behavior. His father is seen as having been disinterested in most of the client's activities and demeaned his accomplishments. He is reported to have been a very lenient disciplinarian who gave the client more freedom of action than desirable. When they disagreed, the client could get a hearing, but it rarely changed anything. If the client misbehaved, punishment was infrequent. To punish the client psychologically, the father would ignore him, yell at him, tell him that he was ashamed of him, and embarrass him. Typical corporal punishment was slapping. The client reports that the father punched him.

The client's family strongly valued being married and having a close family.

He thinks that obeying authority and being 'manly' and tough were overemphasized to the point of being bothersome. Being socially active, appreciating art/culture, being tolerant of others, and openly expressing feelings were discouraged. There was disagreement in the family over the importance of being religious and being involved with sports.

Developmental History

At birth he was delivered normally. He had a birth defect. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been somewhat unhappy. He reports frequent nightmares. He denies persistent childhood fears or phobias. He had difficulty with short-temperedness, moodiness, showing off, and bragging. He recalls being a roughneck, being a daredevil, repetitive stealing, frequent lying, and getting in many fights. He was ill no more often than peers.

As a child and teenager, he reports running away from home and attempting suicide. [He reports walking back and forth across a busy street, with his eyes closed. "I wanted a truck to crush my skull--I wanted to die.] He denies sexual molestation, deliberate self-injury, and suicidal preoccupations. He first ran away from home at age 11, repeated this twice and once stayed away overnight. At age 13 he attempted suicide.

As a teenager, he was as healthy as others, and he had no unusual eating habits. He describes himself as shy, awkward, short-tempered, a rebel, and felt like he didn't fit with others. His caretakers were lax about rules and acted as if the client's judgment could be trusted only a little. He began to physically mature at about age 13, later than most of the boys he knew. He first learned about sex from a friend and received a somewhat

incorrect explanation. He felt that he could discuss nothing about sex with his parents. He began dating at age 14. On the average he dated less than once per month. His parents did not comment upon the people he dated. He tended to date one person at a time. He first had heterosexual intercourse at age 14 and reports feeling satisfied. He reports having had five sex partners. Currently, he can take sex or leave it. He denies having had homosexual experience before age 18 and afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed elementary school in 1951 and high school by examination (GED) in 1966.

He completed his elementary education in one public school. He reports that his performance was about average. He was held back one semester. He reports problems in learning to read and do arithmetic, but took no special classes for learning problems. He denies serious behavioral problems. Socially, he describes himself as neither shy nor outgoing, not liked nor disliked by most schoolmates, and as having no close friends. In general, he disliked elementary school much of the time.

The client attended one public high school. His academic performance was in the C range. He had difficulty with school due to problems at home, having to work, and involvement with a bad crowd. He admits to repeated trouble with school authorities, repeated truancy, frequent fighting, use of drugs, and having been suspended. He describes himself as being neither shy nor outgoing, somewhat unpopular with other students, and having a difficult experience in high school much of the time.

Marital History

The client's current marriage began when he was 22 years old, and his spouse was 19 years old. He was not married prior to his current marriage. He has suffered the loss by death of one natural child. [The youngest child, a daughter, at age 5, due to appendicitis. She was 1 year younger than I.D. Patient.]

The client's partner is a 39 year-old white Catholic female. She is a homemaker. She has a high school education. He describes his partner as being shy, awkward, cold, impatient, and hard, yet also energetic. His partner is responsible, hardworking, and strong, but unrealistic, mostly unhappy, and short-tempered.

In their relationship he reports that they both have problems with the amount of time spent together, the sexual relationship, and

friends. The client admits to problems with talking about feelings, showing affection, having trust in each other, feeling jealous, fidelity, and drug use. He states that his partner has problems with managing money. Arguments occur several times a year and have resulted in physical attack to the partner. The primary caretaker of the child in the home is his partner.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages. He has had this job for six years, is somewhat satisfied with it, but is thinking about changing jobs. The negative aspects of the job are the compensation, benefit level, lack of stimulating work, lack of future prospects, bad hours and management. He has been neither promoted nor demoted on this job. He has had ten previous jobs in five different occupations. He has quit previous jobs for no particular reason. On three occasions he has simply quit a job for no pressing reason and with no new job to go to. He has been fired twice.

Income supports three people, has remained about the same over the past year, and is insufficient to pay for basic necessities. Primary responsibility for money management resides with the client. He is having debt problems and is concerned about bankruptcy. He has gambling debts.

Military History

The client was excluded for reasons of drug use.

Legal History

The client denies initiating lawsuits, criminal charges, court-ordered psychological evaluations, civil commitments, other legal conflicts. He has been picked up as a juvenile for delinquency, truancy, and running away. He has been denied a claim for disability. He has been sued twice for delinquent debt and he has declared personal bankruptcy once.

Physical Symptom Screen

He has never had a physical exam. He has never visited a dentist, and he is having problems with both teeth and gums. He has never had surgery. Current physical health is rated as good. He has no known allergies. Recently, he has experienced difficulty concentrating. He is near-sighted. He reports having had recent coughing up of green sputum. He has had frequent bronchitis. As to sexual intercourse, he complains of erectile difficulty, premature ejaculation, ejaculatory difficulties, and inhibited arousal/interest. He reports recent neck pain, back pain, joint pain, muscle cramps, muscle weakness, and stiff neck/joints.

Psychological Symptom Screen

He began drinking alcohol at age 18 and now drinks once or twice a month. He usually drinks beer. He denies usual diagnostic signs of pathological alcohol use and psychosocial impairment. He reports no increase in tolerance over time. He has used cocaine, cannabis, and inhalants. He began taking drugs at age 18, and uses them once or twice a week now. He reports difficulty reducing drug use, using drugs throughout the day, using drugs nearly every day for a month or more. and nearly overdosing. Drug use has resulted in missed work, trouble on the job, arguments over drug use with significant others, and loss of interest in usual activities. Compared to when he started using them, he reports an increase in the amount of drugs necessary to produce the same effect. Discontinuation of cocaine has produced depression, anxiety/tension, tiredness, insomnia, hypersomnia, agitation, and suicidal ideation. He has received treatment for drug use. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, anorexia, sleep disturbance, and suicidal ideation accompanied by difficulty concentrating, guilt feelings, loss of interest in sex, social withdrawal, agitation, and irritability. He reports one suicide attempt. He denies periods of elated mood and hyperactivity lasting one week or more. He denies having experienced feelings of being controlled, thought broadcasting, thought insertion, thought withdrawal, auditory distortions/hallucinations, grandiose beliefs, and persecutory beliefs. He reports having experienced no anxiety/panic attacks. He denies specific phobias. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, feeling unrefreshed by sleep, and excessive daytime somnolence.

Summary and Findings

Adult Problems

Note: The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
- Alcohol
- Drugs
  - Types
    - cocaine
    - cannabis
    - inhalants

Pathological Use
attempts to cut down or stop
used throughout the day
used every day for at least a month
near overdose
used in high school
Psychosocial Impairment
missed work
trouble on job
arguments with family/friends over drug use
lost interest in previously performed activities
Tolerance/Withdrawal
needs more for same effect
cocaine
depression
anxiety/tension
tiredness
insomnia
hypersomnia
agitation
suicidal ideation
Previous
Yes

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
None endorsed

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
Depression
depressed mood
loss of interest in sex
sleep disturbance
difficulty concentrating
agitation
social withdrawal
loss of appetite
diminished energy
guilt
irritability
suicidal ideation
suicide attempt (age 13/serious attempt)

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
Possible anxiety-related somatic symptoms, if physical etiology ruled out.
trouble concentrating
muscle cramps

Somatoform Symptoms (300.xx; 307.80; 316.00)
(If R/O physical etiology, somatization disorder requires 13 symptoms)
- Pain
  - back pain
  - joint pain
  - neck pain
- Conversion/pseudoneurological
  - muscle weakness
- Psychosexual symptoms
  - not interested in sex or can't become aroused
  - erectile difficulty

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused
- failure to attain erection
- inhibited orgasm
- premature ejaculation

Sleep and arousal (307.4x; 780.5x)
- sleep onset insomnia
- early awakening
- nonrestorative sleep
- daytime somnolence

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
- truancy (high school)
- suspension (high school)
- picked up for delinquency as a juvenile
- ran away from home overnight
- frequent fights (age less than 13)
- frequent fights (high school)
- persistent lying (age less than 13)
- precocious age first intercourse
- theft (age less than 13)
- repeated trouble with school authorities (high school)
- quit job for no particular reason
- quit job without other jobs in sight
- bankruptcy

Other Potential Adult Problems/Stressors
- Loss
  - death of natural child
- Domestic
  - domestic violence

Case 14: Michael S

Identifying Data

Michael S is a 59 year-old white Jewish male. He is employed full-time working 60 hours per week as a Tile Man and taking home $2,500 per month. Income of approximately $1,000 per month comes from his spouse's employment. The client is married and has had one natural child. He resides in an apartment, which he rents, and has lived there for about 7 years. He lives with his spouse, spouse's mother, and one natural child from his current spouse. He has had no previous psychiatric hospitalizations and no previous outpatient mental health services. [His son, diagnosed as schizophrenic/ paranoid type, is 25 years of age.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother, one stepfather, and a maternal grandmother. The natural father never lived with the client because he left the mother (when subject was 5 months old).

The natural mother died from illness when the client was 30 years old. The natural father may or may not still be living.

He has one older brother and one older half sister. The natural mother is reported to had a nervous condition, required hospitalization for nervous problems, suffered from depression, attempted suicide, acted hyperenergetically at times, acted peculiarly at times, had problems with headaches, and had gastrointestinal problems.

He considers himself to have been raised primarily by his mother and his stepfather. When the client was born, his mother was 20 years old. He describes his mother as being talkative, yet also shy, awkward, cold, and hard. She was viewed as irresponsible, unrealistic, a failure, immature, mostly unhappy, and insecure. The client perceives his mother as having hated him. The mother reportedly was never physically affectionate and made him feel she would have been better off without him. The client could not talk to her about problems. She is said to have been accepting even of poor behavior. His mother is seen as having ignored most of the client's activities and ignored his accomplishments. She is reported to have been a very lenient disciplinarian who gave the client unrestricted freedom of action. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his stepfather was 25 years old. He describes his stepfather as being awkward, cautious, quiet, cold,

impatient, and hard. He was viewed as a failure, weak, and short-tempered. The client perceives his stepfather as having hated him. The stepfather reportedly was never physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems, He is said to have criticized the client over almost everything, His stepfather is seen as having ignored most of the client's activities and resented his accomplishments as if they were in competition. He is reported to have been an extremely strict disciplinarian but gave the client unrestricted freedom of action. When they disagreed, the client could not persuade him to change his mind. If the client misbehaved, punishment never occurred.

Developmental History.

At birth he was delivered normally. He had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He reports nail biting after age 5, stuttering after age 5, enuresis after age 4, encopresis after age 4, repetitive head bumping, insomnia, and frequent nightmares. He admits to frequent vomiting and repeated eating of nonfood substances, including dirt and clay. He recalls being very afraid of the dark, certain animals, monsters, leaving home, separation from his caretakers, and going to school. He had repeated panics without apparent precipitants. He had difficulty with learning activities requiring coordination, completing tasks requiring concentration, moodiness, showing off, and bothering other children. He recalls being a roughneck, hurting animals, repetitive stealing, setting fires, frequent lying, and deliberate vandalism. He was ill no more than other peers.

As a child and teenager, he reports sexual molestation and denies running away from home, deliberate self-injury, suicidal preoccupations, and attempted suicide. He was sexually molested by his male caretaker. The first incident occurred at age 7 and reoccurred many times over a period of years [until age 12, when the client threatened to tell his teacher, and it stopped].

As a teenager, he was as healthy as others, had no unusual eating habits and considered himself unattractive. He describes himself as shy, unhappy, quiet, nervous, a conservative, and felt like he didn't fit with others. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 13, at roughly the same time as most of the boys he knew. He first learned about sex from a relative (his stepfather) and received an incorrect explanation. He felt that he could discuss nothing about sex with his parents. He did not date by age 18, but began at age 27. On the average he dated less than once per month. His parents did not comment upon

the people he dated. He dated one person only. He first had heterosexual intercourse at age 29 and reports feeling sad, nervous, guilty, ashamed, and unsatisfied. He reports having had 1 sex partner. Currently, he would rather avoid sex. He had homosexual experience before age 18 [with his stepfather between 7 - 12 years of age], but not afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed high school by examination (GED) in 1953.

The client attended 4 high schools (public). His academic performance was in the D range and included taking remedial classes, getting held back, and taking special classes for behavior problems. He had difficulty with school due to problems at home and poor relationships with other students. He admits to repeated trouble with school authorities, repeated truancy, and having been suspended. He describes himself as being shy, very unpopular with other students, and having a difficult experience in high school much of the time.

Marital History

The client's current marriage began when he was 31 years old, and his spouse was 29 years old. He was not married prior to his current marriage.

The client's partner is a 56 year-old Hispanic Born-again Christian female. She is a homemaker. She has some college education. He describes his partner as being outgoing, confident, and talkative, yet also cold, impatient and hard. His partner is irresponsible, unrealistic, a failure, immature, mostly unhappy and short-tempered.

In their relationship he reports that they both have problems with managing money and religion. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, the sexual relationship, and friends. He states that his partner has problems with having trust in each other, fidelity, and in-laws. Arguments occur several times a year and have resulted in physical attack to the partner. The primary caretaker of the children in the home is a relative. Child rearing has been problematic because antisocial behavior, attempted suicide, chronic illness, trouble with the law, and drug use occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages. He has had this job for 258 years, is very unhappy with it, but is not thinking about changing jobs. The compensation, benefit level, lack of stimulating work, lack of future prospects, lack of security, bad hours, management, relationships with co-workers, and lack of fulfillment in it. He has been neither promoted nor demoted on his job. Complaints have been made about him regarding conflicts with others (his co-workers have complained about his moodiness, isolation, and generally ignoring them), violation of policy, and he has been threatened with dismissal. He believes these complaints are due to politics, personality conflicts, and deliberate attempts to create problems for him. He has had 10 previous jobs in the same occupation. He has never quit a job. He has been fired 5 times.

Income supports 3 people, has increased somewhat over the past year, yet is barely sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. He is having debt problems, but is not concerned about bankruptcy. He has gambling debts. (Subject is a compulsive gambler.)

Military History

The client was drafted and served on active duty in the Army. He entered the service at age 19. Upon entering the service he had less than a high school education. He attained the rank of E-11 and completed 2 months of active duty. He was discharged early for unsuitability. He received an undesirable discharge. While in the service, he was involved with wartime assignments. He witnessed enemy casualties and was not personally wounded. He was treated for nervous/emotional problems (while in the service).

Legal History

The client denies disability claims, initiating lawsuits, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, and legal conflicts. He has been picked up as a juvenile for running away.

Physical Symptoms Screen

Last physical exam occurred more than one year ago and he can't recall if the physician did say that problems were detected. It's been over a year since he visited a dentist, and he is having problems with both teeth and gums. He has had one surgery. Current physical health is rated as good. He has no known allergies. The client reports recent problems with being overweight. He has a history of high blood sugar. He is near-sighted. Recently, he has experienced swollen ankles and awakenings from leg cramps. He

reports having had recent coughing up green sputum and coughing up sputum with foul odor. He has had pneumonia and frequent bronchitis. Recently, he has had abdominal pain and abdominal bloating. Since age 18, he admits to having engaged in self-induced vomiting, binge eating, crash dieting, and use of laxatives to control weight. He has a history of hemorrhoids. As to sexual intercourse, he complains of inhibited arousal/interest. He reports having had gout.

Psychological Symptom Screen

He began drinking alcohol at age 20 and now drinks three or four times a week. He usually drinks beer and hard liquor. He reports attempts to control his intake, difficulty controlling intake, having drunk a fifth or equivalent in one day on more than one occasion, and drinking despite contraindicating physical condition. Drinking has resulted in missed work, trouble on the job, arguments over drinking with significant others, violence, and suicidal ideation. He reports some increase in tolerance over time. Upon discontinuation of drinking, he has experienced anxiety/tension, depression, and insomnia. He has attended AA meetings for his alcohol problem. He has used cannabis. He began taking drugs at age 22, and uses them once or twice a week now. He reports difficulty reducing drug use and using drugs throughout the day, and using drugs nearly every day for a month or more. Drug use has resulted in arguments over drug use with significant others, violent behavior, loss of interest in usual activities, and suicidal ideation. Compared to when he started using them, he reports no increase in the amount of drugs necessary to produce the same effect. He has not received treatment for drug use. He reports that he has experienced the unrelated occurrence of persistent depressed mood, sleep disturbance, and suicidal ideation. He reports 2 suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He admits to having experienced thought broadcasting, thought insertion, auditory distortions/hallucinations, and persecutory beliefs but no feelings of being controlled, thought withdrawal, and grandiose beliefs. He reports having experienced no anxiety/panic attacks. He reports unreasonable fears of certain social situations, admits having had repetitive thoughts and denies having performed repetitive acts. He reports having repeatedly experienced depersonalization. His current sleep pattern is characterized by trouble falling asleep, waking up too early and having trouble falling back asleep, and feeling unrefreshed by sleep.

Summary and Findings

Adult Problems

Note; The following findings may be recent or remote in time.
Refer to the narrative for the context of occurrence.

Substance Use
- Alcohol (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
  - Pathological Use
    - attempts to control drinking
    - difficulty cutting down or stopping
    - drank fifth or equivalent per day, more than once
    - drinks despite physical problem
  - Psychosocial impairment
    - missed work
    - trouble on job
    - arguments with family/friends about drinking
    - became violent
    - SUICIDAL IDEATION
  - Tolerance/Withdrawal
    - needs more for same effect
    - anxiety/tension
    - depression
    - insomnia
  - Previous Tx
    - AA meeting

Drugs
- Type
  - cannabis
- Pathological Use
  - attempts to cut down or stop
  - used throughout the day
  - used every day for at least a month
- Psychosocial Impairment
  - arguments with family/friends over drug use
  - became violent
  - lost interest in previously performed activities
  - SUICIDAL IDEATION

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- thought broadcasting
- thought insertion
- Persecutory Beliefs
- auditory hallucinations
- depersonalization

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)
- Depression
  - depressed mood
  - sleep disturbance
  - SUICIDAL IDEATION
  - SUICIDE ATTEMPTS

Anxiety-related Symptoms (294.80; 300.xx; 309.89)
- Fears/Phobias
  - certain social situations
- Other
  - obsessions

Somatoform Symptoms (300.xx; 307.80; 316.00)
(Of R/O physical etiology, somatization disorder requires 13 symptoms)
- Gastrointestinal
  - abdominal pain
  - abdominal bloating
- Pain
  - abdominal pain
- Psychosexual symptoms
  - not interested in sex or can't become aroused

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused

Sleep and Arousal (307.4x; 780.5x)
- sleep onset insomnia
- early awakening
- nonrestorative sleep

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
- truancy (high school)
- suspension (high school)
- persistent lying (age less then 13)
- theft (age less then 13)
- vandalism (age less than 13)
- repeated trouble with school authorities (high school)
- fired from more than 2 jobs)

Other Potential Adult Problems/Stressors
- Domestic
  - domestic violence
  - child attempted suicide
  - child with chronic disease
  - child in trouble with law
  - child drug abuse

Case 15: Frank S

Identifying Data

Frank S. is a 48 year-old white Catholic male. He is employed full-time working 40 hours per week as a a Postal Worker and taking home $2,700 per month. Income of approximately $600 per month comes from his spouse's part-time employment. The client is married and has had three natural children (three sons, the middle one is the J.D. patient). He resides in multiple family dwelling, which he rents, and has lived there for about 17 years. He lives with his spouse and one natural child from his current spouse. He has had one previous psychiatric hospitalization and has had previous outpatient mental health services. Currently, he is using prescription medication. [The son, diagnosed schizophrenic/paranoid type is 23 years old. He has a younger son who is 19 years old. His oldest son would have been 25 years old but has been deceased for 15 months.]

Family of Origin

During childhood and adolescence, the client was raised by his natural mother and his natural father.

Both natural parents are still living.

He has 1 older sister, 1 younger sister, and 1 sibling died since the client was 18. The natural mother is reported to have had a nervous condition, required hospitalization for nervous problems, suffered from depression, attempted suicide, acted hyperenergetic at times, and acted peculiar at times. The natural father is reported to have drunk excessively, suffered from a serious medical condition, and visited a physician frequently. His siblings are reported to have had a nervous condition, required hospitalization for nervous problems, suffered from depression, attempted suicide, used drugs excessively, and acted peculiarly at times. When the client was born, his mother was 24 years old. He describes his mother as being shy, cautious, quiet, cold, impatient, and hard. She was viewed as hardworking, but irresponsible, unrealistic, weak, immature, and insecure. The client perceives his mother as having liked, but not loved, him. The mother reportedly was not physically affectionate enough but was bothersomely attentive. The client could not talk to her about problems. She is said to have been accepting even of poor behavior. His mother is seen as having invaded his privacy and ignored his accomplishments. She is reported to have been a very lenient disciplinarian but always wanted to know where the client was going or what he would be doing. When they disagreed, the client could usually get her to give in. If the client misbehaved, punishment never occurred.

When the client was born, his father was 23 years old. He describes his father as being shy, awkward, quiet, cold, impatient, and stingy. He was viewed as responsible and hardworking, but unrealistic, immature, mostly unhappy, and short-tempered. The client perceives his father as having disliked him. The father reportedly was intermittantly physically affectionate and made him feel he would have been better off without him. The client could not talk to him about problems. He is said to have been accepting even of poor behavior. His father is seen as having ignored most of the client's activities and demeaned his accomplishments. He is reported to have been a very lenient disciplinarian who gave the client unrestricted freedom of action. When they disagreed, the client could not persuade him to change his mind. If the client misbehaved, punishment was sometimes forthcoming and sometimes not. To punish the client psychologically, the father would ignore him, yell at him, tell him that he was ashamed of him, make him feel that he had been hurt, embarrass him, take away privileges. The client was also locked in a room for more than one hour, threatened with abandonment, abandoned, and threatened with a dangerous object. Typical corporal punishment were hand spanking and slapping.

Developmental History

At birth he was delivered normally. He was not put in an incubator and had no birth defects. He is not aware of problems with learning to sit up, crawl, stand, walk, talk, toilet, feed himself, and dress himself. Before age 13, he considers himself to have been very unhappy. He reports frequent nightmares. He recalls being very afraid of the dark, certain animals, monsters, leaving home, and separation from his caretakers, dying, and going to school. He had repeated panics without apparent precipitants. He had difficulty with awkwardness/clumsiness, frequent accidents, learning activities requiring coordination, sitting still, completing tasks requiring concentration, moodiness, bragging, and bothering other children. He recalls frequent lying and attempts to hurt other children. He was ill more frequently than peers.

As a child and teenager, he reports deliberate self-injury and suicidal preoccupations and denies sexual molestation, running away from home, and attempted suicide. He reports three episodes of serious suicidal preoccupations beginning at age 14.

As a teenager, he was not as healthy as others, had no unusual eating habits and considered himself unattractive. He describes himself as shy, unhappy, quiet, nervous, and felt like he didn't fit with others. His caretakers were lax about rules and acted as if the client's judgment could not be trusted at all. He began to physically mature at about age 14, later than most of the boys he knew. He first learned about sex from pornography and received a somewhat incorrect explanation. He felt that he could discuss

nothing about sex with his parents. He did not date by age 18, but began at age 21. On the average he dated every week. His parents objected to and tried to interfere with the people he dated. He dated one person only. He first had heterosexual intercourse at age 21 and reports feeling sad, nervous, guilty, and ashamed. He reports having had one sex partner. Currently, he has problems with sexual enjoyment. He denies having homosexual experience before age 18 or afterwards. Before age 18 he claims not to have had a very close friend with whom he could discuss nearly anything. He has no such friends now.

Educational History

The client completed elementary school in 1955 and high school in 1959.

He completed his elementary education in one parochial school. He reports that his performance was about average. He was held back 3 semesters. He reports problems in learning to read and speak correctly, but took no special classes for learning problems. He admits to repeated trouble with school authorities, but took no special classes for behavioral problems. Socially, he describes himself as being shy, disliked by other schoolmates, and as having no close friends. In general, he disliked elementary school much of the time.

The client attended one parochial high school. His academic performance was in the B range. He denies major antisocial behaviors. He describes himself as being shy, very unpopular with other students, and having a difficult experience in high school much of the time.

Marital History

The client's current marriage began when he was 22 years old, and his spouse was 27 years old. He was not married prior to his current marriage. He has suffered the loss by death of 1 natural child. (His oldest son committed suicide, at age 23, by illegal drug overdose. He left a note saying that he was a "dope fiend and homosexual" and didn't want to live.")

The client's partner is a 53 year-old white Catholic female. She is employed and works part-time for 25 hours per week as a waitress. She has a high school education. He describes his partner as being confident, energetic, and talkative, yet also cold, impatient, and hard. His partner is responsible, hardworking, and strong, but unrealistic, mostly unhappy, and insecure. The client admits to problems with the amount of time spent together, talking about feelings, showing affection, having trust in each other, feeling jealous, the sexual relationship, drug use, and friends. He

states that his partner has problems with in-laws and relatives. Arguments occur once or twice a year. The primary caretaker of the children in the home is his partner. Child rearing has been problematic because of antisocial behavior, suicide attempts (the J.D. patient), a suicide, and chronic illness having occurred with his offspring.

Occupational History/Financial Status

The client works for an employer and is paid in hourly wages. He is a union member. He has had this job for 21 years, is very unhappy with it, but is not thinking about changing jobs. The positive aspects of the job are the benefits and security. The negative aspects of the job are the compensation, lack of stimulating work, lack of future prospects, management, and relationships with co-workers. He has been neither promoted nor demoted on this job. Complaints have been made about him regarding improper attire and conflicts with others, and he has had a formal complaint filed against him and been threatened with dismissal. He believes these complaints are due to misunderstanding, politics, personality conflicts, his illness, deliberate attempts to create problems for him, and his not performing as expected.

Income supports 4 people, has increased somewhat over the past year, and is more than sufficient to pay for basic necessities. Primary responsibility for money management resides with his spouse. (Client did not easily volunteer fact that his wife contributes $7,200 annually to the family budget.)

Military History

The client was neither drafted nor tried to enlist.

Legal History

The client denies being picked up by legal authorities as a juvenile, disability claims, initiating lawsuits, being sued, declaring bankruptcy, criminal charges, court-ordered psychological evaluations, civil commitments, or other legal conflicts.

Physical Symptoms Screen

Last physical exam occurred within the last month and the physician did say that problems were detected. Within the last six months he visited a dentist, and he is having no dental or gum problems. He had had 1 surgery. Current physical health is rated as fair. He reports having blood relatives with diabetes. He is allergic to certain medication, pollen, and dust. Recently, he has experienced tremulousness, memory difficulty, and difficulty concentrating. He is near-sighted. He has had frequent bronchitis.

Recently, he has had abdominal bloating. Since age 18, he admits to having engaged in self-induced vomiting, binge eating, crash dieting, and use of laxatives to control weight. He has a history of hemorrhoids. As to sexual intercourse he complains of loss of erection, ejaculatory difficulties, and inhibited arousal/interest. He reports recent back pain, joint pain, muscle cramps, swollen/ tender joint, and stiff neck/joints. He reports having had gout.

Psychological Symptom Screen

He has never used alcohol. He denies use of unprescribed psychoactive drugs. He reports that he has experienced repeated episodes of persistent depressed mood, diminished energy level, sleep disturbance, and suicidal ideation accompanied by a significant weight change, stomach/bowel problems, difficulty concentrating, loss of interest in sex, social withdrawal, irritability, and persecutory distortions/delusions, He reports no history of suicide attempts. He denies periods of elated mood and hyperactivity lasting one week or more. He admits to having experienced thought broadcasting, thought withdrawal, and persecutory beliefs but not feelings of being controlled, thought insertion, auditory auditory distortions/ hallucinations, and grandiose beliefs. He reports having experienced multiple anxiety/ panic attacks that were questionably situation specific. He reports unreasonable fears of confined spaces, being alone, traveling, and certain social situations, admits having had repetitive thoughts and denies having performed repetitive acts. He reports having repeatedly experienced visual hallucinations, visual distortions, strong odors not perceived by others, peculiar tastes in food or drink, derealization, and depersonalization.

Summary and Findings

Indeterminate Response

first source of knowledge re: intercourse
(clarified in follow-up interview)

Adult Problems

Note; The following findings may be recent or remote in time. Refer to the narrative for the context of occurrence.

Substance Use (291.xx; 292.xx; 303.xx; 304.xx; 305.xx)
Alcohol
None endorsed

Drugs
None endorsed

Psychotic Symptoms (290.xx; 293.xx; 295.xx; 297.xx; 298.xx)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)

- thought broadcasting
- thought withdrawal
- persecutory beliefs
- visual hallucinations
- visual distortions
- olfactory distortions
- gustatory distortions
- derealization
- depersonalization

Mood Symptoms (290.xx; 293.83; 296.xx; 301.13; 311.00)
(See Other Potential Developmental Problems/Stressors below for pathology in first degree relatives)

Depression

- depressed mood
- loss of interest in sex
- weight change
- stomach/bowel problems
- sleep disturbance
- difficulty concentrating
- social withdrawal
- diminished energy
- irritability
- persecutory distortions/delusions
- SUICIDAL IDEATION
- SUICIDE ATTEMPT

Anxiety-related Symptoms (294.80; 300.xx; 309.89)

Fears/Phobias

- confined spaces
- being alone
- traveling
- certain social situations

Other

- panic attack(s)
- obsessions

Possible anxiety related somatic symptoms, if physical etiology ruled out.

- trouble concentrating
- shakiness
- muscle cramps

Somatoform Symptoms (300.xx; 307.80; 316.00)
(Of R/O physical etiology, somatization disorder requires 13 symptoms)
- Sickly
  - sick often as a child
  - sick often as teen
- Gastrointestinal
  - abdominal pain
- Pain
  - back pain
  - joint pain
- Conversion/pseudoneurological
  - trouble remembering
- Psychosexual symptoms
  - not interested in sex or can't become aroused
  - erectile difficulty

Psychosexual Problems (302.xx; 306.51)
- not interested in sex or can't become aroused
- failure to maintain erection
- inhibited orgasm
- loss of interest

Sleep and Arousal (307.4x; 780.5x)
None endorsed

Antisocial Personality (301.70)
(Also note findings in Substance Use above)
- persistent lying (age less than 13)
- repeated trouble with school authorities (elementary school)

Other Potential Adult Problems/Stressors
- Loss
  - death of sibling
  - death of natural child
- Domestic
  - child with behavior problem(s) before age of 12
  - child committed suicide
  - child with chronic disease

APPENDIX D

Introduction to GOLPH Manual

Introduction to GOLPH Manual

The GOLPH Psychosocial History: Response-Contingent Data Acquisition and Reporting

by

Ronald A Giannetti

The psychological history is indispensable in the proper evaluation of a patient, whereas psychometric tests and laboratory studies are, for the most part, elective procedures. Standard textbooks emphasize the central role of history taking in clinical practice. According to Korchin (1976)[1] "Knowing the history of a person is important to the understanding of his current personality structure and functioning. Similarly important is knowledge of his current life situations, the stresses and realities within which he lives." Kolb and Brodie (1982) state that "the purpose

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[1]All references are included in Reference List of dissertation.

Note: Reprinted by permission of Basic Books, New York, from: Butcher, James N. (1987). Computerized psychological assessment: A practitioner's guide. New York: Basic Books.

of the psychiatric examination is . . . to secure a biographical historical perspective of the personality, a clear psychological picture of the living person as a specific human being with individual problems." And Kaplan and Saddock (1981) believe that "the psychiatric history strives to convey the more elusive picture of the patient's individual personality, characteristics, including both his strengths and his weaknesses. It provides insight into the nature of his relationship with those closest to him, and includes all of the important people in his past and present life."
The role of the psychosocial history in clinical assessment can be contrasted with that of psychological tests. Tests provide standardized estimates on a set of personality, intellectual, or symptomatic variables. They inform us about the person's internal characteristics, resources, and patterns of behavior in a normative framework. The psychosocial history, on the other hand, provides information on the long series of external stimuli, events, and individuals with which the person has interacted, including the consequences of those interactions. It describes how internal characteristics, resources and patterns of behavior measured by psychological tests have been externally

applied and shaped.

Of course, the history has a purpose beyond simple description. It has an inferential, or predictive, value as well. Clinical hypotheses, diagnoses, and formulations are derived from this material. Two studies on the incremental predictive value of psychological tests have also provided evidence on the history's predictive value. Using a Latin-square design, Kostlan (1954) studied the accuracy of twenty clinical psychologists in predicting various criteria on five patients from different combinations of tests frequently found in test batteries: social case history, Minnesota Multiphasic Personality Inventory (MMPI), Rorschach, and sentence completion. The predictive value of any combination of tests was measured as the increment in validity over predictions made from a biographical face sheet containing only age, marital status, occupation, education, and referral source. Only two combinations produced predictive accuracy greater than simple biographical data alone: social history, MMPI, and either the sentence completion or Rorschach. If either the MMPI or social history was not part of a battery, predictive accuracy did not exceed that obtainable from face sheet

data alone.

In a similar study Sines (1959) had five clinicians use different combinations of a biographical data sheet, interview, MMPI, and Rorschach to predict therapists' Q-sort descriptions of thirty patients. He found only two combinations yielding average predictive validities significantly greater than that obtainable from the biographical data sheet alone (0.396): biographical data plus interview (0.566) and biographical data plus interview plus MMPI (0.595). Thus these studies suggest that biographical data have considerable predictive value independent of psychological tests. Garb's (1984) recent review of incremental validity studies supports this conclusion. Numerous other studies have demonstrated the value of psychosocial history data in classification and prognosis (Strauss, Carpenter, & Nasrallah, 1978).

Although computers have been used for decades to facilitate the scoring and interpretation of psychological tests, the psychosocial history has been virtually ignored. There is a simple reason for this phenomenon. The tests that have been computerized are primarily those that can be administered vie self-report, consist of items that can be answered

independently of one another, and have invariable scoring procedures. These features make computerization relatively straightforward. The characteristics of the psychosocial history are another matter entirely. With the exception of the Minnesota-Briggs (Briggs, Rouzer, Hamberg, & Holman, 1972), a self-report history consisting of independently answered items, no standardized self-report history exits. Furthermore, an examination of the literature on the psychosocial history reveals no theory or model providing a rationale for specifying its content. Even if the content were specified, however, a comprehensive history could not be reduced to a set of independently answered true-false or multiple-choice self-report items that constitute the typical psychological test. Questions asked to collect history data are necessarily interdependent or response-contingent. One does not ask about a patient's marital relationship without first inquiring if the patient is married. In the past, this interdependence required that historical data be collected by an interviewer who could select questions based on the patient's prior responses. Because of this response-contingent structure, routine collection of comprehensive history data vie self-

report was impractical until on-line, interactive computer technology became inexpensive and generally available. With on-line technology, the branching capabilities of the computer could be used to administer items contingent upon responses to previous items in order to collect highly detailed historical data (Giannetti, Klingler, Johnson, & Williams, 1976). The technological feasibility of a computerized procedure is insufficient to justify its development (Giannetti & Klingler, 1980). There is evidence, however, that an automated self-report psychosocial history would have advantages for both clinical practice and research. First, previous research has clearly established that most patients, both medical and mental heath, accept and enjoy responding to on-line computerized questionnaires and frequently prefer them over clinical interviews or paper-and-pencil questionnaires. A majority of in-patients, including many of the more chronic and severely disturbed ones, can answer computer-presented questions without assistance (Carr, Ghosh, & Ancill, 1983; Stillman, Roth, Colby, & Rosenbaum, 1969). Second, development of a computerized questionnaire requires the imposition of a specific structure on the information to be

gathered. Structured techniques have been shown to produce more thorough coverage than unstructured interviews (Briggs et al., 1972); Carr, Ghosh, & Ancill, 1983; Climent, et al., 1975). Furthermore, there are indications that respondents may be more likely to report socially undesirable behavior to computer. Two studies using alcohol questionnaires have shown that respondents report greater alcohol consumption to computers than to interviewers (Duffy & Waterton, 1984; Lucas, Mullin, Luna, & McInroy, 1977), although a third study found no difference (Skinner & Allen, 1983). Third, self-report and interviewer-collected history data show high agreement. Grady and Ephross (1977) found a 94.6 percent correspondence between a self-report and interviewer history collected on the same sample of patients. Fourth, a history would be less expensive to collect by computer than by traditional means (Elwood & Griffin, 1972; Johnson & Williams, 1980; Space, 1981). In summary, a computerized self-report psychosocial history is likely to prove acceptable to patients and be more reliable and thorough, as accurate, and less expensive than a history obtained by the traditional interview method.

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