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A study of manipulative techniques used in the casework treatment of twenty chronic-dependent patients released from the Metropolitan State Hospital.

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Boston University
A STUDY OF MANIPULATIVE TECHNIQUES USED
IN THE CASEWORK TREATMENT OF TWENTY
CHRONIC-DEPENDENT PATIENTS RELEASED
FROM THE METROPOLITAN STATE HOSPITAL

A Thesis

Submitted by
David Kantor
(A.B., Brooklyn College, 1950)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1953
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CHAPTER I
INTRODUCTION

The chronic mental patient constitutes a vexing clinical problem to the psychiatrist and others concerned with his care and treatment, and a costly one to the community. It is quickly acknowledged that there is a backlog of cases who can be, but have not been restored to useful life in the community because of the inadequate features in our treatment processes and in our methods of organizing services. Resolution of these difficulties constitutes an immediate challenge to everyone remotely responsible for the treatment and care of the mentally ill. In recent years there has been growing recognition of the vital part social work can contribute in meeting this challenge.

Psychiatric social work in state hospitals has had less than fifty years of history. In 1906 the State Charities Aid Association introduced the practice in the Manhattan State Hospital wherein social workers visited patient's families to obtain personal and social data needed by the psychiatrists about the patients' lives. Today psychiatric social work is an integral and indispensible part of the service of practically all state hospitals serving the mentally ill. Responsibility in intake, reception, treatment, family care,
after care, community interpretation, and research are found among the functions of the Social Service Department in the mental hospital. The gathering of histories continues to be a vital service but of the therapeutic activities of the social worker, discharge planning and follow up service are among the most important kinds of social work help.

One important phase of psychiatric social work in the mental hospital has been selected for this study—-that of helping the patient bridge the gap between the hospital and the community. The rehabilitative emphasis is certainly one of the most important aspects of institutional treatment and aftercare. Through the close cooperation between the social worker and the psychiatrist, the role of social work is to help adjust patients to the community as useful, self-directing citizens. We cannot attach minor significance to such a task. According to Towle,¹ "The very core of social casework is the rehabilitation of the individual."

In this paper we have dealt mostly with the "chronic"

patient. In a definition by Shea she chronicity is said to imply "continuous treatment or a long period of hospitalization." When a patient's illness is chronic, prescriptions for treatment demand consideration of complex factors involving the patient's immediate capacity for help. Treatment in the hospital setting is "the total process...by means of which the patient is helped toward more effective living" and social workers more and more are taking a major treatment role in helping restore hospital patients in the community. Shea has pointed out that:

As workers become comfortable with, and secure in, their contribution to the team relationship, trial visit and discharge planning become an integral part of the total treatment process...

If social work is to effectively perform this function, however, it must gain more precise control over its techniques. To do this we must learn more about the patients, what happens to the patient in the casework process and upon his return to the community, and the accomplishments of our treatment methods in terms of patient benefits. In short, testing and evaluation of casework methods is urgently needed.


4 Shea, op. cit., p. 421
Purpose of the Study:

The study deals with ten patients with chronic mental illness who manifest dependency upon the institution and the worker. For reasons which will be developed later insight techniques were eschewed in treatment. In evaluating the casework treatment methods used with this group of patients, emphasis was given to the worker's employment of "manipulation" as a specific casework technique. The concept of manipulation as a distinct and purposive therapeutic technique, the use of which requires casework skill based on a dynamic understanding of existing personality systems within the patient, is taken in part from Dr. Bibring's theoretical formulations.5

The purpose of the investigation was, through systematic examination of case records, to identify and point up the dynamic significance of manipulative techniques being used with these patients, to determine whether or not these methods are put into practice in the treatment situation and, if so, with what aim and effect. The project also represents an effort to point up the need for a broader and more purposeful methodological framework in the treatment of chronic mental patients.

In addition, the following general questions were posed as a framework for the investigation:

5 Dr. Bibring's formulations, unpublished at present, were delivered in class lectures at Boston University. They will be presented and discussed at length in chapter III.
1. Does prolonged dependence upon the institution instil motives that support the patient in being ill even when he is judged well enough to merit trial-visit status in the community?

2. Is there a set of general principles applicable to this type of patient—chronic—dependent—which help the caseworker to handle the therapeutic relationship, and to deal with the casework problems which the patients present?

3. What techniques actually were used?

4. What diagnostic considerations made manipulative, rather than insight-giving methods necessary?

Plan and Scope of the Study

The twenty cases which comprise the sample were chosen from a larger selection of chronic patients who received casework help just prior to, or immediately following their release from the hospital. Seven of these are presented for discussion and evaluation. In choosing the sample the larger group of cases was reviewed with these determinants in mind:

1. The patient's illness must have been of sufficient duration to be termed chronic.

2. Evidence that the worker or doctor felt that exploratory and insight-giving techniques were deemed inappropriate or ill-advised.

3. Recording, complete enough to illustrate worker activity.
The sample includes cases in which casework help led to 
general improvement and ones in which there was no substan-
tial change. In some cases the patient was seen in inter-
views by the worker for help in being readied for return to 
the community. In others the patient was not seen until he 
left the hospital or was ready for departure. The data on 
which the study was based was secured from the case records 
of the Social Service Department of the Metropolitan State 
Hospital. In examining the casework treatment with this 
group of patients, it will be helpful to know something about 
the setting in which the study was made.

The Metropolitan State Hospital is a public hospital for 
the treatment and custodial care of mentally ill patients. 
In addition it serves as a teaching hospital providing facili-
ties and supervision for schools of nursing, occupational 
therapy and students of schools of social work.

There are two separate units within the hospital, one 
for adults and one for children through sixteen years of age. 
In the Adult Unit the Social Service Department has a full-
time staff of five workers—a head social worker, two psychi-
atric social workers, and two assistant psychiatric social 
workers—and three students following the psychiatric sequence 
at the Boston University School of Social Work.

A cooperative and co-responsible relationship exists be-
between the Social Service Department and the Medical and other units at the hospital. The head social worker makes ward rounds with the doctors of both the male and female division so that she is constantly aware of the patients, their progress, needs and problems. In this way not only is the referral process shed of inefficient administrative formality but immediate and meaningful coordination between the social service and psychiatric efforts is assured.

The functions of social service in this setting can be briefly outlined as follows: Social workers do casework with patients on trial-visit status from the hospital and with their families; they also do casework with a limited number of patients who are too ill at the time of referral to have their return to the community as the immediate goal; they obtain medical social histories on cases which are sent to the hospital for observation by the courts, and on other types of committment where relatives are unable to come to the hospital; in addition to helping patients in the planning for their return to the community, the social worker has a limited number of patients who he sees only after they have left the hospital.
CHAPTER II

DEPENDENCY AND THE INSTITUTION

Before entering into a discussion of manipulation, some prefatory remarks on the subject of dependency ought to be given because the topic not only "embraces the whole purpose as well as the whole problem of social work," ¹ but also because it has a prominent bearing on the present study. A dependency situation is created any time an individual asks for help with a problem. When a person requests casework service in any agency or setting he is, by reason of his helplessness and need for help, thrown into a dependency relationship with the helping agent.

An intensification of this dependency situation is inevitable with patients in the psychiatric hospital, particularly if they have been hospitalized for a long period. Even when psychotic symptoms are for a long time in remission, this type of patient often becomes satisfied with his hospital adjustment and he further inhibits energies for independence and self-determination, reinforcing, as it were, the state of emotional dependency. The tendency to derive secondary gain and positive satisfaction from the care, support and protection provided by the hospital

is pointed up by Saul:

Consciously or unconsciously, very many patients love the hospital because, whatever its disadvantages, it re-establishes a childhood situation of interest, care and dependency and is a haven of escape from the burdens of our complex life, which demands so much energy, initiative, independence, responsibility and social productivity. 2

Whereas, in one form or another dependency-independence feelings enter most helping situations, it appears to be of special significance when working with chronic patients who are being helped in the transition from hospital to community living. Features of dependency seem to be revealed in three areas of the helping process with these patients: 1. in their reactions toward leaving the hospital; 2. in the defenses which the patients employ to protect themselves against psychological dangers; 3. in the relationship with the caseworker. Each shall be amplified in the attempt to show its pertinence to the social worker's efforts in the mental hospital.

REACTION TO DISCHARGE

Patients who have been hospitalized for long periods often evidence marked ambivalence regarding the prospect of leaving the secure, protective care which the hospital offers them. Many of the patients have made a very good adjustment to the hospital. Faced with the prospect of

2 Leon J. Saul, M.D., Emotional Maturity, p. 34.
leaving the hospital they are thereby confronted also with the prospect of having a suitable and by now satisfactory pattern of living disrupted. This may account for much of the ambivalence often observed at this time. Saul reports that of the reactions of about fifty state hospital patients to the proposal that they leave the hospital:

A very large percentage resisted this strongly and some became panicky at the prospect. Among these were patients who had previously claimed that they were kept there against their wills. Of course, there were other reasons too, but this wish for passive, receptive, dependent care was a central one for their finding all sorts of reasons why they should not be discharged from the protected hospital environment into all the struggles of independent life in the outside world. 3

Many mental patients suffer to some extent from an impairment of self-assurance. The person who is hospitalized for a long duration suffers from more intensified feelings of uselessness and inadequacy. Often, a point of concern in the patient's mind is whether the worker will continue to see him on a regular basis after he leaves the hospital. Out of the hospital the individual is "alone, unattached, unidentified and confronted by an alien, hostile world." 4 He is frightened by this and may seek to tie himself dependently to the person of the worker, or, he may rigidly deny

3 Leon J. Saul, M.D., Ibid, p. 35.
4 Erich Fromm, Escape From Freedom, p. 152.
the need for assistance, or, he may react with fear and hostility, these reactions all stemming from the same source—anxiety. Some patients, it is true, need little or no help in returning to community life. Many of the chronic patients, however, show certain symptoms of anxiety which seem to result from the threat to security which news of their return to the community may bring. According to one writer, the patient may react hostilely or apprehensively at the point of discharge because in essence the hospital is saying to the patient, "We feel that you have grown strong enough so that you can get along without nurturinig", or 'We have done all that we can for you and are wanting you to leave.'  

Often the anxiety is related to reality problems—economic survival, living arrangements, choice of occupation, family ties and changes within the family—but, too, upon these problems the individual may project unconscious conflicts relative to fears or feelings about dependency. The obligation on the part of the worker to "perceive the real sources of the individual's ambivalence and to direct our help to his underlying problems to the degree that we are able as social workers," is raised by Cockerill:  

We can extend this aid and still see our function as essentially that of enabling the patient to make a suitable adjustment to the community. Actually, we must deal with these attitudes whether directly or indirectly in treatment because they may seriously interfere with the individual's capacity to withstand emotional pressure they put on him and thus obstruct the patient and the caseworker in the achievement of their mutual purposes.

The obvious conclusion to be drawn from these statements is that it is important for the social worker to understand why the patient becomes anxious, what discharge means to them as individuals, and how we can best handle the problem in treatment.

THE PATIENT'S DEFENSES

While some patients show their dependence openly, a prominent defense of others is a denial of the very fact that they wish to lean on others. Particularly if the patient comes to the interview from the hospital ward, or is interviewed right in the ward, he may be very defensive. Whenever external dangers or one's own impulses threaten in any way, anxiety is felt. Various defense mechanisms which protect the individual from experiencing anxiety are called forth to cope with the effect of the stress. For example, denial of

symptoms, projection of their own feelings regarding the stigma of being a "patient", flight and fantasy, rationalization and retreat to the past are some of the characteristic defenses. The caseworker traditionally is faced with the problem of recognizing, identifying and understanding in the fullest sense the patient's use of his defenses. Defenses very often have constructive value to the individual. Many writers in the field conclude that it is probably fortunate that an individual's defenses are resistant to change. Otherwise, as one psychiatrist pointed out, "...over-enthusiastic psychotherapists...might do more harm than good." 7 He emphasizes that...

...the neurotic defenses, troublesome and hindering as they may be, have considerable value in maintaining some kind of stability, and the therapist should not attempt to blast them away without careful provision of other supportive measures and thoughtful consideration of the patient's alternative modes of adjustment. 8

Towle is another who strongly expresses the importance of understanding the purposes served by the patient's defenses and suggests that in many instances these must be seen as a resource to be conserved. She notes three factors which determine whether the defenses serve the patient well or


8 Ibid, p. 205.
whether they crumble: "1. The nature and extent of the present pressures; 2. The nature of his early life relationships; 3. The adequacy of the agency service as he seeks a solution to his present problem." 9 We feel that these factors might well be used as a guide by caseworkers in whatever setting they encounter patients' defenses, but, because the psychotic's stability is often more precarious, it is particularly applicable to them.

THE HELPING RELATIONSHIP

The professional relationship is by virtue of its purposeful nature a treatment measure, for it is truly in the patient-worker relationship that the substance and verity of the helping process is to be found. We know that within the worker-patient relationship transference, "the unconscious projection of the client's attitudes toward a parent figure of his early childhood onto the caseworker," 10 may be something with which the worker must contend. Caseworkers and psychiatrists alike have warned workers against the dangers of allowing transference to become a hindrance to treatment but purposeful, controlled use of transference


elements in the relationship can be an aid in treatment. Casework limits frequently are prescribed to a marked degree with these patients. Consequently, exploration and the giving of deep insight, especially as regards any transference elements which may exist in the relationship, often must be avoided. Because the dependent patient is apt to transfer his dependency from the hospital or his true parental figures onto the caseworker, a greater degree of control and awareness of the relationship is vitally important.

On this subject of handling the relationship with patients who show pronounced dependency needs, Fitzimmons says:

Case work with the handicapped who have marked needs for a strong parent suggests that we should ask ourselves if we can tolerate our own dependencies, those in patients, and those in all people. If a worker is going to help a dependent person, she needs the capacity to sense his dependency regardless of how it is expressed. She must then be ready to give support consistently and patiently. The patient has to find out that the worker is in reality a giving, understanding person who likes him and not the depriving parent whom he expects...Let the patient who has depended upon his illness grow to depend on her, then slowly regain strength and insight. 11

In Gordon's opinion also, it is important that a worker not fear dependency but, on the other hand, "...it is also important that it not be fostered any longer than necessary," 12


12 Gordon, op. cit., p. 218.
CHAPTER III
MANIPULATION

"Psychotherapy," "intensive," or "insight therapy" are some of the terms variously used to depict the kind of casework therapy which is distinguished from other therapeutic approaches by its attempts to directly utilize past material, to uncover fantasies, early memories and hostile feelings; and by its aim to increase self-awareness through the gaining of insight. While in the family agency and the community clinics certain types of clients will be found "not amenable" to exploratory techniques, this situation frequently occurs in the treatment of patients in the mental hospital. Since a psychotic episode by and large represents the breaking through of unconscious material, the emphasis here is on suppressing repressed material to avoid precipitating another episode. "Whereas in neurosis the therapist-patient relationship is used to make repressed material free, in psychosis it should be used to make free material repressed."¹

With a great many psychotic patients, therefore, intensive insight therapy would be contra-indicated. Hollis, in a discussion of the treatment of the psychotic, remarked that:

The presence of psychosis warns one immediately against reliance on techniques designed to uncover early experiences and feeling, and points in the direction of doing what one can to strengthen the hold of the ego on reality. In contrast to neurosis, in which the ego is relatively strong, psychosis represents a breakdown in the part of the personality which is supposed to hold id impulses in check and to understand and judge the realities of the external world. When this check on the id is already weak we do not want to do anything to lessen its control further by techniques that might encourage troublesome buried material to come to the surface. Rather, we want to become an assistant ego in helping the client to perceive external realities more accurately and to correct, in so far as we can, his tendencies toward distortion.”

She suggests three criteria in establishing the general level of treatment: the depth of the neurosis, the extensiveness to which it involves the total personality, and the relative strength of the ego.

In general, the treatment objective for the patients studied was to make and maintain a moderately acceptable social, personal and economic adjustment. With a psychotic patient the caseworker does not hope to correct the underlying difficulties "...but can make a valid contribution to the ability of the intact part of the personality to function if he understands the implications of the diagnosis and the ways in which the client is currently functioning,


3 Ibid, p. 72.
and is guided in his treatment thereby."4

Starting with Axelrode 5 the term "ego supportive therapy" has come into widespread use to describe the kind, quality and degree of the treatment used when insight therapy is inappropriate or inapplicable. This situation was almost universally found with the patients used in this study but the specific reasons (developed in the case material) for using supportive, rather than interpretative, techniques will be reserved for a later discussion.

In order to clarify our function in any treatment situation we ask ourselves what it is that we are called upon to accomplish. Rehabilitation, "...the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable," 6 with the chronic mental patient involves, first of all, supporting his ego needs to prevent further breakdown of personality. The worker's primary concern is with healthy ego functioning; his role is to help the patient use existing strengths to effect a satisfactory adjustment.

Granted that insight therapy is to be avoided with these

4 Ibid, p. 70.

5 Jeanette Axelrode, "Some Indications for Supportive Therapy," The American Journal of Orthopsychiatry, April, 1940.

patients, what therapeutic procedures do we have at our disposal to implement treatment plans, especially when problems arise in treatment such as those discussed in the preceding chapter? To answer this question, the writer turned first to the literature in the field. Review of the literature revealed that recently we have, to an increasing degree, recognized the importance of "manipulative" techniques as a valuable therapeutic instrument which is particularly suitable in the treatment of patients with whom interpretative techniques are to be expressly avoided. This is not an entirely new concept, for, as one writer points out, 'old fashioned casework' abounds with examples of abundant activity and manipulation. What is new, is the idea of making more conscious and more scientific use of manipulation, and basing our activities on an understanding of the patient's personality and its dynamics. Such activity has been implicit in supportive therapy but this term is loosely used and variously defined today. For the purposes of this paper the term manipulative therapy will replace supportive therapy.

Although they are somewhat equivalent approaches to the same treatment problems--both are used in distinction to intensive therapy--the latter seems to offer a more precise and scientific definition of the principles and methods involved.

7 Axelrod, op. cit., p. 264.
Manipulation can be broken down into three areas; manipulation of the patient and his personality systems; manipulation of the environment and people in it; manipulation of the worker. The discussion of each which follows represents in part the theoretical groundwork of the investigation.

MANIPULATION OF THE PATIENT

Dr. Edward Bibring 8 has identified and described a scheme of treatment methods of which "manipulation" is a part. His categorization of methods includes suggestion, abreaction, manipulation and insight approaches. The concern here is with his description of "manipulative" therapy.

According to him, patient manipulation consists essentially of making use of existing emotional systems and forces within the patient for purpose of curative effects and for the sake of promoting treatment. Without resorting to interpretation or clarification, the usual techniques of insight therapy, the caseworker can help patients toward a better personality adjustment. The bases for manipulative techniques are: understanding the individual and his needs; with or through the relationship, making use of existing emotional systems to modify present patterns of ego functioning. It presumes having a sound knowledge of the patient's underlying

8 See footnote, page 4.
problems of adjustment and an exhaustive understanding of his personality and its dynamics so that his adjustive capacities can be assessed and assisted.

With these concepts as an understructure, there are three aspects to manipulation of the patient:

**Positive Manipulation.** To activate or mobilize certain emotional systems and attitudes within the individual, for example, guilt, hostility, ego strengths and positive forces, prestige, interests or values. Accentuating or intensifying these feelings, attitudes or forces may lead to their being modified or strengthened which then frees the individual of the adverse effects of being without them and brings into play forces which may assist the patient in his adjustment.

**Negative Manipulation.** To repress certain emotional systems and attitudes when these are deliterious to improved functioning. The repression of guilt, hostility, fantasy material or even of conflict material which in approaching consciousness threatens to unbalance the individual's present adjustment. Minimizing or repressing guilt, for example, may make it possible for the patient to act freely to his advantage. This technique is especially useful with relatives of patients who are unable to cooperate in discharge planning until hostility subsides as a result of relief from guilt.

**Corrective Experience.** To afford the patient a new or corrective experience. Because of a change in feeling about himself,
or a modified attitude toward some situation about which he previously had set feelings, the patient may be able to view himself, the situation or his problem more realistically and thus set free the capacity for change. As an example, in the case of a patient who suffers from intense feelings of inadequacy and is, as a result, unable to establish a gratifying relationship. The worker's accepting attitude will tend to ease feelings of humiliation and restore self-respect.

Manipulation thus described can be especially useful with individuals whose ego structure is fragile. The individual is sustained by the worker's selective use of manipulative devices, based on the worker's thorough knowledge of his personality systems and the nature of present patterns of functioning. While positive forces and defense systems can be sustained where indicated, the patient's weakened or negative ego functions, an area to be avoided in some treatment situations, can also be dealt with indirectly through manipulation of these systems.

MANIPULATION OF THE WORKER

Implied in the above material on the corrective experience is the therapeutic potential of the relationship between the patient and the worker. "The therapist himself is of course one very important part of the patient's environment; and the therapist's own behavior toward the patient obviously
is or should be more under the therapist's control than any other part of the environment." Accordant with this, use can be made of the patient's predilection for a transference relationship with the worker. Relief of symptoms sometimes occurs as soon as a patient enters treatment as in examples of transference cures. A transference cure is a spontaneous relief of symptoms or a resolution of some aspects of a neurosis (without gaining insight) simply because of the emotional relationship with a "helping person." The improvement or "cure" thereby achieved depends largely on the non-condemning attitude of the therapist. When this occurs without insight and when the worker consciously plans his behavior or controls his role in a specific way, it can be seen as a manipulative technique.

Discriminate utilization of the emotional relationship between the patient and the worker can also be extended to give the patient a "new" or "corrective" experience. For example, the worker, guided by the dynamic formulation of the case and knowledge of the childhood relationships experienced by the patient, might be permissive or firm in his behavior according to whether the individual received punitive or uncontrolled treatment from parent figures. The special value of such manipulative devices with patients having strong

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dependency needs can be readily seen provided, of course, the worker is cognizant of the danger of allowing a too intense attachment to develop.

MANIPULATION OF THE ENVIRONMENT

When specific services and environmental manipulation administered by the worker are oriented to a sound understanding of the patient and his needs, a great deal can be accomplished. This topic has been reviewed often and will be briefly discussed here. As one author has said:

Frequently, we attach minor significance to services which are primarily intended to effect change in the environment. The human organism's opportunity to maintain equilibrium may be either enhanced or seriously limited by the influence of factors in the environment. Skillful manipulation of the environment for the purpose of providing an optimal opportunity for the individual to recover ease is indeed a significant contribution to his well being.¹⁰

Various estimates have been made as to the extent to which current factors in the environment influence the individual's personality. Ackerman has expressed the viewpoint that not only can "current factors in the environment influence the social levels of personality integration," but may, "under some circumstances, penetrate down through the social layers of character to effect the deeper aspects of personal-

ity as well." The hypothesis developed in his paper bears significantly on the present discussion, for it supports the view that therapeutic value can result from skillful manipulation of the patient's current environment.

By way of summary, manipulation in its total aspects as here used can be defined as therapeutic activity wherein the implementation of specific techniques of control of the patient (and his personality systems), the therapist and the environment is aimed at stimulating the adaptational forces of the ego for the ultimate purpose of modifying or improving present modes of adjustment.

The presentation of the data which follows attempts to demonstrate the extent and kind of manipulative techniques utilized in the treatment of twenty psychotic patients, previously classified as chronic-dependent individuals, who were judged by the physician or caseworker to be incapable of tolerating exploratory or insight techniques. Also, the material has been organized in such a way as to attempt to answer other questions sought in the study.

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CHAPTER IV
PRESENTATION OF DATA

In this chapter detailed material is given on, and/or tabular reference made to, the twenty cases studied from which will be drawn the inferences and conclusions pertaining to the general questions and purposes of the study. This will be done through (1) presentation and evaluation of tables and descriptive information which, broadly, are concerned with pointing up factors regarding the treatment of chronic-dependent patients and (2) eight cases offered in detail essentially to illustrate the types of manipulative devices used by the caseworker in treatment of chronic-dependent patients.

The first three tables--Age of Patients, Reaction of Relatives, Previous Admissions--and the descriptive summaries--Diagnosis, Degree of Insight and Judgment, and Financial and Marital Status--are presented as a background for understanding the patients studied. They are intended also to afford a basis for establishing factors which aid in deciding on the treatment level.

Of the patients, eight were males and twelve females. Their ages at initiation of indefinite visit ranged from twenty-seven to sixty-six, with fourteen, or 70 percent, of
the group falling between the ages of forty-five and sixty-six years.

### TABLE I

**AGE OF PATIENTS**

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<th>Age Groups</th>
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<td>30 to 34 years</td>
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<td>35 to 39 years</td>
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<td>60 to 64 years</td>
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<td>65 to 69 years</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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The attitude of patients' relatives and families toward his departure from the hospital, often an important determinant in his adjustment, was found to be decidedly negative. Table II shows that in 40 percent of the cases relatives of the patients evidenced negative feelings toward the patient or the hospital when notified of the disposition. In addition, 35 percent more showed ambivalence, which term indicates that although they could be counted on to cooperate in any plans the patient might have, they preferred leaving the
patient within the institution.

**TABLE II**

**REACTION OF RELATIVES**

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<th>Attitude</th>
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<td>Ambivalent</td>
<td>7</td>
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<tr>
<td>Negative</td>
<td>8</td>
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<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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**Previous Admissions**

The number of previous hospitalizations, exclusive of the one during which the study was made, ranged from one to seven admissions. Insofar as a patient who transfers to one or more mental hospitals during the course of one episode increases the number of admissions accordingly, the figures are not a reliable basis upon which to judge the repetitiveness of their attacks. Nevertheless, the table shows that there exists a repetitious character to their illness and suggests that prognosis for the future is guarded.
### TABLE III

**PREVIOUS ADMISSIONS**

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<th>Number of Previous Hospitalizations</th>
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<tr>
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<td><strong>Total</strong></td>
<td><strong>20</strong></td>
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**Diagnosis**

One half of the patients studied were schizophrenics, five with a diagnosis of dementia praecox, catatonic type and five, dementia praecox, paranoid type; four carried a diagnosis of psychoneurosis and had regular commitments because the severity of their illnesses left them in a marked state of disfunctioning; of the remaining six patients, one was manic depressive, depressed; one, psychosis associated with organic changes of the nervous system; one, alcoholic psychosis; one, paranoia, paranoid conditions; two, psychosis with psychopathic personality.

**Insight and Judgment**

Although very few of the patients selected for this
study had shown active psychotic manifestations for some time, some residue of their psychoses or neuroses was observed in the form of defective insight and impaired judgment. Twelve patients were judged by the physicians or caseworker to have had poor insight and poor judgment. Of the rest, five were found to have had poor insight but fair judgment, and three, fair insight and fair judgment.

Marital and Financial Status

Fourteen patients were single, two married, one separated, two divorced, and one widowed. Thirteen had no source of income and no relatives to contribute to their support; seven received at least partial support from relatives, usually to supplement financial aid from the Department of Welfare.

Level of Treatment

The case material demonstrates that limited treatment goals was a recognized necessity in almost every case. Where a worker did utilize principles of insight to increase self-awareness, the patients' defense reactions soon warned him against attempting to break down the resistance. All of the patients had become fairly well stabilized in their behavior and, while they were not reacting to delusions and hallucinations, some were known to have them but had managed to keep them under control, a process which frequently occurs with
the chronic patient who has spent many years in institutions. Many of the caseworkers recognized the need to repress unconscious and preconscious conflict material in order to sustain the patient in his present adjustment. The relative strength of the ego, as seen in the quality and degree of insight and judgment and in the patient's defense mechanisms, was an important diagnostic criterion in establishing the general level of treatment. In addition, the preceding tables and headings reveal reasons for using supportive, rather than interpretative techniques in treatment. The following are some of the factors to be considered:

1. Degree of insight into the nature of his illness;

2. Chronicity of illness. When a patient has after many years learned to maintain an equilibrium between his impulses and his symptoms or controls, disturbing this balance often results in reawakening old symptoms;

3. Capacity to establish a therapeutic relationship;

4. With chronic patients there is the additional factor of age and the patient's physical condition;

5. Suitability of defenses and adequacy of remaining ego strengths;
6. External conditions, e.g., accessibility of the patient after discharge, factors such as financial situation, the environment to which he is returning, employability and so on which influence the treatment goals and emphases.

Dependence on the Institution

The data complied in the last table attempts to answer the question, "Does prolonged dependence upon the institution instil motives that support the patient in being ill even when he is judged well enough to merit trial-visit status in the community?" The discussion in Chapter II on Dependency and the Institution suggests that for some patients the hospital becomes a reservoir of security. Against this background four factors, average length of hospitalization, hospital adjustment, patient's reaction to discharge and initiation of referral will be cross-sectionally examined to test the above contention.

In their reaction to discharge the patients were classified as having positive, negative or ambivalent attitudes. A positive attitude signifies that he appeared relatively happy, optimistic or cooperative when he learned he merited trial-visit in the community; ambivalent, that he was pessimistic, fearful, had no plans for himself but was willing to cooperate with any the worker might have; negative, that
he was unduly fearful or resistive and tried to delay his release. In Table IV the patients are grouped according to this reaction in order to facilitate interpretation of the data.

Length of hospitalization is given to the nearest half year in the table. It includes the total of all hospital admissions up to departure from the hospital on indefinite visit.

Judgment of hospital adjustment, described here as poor, fair, good or excellent, is, of course, highly subjective. One of the descriptive terms along the scale was assigned to the patient according to the degree to which he was satisfied with his patterns of living at the hospital. Poor adjustment indicates that the patient felt he was kept at the hospital against his will, wanted out, did not utilize hospital resources for social activities or, generally, did not seem happy there. The patient who made an "excellent" hospital adjustment entered social relationships, engaged in activities and seemed somewhat more than reconciled to living interminably at the hospital even when major symptoms were in remission.
Table IV shows that the greater the total period of hospitalization, the more marked was the resistance to leaving the hospital. It is interesting to note that of the twenty patients studied, fourteen had either ambivalent or negative attitudes toward their release from the hospital.
Of the fourteen only one patient had a part in initiating referral whereas in the group of six who had a positive reaction to discharge, five patients took the initiative. In the latter group only one patient made an excellent adjustment while ten of the fourteen in the two other groups made excellent adjustments showing that patients with ambivalent or negative reactions to discharge were more satisfied with the hospital life. The average length of hospitalization of the three groups—Positive Reaction, 6.1 years; Ambivalent Reaction, 9.9 years; Negative Reaction, 10.4 years—suggests that the longer the hospitalization, the greater resistance to leaving, or, the greater the chronicity, the more marked is the dependency.
PRESENTATION OF CASES

In most instances, the doctors referred the patients to the Social Service Department for assistance with problems of social adjustment, problems of employment, help with living arrangements or because they felt the patient, though not yet ready to leave the hospital, could reach the point of readiness with the help of a caseworker.

The following seven cases were selected for presentation not on the basis of successful casework but because they illustrate one of the areas being discussed. Manipulation is the emphasized treatment method in all seven cases presented for discussion and analysis. To a greater or lesser degree each case involved all three of the differential aspects of manipulation discussed in this paper--manipulation of the environment, manipulation of the worker relationship and manipulation of the patient and his emotional systems. In three of the cases presented the outstanding feature was manipulation of the environment and the worker. Two presentations illustrate manipulation of the patient (and his personality systems) and the worker. The two remaining cases show the worker's use of manipulation with patients who resist leaving as the threat of losing the security of the hospital brings their dependency into open expression.
Case I

This is the case of a 53 year old male patient who transferred to this hospital from another state hospital where he was for one month. He spent three years in a mental hospital from 1934 to 1937 for drug addiction and alcoholism. About six weeks prior to being admitted to this hospital his behavior became peculiar; he had visions and developed unusual philosophical concepts, about which he wrote extensively, and took a vital interest in biblical history. The diagnosis here was: Psychosis with Psychopathia Personality.

His psychotic symptoms subsided at this hospital and the patient made a good hospital adjustment, showing cooperative and social tendencies. He remained here for one and one-half years before being released on indefinite visit, having a total hospital residence of four and one-half years.

The physician referred the patient to Social Service for placement in the community. Insight and judgment were impaired and prognosis was extremely unfavorable, though it was felt he might eventually stabilize himself as he became older.

He always had an unsatisfactory way of adjusting to life. Endowed with superior intelligence and having the benefit of a college education he nevertheless had no known occupation. He married at the age of thirty-two but was divorced two years later, making a very poor sex adjustment. History and psychiatric observations reveal a profound emotional immaturity. His mother was known to be a domineering person who indirectly fostered parasitic dependency attitudes in her son. She refused to accommodate him in her home and the only other relative lived out of the state and could not be of assistance.

The patient was seen by the worker eight times before placement was made. The patient had no plans for himself but was corresponding with an executive of an obscure spiritual group for help in this regard. While the latter's motive
evidently was proselytism, the patient interpreted the interest as personal, expecting some magical solution to his problems to be forthcoming. No until two representatives from this religious group visited the hospital was this situation cleared up. When the worker explained the circumstances they willingly cooperated by gradually withdrawing their interest in the patient.

Meanwhile the worker continued to see the patient in ward interviews trying to build a relationship and to initiate realistic plans. The patient transferred his trust from the spiritual leader to the worker and an acceptable plan was worked out for placement in a rest home. To counterbalance the patient's blind confidence in her, the worker attempted to involve him in preparations, affording him the opportunity to approve the home in an interview with its owner. The home which was selected appeared suitable to the patient's personality needs for maximum independence and modicum responsibility.

The owner of the home was resistant to mental patients but in interviews with her, her attitude was altered through the worker's explanations of the nature of the patient's illness and ways in which she could assist his adjustments. There also were frequent contacts with the patient's mother who, though economically comfortable, refused to share her
large home with her son. As the guilt reaction from this rejection was severe, she was encouraged to actively participate in finding sources of financial help for her son. She contributed toward the convalescent home fee, provided a weekly allowance for the patient, and gave him many household items to enhance his comfort. The Department of Public Welfare supplemented the contributions of the mother and a brother of the patient.

During the ensuing year of required supervision the worker visited the patient accordingly as the need arose—two or three times a month for the first six months and once a month thereafter until the patient was discharged. Casework treatment goals were very limited. The worker acted as intermediary between the patient and the environment, including the mother, personalities at the home and the community. The worker consciously assumed a permissive mother role and was an ego stabilizing influence in keeping the patient reality oriented.

In the course of these interviews the patient requested help with his poor relationship with his mother who still attempted to dominate and direct his life. The worker accepted his hostile feelings against his mother, communicating sanction without offering insight. In this connection the mother was also seen. The patient's needs were pointed out
and she was given recognition for her positive contributions to her son's welfare, which became possible after she expressed her own hostile feelings. As a result the mother's domination decreased and the patient's desire for more independence was met.

Prior to termination of the one year period of supervision the patient wished to change his situation. A private home was found which provided an ideal substitute family arrangement. The parental figures here accepted him as an intelligent, independent, grown man and the patient grew genuinely fond of the family. When treatment was terminated it was felt the patient should be allowed to feel it was not completely ended and he was encouraged to contact the hospital at his own discretion.

Evaluation

It was felt that permanent personality change—by helping the patient develop insight—could not be achieved in casework treatment with this patient. Although in his intense interest in spiritual matters he was still reacting to hallucinatory material, his chances of adjustment in the community were good. Treatment procedure involved a supportive relationship, the high point in treatment being manipulation of the environment including personalities in the environment, namely, the worker, the patient's mother and the owner of the
convalescent home.

The most significant immediate factor in the environment, the convalescent home, was selected and exploited for favorable factors as indicated by the worker's knowledge of the patient's personality; it was manipulated in such a way as to meet the needs of the patient. His mother, a controlling, dominating, authoritative parent, was still an active influence in the life of the patient. Knowing the quality and character of the childhood relationship experienced by this patient with his mother, the worker, who was a mother figure in the emotional contract with the patient, offered him an important "corrective" experience. Throughout the contact she maintained the role of the permissive mother who respected his intelligence and independence. Every possible sign of independence and accomplishment within the personality or behavior of the patient was mobilized and activated.

Emotional relief and clarification were used to some extent in addition to the main manipulative method. In interviews with the mother hostile feelings toward her son were expressed, she experienced relief, and with the help of the worker, was able to use her energies more constructively to his benefit. Guilt was repressed and positive feelings were encouraged and praised. A similar process went on in the patient regarding negative attitudes toward the mother.
Thus, modification of attitudes in the patient and his mother brought about almost exclusively by manipulative devices and maneuvering of factors in the environment, resulted in a better and more favorable pattern of adjustment.

Case II

A sixty-four year old woman with a long history of previous hospitalizations, this patient transferred here after nine continuous years at another hospital. Seven previous admissions totaled twelve years and ten months, and total time spent in mental institutions including this admission was fifteen years. Education consisted of two years of high school, an equal period of evening school and secretarial school where she studied typing and shorthand. She was employed as a typist until her marriage at twenty-two. The marriage, which produced one son, ended in divorce after twenty years, the husband failing to support the patient.

The symptom picture included the expression of many somatic complaints without physical basis, and complaints regarding her environment, though there is an absence of real delusions or of hallucinatory experiences. "She whines, finds fault with everything, complains of great fatigue and begs constantly to be allowed to lie down." She was diagnosed as Psychoneurosis; Mixed type.

In general she was cooperative but experienced a poor hospital adjustment. Her endless complaints and the contentment to remain in bed constantly, kept her apart from other patients who, she felt, wore her down. Although in good contact with her surroundings and well oriented, the patient was completely lacking in insight and denied that she had ever been mentally ill.

Personal history showed that owing to a separation of her parents, the patient lived with her mother and maternal grandmother. They pampered her considerably and impressed her with the idea that she was not strong
and could not indulge in activities like other children. Neurotic symptoms developed following the birth of her child when she began to stay in bed and complained of weakness. The mother, who during the contact was cared for in a Home for the Aged, was always a ready source of satisfaction of the patient's dependent needs.

Referral to the Social Service Department was initiated by the social worker after performing a routine service for the patient. The case was discussed with the physicians and it was agreed that the worker would see the patient to plan for return to the community. The age and impervious, demanding nature of the patient virtually eliminated the possibility of finding employment. As there were no relatives nearby to help, a rest home was recommended as the only conceivable situation.

There were approximately four pre-release interviews with the patient. Her reaction to leaving the hospital was positive and enthusiastic. The treatment goal essentially was to find a community situation in which the patient would find sufficient satisfactions and where her peculiarities would be tolerated. The patient had no plans for herself and consented to the worker's suggestion that she enter a Nursing Home. This environment appealed to her. Activities of the worker centered around securing assistance to finance nursing care, and in finding a suitable home. One was conveniently found in the same neighborhood with the home where the patient's mother resided. Both mother and daughter were overjoyed with the advantages of such propinquity.

In visits to the home, the worker concentrated on pointing up the patient's accomplishments, particularly when she
engaged in normal activities unaccompanied by complaints. At
the hospital she was so completely preoccupied with physical
complaints that "ground privilege" was never requested. In
this home, however, she soon began to visit her mother and
was praised by the worker for her efforts. In this worker-
patient relationship based on a mother role for the worker,
the patient imposed extraordinary demands upon the worker;
she wanted clothes, asked the worker to write her once weekly
and wanted an allowance. It was arranged with the superin-
tendent of the home for the patient to receive two dollars
each week in turn for simple services but the other requests
were firmly turned down with assurance given that the worker
still cared for her.

In spite of frequent interviews with the attendant nurse,
intended to increase her understanding of the patient, the
patients behavior reverted to such extremely dependent, un-
cooperative level, disrupting the routine of the home, that
the patient was returned to the hospital. Six months later
the patient was again tried in the community. The worker at-
ttempted to duplicate all the positive features of the previous
placement, again chose a home located near the mother, con-
ferred with nurses and continued in her role of the firm but
encouraging mother.

In the meantime, the patient reached the age of sixty-five
and began to receive an allowance in addition to subsistence from the Department of Welfare. Her behavior showed improvement; she continued to visit her mother, took more interest in her appearance and even went into town. In the following months the patient's mother became ill, while she continued to improve. Money was handled wisely, she took daily walks, visited the library, went to movies and took on a new interest—embroidery. The worker's visits became less frequent and the patient was discharged officially after maintaining a satisfactory adjustment for one year.

Evaluation

The patient, suffering from severe psychoneurotic symptoms, was using the institution for satisfaction of pronounced dependency needs; the hospital offered many opportunities for satisfaction of secondary gains. Accordingly one might ordinarily expect that she would not want to leave the hospital, but this patient reacted in a positive way to her release from the hospital.

Insight therapy was nowhere attempted. Casework was singularly manipulative with the emphasis on manipulation of the environment and the worker. The community placement selected was relevant to the patient's needs. A "corrective" experience was offered, reflected in the attitude this worker
had toward the patient and the way her demands were managed. The patient's over-exposure to over-solicitousness in parental relationships was a liability to her adjustment. This was compensated for in the worker-patient relationship by the worker's consistent, firm management. There is some evidence of positive manipulation with the patient in the worker's activation of positive aspects of her ego, but, by and large, treatment goals and activity were comparatively limited.

Case III

This thirty-six year old female entered this hospital in December, 1944. She had a high school education, following which she did clerical work and made an excellent occupational adjustment. She was a healthy child who developed normally in her early years, showing no evidence of neurotic traits but she was always a shy, retiring person who, except for an interest in music and reading, had no outside interests and never married.

For several years prior to hospitalization the patient had been showing mental changes; she became more shut in, developed the delusion that she was being followed and heard voices directing her life. Following a visit to her mother in a nursing home she became confused, lost her way and did not return home. A psychiatrist found her to be confused, depressed and irrelevant, expressing feelings of guilt and inadequacy. In November, 1944, she was admitted to a mental hospital and was deluded, had ideas of reference and reacted to auditory hallucinations. The patient reacted poorly to Electric Shock Therapy and was transferred to this hospital one month later.

The above symptoms continued here and she was diag-
nosed, Dementia Praecox, Catatonic type. Her hospital course was one of gradual regression and withdrawal. She was retarded and blocked, showing defective insight and judgment. She was seclusive and continued to react to auditory hallucinations. In September, 1947 the patient was operated on for a prefrontal lobotomy, and subsequently there was improvement in her condition; she began to make an adequate ward adjustment, getting along quite well with other patients.

The doctors felt that, although she had been making a good hospital adjustment, she still was not quite ready to be placed outside in the community because of poor insight and impaired judgment and referral was made to Social Service in the hope that with casework she might be able to reach that stage.

From March, 1949 through January, 1950 the patient was seen regularly by a social worker in office interviews or planned visits to the community. Throughout the pre-release contact there were two major treatment problems. First, the patient seemed to have a great deal of guilt that she had not taken care of her mother and brother. When these feelings were elicited the worker reviewed with the patient her excellent work record prior to illness, the fact that she had done so well at many jobs and was a dependable person with many responsibilities. Frequently, she was given credit for her ability to assume family responsibility under conditions of extreme economic hardship. Other accomplishments, her efficiency as a typist and a stenographer, her cultural and musical interests were also stressed.

The second main problem was the patient's lack of insight.
into her illness, with partial amnesia (resulting from the lobotomy) further complicating the picture. Although it was attempted without success, there was little likelihood that the patient would gain appreciable insight and, therefore, casework was directed toward the future.

Besides the customary casework interviews, the worker took walks with the patient, accompanied her into town for cultural events and shopping trips, trying to get her interested in her appearance and the surroundings. A part-time typing position was secured for her at the hospital, and other steps were taken intended to prepare her for resumption of community activities.

The worker maintained a close contact with the patient's family, keeping them informed of the patient's progress and interpreting what might be expected of her and how they could help.

In dealing with the patient's completely unrealistic plans for the future the worker assumed an active supportive role, offering stability and judgment where the patient lacked them. Gradually her pre-hospital interest in music returned, her standards regarding personal appearance improved and she became more realistic in evaluating opportunities for herself in the community. She continued in her job at the hospital while the worker helped her review stenographic
skills preparatory to taking a job in the community. As the staff felt she was not yet ready to manage her affairs without support, a job was sought which would carry over from her work at the hospital, provide maintenance and an employer who could understand that it would take time for her to adjust.

In January, 1950 the patient was interviewed and accepted for a position as typist in the record room of a hospital in the community. The employer and the cousin of the patient were interviewed several times and their positive contributions to her adjustment were encouraged by the worker, who, meanwhile, continued to see the patient weekly. Throughout the following months the worker helped with the practical problems with which the patient was confronted; the relationship role was one of friend and advisor.

As the patient continued to make a very good adjustment intervals between visits increased and the dependency upon the worker, although not immediately discouraged, was transferred to others in the environment. She became more adept at managing her affairs, developed wider interests and increased friendships, before being discharged from the hospital records.

Evaluation

The pre-release contact lasted almost one year with this
patient. Interview activity centered mostly on helping the patient to function better in preparation for her return to the community. Treatment depended largely on identification with the worker, through which the patient was gradually encouraged to resume former interests. Her defenses at first encountered interpretation but the worker soon discontinued this, recognizing her faulty judgment, poor insight, the mechanism of denial and the degree of ego impairment as cautions against intensive treatment. The worker thereafter focused on rebuilding positive ego elements, using various manipulative devises intuitively. Although there was a certain amount of manipulation—negative, in the repression of guilt regarding unfulfilled responsibilities; positive, in the appeal to the patient's positive ego—the dominant feature of treatment was manipulation of the environment.

The tempo was slow, indicated by the patient's progress. She was introduced to employment while still in the hospital. When she was ready to leave the worker assisted in finding employment and in re-training her for the job. A situation in keeping with her capacity for functioning was found. The worker, while continuing to see the patient weekly, also engaged in interviews with important people in her immediate environment.
The case illustrates the sort of treatment which the writer found to be typical of the group studied, characterized by fairly intensive casework on a supportive level wherein dynamic material, while used diagnostically, was not directly handled in interviews.

Case IV

The patient is a fifty year old single male who transferred here from another mental hospital in 1939 with an institutional history amounting to nine and one-half years from four hospital admissions; he carried a diagnosis of Psychosis Associated with Organic Changes of the Nervous System, with Multiple Sclerosis. He does not attend church and religion does not seem to have played an important part in his development.

He had a younger married sister who died of typhus in 1932 when the patient was already admitted to a mental hospital. His mother died when the patient was five and he grew up in the household of an aunt who supported the patient, his sister, another aunt who was psychotic—all crowded into inadequate quarters. His father was an unattached alcoholic who was absent from the home and died when the patient was twelve. Although a superior student, he left school after two years of high school and took a job as an office boy and junior salesman. He was devoted to, and conspicuously dependent upon, his aunt. In the attempt to establish himself as an adult, he left the home, motivated by high standards for himself and a desire to prosper. Subsequent to an injury to his legs in which he was struck by a bowling ball, he developed a condition diagnosed as multiple sclerosis, and was forced to stop work. Shortly thereafter he experienced hallucinations and began to react to grandiose delusions. After a seven month period of hospitalization he went back into the community, making a precarious adjustment, and six years later, in 1930 when he was 28, a recurrence of symptoms resulted in
readmission. He has since had continuous hospital residence, coming to this hospital on transfer in 1939.

Although at this hospital there were no hallucinations or delusions observed, the death of his sister resulted in depressions and twice he attempted suicide. About the ward his behavior was adequate: allowance was made for his physical handicap which posed extreme limits on locomotion. Adaptation to the hospital regime was excellent; he displayed social tendencies and maintained a tidy appearance. In September, 1952, with a net duration of hospital residence totalling twenty-three years, he was referred to social service "to determine to what extent he can function in a setting outside the hospital."

The patient functioned under extreme physical handicaps, a condition which was growing progressively worse with time. He was apologetic about a marked limp and hand tremors which he tried to hide. Insight was superficial; he displayed a failure to fully comprehend his underlying limitations and blamed his plight and hospitalization solely upon his handicap. Judgment, too, was defective in that he had no concrete plans for himself and insisted upon trying to support himself independently in the community. Employability potential was very limited and the only available relative, the paternal aunt 80 years old, was hardly able to contribute to his support.

There are several factors of importance to be considered in this case. In the first place it was obvious that the patient, because of his physical limitations, was unable to make a suitable economic adjustment to the outside world. His complaints, however, were chiefly neurological in character which made him eligible for trial status in the community. Because of such factors as age, duration of illness, faulty
insight and judgment, inability to tolerate insights, unfavorable early background and the depth of his neurosis, alteration of his personality through insight techniques was inadvisable. The problem on hand was to aid the patient in his attempts to adjust happily to his environment and, so far as possible, "to install the element of usefulness into the patient's work and life." The broad, ultimate goal of treatment was to help him to find a placement in the community which would provide these satisfactions.

The patient was seen in weekly interviews for sixteen weeks before placement was made. Treatment focussed almost exclusively on current realities and on relieving the patient's anxieties about his disabilities as far as this was possible. Another important area in this connection was the assistance he needed in overcoming anxieties related to leaving the comfort and protection of the hospital to go into the hostile, threatening community. There was very little use of past life material because the patient dwelt on certain traumatic aspects of his past, and when such material came up in interviews the patient became depressed. With some direction by the worker the interviews, after enough material was given to formulate thorough diagnostic understanding, began to be used for discussion of current realities. There was much guilt, phantasy, anxiety and feelings of inadequacy underlying the
events in his past which he repeatedly brought up. The worker constantly counterbalanced these feelings through giving him positive satisfactions in the relationship and by using techniques intended to repress the upsetting material. Some measure of self-esteem was re-established with praise for his intelligence and knowledge. Emphasis was given to his strengths and achievements and he was made to feel useful again. His pattern of completely rejecting insights helped set the level of treatment within prescribed limits.

The outstanding obstacle to movement, an important casework area, involved the patient's feelings around dependency. He leaned upon the worker for emotional support, leaving his "fate" in the worker's hands. He seemed to find comfort in explicit directions but, notwithstanding these signs of dependent needs, most of his precarious defenses centered around very ambivalent dependence-independence feelings. Since there was no source of financial support and the prospect that he could be employed was slim, Disability Assistance from Welfare was the logical solution to the financial problem. It was several months from initiation of application procedure before it was approved. Although he participated in establishing eligibility the patient was compliant and wished to leave all decisions to the worker with one noteworthy exception: he "would not go to a nursing home where he would be treated as a
feeble old man," which, nevertheless was indicated in view of his physical condition which with time was growing progressively worse. Unsteady footing and poor balance made travel dangerous yet he was unable to fact his limitations until he was convinced from the worker's accepting attitude that his physical limits did not reflect on his adequacy as a man. This was accomplished when, after several visits into the community together during which the disabilities were unmistakably viewed by the worker, the worker's attitude toward him did not change.

Before these experiences dependency conflicts blocked movement. For example, when it was suggested he take more responsibility in establishing eligibility for assistance he became apprehensive; his need to be dependent upon the worker was accepted but gradually he was encouraged to assume self-direction; he reacted defensively to the threat of dependency feelings by refusing any assistance for his physical disability and would not use a cane which was noticably needed; pronounced feelings of unworthiness and loss of self-esteem were everywhere apparent.

After these "Corrective experiences" which were backed up with the repressive and positive manipulative techniques discussed above, the patient's attitude toward his illness
became more realistic, he consented to use a cane and began to evaluate possible placement situations in terms of his physical defect. Defenses around dependency relaxed and resistance to a nursing home situation also broke down. He entered a nursing home which was chosen for its unique qualities. It was newly licensed and planned on accommodating only a few patients of which this patient was the second. When this investigation was made the patient was maintaining a satisfactory adjustment and was seen in weekly interviews by the worker.

**Evaluation**

This was the typical case encountered in the study except that the worker here consciously employed manipulative techniques. There were many examples of positive and negative manipulation which did not seem to result in radical improvement but nevertheless the patient enjoyed a more stable existence and was achieving a relatively satisfactory adjustment. The greatest change became apparent in his attitude toward his dependency which, though not completely modified, was altered somewhat as he gained increased self-respect. The restoration of self-respect came about through a corrective experience in the relationship with the worker who demonstrated that he could accept the patient despite his infirmity.
Positive manipulation was frequently used to bring out the healthy aspects of the patient's personality and to point up his actual achievements and accomplishments. Negative manipulation was often employed as a measure to repress guilt and crucial conflict material.

Case V

The patient, a 41 year old male, was voluntarily committed to a State Hospital in December, 1934 when he was 23 years old. Seven days later he transferred to another State Hospital, where he stayed three days and was released on trial visit at the insistent demands of the patient's parents. After seven months on trial visit, he transferred voluntarily to this hospital in July, 1935, and was regularly committed with a diagnosis of Psychoneurosis; Psychasthenia, Obsession.

The patient, according to the history, allegedly had a normal development. He did excellent work at school until the last few years of high school, when he began to fail in his grades. With much difficulty he found work about a year after graduation from high school but was discharged for carelessness and making mistakes. From that time on he began to develop hypochondriacal ideas about his eyes, nose and general appearance. The record states that "he had no delusions, only hypochondriacal, somatic ideas. He does not show evidence of intellectual impairment, or active psychotic symptoms."

At this hospital the patient continued to be preoccupied with obsessive thoughts concerning his appearance. He made an excellent hospital adjustment, had many friends, partook of social and recreational outlets, was a good worker and enjoyed ground privilege all the time he was here. In November, 1936, he left the hospital but did not make an entirely satisfactory adjustment. While at home he could not bring himself to work, avoided all social contacts and became somewhat self-conscious in his behavior. After his mother's sud-
den death he returned to the hospital voluntarily—though urged to do so by his father—in July, 1937. For about five years the patient was allowed periodic visits at home with his father. He continued to make an excellent hospital adjustment, but showed very little initiative or desire for a change until 1934 when he expressed a desire to leave the hospital and work although admitting he did not believe he could ever get rid of his feeling of self-consciousness.

Social Service assisted in placing the patient on a farm in a rather protective, non-competitive setting, but the placement did not work out well. He complained about the setting and yearned to return to the hospital which he did in June, 1943. In December 1952 he was urged by the staff to again try himself in the community. At the time of this contact the total period of hospitalization amounted to fifteen years. The patient at the time of referral to Social Service was judged by the staff to have fair insight and judgment.

In the diagnostic material revealed in interviews there was considerable evidence as to the patient's anxiety about his sexual role. The outstanding diagnostic points which influenced casework treatment and the goals of treatment were the self-centered ideas of inferiority feelings regarding personal appearance, feelings of inadequacy and the lack of feelings of essential worth. Sexual and aggressive feelings were renounced; there were no signs of aggression or normal self-assertion. Superficially the patient's father was devoted to him—he visited regularly and watched over him like a "child." There was evidence in the case material of much unconscious hostility toward the son hidden behind a facade of devotion. Also, in childhood the attitudes of the parents tended to
strip the patient of his capacity for independence, confidence, and growth. The patient seemed to have had a vague sense of forboding about the father, perhaps feeling the father's unconscious hostility.

The patient was seen in twelve weekly office interviews before he left the hospital, though he was free to leave earlier. He was not capable of tolerating or responding to insight techniques; his defenses were weak but important to him, particularly his fear of failing to adjust in the community. He was allowed to set the tempo in planning for his release from the hospital and was grateful to learn he was not being turned out until he felt he was ready.

Treatment goals with this patient centered mainly around the following: helping him to make and maintain a modestly satisfying social adjustment; to whatever extent possible, to help him improve in social relations; helping him to effectively utilize community facilities.

The patient would not take a job which required intelligence, ambition or the ability to take responsibility. (The oedipal implications of such denial of aggression are apparent.) He was extremely dependent upon the worker and for weeks would not make any effort toward rehabilitation without being accompanied by the worker. The male worker, in some respects a father figure in the relationship, offered him genuine respect
and emphasized and encouraged the healthy aspects of his personality. Portions of most interviews were devoted to discussing current events, relationships and interests. Acknowledgement was given to the patient for his intelligence, work achievements at the hospital and other accomplishments. He gradually was encouraged to take more initiative in locating community facilities, applying for employment and in finding lodgings. The worker’s activity diminished as the patient himself assumed responsibility for these things as he gained confidence.

Gradually he seemed to recover ease, feelings of inadequacy apparently diminished and with it some of his defenses; he began to talk more about his feelings of self-consciousness. This, his dominant symptom, was not dynamically interpreted but he learned to pattern his responses by anticipating his reactions. A question which came up frequently was whether he should relate his hospital experience when applying for a position. It was decided that he could use his own discretion, something he saw as another stamp of approval which served to reaffirm his feelings of adequacy and self-respect.

With the help of the worker he obtained a position as a factory worker and left the hospital but left the job before the day was out; the responsibility involved in the work pro-
voked more anxiety than he could handle. He was seen many times in the next few days and given much reassurance. As he was fearful of repreach for failing to keep the job, the worker's attitude was important at this point. He soon found a job as a dishwasher and made a successful work adjustment.

Before he had left the hospital he renounced immediate assistance from his father and decided to reside at the Y.M. C.A. where anonymity was accepted. This was important to combat feelings of self-consciousness. In his free time he visited members of the family and here at least spent an active social life. In the last interviews recorded the patient seemed to have a better perspective on his problems. For the first time he speculated on the possibility of taking a "better" job and talked with insight about his symptoms which he declared he no longer experienced.

Evaluation

Although in this case the worker did not abstain completely from using insight techniques, he explicitly established manipulation as the major treatment method. There was evidence that treatment activity was based on the diagnostic formulation of the case. The patient's problems were partly pre-oedipal. The depth of his neurosis and the extent to which it involved the total personality set limits on the depth of treatment.
Employment of positive manipulation, in evidence in the above discussion, seems to have paid dividends. The basic conflicts still exist but in terms of past performance it is reasonable to say that the outcome of treatment was a certain degree of improved ego functioning. The patient seems to have greater stability and has been able to maintain a satisfactory social and vocational adjustment.

Case VI

This is the case of a 42 year old single woman patient who entered this hospital in October 1945 with a diagnosis of Manic Depressive; Depressed. There were three previous hospitalizations following episodes of depression and in each there was an actual attempt at, or a threat of, suicide. She remained at this hospital five years this admission, having a total hospital residence of ten and one half years.

The patient left high school in the second year because of gland trouble but in 1927 at age 20 years, attended business school for nine months. Employment history was poor; she worked at Grants and Woolworths but was discharged for being late and inadequacy, this being characteristic of her employment adjustment. As a child she was slow, seclusive and withdrawn, preferring to read at home than to play with other children. At 22 an argument with her boyfriend and disappointment with her mother, resulted in wandering and depression and commitment was recommended. Upon her release she worked as a practical nurse for a few years but remained seclusive, sad and slow. In 1937 severe depression and a suicidal attempt caused readmission for four years and after a similar episode in 1945 she entered this hospital.

At the hospital she remained potentially suicidal but made a good hospital adjustment. With her pleasant disposition she was well liked by patients and personell.
Her occupation here consisted chiefly of general work in the marking room where she sewed and taped clothes. No hallucinations, delusions, illusions or phobias were observed. Self-deprecatiory ideas were always present, however. The patient seemed to have insight into her condition and knew that she was mentally ill, and that treatment was necessary. Judgment did not seem to be impaired except regarding plans for the future which were nil.

Patient was released on indefinite visit in 1947 but returned to the hospital a few months later by the police when another suicidal attempt was feared. In 1949 the staff felt she had improved, was cheerful and ready to leave the hospital. When approached with the idea, however, the patient reacted negatively. She became shaky, cried, saying she felt she was not ready to leave the hospital and asked the worker if she could remain until she thought she was better. The anxiety could not be stayed in subsequent interviews. The patient was assured freedom to decide when she felt ready to leave. Although interviews were discontinued the worker saw her occasionally. Her employer at the hospital, with whom she had a good relationship, continued to encourage her, and about a year later, cheerful and optimistic, the patient asked to talk with worker about leaving.

The patient was eager for a relationship with the worker and talked freely about herself, "showing good insight into some aspects of her problem." As regards plans, the patient was vague and uncertain. She proposed "just getting used to
the community and gradually working toward employment." The patient's mother, who couldn't house the patient because she lived-in in her job as a practical nurse, was taken actively into the planning. The mother, taking a positive cooperative attitude toward the patient's rehabilitation, proposed a plan for her to live in the private home of a psychiatrist who boarded patients of this type and seemed to do quite well with them. The worker continued to see the patient almost daily "in order to keep assuring her about going out." The more she talked about leaving the hospital the more she seemed to want to go as soon as she could. The mother agreed to contribute ten dollars weekly toward the thirty dollars required for care, while the worker engaged the help of Welfare to supplement the rest. Conferences with the psychiatrist were geared toward briefing this skilled person on the patient's history and working out cooperatively a plan of responsibility between worker and psychiatrist that was most propitious to the patient's welfare.

Although the worker continued supervision the visits were infrequent and superficial in content as it was felt the psychiatrist was in a better position to assume dependency and treatment responsibilities. A good adjustment was made and maintained for one year and the patient was discharged from the hospital.
Evaluation

The pronounced opposition to discharge observed with this patient was atypical. Although other patients had negative attitudes none reacted quite so violently and none actually refused to leave. A year passed between the first proposal and the actual initiation of discharge plans. The case illustrates an extreme form of dependency on the hospital. But for one unusual feature, the presence of a trained psychiatrist with whom the patient was boarded, the procedure taken to handle the dependency was generally representative. Because the mother had a plan to offer, the nature of which was suggested the worker's immediate withdrawal, very little was attempted in treatment. Briefly the following steps were taken to dispel the patients anxieties: 1. she was given ample time, one year in this instance, to feel ready; 2. the appeal to the positive urges of the ego. Community adjustment as a value was encouraged; 3. relatives and other important figures in the environment were actively brought into the case, and helped to see their roles by the worker; 5. the effort was made to provide a situation giving basic security; 6. the dependency needs which were being satisfied by the hospital and in relationships with the worker were transferred to individuals in the environment, while the patient was also helped toward independence.
Case VII

This patient is a 45 year old single woman who went to school only as far as the fifth grade and before her illness worked always as a domestic. At age 20 the patient developed tuberculosis accompanied by ideas of reference, and other mental symptoms. She entered a T. B. Sanitarium and, three years later when mental symptoms became more pronounced, was admitted to the X State hospital where she resided eleven years, transferring to this hospital in 1944. The history states that the patient expressed paranoid ideas, felt people were annoying her and also reacted to auditory and visual hallucinations. She carried a diagnosis of Dementia Praecox; Paranoid.

At the hospital she was confined to bed on the T. B. ward, as she had pulmonary tuberculosis, inactive during hospitalization. Her emotional reactions noted in interviews was dull, apathetic and rather flattened but she used her knowledge of, and long experience with mental patients to advantage, avoiding responses that would be considered psychotic. She was evasive and suspicious, and denied having or ever having had delusions or hallucinations. Insight was lacking and judgment poor. In view of her poor prognosis, custodial care and symptomatic treatment for tubercular condition was recommended treatment.

The patient made good hospital adjustment, was quiet, cooperative and neat in person and habits. Although a little withdrawn, she made friends among the nurses and patients, and, as her physical condition improved, she helped with other patients with T. B., making beds and doing other chores about the ward. As her mental condition improved (the tuberculosis also remained inactive), the doctors felt it was time for her to try light work in the community and she was referred to Social Service. The social worker learned that the patient's sister was willing to help with the plan and if necessary would finance a boarding home situation until the patient could find suitable work. The patient spent three years, nine months at this hospital, and had a total hospital residence of thirteen years, nine months.

The patient was seen in three ward interviews having two
foci: 1. allowing the patient to participate in planning for the placement; 2. managing the anxiety the patient felt about leaving the hospital. Regarding the first point, a convalescent home was selected which gave the patient the opportunity to work. Her duties, arranged with the woman in charge of the home, were within her capacities and experience. The patient's anxiety around leaving the hospital—she felt her friends on the ward would be missed—was handled through the worker-patient relationship. The worker was aware that the patient saw her as a mother figure, someone who would interpret her needs and wishes to her sister and employer. The worker, with warm assurance, did not discourage these dependency needs, but nevertheless, helped the patient reach her own recognized goal to become self-sufficient and independent. She earned a small allowance helping out around the home. The positive features of the placement were exploited to increase the patient's sense of independence and satisfaction from helping others. The worker also interviewed the patient's sister, brother, sister-in-law, helping them see their roles with the patient.

The patient adjusted well in the convalescent home. She was visited about five times in the next year. Casework was superficial and consisted of assisting the patient with problems of adjustment and social relationships.
Evaluation

The outstanding feature of this case was environmental manipulation which aimed at transferring the source of security from the hospital to the community situation into which the patient went. There was some use of the emotional relationship in the worker's use of the patient's predilection for a transference relationship and to ease anxieties around leaving the hospital, but it did not seem to be based to any great extent upon a deep diagnostic understanding.

The brevity of the pre-release contact seemed to be due to administrative procedure and considerations. Visits to the patient in the community were few and superficial primarily because this patient, institutionalized in her reactions did not request help with problems requiring casework. Thus, aside from the handling of anxieties which the patient felt about leaving the satisfying life to which she had become accustomed, manipulation of the environment to provide a relatively harmonious situation for the patient was the chief tool of the treatment.
CHAPTER V.
SUMMARY AND CONCLUSIONS

The major purpose of this study has been to identify and point up the dynamic significance of manipulative techniques used in the casework treatment of chronic-dependent patients, through a systematic examination of twenty cases, seven of which were described in detail. The investigation also undertook to arrive at a dynamic understanding of the chronic patient and to relate any distinguishing characteristics which might evolve.

Except for one determinant, chronicity, the cases were arbitrarily chosen from a larger sample. This type of patient was selected because he constitutes a growing problem in the field and because he seems to be representative of the type of case which gets superficial treatment. The small number of cases studied and the relative paucity of process recording, particularly as it illustrates the treatment process, suggest that only the most tentative conclusions can be drawn from the data.

In none of the twenty cases examined was interpretation of dynamics used as a principal technique. The diagnostic and other considerations which made manipulative, rather than insight-giving methods necessary were previously elaborated in Chapter IV. Briefly, they were: degree of insight, chro-
nicity of illness, capacity for a relationship, age and physical condition, suitability of neurotic defenses, and external factors.

The data suggests a relation between chronicity and dependence upon the hospital. Table III shows that the greater the period of hospitalization, the more marked was the resistance to leaving the hospital. The degree of resistance was measured in terms of three factors, reaction to discharge, hospital adjustment and initiation of referral. Resistance was then correlated with dependency for purposes of this study. It appears from the data that chronic patients derive secondary gains from their passive dependent adjustment patterns. (Refer to Table IV.) Two tentative conclusions can be drawn from the material:

1. That the threat of having a satisfying pattern of adjustment disrupted, resulted in anxiety reaction.

2. The tendency to derive positive satisfaction from the care, support and protection provided by the hospital instils motives that support the patient in being ill even when he is judged well enough to merit trial visit status in the community.

The casework involved in the treatment of hospitalized psychotic patients and individuals in treatment in other settings were found to have many features in common. A few definite trends stand out sufficiently, however, to justify the
conclusion that there are general principles worth noting which apply particularly to the treatment of chronic mental patients returning to the community.

Dependency

The initial dependency needs of the patient should be met freely by reason of the influence of long-term hospitalization upon anxieties he might have regarding what lies ahead in the community. Also, in this connection, the patient's defenses should be viewed as an important means of maintaining stability and should not be removed except when the patient is ready for it.

Reaction to Discharge

The frequency of ambivalent or negative reactions to discharge can be seen in relation to the pre-existing personalities of the patients and to essentially reality based anxieties. The former cause, especially when it bears upon basic conflicts, often evades treatment. It is essential, however, for the worker to participate in evaluating environmental factors awaiting the patient when he leaves the hospital and to attempt to alleviate any disturbing reality factors which might exist.

Pace

Where possible, the period between the first interview with the patient and the point at which he actually leaves the hospital, should be left to the patient. This tends to
increase the sense of being in control and of participating in the planning. Moreover, if the patient is allowed to make short home visits before finally leaving, or, when he is not returning to a family, visits into the community for other purposes, they can be used to acclimate him to the outside and to uncover specific anxieties which can still be handled while he is at the hospital.

The data shows that regardless of the diagnosis, the chronic patient is likely to require readmission; one half of the cases studied had between three and seven admissions. Various estimates have been made as to the ratio of readmissions as compared with the number of patients released from mental hospitals in a given period. Lowry ¹ attests that traffic into and out of hospitals is considerable. This outlines the need for improving our techniques with chronic patients so that we can help them to achieve a stable and more permanent adjustment to the community. Although many complex variables are involved, the dependency satisfaction afforded by the hospital is one factor determining the rate of readmission. Many of these patients sense a rejection by the community, on the one hand, and the protection of the hospital on the other. Negativism, or ambiva-

lence toward leaving the hospital seems to represent the presence of more or less repressed anxieties. In addition to aiding the patient relieve these fears, it is the social worker's responsibility to use his knowledge of community resources to promote the most harmonious relationship possible between the patient and his surroundings in order to give the patient a situation with a basic security.

Frequently it is important to find community situations for a patient through which his dependency needs can be met. It is not uncommon for the excessively dependent patient, whose personality has fixated on, or regressed to an oral demanding level, to return to the hospital after a short period in the community unless these excessive needs are in some way met or modified. Modification of the environment in terms of the patient's individual needs can thus represent therapeutically significant casework activity.

This leads us to the main body of the investigation, the evaluation of the three types of manipulative activity—manipulation of the environment, the worker-patient relationship and manipulation of the patient and his emotional systems.

In the present study, casework services frequently involved modification of the environment. The following are typical of the types of activity found in the case material: Helping relatives to realize their roles, to understand and
assist the patient in his adjustment. Positive and negative manipulation was used, in some instances, with relatives to mobilize guilt for the purpose of precipitating a sense of responsibility toward the patient, to repress, guilt, hostility, over-protection and so on when these militated against the patient. In the interests of ultimate rehabilitation, manipulative techniques were often instituted in attempts to modify family difficulties, inimical attitudes or adverse circumstances where indicated. For the same reasons the social worker also saw employers and other important figures in the immediate life situation to which the patient was going. The job, nursing home or boarding home were chosen with extreme care and other community facilities were brought into use and adapted to meet the individual needs of the patient. Inasmuch as the patient is usually confined to the hospital until a situation is found, the therapist was found to be very active in these areas. In those instances where the patient was employable, it was common for the worker to help with employment or training.

The case material demonstrates the therapeutic significance of this activity. In cases I, II, and III and again in case IV the choice of community situations and facilities reflected the worker's knowledge of the patients, and greatly influenced the type of adjustment made. In some cases more than in others, a sound and thoroughgoing diagnostic under-
standing of the patient was implicit in the type of environmental activity called into use in the case. The material leads to the conclusion that environmental manipulation, far from being an obsolescent or compromise technique, can, if oriented to the specific needs of the individual, be a purposeful and valuable therapeutic method in the work of rehabilitation.

The conscious use of the relationship for the purpose of providing a corrective experience was seen with good effect in several of the cases presented. In some instances the worker's own behavior was consciously controlled, guided by a sound diagnostic formulation of the case. Thus, for example, the patient in case I, who experienced harsh, dominating, critical mothering was given a new or corrective experience by the worker who recognized his need for a permissive mother figure who would respect his need for independence. In case V the patient's father was seen to have pronounced hostility toward his son, hidden behind a mask of solicitous concern with the consequence that the patient's fears of inadequacy were constantly reaffirmed. The male worker, a father figure in the relationship, accepted his idiosyncrasies, treated him in every way as a "man" with adult capacities for judgment, allowed him to set the pace in treatment and afforded him every opportunity to make his own decisions. This new experience resulted in diminished
anxieties and improved functioning without getting at the source of the difficulty.

On the basis of this study it would appear that with the type of patient studied, conscious manipulative activity concerned with the individual's personality systems can be an extremely valuable technique. The fact that it was not extensively employed, that frequently it was used intuitively and that where consciously utilized it had good effect, supports the above conclusion and suggests that the theoretical framework is something with which social workers will do well to become familiar when it is available.

In cases IV and V, manipulation of the patients' emotional systems was the main tool of treatment. Each has numerous examples of positive and negative manipulation. In each, the outcome of treatment was a certain amount of stabilization, improved ego functioning and the achievement of a relatively satisfactory adjustment. It was possible for these patients to gain a better perspective on their problems without getting enlightenment or self-awareness of the deep and permanent kind.

The facts of the study, on the whole, suggest that the potentialities of manipulation for increasing the precision of supportive therapy are considerable. Because of the cautions against attempting intensive psychotherapy with many patients there is a resistance to exerting professional
skills and energies toward full diagnostic understanding of their situations and personalities, at least to the same extent that is done with less disabled patients. Furthermore, it has been observed that this group of patients, though not necessarily neglected, is frequently given perfunctory casework service. Manipulation, which permits an intensive kind of treatment in terms of indirectly dealing with emotional systems of the individual and relating diagnosis to all treatment activity, can augment treatment skills and contribute to the end of helping patients improve functioning sufficiently to make a good social adjustment.

The study points up the necessity to further increase the precision of existing techniques. In view of the vital and growing contribution of social work to the field of mental health, further testing and evaluation of casework methods is urgently needed. It is hoped that this project will induce others to make a more exhaustive study.

Approved:

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Dean
GUIDE FOR ABSTRACTS

Identifying Data

Name _______ Age _______ Sex _______ Education _______
Marital Status _______

Course of Illness

Hospital Adjustment _______ Previous Occurrence _______
Onset _______ Symptomatology _______ Referral _______

Factors Determining Kind of Casework

Clinical Factors

Diagnosis _______ Age on Release _______
Length of Stay in Hospital _______
Diagnostic Considerations _______

Factors in Community Environment

Situation to which patient is returning

Family _______ Relatives _______ Other _______
Attitude of Family or Relatives _______
Need for Financial Support

Employability _______ Physical Handicap _______

Other Factors

General Intelligence _______ Skills _______
Trade or Profession _______
Pre-Release Social Service Contact

If Yes:

Number of Interviews_
Factors Determining Number of Interviews_
Reaction to Discharge_

If Not:

Reason or Reasons

Social Service Contact

Summary of Casework

Caseworker's use of Manipulation of:

The Environment_
The Patient_
The Worker_
BIBLIOGRAPHY

BOOKS


PERIODICAL LITERATURE


PAMPHLETS