A study of psychiatric referrals of veterans by the Boston Metropolitan Chapter of the American Red Cross, June 1943 to October 1945

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Boston University
A STUDY OF PSYCHIATRIC REFERRALS OF VETERANS

by the

BOSTON METROPOLITAN CHAPTER OF THE AMERICAN RED CROSS

June 1943 to October 1945

A Thesis

Submitted by

Ida Burwash

(A. B., Radcliffe College, 1920)

In Partial Fulfillment of Requirements For

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CHAPTER I
INTRODUCTION

By July 1, 1945, 314,500 men were discharged from military service for neuropsychiatric causes, a figure representing forty-three per cent of all men discharged for medical reasons.¹ This estimate does not include the physically disabled who have or will become psychiatric casualties after discharge when they are faced with new difficulties at home. Many will need help.

By virtue of both its unique position as the only civilian case work agency operating overseas during the war and its program in the United States for servicemen and veterans, the American Red Cross recognizes that it has a responsibility of giving service to these men following their discharge.

Long before the war was at an end, it was seen that although many discharged men were in need of psychiatric treatment, a small percentage accepted it when made available to them.² In their contacts with these veterans the Home Service workers of the Boston Chapter of the American Red Cross have experienced varying degrees of success in their attempts at referral for out-patient psychiatric care. Failure was particularly frustrating especially when the medical officers in their recommendations


stressed the point that after-care was needed. This study was, therefore, undertaken to determine what factors operated in the successes or failures of referrals for treatment and ways in which these referrals can be made more effective.

As early as the summer of 1943 the American Red Cross began to have considerable numbers of applications for case work service for veterans. These requests for help came from the Red Cross field directors stationed at military hospitals and at military separation units, as well as from the veterans themselves, who, home again and having difficulties, recognized their need for help and as a result, came to the agency. In the instances where the field director referred the veteran, it was either 1) on the basis of his interviews with him, or 2) at the recommendations of the medical staff. By February 1944 requests for help with a plan for psychiatric treatment made up forty per cent of the applications for help (either through the field directors or from the veterans themselves) that the agency was receiving. Since the agency has kept no statistics on the number of referrals for psychiatric care made by the staff at any time during the period arbitrarily chosen for the limits of this study, June 1943 to October 1945, the writer has had to resort to a number of devices to obtain case material. One source used was the lists sent to the agency by the Psychiatry Clinic of the Psychoanalytic Institute on July 1, 1943, November 1, 1943, and February 8, 1944. These lists were made up of the names of cases active with the Clinic as a result of Red Cross referrals. The purpose

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3 Marion Perkins, "Report on Disability Discharged Veterans, Boston Metropolitan Chapter, American Red Cross", February 1944.
for the lists was to give brief treatment reports to the agency. In addition to the Psychiatry Clinic lists, the writer made selection from her own case loads and those of two other workers whom she knew to be particularly interested in the problem of helping the veteran accept psychiatric treatment. Not all the cases known to the worker and her colleagues during this period from June 1943 to October 1945, but only those cases were selected for study wherein the worker was able to help the veteran to some acceptance, however minimal, of his need for treatment. Those cases rejected for study purposes fall into two groups, 1) those in which there was no discussion of treatment, and 2) those in which the worker accepted without further exploration the veteran's statement that he was not interested in treatment. The number of cases chosen according to the above criteria came to thirty-six, a large enough number, the writer feels, to allow for the comparative study of methods. It is obvious that from the preceding discussion the number of cases chosen has no statistical significance. However, the writer felt that a study of method, without regard to statistical value of the material chosen in terms of number of cases, would be of value because of the need for increased skill, on the part of the case workers, in the area of helping the veteran accept the kind of care that will help him.

The thirty-six referrals made in the period between June 1943 and October 1945 will be considered in the following groupings: 1) those who accepted referral, but did not report to the clinic; 2) those who withdrew from treatment after one visit; and 3) those who went and continued treatment.
The findings of this study are based upon the records from the files of the Home Service Department of the American Red Cross. The approach to the study is guided by considering how the veteran came to the attention of the agency, whether it was through his own initiative, through routine or direct referral by the Red Cross field director at the point of discharge, or through the intervention of his family. Consideration is given to the problems he presented, how Red Cross referral to a clinic came about, how he was prepared for referral to a psychiatry clinic, and what his attitude toward treatment was. Analysis of the referral as well as an evaluation of the worker's relationship with the client will be made wherever possible. Sample cases are included in the study to substantiate the writer's findings.

Consideration was given to one case in Group I, that of Perry B., which actually does not fall into any of the groupings, but it was included in the study because it contained an example of referral technique not employed in any of the remaining thirty-five cases. This case is given as one of the illustrations.

Although two cases included in this study deal with veterans suffering from psychoses, it is the plan to consider mainly those who have manifested psychoneurotic symptoms which were presumably treatable in a clinic rather than in a hospital setting.

Some of the interviews studied were not dictated either at length or by process. In such instances the writer felt that although the worker's methods may not be as clearly defined as could be hoped for, the success or failure of her referral can be measured by the client's
response, in terms, particularly, of his use of referral plan and/or
his further use of the worker for discussion of his feelings and plans in
relation to the referral.
CHAPTER II

1. FINDINGS OF WORLD WAR I

From the experience of the first World War it was learned that many men were unfit for military service. These men were excluded for neuropsychiatric reasons, but under stress of combat and even in service without combat experience many men developed mental conditions necessitating care and treatment. From the statistics which follow, it can be seen that the numbers of World War I veterans seeking treatment tend to increase. In June 1920, eighteen months after the Armistice, there were 17,471 veterans remaining under hospital care. By June 1942 these figures jumped to 56,073, over fifty per cent of which represents neuropsychiatric cases. In the thirty-three months from April 1, 1917 to December 31, 1919, there were 96,657 men with psychiatric disorders admitted to various military hospitals. It is estimated that there were probably as many more with milder degrees of disability who were not hospitalized. Of the 67,000 beds in the Veterans' Administration hospitals almost half are still occupied by psychiatric cases of World War I. At the end of 1937 these hospitals admitted 4,500 World War I veterans who were requesting treatment for the first time.

Following the close of World War I there was slow recognition of the need for treatment and the Veterans' Administration was established in

4 George E. Pratt, Soldier to Civilian, pp. 16-17
5 Willard Waller, The Veteran Comes Back, P. 166.
1921 only after tremendous pressure by veterans' organizations. Chicanery, politics, and misuse of funds further delayed the building of hospitals for the care of veterans, and as late as 1923 hospitals were still far from completion.\(^7\) Up to the time that the hospitals were ready for admissions, disabled veterans received treatment either in military or Public Health hospitals or in the clinics operated under their auspices.

The cost of care to the tax-payer is enormous. In fourteen years the government has spent \textbf{one billion dollars} in caring for these psychiatric patients and in compensation for the varying degrees of disability they present,\(^8\) and to quote Willard Waller\(^9\) "... their cost (referring to care of patients) being sometimes computed at $30,000 a case."

It has been found that psychiatric casualties are sixteen times more likely to result in permanent disabilities than other kinds of illness. If this is the situation with regard to World War I, it can be estimated what lies ahead, after World War II with its nearly three times as many men involved.\(^10\) The importance of considering the psychiatric casualties of World War II as a special group is not difficult to see when it is realized that this group constitutes almost half of all the men discharged for medical reasons.

The first World War gave considerable stimulation to further developments in psychiatry here in the United States as well as in England.\(^11\) It was the large numbers of combatants suffering from "battle neurosis"

\(^{7,8,9,10,11}\) Willard Waller, \textit{op. cit.}, P. 237.  
\(^8\) George K. Pratt, \textit{op. cit.}, P. 17.  
\(^9\) Willard Waller, \textit{op. cit.}, P. 166.  
\(^{10,11}\) George K. Pratt, \textit{op. cit.}, P. 18.  
\(^{11}\) John Rawlings Reese, \textit{The Shaping of Psychiatry by War}, P. 28.
which awakened some English psychiatrists to the fact that what they had been practicing up to that time did not apply. The use of the term "shell-shock" in this country as well as in England is evidence of the fact that our psychiatrists, too, were loath to admit that most of the disturbances were familiar and ordinary types of neurotic or psychotic reactions, and not disturbances which were organic in origin as they wished to believe.

As Rees points out, it is seen that in spite of resistance to new trends in psychiatry, much was learned about neuroses and psychiatrists' attitude to the neurotic changed. In this second World War their lessons will have been "relearned" and they will have gone further in their appreciation of this major medical and social problem.

12 John Rawlings Reese, op. cit., P. 313.
2. CURRENT STATISTICS

If the experience in World War I can be used as an indicator, we can expect that great numbers of psychoneurotics will be added to the rolls in the post-war years. As to the present statistics, one figure quoted in the introduction to this study on page 1 was given as forty-three per cent as estimated in July 1945. The largest single category of evacuees from the Pacific alone consisted of neuropsychiatric cases. In spite of more careful screening in World War II, "the incidence of mental illness among troops was probably higher in the second than in the first war."13 Further substantiation of this statement14 is found in the figures given by the United States News of January 14, 1944, which are quoted as follows:

Thirty-five per cent of all rejections in the army in this war's draft have been N. P., (neuropsychiatric), as against only three per cent in the last war. Furthermore, fifty men per thousand develop N. P. disorders in training camps, and a higher percentage overseas; as against thirty per thousand in World War I training camps and only twenty per thousand in the A. E. F.

Two other writers quote the figure as thirty per cent of all casualties.15, 16 While there is some disparity in these percentages, the important fact is that even thirty per cent represents a large proportion of discharges and that the communities to which these men

14 Dwight McDonald, "War as an Institution", Politics, P. 242.
15 John Rawlings Reese, op. cit., P. 108.
16 Willard Waller, op. cit., P. 166.
return have a tremendous task of helping them in their reintegration to community life. The transition from military to civilian life will be difficult for many and it is anticipated that there will be for the next five or ten years personal and family crises which had their beginnings in this period. It is obvious that the highly disturbing emotional experiences will handicap many of the soldiers when they return to civilian life. Many may be expected to break for reasons of psychoneurosis, years after the end of the war, when the difficulties of living in the community put some unusual strain upon a weakened segment of their emotional structure. This has been borne out by our experience after the first World War. We might question, in this connection, the cause of new admissions of World War I veterans to the Veterans' hospitals in 1937, previously mentioned in this study. Could it not have been in some way related to the fact that we were then in the midst of a devastating business depression and these men broke from the effects of it?

CHAPTER III

1. COMMUNITY RESOURCES FOR TREATMENT AT THE PRESENT TIME

According to the Health Committee of the Senate, 1,400,000 men have been rejected by their draft boards because of some type of neuropsychiatric disability. This is evidence that these problems of mental breakdowns in civilian life were similar to those met with in the military setting. As these figures were released and as men with neuropsychiatric discharges began to return to their communities, there was a growing awareness that a definite program had to be set up to meet the need for service.

Case work agencies, long familiar with the emotionally disturbed clients, prepared to assume the heavy burden placed upon them by the returning veteran. The subjects chosen for discussion at regional conferences held during the war years dealt mainly with the disabled veteran indicating the agencies' deep concern. It was clear that new skills or the sharpening of those already acquired would be needed in dealing with this new group of clients.

Although a great number of veterans will not need special consideration, there are many of them who will have changed by virtue of their experiences in the service and require the attention of a social agency or clinic. In time to come many types of service will be needed by the neuropsychiatric

casualties, but the writer is only concerned here with those who showed a need for treatment by the time of or shortly after discharge. It has been pointed out that for the most of these men out-patient rather than hospital care is indicated.

On the whole, the man with neurosis is better treated as an out-patient and it is very desirable that he should continue his work while having treatment. Consequently better clinics giving more active treatment with far better facilities for psychiatric social work and occupational placement are needed.19

In treatment of many cases the social worker can play the primary role but there are those for whom psychiatric care will be strongly indicated. Up to recent months, the only sources for referral for out-patient care in Boston were available at two general hospitals, the Boston Dispensary, Southard Clinic of the Boston Psychopathic, and the Psychiatry Clinic under the auspices of the Boston Psychoanalytical Institute. It was not long before the workers making psychiatric referrals realized that some of the clinics offered specialized service which at times limited the choice of clinic available for referral. For example, the Psychiatry Clinic of the Psychoanalytic Institute was interested in patients whose mental condition could be attributed to conditions of war. Then, too, it confined itself to short term cases. The policy of the clinic is explained in its first Annual Report, as follows:20

The intention in founding the Clinic has been to treat the so-called "Civilian War Neurosis" including those of discharged

19 John Rawlings Reese, op. cit., P. 122.
20 First Annual Report, Psychiatry Clinic under Auspices of the Boston Psychoanalytic Institute, Inc., 1943.
servicemen who had returned to civilian life with nervous symptoms which did not completely incapacitate the persons but which diminished their efficiency and interfered with satisfactory relationship with people at home or at work.

The report continues to say later:

When the information (referring to referral information) shows that the patient's condition is not due to war or is otherwise unsuitable for short treatment the patient is referred to some other community service.

Among such conditions are:

(1) Mental disease which might require hospitalization.
(2) Mental symptoms due principally to disease or injury of the nervous system.
(3) Chronic alcoholism.

The Red Cross worker, therefore, made it a practice to discuss the symptoms of the veteran with the clinic social worker in charge of admissions before making a referral. It is obvious that this step was important in order to spare the veteran the frustration of being rejected, a situation which would only make him feel that he had been given the "run-around" and that he differed so much from his fellows that he was ineligible for treatment at the particular clinic to which he had been referred. Sometimes the Red Cross worker made the clinic appointment for the veteran; at other times, depending upon the situation, the veteran was encouraged to make his own arrangements for treatment. After the veteran reported to the clinic, the worker governed her future contacts with the veteran by the recommendations of the psychiatrist. In some cases, when it was indicated that the problem presented by the veteran only involved psychiatric treatment, the Red Cross contact with him terminated at the point of referral, if he continued under the care of a
Clinic. However, there were instances where the veteran continued his contacts with the worker which point possibly to the failure of the worker to help the veteran transfer the relationship to the psychiatrist.

It is the writer's experience, and that of other workers, that during the period of this study, the policy for treatment varied in the general hospitals, one of them refusing to treat the veteran who was receiving pension for his disability. As the numbers of veterans seeking treatment increased, the shortage of psychiatric personnel and inadequate facilities no doubt had a great deal to do with the refusal of the hospital to treat veterans receiving pension. Presumably, too, the thinking behind this stand was that treatment of these men was a responsibility of the government. A few months ago saw the inception of a Mental Hygiene clinic in the Regional Office of the Veterans' Administration, where the veteran with a pensionable disability can receive treatment. There still remains a large group who will not be eligible for pension and for these men treatment will have to be provided elsewhere.

The provision for adequate care is not so easily attained.

Cunningham stresses this point:

Before the war, there were not enough adequately trained psychiatric personnel to take care of the psychiatric problems presenting themselves. The war has increased the problem by being responsible for the finding of many cases and also by producing or precipitating difficulties that would not have arisen. The military services have taken a considerable part of the available psychiatric personnel ( . . . ). One of the major functions of the psychiatrist in the service has been the exclusion of those individuals with neuropsychiatric handicaps. These have been added to the load of the depleted civilian psychiatric resources. As a result, the
various agencies are competing with each other for psychiatric help. The requests for psychiatric assistance are greater at a time when there are fewer people to give it.21

Cunningham goes on to say that the shortage of adequately trained personnel precludes development of an immediate large scale program of psychiatric service. Even with the war at an end it will take some time before trained personnel will be available. Hampered by this shortage as communities are, it is anticipated that social agencies will be called upon to carry increased case loads.

The outlook for the immediate future is not very hopeful. The task confronting social agencies lies, then, in the area of developing the skills of their workers in environmental manipulation and therapy through case work treatment.

2. DISCUSSION OF HOME SERVICE FUNCTION

IN RELATION TO SPECIFIC

RESPONSIBILITIES TO THE VETERAN

As has been previously stated in the introduction to this study, many veterans who need help, turn to Home Service because the American Red Cross is the agency they knew while they were at camp, in the hospital, or at an overseas club. Veterans come to Red Cross through referral from community social agencies who are aware of the specialized services which Red Cross offers. A War Department pamphlet issued in 1945 for distribution to men discharged for psychiatric disability advises them to seek further advice and treatment if needed. In speaking of resources, the pamphlet mentions the Veterans' Administration, civilian psychiatrists, and mental hygiene clinics, adding that "certain social agencies have skilled psychiatric social workers and psychiatrists who can help you."

What, then, is the function of Home Service with reference to veterans?

Home Service is a program of family service through which the American Red Cross carries out in communities its primary responsibility to servicemen and veterans, and their dependents.23


23 The American National Red Cross, Home Service 'Services to the Armed Forces and to Veterans' Washington: ARC 1214, Revised October, 1945.
This program of service includes counseling in personal and family problems and the giving of financial assistance during the temporary period pending first receipt of federal disability or death benefits and during periods when such payments as may be due are delayed or interrupted. Assistance may be given to any veteran during his period of adjustment from military service to civilian life. However, in planning with the veteran for financial assistance, consideration is given to the resources available to him through federal, state, and local agencies, both public and private, including those especially provided for veterans and their dependents.

Among the services furnished to veterans is that of referral to agencies offering the service appropriate to their needs. The Home Service worker is trained to assist the veteran in filing claims for pension and other benefits; she keeps herself informed concerning legislation affecting veterans and their dependents and concerning community resources, information which she shares with the veteran seeking her help.

Reporting service is another function of Home Service. Reports such as social histories needed in diagnosis and treatment of veterans, and social surveys in relation to incompetent veterans and minor wards of the government are furnished at the request of the Veterans Administration.2

Because of their inability to make an adequate adjustment, these veterans with psychiatric disabilities, who ask for help, will in some instances have difficulties in the areas connected with their claims for pension, employment, or family life. Although the writer is chiefly

24 Ibid
concerned with the treatment angle of the veteran's needs and the services of counseling and referral in connection with it, recognition is given to the fact that interwoven in his neurotic pattern are these other factors which play a part in the veteran's difficulties.

As will be shown in the statistical study on page thirty-two, nine veterans requested treatment and twenty-five focussed on other problems. These problems were in some instances used as a springboard to treatment. From cases selected for this study, it has been seen that although the client came to the agency with a request for service other than treatment, it was often because he was confused as to his real problem, feared to ask for treatment, or lacked the insight to understand why he was in such difficulty.

Thus we see that upon the Home Service worker rested a tremendous responsibility necessitating the use of utmost skill, understanding, and sensitivity. The rapid rate of discharge and the increasing need for service in the period selected for this study overtaxed the facilities of the Red Cross. Often the worker was hampered by a very large case load. Individual workers sometimes carried one hundred or more cases. While not all the cases needed long-term service, it is recognized that a case load involving twenty-five or thirty-five cases is about all a worker can handle if they consist of complicated problems requiring thoughtful, constructive, and skilful planning. The above findings were based upon a survey\textsuperscript{25} of the Red Cross Chapter, Richmond, Virginia. The authors commented that "somewhat similar conditions exist in many other communities

\textsuperscript{25} Bradley Buell and Reginald Robinson, \textit{op. cit.}, P. 9.
throughout the country."

Through the very nature of her work, the Red Cross worker has been made aware of the fact that many veterans she will see will need psychiatric help. She has been told that the sooner treatment is begun the better it is for the client. Quite often the letter of referral received from the Red Cross field director will read something like this: "The medical officer feels that treatment immediately after discharge is indicated before symptoms become fixed" or with slight variation the letter will state that treatment is urgent or the condition may become serious. Grinker affirms this in the following statement:

Our war experiences indicate that early and adequate treatment of most psychosomatic disturbances is effective, and point clearly to an application to civilian medicine. Patients should not be treated medically for years if recovery is desired. On the contrary, symptomatic relief does not stop the process of structural alteration or fixation of psychological patterns. These states of "functional disturbances" must receive early psychiatric treatment. 26

On the one hand there is the urgency of the situation and on the other, there is the resistance with which all social workers are so familiar.

26 Roy R. Grinker and John P. Spiegel, Men Under Stress, P. 277.
CHAPTER IV

1. RED CROSS SERVICES TO VETERANS OF WORLD WAR I

The Home Service Department of the American Red Cross came into being as a wartime development of the first World War in response to the charter obligations to "serve as a medium of communication between the people of the United States of America and their Army and Navy." As the service expanded, it became a means of assisting families in their difficulties which caused the servicemen worry and anxiety. During the year 1918, 500,000 families of servicemen received information, advice, financial help, or other assistance from the Red Cross. A year later the number of families assisted increased by 300,000.27

Early in the war, and before the passage of the Congressional act providing for the government program, the Red Cross became interested in the rehabilitation of the disabled veteran. At the request of the Surgeon General of the United States Public Health Service, Red Cross workers were placed in Public Health Service hospitals and in institutions caring for veterans to do medical and psychiatric social work. Veterans were encouraged to accept hospital treatment and to remain until they were ready for discharge. The workers helped these men with their personal as well as family problems by contact with the local chapters in their communities. Men discharged from the hospitals were helped in returning and adjusting to civilian life.28

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27 The American National Red Cross, The American Red Cross - A Brief Story, ARC 626, Revised, February, 1944.

28 Ibid
Few Home Service Departments had the advantage of a psychiatric consultant to guide them in their planning for the veteran. The writer recalls that in her Red Cross work following the post-war years there was close cooperation with the Regional Office of the Veterans' Administration and that treatment was considered only in terms of hospitalization. Many psychotic patients were living with their families, presenting innumerable problems in their inability to adjust. It was only when the home situation became intolerable or the veteran became violent that hospitalization through commitment by the court or family could be arranged, if the veteran would not consent to voluntary commitment.
2. RED CROSS SERVICE TO VETERANS OF WORLD WAR II

With Red Cross workers serving at home and abroad, at the army camps, naval stations, military reception and separation centers, the serviceman in one way or another has come to know something about the organization and its function. He learned that it was through the Red Cross field directors that he could obtain a loan to make that emergency trip home, that he might secure a welfare report on his family; if he was particularly concerned about his discharge, it was the field director who talked with him about it and discussed the Red Cross resource in his community to which he could turn for help. More often than not, while he was being processed for discharge, it was the field director who helped him file his claim for pension and then notified the local chapter that he was being discharged. If the discharge was from a hospital, and specific recommendations were made by the medical officer, this, too, was included in the referral to the local chapter. In some instances where it was felt that the veteran might not be able to take the initiative in seeking the help he needed, the field director let this be known also. The procedure following such a communication has been to write the veteran giving him a definite appointment and offering him Red Cross services.

To many the services of the local chapter were not unknown as they learned through correspondence with their families how the Red Cross had assisted them. Often a serviceman has written his wife to contact the local chapter for help with whatever problem they had been discussing. At times servicemen wrote of their own accord direct to the chapter asking
for specific information concerning their families. When stationed in this country and on emergency furloughs, men desiring extensions have sought advice regarding the extension or the problem which brought them home.

It is no small wonder, then, that a greater number of veterans find their way to the chapter to seek financial assistance, help with marital problems, vocational guidance, consultation regarding claims, and treatment.
CHAPTER V

FACTORS INFLUENCING RESPONSE OF VETERAN TO REFERRAL FOR TREATMENT

With the all-inclusive service offered by the Red Cross, it is understandable that any group of cases selected from its files for a study would contain a certain number already known to the agency. In the group of thirty-six considered here, twenty-six had been known prior to discharge from the service through personal or family contact. Twelve of the twenty-six were men whose families were interviewed for a psychiatric social history requested by the medical officer while the men were under observation in the military hospital. Ten out of the entire group came to the Red Cross for the first time after discharge from the service.

The veterans ranged in age from seventeen to thirty-nine years; eight were under twenty, eighteen under thirty, and ten under forty years of age. As is seen in Table I on page twenty-five, it is perhaps significant that twenty-six men, representing about two-thirds of the veterans in this study, were under thirty years of age. Marion Perkins in her study of 636 cases, made in March, 1944, also found that most of the discharged men who came to the Boston Red Cross were under thirty and a large percentage were between twenty and twenty-five years of age. (No percentages were given.) She makes the observation that many of these veterans grew up in families that suffered the deprivation and stresses of the depression years and

29 Marion Perkins, op. cit., P. 4.
suggests the probability of a correlation between the childhood years of these men and the breakdowns they suffered under the strain of military life. The significance of these figures, too, is that the veterans are still in their youth and if they do not have or accept the help they need, may present in the future, as they do now, in a lesser way, problems of tremendous proportions to their communities should there be an economic decline as followed the first World War.

**TABLE I**

**AGE GROUPINGS OF VETERANS REFERRED TO A CLINIC**

<table>
<thead>
<tr>
<th>AGES IN YEARS</th>
<th>GROUP I</th>
<th>GROUP II</th>
<th>GROUP III</th>
<th>TOTAL NUMBER OF VETERANS</th>
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<td>17-19</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>8</td>
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<td>20-29</td>
<td>3</td>
<td>10</td>
<td>5</td>
<td>18</td>
</tr>
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<td>30-40</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>TOTALS</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>36</td>
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Twenty-five were single, nine married, and two were divorced. Since the writer does not have the statistical data on the total number of single and married men discharged for psychiatric disabilities, the predominance of single men in this study may not have any significance. On the other hand, it may have meaning, when correlated with the ages of these men in terms of inability to adjust to situations without the protective
environment given them by their home.

The length of service in the armed forces ranged from six weeks to the longest period of forty-six months. Ten veterans, the largest proportion of the group studied, had spent six months or less in the service; seven served from seven to twelve months, five from thirteen to eighteen months, six from nineteen to twenty-four months, three from twenty-five to thirty months, two from thirty-one to thirty-six months, and one each for the periods from thirty-seven to forty-eight months. (One case did not show length of service.) Of these men, only six served overseas. The fact that only six veterans needing psychiatric treatment served overseas and that seventeen served less than one year is an indication that the threshold of endurance varies with the individual. This should be of significance to the worker in her evaluation of the veteran who asks for help since the individual suffering from a mental breakdown early in his service may well be one who had not been well adjusted prior to service. This observation has been borne out by the twelve cases in this study where a psychiatric social history was requested by the military while the men were under observation in the hospital. The histories revealed considerable incidence of early maladjustment in school, on the job, or in the family setting. One veteran was discharged under the point system,\(^{30}\) three for physical disabilities, and thirty-two for a nervous disorder.

The thirty-six cases selected for this study fall into three groups: Group I is represented by ten veterans who accepted referral, but did not report to the clinic; Group II consisted of twelve who withdrew from

\(\text{30 Point Score and Length of Service schedule is a system by which the military determined a serviceman's eligibility for discharge from the service.}\)
treatment after their initial clinic visit; and Group III comprised fourteen veterans who continued treatment for a period of time varying from two clinic visits to the length of time needed to complete treatment. Nine veterans out of the entire group were recommended for further treatment by the medical officers of the military hospital. Group I and II each had a single veteran with such a recommendation. It is interesting to note that although thirty-two out of the thirty-six cases studied here were discharged from the service for a nervous condition, that only a small number (nine) were recommended for further treatment. In view of the results obtained from this study, that is, that twenty-two cases, comprising Group I and Group II, either did not follow through on the referral to a psychiatry clinic or failed to continue treatment, the writer raises the question as to whether the failure of the military medical staff to recommend further treatment does not correlate with the veteran's ability to accept it. Resistance and lack of insight, two factors important in the consideration of psychiatric treatment, are not only a source of concern to the case worker but also to the medical officers in the military hospitals. Numerous references to this situation have been made in the literature on the subject of psychiatric treatment. In this connection, Blau and Lenzner, members of the Naval psychiatric staff, in a study of five hundred naval psychiatric dischargees, ask the following questions:

To what shall we attribute the apparent failure of these men to understand their psychiatric needs? Is it due to deficiency in our treatment at the hospital leading to lack of faith in our therapeutic powers? Does it arise from a general poor opinion
of psychiatry by the laity? Or is it the result of poor insight due to resistance by the patients?  

The fact that half, that is seven, in Group III who continued treatment had not been directly referred for further treatment by the military indicates to the writer a possibility that these men rejecting treatment at the point of discharge had gained by the interpretation and were making use of it when, after failure to adjust in civilian life, the need of treatment became apparent to them.

The course indicated for the military medical staff would seem to be, then, to make the recommendation for further treatment, giving the added information regarding the man's attitude toward it. It may well be that the veteran, freed from the restrictions and frustrations of military service and its authoritarian approach, would be able to accept the offer of such help from a civilian agency.

In this connection it is important to know that the military attempts to explain to the psychiatric dischargees the nature of their illness, but in this study of thirty-six cases this fact has not always been clear through the recording. However, in six cases of Group III, not only had the men been referred to Red Cross with a suggestion for further treatment, but they had been given some interpretation of the meaning of treatment as well.

A comparison of how referral for treatment was initiated indicates significant differences. As is shown in Table II, the Red Cross worker

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32 Ibid, p. 476.
suggested treatment to twenty-five men for all three groups. In Group I, nine out of ten were approached by the worker, in Group II, nine out of twelve, while in Group III, seven out of fourteen had treatment proposed to them. In view of this, it is interesting, too, that in Groups I and II, only one veteran was recommended for further treatment in the discharge referral letter received from the military hospital, while seven in Group III were thus recommended. The success of referrals in the last group points to the recommendations by the medical officer as one important factor in consideration of these successes. The large proportion, twenty-five out of thirty-six, to whom the worker suggested treatment, may also indicate a reason for the large percentage of failures since it would seem that the worker saw the need for treatment before it could be accepted by the veteran.

Of the entire number studied, only two veterans were referred by their families to Red Cross for help with treatment. Both of these veterans were immature, dependent individuals who were too ill to take the initiative in arranging for treatment themselves. Nine veterans in all three groups requested treatment themselves. It is extremely significant here that of these, four had not been referred by the medical officer. The inference from this leads the writer to believe that sometimes the medical officer may not be able to evaluate the veteran's potentialities for making use of psychiatric help. The writer is aware, of course, that such a factor as pressure of work may have made it difficult for the medical officers to find time to take the necessary steps in making such a recommendation. In several instances the medical officer was of the opinion that adjustment would be possible without further treatment.
TABLE II
INITIATION OF REFERRAL OF VETERANS FOR TREATMENT

<table>
<thead>
<tr>
<th>BY WHOM TREATMENT WAS SUGGESTED</th>
<th>GROUP I</th>
<th>GROUP II</th>
<th>GROUP III</th>
<th>TOTAL NUMBER OF VETERANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Worker</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>By Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Veteran</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>36</td>
</tr>
</tbody>
</table>

How the veteran made his first contact with Red Cross depended upon several factors; it depended upon his previous contact with the agency, the interpretation of Red Cross function or direct referral by the Red Cross field director before discharge, whether he had been referred by a community agency, his family, or whether the Red Cross chapter took the initiative in arranging for an interview.

The service requested by the veteran on first contact is important in terms of focus upon the problem and its influence upon the success or failure of the referral for psychiatric treatment. Table III, page thirty-two, is a breakdown of the first requests for service made by the veteran in his initial contact with the agency. It is seen that more than one type of service was desired. In all, forty-one requests for
service were made by the thirty-six veterans. The greatest number, that is, thirteen, requested financial assistance. It is by this group of thirteen that additional help with other problems was sought; two wanted vocational guidance and help with educational plans; one asked for advice regarding a marital problem, one about medical treatment, and another concerning his claim for pension. Twenty-one veterans had only one request to make; five asked about employment, two regarding vocational guidance, four about their claims, one concerning his citation, one about annulment of his marriage, and eight asked advice regarding treatment.

Two veterans who came for an interview at the invitation of the worker made no request for service.

Of the nine men who requested treatment, three requested examination for an organic disturbance, although admitting that they were "nervous" and upset. This may be considered further indication of resistance to psychiatric treatment and lack of insight discussed previously in this chapter. The possible deductions from the foregoing figures are that veterans coming to Red Cross for service other than psychiatric care see their need as lying only in the area where, for the moment, the most pressure seems to be; that they may have no understanding of their basic difficulty, i.e., inability to adjust; that they may be resistant to psychiatric treatment, or that they are confused and only know that they are in trouble and project their need upon something tangible, as for instance, financial assistance, where actually it may not be necessary, or employment, when they are too ill to take a job. The fact that in twenty-five cases (see Table II) the worker took the initiative to advise treatment is corroboration of the fact that the veterans did not see their
### TABLE III

**SERVICES REQUESTED BY VETERANS ON FIRST CONTACT WITH AMERICAN RED CROSS**

<table>
<thead>
<tr>
<th>TYPES OF SERVICES REQUESTED</th>
<th>GROUP I</th>
<th>GROUP II</th>
<th>GROUP III</th>
<th>TOTAL NUMBER OF EACH SERVICE FOR THE THREE GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td>3</td>
<td>9</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Vocational Counseling</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Claims</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Marital Difficulties</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Employment</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Treatment (Medical and Psychiatric)</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of services requested</strong></td>
<td>12</td>
<td>14</td>
<td>15</td>
<td>41</td>
</tr>
</tbody>
</table>
need at first to be that of treatment, but when this figure is correlated with twenty-two, the number of veterans in Group I and Group II who did not follow through with treatment, the question which arises is, what happened between worker and veteran to bring about this result?

From Table IV it is seen that thirteen veterans in all groups initiated the first contact; five were seen at the request of the family, four were referred by community agencies, and fourteen were either approached by letter or through a home visit by the Red Cross worker. The number of veterans seeking help themselves was proportionately the same for all three groups.

Although other factors, which are discussed later in this paper, may be responsible for the failures, the writer feels that in view of the poor response to referral for psychiatric treatment, the method of seeking out the veteran to offer him service may be questioned.

Preparation for referral to a clinic varied; the number of interviews with the Red Cross prior to referral ranged from one to nine. Eighteen men, fifty per cent of those seen, had been interviewed only once when referral was made. Of these, eleven were in Group III. In Group I, two veterans were seen nine times. The greatest number of interviews in Group II was six, with three veterans in this category. The total number of interviews for each group is as follows: Group I, thirty; Group II, thirty-four; and Group III, nineteen. (See Table No. V, page thirty-five.)

It is interesting to note that in Group III comprising fourteen of the men who continued treatment, the lowest number of interviews before referral was necessary. It is in this category also that a greater
TABLE IV

HOW FIRST CONTACT WITH RED CROSS WAS INITIATED

<table>
<thead>
<tr>
<th>INITIATING AGENT</th>
<th>GROUP I</th>
<th>GROUP II</th>
<th>GROUP III</th>
<th>TOTAL NUMBER OF VETERANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Red Cross Worker</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Outside Agency</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>36</td>
</tr>
</tbody>
</table>
TABLE V

NUMBER OF INTERVIEWS PRIOR TO
REFERRAL TO A CLINIC

<table>
<thead>
<tr>
<th>NUMBER OF INTERVIEWS</th>
<th>GROUP I</th>
<th>GROUP II</th>
<th>GROUP III</th>
<th>TOTAL NUMBER OF VETERANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>4</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Total number of Interviews for each group 30 34 19

Number of Men 10 12 14 36
number of men had been recommended for treatment.

If a relationship between client and social worker is the means through which the client is guided to help himself, does it necessarily mean that repeated interviews make for that relationship? From the material presented above, can it be assumed that a relationship was not established in the nine interviews with the two veterans in Group I who accepted referral to a clinic, but failed to report? What factors operated to make one interview so successful with the men in Group III? What does the social worker need to know in order to serve her clients best? These are the questions which the writer will attempt to answer.
CHAPTER VI
DISCUSSION OF FACTORS RELATING TO THE SUCCESS AND FAILURE OF REFERRALS

From the statistical analysis of the three groups of veterans, it was found that many factors entered into the consideration of the problem relating to referrals for treatment. It would seem the longer the contact with the worker, the more successful the referral, but this would not appear to be the case. While indifferent interviewing techniques are undoubtedly one of the factors, the indication from this study points to others. One of the outstanding difficulties has been the public's attitude toward treatment.

Resistance to psychiatrists and psychiatric concepts has been a problem for a long time. In spite of the efforts in educating the public to an acceptance of mental as any other illness, there is still a great deal of ignorance to be overcome. Along with ignorance, there is fear of being stigmatized. Pratt makes this very point when he says:

( . . . ) The majority of men who broke down in military service suffered from one of the many disorders coming under the head of "psychiatric." In recent years, and especially since the outbreak of the war, this term is seeing frequent usage. ( . . . ) Nevertheless, to many it still carries some mysterious, half-fearful meaning, and since misconception about the term is rife and since if it is incorrectly interpreted it is apt to bring unmerited alarm or stigma ( . . . )33

33 George K. Pratt, op. cit., P. 80.
Waller substantiates Pratt's statement:

A principal difficulty in the readjustment of the psychoneurotic is the public attitude toward him. While the physically disabled veteran is in general kindly regarded by society, our attitude toward those broken in mind is far less sympathetic. There is a stigma connected with psychological breakdown, even a suspicion of malingering.34

Resistance often comes from the family who think that if they give Johnny good food and loving care, he will recover. There is the family physician who will tell his patient "to forget all about it" giving him the oftentimes false assurance that once he settles down, he will feel better. Then, too, there is the veteran who admits that he is ill, but defers treatment because he wants to try to work or rest first. A large group of veterans having somatic complaints for which there is no organic cause will not accept the interpretation that their ailment is psychosomatic. All these factors make for an almost insurmountable hurdle requiring the utmost skill in handling.

The writer has decided to isolate certain factors in the case material studied. The purpose of this plan is, of course, to determine the effect of the factors described on the success or failure of the referral. The decision as to the specific factors to be studied was made in terms of basic case work practice as well as the case work material under consideration from the standpoint of trends that were revealed to be significant by the material studied. The factors are as follows:

34 Willard Waller, op. cit., P. 168.
1. The impetus that brought the veteran to Red Cross and how was the initial request made by the veteran at time of his initial approach to Red Cross handled?

2. If the veteran came at the initiation of the worker (by letter, telephone, or home visit), how did she explain the reason for her desire to see him?

3. Was there evidence that the worker put pressure upon the veteran to go for treatment or was the worker free to accept the client's pace?

4. Was there evidence of the worker's ability to make a social diagnosis?

5. How did the veteran feel about his disability and how did it affect the treatment plan?

6. What evidence was there of a relationship between veteran and worker and how did it operate in relation to treatment?

7. Did the client participate in the treatment plan?

8. Was there a focus in the interviews and did the worker and veteran meet on common ground?
CHAPTER VII

APPLICATION OF FACTORS TO CASE MATERIAL WITH
ILLUSTRATIONS FROM THE RECORDS STUDIED

From the discussion in Chapter I we see that the block of cases selected for this study was divided into three classifications: Group I represented ten veterans who accepted treatment by indicating some interest, but did not report to clinic; Group II consisted of twelve who withdrew from treatment after one clinic visit; Group III numbered fourteen veterans who continued treatment.

According to Table III, on page thirty-two, it was found that in all but two of the ten cases in Group I, the veteran made a request for service other than treatment in his initial visit to the agency. Two veterans made no request for service, but came to the Red Cross in answer to a letter giving them an appointment. It is seen that in this group none of the veterans recognized his need as being in the area of psychiatric treatment.

From the twelve veterans in Group II, only two asked for treatment while the remaining ten sought help with other problems. In this group, too, the major concern of the veteran is other than that of regaining his health. Seven out of the fourteen in Group III initiated the request for treatment in their first visit to the agency and seven indicated other needs. Group III presents a picture which differs with the other two groups in that half the number of veterans asked help in arranging for treatment.
When the criteria set up for evaluation of the interviews were applied to the thirty-six cases in this study, it was found that while the majority of requests for help in the initial contact with the veteran concerned themselves with problems outside of psychiatric treatment, (see Table III) the worker was able to follow through on these requests, although treatment was indicated as one of the veteran's needs. However, in four cases of the ten in Group I, this procedure was not evident. In two of these four cases, the purpose of the veteran's visit to the agency was not clear. As an example of the first two of these four cases, the writer cites the case of Rocco U., who came to discuss his claim for pension. Some recognition is given to this request for help, but the worker places the emphasis upon the circumstances which led to the veteran's discharge from the service. Since he was discharged because he was emotionally unstable and enuretic, she immediately arranged for referral to a psychiatry clinic and made an appointment for him to go that very day. While he accepted the referral and kept the first appointment, he never went again. In the two cases where no request for service of any kind was indicated in the record, an evaluation of the first interviews showed that the worker did not give the veteran an opportunity to state why he came to the Red Cross. This is shown in the case of Alfonso P. The initial interview with him is given almost in entirety, as follows:

Alfonso P. came to the Red Cross office in response to a letter giving him an appointment. He launched into a description of his illness after the worker asked the opening question regarding his health. He had seen intense and active service in the African campaign. While overseas, he suffered paralysis of the arm, which improved
upon his return to the United States, but he still had pain which interfered with his work. He was subject to nightmares which made him scream out and had fits of uncontrolled temper. He had been having treatment for his arm from his family physician, but it had done him no good.

The following is direct quotation from the record:

The worker wondered whether he thought of having treatment for his nerves. At the mention of the word "psychiatrist" he became very much excited. He said he had been seen by twenty-two psychiatrists and he had enough of them. He had kept a list of their names, and he hoped that some day he would have the opportunity to "get even" with at least two of them. "If it takes me fifty years I'm going to find them and black their eyes at least." He said that they had accused him of malingering. He resented this accusation and pointed out to the worker by way of denying this accusation that when he was in Africa he had delivered medical supplies to the front lines under terrific gun fire, even though he was ready to collapse from pain, and that he had not given up until the campaign was over.

Mr. P then went on to tell about the situation in his home, his work with his father in a meat market, and his medical history.

Quotation from the record follows:

Worker discussed treatment further with Mr. P., and after explaining the treatment very carefully, he said he would be willing to "try anything once." He felt discouraged because his family physician was unable to alleviate the pain in his arm. Mr. P. was advised that he would be notified directly by the clinic as to the date of his appointment there.

Mr. P. did not keep his appointment at the clinic nor did he respond to a follow-up letter sent him by the worker three weeks later. It is obvious from this interview that the worker had been so intent upon her own plan that she did not stop to find out what the veteran had to suggest
himself. It is not quite clear from the recording why the veteran came to the agency although his response to the appointment letter would indicate that he had some purpose in coming. Although the writer is aware that other factors are involved in the poor handling of this interview, the illustration is used here to show the worker's failure to help Mr. P. in verbalizing his need.

While the handling of the veteran's initial request for service does not seem to account entirely for the failure to respond to referral for treatment or the acceptance of treatment, further analysis of the thirty-six cases seems to indicate that no one factor can be isolated as responsible for the failure or success of the referral.

The letter written to the veteran offering him the services of the chapter is considered one of the important means of conveying to him the warm personal interest in his welfare. In a recent study of Red Cross services to veterans completed in July 1946 by a committee composed of staff members of the Red Cross Home Service, the subject of letters to veterans received special attention.

It was found that the satisfactory letter must be direct, simple, and brief, with an individualized approach wherever possible. Those letters with a negative approach may well give the veteran the feeling that even a response by telephone in unnecessary unless he has a conscious, specific need. The findings of this study regarding letters indicated that a warm, sincere letter with a definite appointment will more often bring about a response from the veteran. 36

35 Boston Metropolitan Chapter, American Red Cross, "A Study of Red Cross Services to Veterans in October 1945 Supplemented by a Brief Comparative Study in February, 1946." Boston, July 1946.

36 Ibid.
From Table IV, page thirty-four, it is seen that in sixteen cases out of thirty-six, the veteran came to the agency after he was approached by the Red Cross worker. To these sixteen veterans, letters were written offering the services of the Red Cross. On the whole, the letters were rather stilted in phraseology, but in spite of it, the desire to give service was apparent. Some letters described fully the services the chapter had to offer, while others were brief although not lacking in warmth or personal interest. In most letters a definite appointment was offered. Four letters stand out as cold and impersonal. The following is one example from a case in Group I:

Dear Mr. B:

We understand that you have been discharged from the service and wish to take this opportunity to offer you the services of this chapter. If there are any problems you care to discuss with us, we shall be glad to see you on December fourteenth at one-thirty. If you cannot keep the appointment, will you kindly call the undersigned at .......

The following letter taken from the Edward C. record in Group III is brief yet cordial, giving the veteran a definite appointment.

My dear Mr. C:

We have a letter from the Station Hospital at Westover Field telling us that you received a Certificate of Disability Discharge on March 2.

I would like to be of service to you and am therefore saving time for you on Thursday, March ..., at 11 a.m. Please phone me at ... if this is not a convenient time.

Sincerely yours,
Although the findings of the study of the Red Cross Services to Veterans indicate that the veteran's response to the offer of an appointment depends in part upon the type of letter sent him, this was apparently not the situation with the sixteen veterans in this study to whom letters were sent; the implication from this observation is that the veteran had some need for service and the offer of an appointment helped him to make the approach to the agency. In the initial interviews there was a marked paucity of interpretation to the veteran as to why the services were offered. The omission may be due in part to contents of the letter which set forth the writer's interest in the veteran and the services which she could offer him.

One of the outstanding factors in the analysis of the techniques employed in referral of veterans was the use of pressure on the part of the worker upon the veteran to accept treatment. This pressure was manifested in many ways; for example, it was seen when the worker focussed upon treatment while the veteran sought other help; it was also observed where the worker showed haste in making a clinic appointment after the first interview, or as in the Rocco U. case, the very same day, before the veteran had an opportunity to actually decide what he wanted to do. It is also seen by the choice of words in the interview, as for instance, in the case of George A., Group II, the worker makes use of this expression repeatedly, "Worker said that it is imperative for him to continue going,"

37 Supra, page 43.
38 Supra, page 41.
39 Italics, the writer's.
(referring to the clinic.) Often the pressure is seen in creating anxiety, as in the case of Perry B. from Group I.

Perry B., age 19, single, was seen for the first time seventeen months after discharge when he came in response to an appointment letter sent to him a year before. The worker had had interviews with his father who requested advice when Perry was making a poor adjustment, but she was unable to talk with Perry because of his refusal to see the worker. Shortly after he was discharged from the service, he became greatly disturbed and was committed by his family to the Boston State Hospital. The worker had only one interview with him in which he told her about the nature of his discharge and his experience at the State Hospital. He seemed to relate to her fairly easily although it was difficult for him to talk about his experiences. He impressed her with his intelligence. (Prior to service he was a first year university student in engineering.) He wanted to get started on some kind of a job. He had not been doing much of anything since his discharge from the State Hospital. She discussed vocational guidance, but he was not able to come to any decision about it. The worker explained the services available to him, but he showed little inclination to accept her suggestions.

The worker then said that she could obtain a report from the State Hospital if he wanted her to and talk it over with him. He refused to give her permission to secure it. (When he was discharged from the military hospital, he also refused to sign a release of medical information.)

The worker then interpreted further treatment, stressing how necessary it was. She pointed out carefully the difference between custodial and clinical care. He thought that occupational therapy was probably what he needed. The worker said at that point that occupational therapy could help a great deal, but she doubted whether
it could cure that kind of illness. To quote the worker: "I said it is true that unless one has treatment for such illness, it is possible to have another breakdown. He asked if I really thought that and I said 'I do.' Perry said that he would want to talk things over with his family and then he might get in touch with me." Perry did not return again.

This case is given to illustrate not so much the acceptance of referral for treatment by the veteran as the use of pressure.

At first glance, this first interview would seem to have been well thought out and sensitively handled, but upon analysis, the feeling gained is that the worker moved too fast for the client and in using pressure had revealed her own need in seeing the veteran move toward treatment. The use of the words "another breakdown", and the request for his permission to obtain his medical record were extremely threatening, as his withdrawal at this point seems to indicate. The relationship was too tenuous to have expected a positive response. At no time during the worker's contact with the father or Perry had there been much exploration of either one's feelings about hospital care or mental illness. This would seem to have been the course to take in the interviewing process especially since Perry's mother had been a patient at the Boston Psychopathic Hospital at one time. We see here that the worker had taken the course of heightening Perry's fear rather than that of deepening their relationship.

The pressure exerted by the worker is seen, also, where resistance to treatment is apparent. Sometimes the client goes to the clinic because the worker desires it. This was seen in the Paul D. case of Group II, where the veteran tells the worker that he will go to the clinic if she
thinks "it is the thing to do." Again it is seen in the George A. case of Group II when the worker, having broached the subject of treatment in a previous interview, asked Mr. A. again if it would not be a good idea to have "an examination for his nerves." Mr. A's response to this is that "he thinks probably it might be best to 'get it over with', although he says again 'he knows he will be all right once he gets his teeth.'" The worker then follows up the veteran's statement with the following: "Worker mentions the fact that if he does not take care of his condition now, it will probably become worse and when he is about forty or fifty, he will see the results." Mr. A. agrees, saying that his father is seeing the effects of what he went through in the last war. The worker then proceeds to make arrangements for referral to the clinic.

This veteran reported to clinic only once, and although the worker brought up the matter of continuing treatment again, she made no headway. From this example, it is seen that Mr. A. was interested in having dental treatment while the worker saw his need to be psychiatric treatment. In order to be relieved from the pressure of the worker, he finally submits while at the same time indicating his feeling about treatment when he says that "it might be best to get over with it."

In Group I, pressure was seen to exist in six out of ten cases, while in Group II, the George A. case was the most outstanding example of this technique. In two of the cases in this group, pressure to go to the clinic was applied by seeking the help of members of the family, or in one other case, the help of veteran's fiancee. It is not surprising, then, that in the instances where pressure such as has been described has been used that the referral to a psychiatric clinic met with failure.
In Group III an entirely different situation is found. In none of the fourteen cases was there any evidence of pressure. In the Alfred O. case from this group, there is only one interview, which is brief. The referral letter from the field director of the Army hospital stated that Mr. O. expressed interest in having the chapter worker get in touch with him for the purpose of discussing further psychiatric treatment.

Mr. O., age 30, had been in the service twenty-one months when he was discharged because he began to feel that his comrades disliked him on account of his nervous condition manifested by shrill screaming at night which did not seem to awaken him. In the morning he could not recall the content of his dreams. His condition was extremely disturbing even in the hospital where special sleeping arrangements were provided for him. During the day he did not consciously worry about anything and was not aware of any unusual emotional problems. The veteran's background provided sufficient cause for his emotional condition as he lived as a child in Germany during Hitler's rise to power and had witnessed considerable persecution. He himself had had a number of frights and close escapes. Neither the medical officers nor the social workers in the hospital were able to elicit any amount of feeling from Mr. O. in connection with his past experiences which seemed well repressed. He had some awareness of his difficulty and some desire for a better emotional adjustment.

Mr. O. came to the office in response to the letter sent him by the worker. When she mentioned the letter the chapter received from the hospital, he responded immediately that he wished to discuss further treatment. The material he gave her coincided pretty much with that in the letter of referral. He did tell the worker that he had been assigned as an interpreter for the Army with the German prisoners. It was the worker's feeling that the close proximity with the German prisoners might have intensified his nightmares. He
admitted that he often did feel jittery and nervous within himself and quoted the Army psychiatrist as advising him to have treatment. He was referred to the Southard Clinic where he continued for about two months during which time he gained considerable insight. He was then referred to an analyst for further treatment.

The above case is typical of those in Group III in which a referral is received from an Army hospital with recommendations made by the medical officer for further treatment. Interpretation of the meaning of treatment had already been made at the time it had the most significance to the veteran. Of course, some insight on the part of the patient is necessary, although in this instance, Mr. O. did not admit any emotional difficulty. It cannot be said from the short interview reviewed above that very much of a relationship between veteran and worker had developed, but it is possible to say that Mr. O. was able to carry over his relationship with the Red Cross worker in the hospital to the worker in the chapter. There was no need to urge the veteran, the focus was sharply delineated, and it can be said that worker and veteran met on common ground.

In only one case of all three groups has there been any evidence of the client making his own application for treatment. The worker in all other instances telephoned the clinic for the appointments. The writer questions this procedure since the things people do for themselves have more meaning for them. Annette Garret expresses this thought as follows:

If people find their own jobs, look for their own houses, make their own applications to hospitals or other agencies, they are more likely to carry plans through. One person's way may not always be the same as another's but each person has to work out his own
manner of meeting situations. We must allow people a large measure of self-determination.40

In the only instance where the worker felt free enough to allow the client to make his own arrangements, the veteran did not continue his treatment. Let us see why this happened.

John L., single, colored, age 21, came to the Red Cross referred for financial assistance by a community agency. A social history had been prepared at the request of the medical officer prior to his discharge from the Army hospital for psychoneurosis. When he was seen by the worker, he talked about the job he expected at the Navy Yard, but as he wondered whether he could do the work, he was asked about his health. He spoke about his nervous symptoms and the worker records that as he felt freer, he talked about his hospitalization and mentioned the fact that he had talked with psychiatrists. The worker felt that he had some insight into his symptoms as not being physical. He then talked about a job and the difficulties in getting one because of the nature of his discharge. He was refused a job some time back and should have remembered then that the Red Cross worker at the Army hospital had suggested his coming to Red Cross in Boston. The worker continued to discuss his illness and told him about the doctors interested in ex-servicemen who had been discharged for nervousness. He expressed much interest. The interview shifted at this point to John's needs and he was given money.

At his next office visit, jobs were again discussed as John had been discharged from the Navy Yard through a misunderstanding. He had been confused with another John L. who had a court record. The worker discussed the subject of jobs and asked John if he had thought any more about treatment. She gave him a card to Psychiatry Clinic and arranged with him to make his own appointment. He lost the card and gave the

40 Annette Garrett, Interviewing, Its Principles and Methods, Family Welfare Association of America, 1944.
loss as his excuse for not making an
appointment. He finally telephoned the
clinic, at the urging of the worker, but
failed to keep the appointment. Nothing was
heard from him until three months later when
he came to Red Cross. There was more dis-
cussion about jobs as he was having difficulty
with his boss. They talked about filing a
claim for pension, which gave the worker another
opportunity to discuss treatment. She interpreted
to him his experience with psychiatrists in the
Army hospitals, but found that he thought psychiatrists
found out "if you are crazy or not."

John agreed to contact the clinic, which he did
soon after this interview. His report to the
worker indicated that the insight she noted was
rather superficial as he inquired, as he asked
of her before, whether he would be given any
medicine. The worker made no further explana-
tion about psychiatric treatment. John discon-
tinued treatment and was not heard from again
until two months later when he approached the
worker about a new problem. He had married.
He said that his wife was five months pregnant
and that was why they got married. He complained
of feeling ill and said he did not think the
psychiatrist could help him. The worker commented
that she would not redirect him to the clinic until
he felt the need to go himself.

During the course of this worker's contact with John,
she had found him prone to deception and at each
opportunity brought it out in the open, apparently
accepting his need to lie.

In analyzing this case, it seems evident that the worker, while giving John
the opportunity to use his own initiative in contacting the clinic, had
urged him at every opportunity to make the appointment. His lack of
interest and insight is shown first by losing the card she gave him,
making an appointment and not keeping it, and finally, when the pressure
became too great, went to keep the peace, as it were. There are other
factors the writer would like to consider here. The worker's evaluation
of John's ability to move seems faulty. His job difficulties incline the writer to feel that he is rather unstable. Then, too, he came to the Red Cross for money, and might he not go to the clinic because it was one way to prove that he is sick and cannot work? It might well be that the worker, being white, represented a person of authority to John and he finally did what he was told although with somewhat of a struggle. The writer questions whether the veteran and the worker were not at cross purposes, as shown by his insistence on talking about his job situations and the worker emphasizing the need for treatment. It is doubtful that this veteran was capable of accepting help. A diagnosis earlier in the contact would have been helpful. This case is also one more illustration of the worker's own need, expressing itself in the use of pressure to get the client to a clinic.

It is always expedient to go at the client's pace. Often when the client balks at referral to a psychiatrist, it is wise to help him go to a medical clinic, if that is what he wishes. He can then be referred for psychiatric treatment. Two veterans in Group III were solely interested in such a referral. Both were referred for psychiatric treatment later through the medical clinic and were satisfied with the doctor's decision. The case of Frank T. is an illustration:

Frank T., 17 years old, was discharged from the Navy for enuresis after six weeks. A social history was obtained from his mother prior to his discharge. She was a woman of low intelligence, had had two illegitimate children, and Frank was the result of a forced marriage. He suffered considerable deprivation and had no use for his father who never lived with the mother after their marriage.
When Frank was discharged, the medical officer requested that the worker steer him to treatment as his condition was serious. When the worker called at the home, she was told that Frank did not need Red Cross services, as he had joined the Coast Guard. A month later Frank telephoned for an appointment. He had not joined the Coast Guard, but had left the state. He was terribly ashamed of his discharge and now wanted to see if he could get back into the service.

He wanted first to regain his health. In describing his symptoms he showed that he was definitely paranoid as he thought people were talking about him because he had a skin condition which involved his genitals. He was also aware that he was different from other boys. When asked about psychiatric treatment, he did not think he needed it although he was nervous on account of his skin condition and because everyone was talking about him. He had had enough of psychiatrists. All he wanted was to be cured of his skin condition. He also wanted a job as an orderly in a hospital so that he could have treatment there and earn money for his mother at the same time. He had been to the Massachusetts General Hospital skin clinic three months ago and the doctor said he was all right. The worker said she would try to help him get treatment at the Massachusetts General Hospital if he wished. This plan was agreeable to him.

Realizing that he was very ill, the worker suggested that she get in touch with his mother. He became alarmed at this as his mother had told him "not to go near the Red Cross." It was acceptable to him to have a letter sent him.

When contact was made with the hospital it was found that Frank was known to their psychiatry clinic, having been referred by the skin clinic, but he was free of symptoms when seen. However, in view of the observations made by the worker, arrangements were made for the hospital worker to write him since there might be some truth in Frank's statement of his mother's hostility to Red Cross.
Later developments revealed that Frank continued treatment, improved, and did well for four months on his job as an orderly in the hospital, but he became disturbed again. The hospital worker reported that he was very vague, confused, and his present diagnosis was ominous. He was thought to be schizoid. Treatments were continuing.

This is a case in which the worker followed through on the veteran's plan. It would have been futile to have urged psychiatric care as the veteran lacked insight, was extremely suspicious and fearful. The worker made good use of her knowledge concerning Frank's background when she withdrew the suggestion that she contact his mother.

Shame, guilt, and fear of disapproval on account of his discharge gave him the desire to seek treatment. He hoped to be able to enlist again. These feelings have been observed in a majority of cases in the first two groups in this study; in three cases, there was a definite request for treatment in terms of establishing eligibility for re-enlistment; in fact, one veteran previously mentioned in this study, Rocco U., discharged for enuresis after six weeks' service in the Navy, requested the draft board to induct him, and as late as March, 1946 he was reported to be in the U. S. Army of Occupation in Germany.

The case material already presented as illustrative of the techniques employed in Groups I and II indicates that the worker could not have taken into account the social factors which could have influenced the veteran in his negative reaction to accepting treatment. From the ten cases of Group I this was apparent in seven cases. Previous to discharge from service, the man or his family had been known to the agency with extensive contact in five of these cases. This would lead one to think that with
this knowledge the worker would make advantageous use of it, but this does not seem to have been the case. The story of Clifford S. is a case in point.

Clifford S., age 18, single, was discharged after two and a half months' service, with a diagnosis of congenital deformity and undescended testicle. His family had been known to the Red Cross for many years as his father was a veteran of both World Wars. The Red Cross was more recently interested in Clifford's unmarried sister who had an illegitimate child. There had been a great deal of friction in the home while Clifford was growing up. The parents had been separated for five years before Clifford came to the Red Cross in response to the worker's discharge follow-up letter, at the same time having been referred by another agency after he requested money for clothing from them. The worker had nine interviews before referral to a clinic was made. For a period of three months the worker helped him financially and assisted him in arranging for vocational guidance as he wanted training for a job. During this time he held several jobs which were of short duration. He either found them too difficult, thought the working conditions were too bad, or he complained that he was too sick to work. When he felt secure enough with the worker, he was able to tell her that he did not like the job. In the ninth interview, he expressed the opinion that he thought his stomach trouble was due to "nerves." The worker explained that there were doctors who treated such complaints. He responded to this by saying that he had had treatment by an Army psychiatrist and that he had been helped. He accepted referral without further discussion, but he did not keep his clinic appointment. The contact with the Red Cross was not broken off at this point; however, nothing more was done about treatment. When Clifford was seen several months later, the worker noted that he had deteriorated considerably since he was last seen.
In the worker's own evaluation of the case, she felt that referral for treatment had been made too soon. It is difficult to say how he felt about treatment since there had been no discussion about it. There had been no exploration of his feelings about his discharge. It is likely that he had some concern about his physical condition and the writer wonders if a great deal of his unrest, dissatisfaction on the various jobs he held were not in some way connected with his feelings of frustration at being different. The record does not disclose any of his feelings regarding the friction in the home or the separation of his parents. A sister, unmarried, with an illegitimate child in the home, and the attendant complications of such a situation could have had some effect upon him but this, too, had not been explored. The worker, up to the point of referral to clinic, seemed to move at the client's pace. She seemed understanding and accepting of his limitations, but had she expected too much from him when she made the referral? It would seem that with an immature, disturbed individual such as Clifford seems to have been, it might have been advisable for the worker to have continued her contact with him on the basis of a case work relationship.

In Group II there were four instances in which the worker failed to take into account the social background of the veteran. It has been noted that it is in this group that the veterans failed to continue treatment. The Edgar G. case is one in which this is illustrated. The worker had previous contact with Edgar's mother and a brother who was discharged from the service for a nervous disability, as Edgar was. His childhood was one of deprivation; he had a poor employment history and there was no stability in his home life. His father deserted and he was placed out. In spite
of this information, the worker urged Edgar to go for treatment in the first interview. The wiser course would have seemed to be to have established a relationship with him and to have measured Edgar's ability to make use of treatment before making any referral.

Group III, comprising the veterans who continued treatment, did not present the same problems as the other two groups. While eleven of the fourteen men were already known to the agency, it was not always necessary to fall back for guidance upon the material previously gathered about them. These men were ripe, as it were, for referral to a clinic. However, in the case of Frank T., previously cited on page fifty-three, the knowledge of Frank's background played a role in the worker's focus on the veteran's problem. In the Luigi C. case, the worker's previous contact with his sister, and her knowledge of his early life which she learned from the sister in obtaining a social history, helped make the one and only interview meaningful to worker and to the veteran. With Luigi C., the worker was able to point to the situations which had influenced the course of his life. For him it was a repetition of what he had heard from the psychiatrist while he was in an Army hospital. The Frank T. case contrasts with the one cited above in that Frank had no insight, while with Luigi, there was no difficulty on this score. Yet Frank was able to move toward treatment because he was accepted by the worker as he was and allowed to see his problem in his own way. As has been stated before, the reaction of the veteran to his discharge was one of mixed feelings. Shame, resentment, fear of stigma, embarrassment, played a part in the majority of cases of all the groups. How this affected the veteran's acceptance of referral to treatment is only shown in a few cases. One case is that of James H.,
in Group II, who received a bad conduct discharge from the Navy. He accepted psychiatric referral in order to clear himself of the stigma of the diagnosis of homosexuality. His purpose was to obtain a diagnosis from the psychiatrist invalidating that of the Navy medical board so that the type of his discharge could be reviewed and changed. Treatment was not continued after he obtained a statement from the psychiatrist.

Armand M., in Group III, was given a Section VIII discharge \(^{41}\) after six months' service. He felt that he was a slacker; he was fearful about what people would think about his not being in the Army. His Army discharge diagnosis was inability to adjust to Army life. He accepted referral to a psychiatry clinic in the hope that he would be able to reenlist. After his second clinic visit, he telephoned the worker and asked "Do you think I will get back into service?" Later he reported to the worker that the psychiatrist had said that he would "back him up" in getting back into the service. Although the doctor made no such promise, and Armand continued treatment until he was discharged from the clinic, he still hoped to get into service. It would seem that in this case, the need to prove that he did not differ from other people was the main factor in his acceptance of treatment.

The factors influencing the success and failure of referrals for psychiatric treatment are so interlocking that it is difficult to consider one without becoming involved in another. This seems to the writer to be particularly true in questions of relationship between worker and client, participation of the veteran in the treatment plan, and whether worker and

\(^{41}\) Section VIII discharge - a discharge without honor, commonly known as a "blue" discharge.
veteran were able to meet in a common plan. In the first group of ten veterans, where the pressure of the worker on the veteran to accept treatment seemed to be greatest, the veteran's focus differed from that of the worker in six cases. While it would seem that a relationship might have been established since the worker, in the majority of cases of all the groups, helped the veteran with his original request for service, the goal of the worker was obviously to have the veteran accept treatment which blocked her from identifying with the veteran's needs as he saw them. In all these instances the study shows that in arranging for the veteran's appointment, the worker took over that function which is rightfully his, that is, participating in the plan. In the two cases in Group I, while the veteran had no voice in stating his problem, (see page forty-one for case illustrations), it is evident to the writer that no relationship could have existed, the veteran seemed to have little opportunity to take part in the plan, nor could there have been any meeting on common ground.

In the two remaining cases in Group I where relationship was evident by the veteran's ability to express freely his feelings about his discharge and his illness, the failure might be attributed to the worker's inability to time her referral to treatment (an evidence of pressure), and the lack of focus on the problem which the veteran presented.

While a relationship seemed to exist at the beginning of the contact in six of the twelve cases in Group II, in two of these the veteran went to clinic because he thought the worker desired it. An example of this is in the John L. case cited on page fifty-one; it is seen that although the veteran returns to see the worker repeatedly, (a possible sign of a relationship) the veteran accepts referral because of the worker's interest
in the plan. The focus of the veteran is on the problem of a job as evidenced by his constant reference to this problem. In two other cases the veterans were unable to continue after the first visit to clinic out of fear of being hospitalized; in one, the veteran was so conflicted about his discharge and his marital situation that he had no energy to follow through with treatment; in the sixth case, that of James H., cited on page fifty-eight, the veteran discontinued treatment after he obtained the statement from the psychiatrist. The worker questions the depth of the relationship between worker and veteran since it did not help the veteran to continue with his treatment. Involved with this factor of relationship, the writer finds the lack of focus on the problem operated in three of these cases. Here, in these cases, as in the majority of cases in all groups, the veteran had no part in making an appointment with the clinic. In the remaining six cases of Group II the writer felt that little relationship existed prior to referral as the emphasis of the worker and client was at variance. Along with this observation, the writer saw that lack of insight on the part of the veteran was responsible in part for failure in three of these cases.

Group III, consisting of the fourteen cases which are considered by the writer to be successful, would seem to indicate, of course, a high degree of relationship between veteran and worker, convergence of focus, and participation of the veteran in the plan for referral. It is true that in all these cases, with the exception of two, the focus was on the one problem of treatment; however, none of these men actually made arrangements himself to go to clinic. The writer has questioned this procedure and wonders if these men would have reported to the clinic if the initiative
were left to them. The conjecture is that the majority of them would have done so because they were already oriented toward treatment, and had greater understanding of the meaning of their disability than the men in the other two groups. 

The high proportion (fifty per cent) of referrals by the medical officer for further treatment in Group III is an indication, too, to the writer, that in most instances these men were possibly more accepting of the medical officer's recommendation. The fact that only two veterans, one each in Group I and II, had such referrals made by the medical officer may be due to the fact that the men in both groups, with the exception of two, were considered by them to be inaccessible to treatment. This deduction is partially borne out by the unsuccessful results seen in the referrals to a psychiatric clinic in these two categories.
CHAPTER VII

SUMMARY AND CONCLUSIONS

This study has attempted to isolate some factors responsible for the success and failure of referrals of veterans for psychiatric help through the evaluations of records from the files of the Boston Chapter of the American Red Cross. The cases have been selected on the basis of the veteran's response to referral for treatment.

Background information was utilized to show the growth of awareness of the nation's concern for the mental health of the veteran with its slow, painful beginnings during and after the first World War and the more concerted efforts since the first psychiatric discharges of World War II began to be felt in the communities. It has been seen that in spite of these efforts, facilities for psychiatric treatment are still inadequate due, in part, to the shortage of adequately trained personnel.

Comparative statistical studies of both wars show a marked increase of mentally disabling disorders among servicemen of World War II with the percentage given as half of all the medical discharges. With many of these men returning to their communities, there will be increasing requests for service by them from social agencies. These agencies will have the major responsibility of helping the veterans adjust to civilian life.

In connection with service to veterans, the function of the American Red Cross in the first and second World Wars was described. Its present program of service is extensive, but the writer is mainly concerned with
counseling in personal problems as it pertains to psychiatric treatment, although recognition was given to the fact that the need for other services often played a part in the total problem of the veteran's adjustment in the community.

Thirty-six cases were selected for this study; their selection was based upon the following three classifications:

Group I is represented by ten veterans who accepted referral, but failed to go to clinic.

Group II consists of twelve veterans who withdrew from treatment after the initial clinic visit.

Group III comprised fourteen veterans who continued treatment for a period varying from two clinic visits to the length of time needed to complete treatment.

The statistical study revealed that approximately seventy-five per cent of these veterans had been known to the Red Cross before discharge from service. Their ages ranged from seventeen to thirty-nine years, with the largest group, representing fifty per cent, between the ages of twenty and thirty years. Approximately thirty-three per cent of the entire number studied were single. The length of service in the armed forces varied from six weeks to forty-six months, about fifty per cent serving a year or less. Only sixteen per cent served overseas. One veteran was discharged under the army point system, three were discharged for physical reasons, and thirty-two, approximately eighty-nine per cent, for a nervous disorder. Nine veterans, twenty-five per cent of the entire group studied, were recommended for further treatment by the medical officers of the military hospitals. Seven of these were successful
referrals for treatment.

In twenty-five cases the worker suggested psychiatric treatment while nine requested treatment themselves. In two cases the family asked for help with treatment. In all but one of the cases, the worker took steps to arrange for the clinic appointment. This in itself has serious implications from the viewpoint of referrals as it has long been established in case work practice that an individual is more likely to carry out a plan if he makes the plan himself. In viewing the total statistical picture, sixty-one per cent of all the cases, that is, those in Group I and Group II, are considered by the writer to be failures.

Preparation for referral in terms of number of interviews varied, with veterans in Group III requiring the least total number of interviews. Group I required thirty interviews for ten veterans, Group II, thirty-four for twelve veterans, and Group III, nineteen for fourteen veterans. In Group III were the largest number of veterans recommended for further treatment, the implication being that these men had already been oriented toward treatment and had some insight into the reasons for their emotional disturbance; therefore, most of them required little or no interpretation by the agency worker. Their need was seen to be mainly in the area of availability of treatment and referral to the appropriate clinic.

Two sets of factors, from the viewpoint of the veteran and the worker, operated in the success and failure of referrals. On the one hand, there is the influence of resistance to treatment by the veteran, his lack of insight as well as his fear of the stigma at being thought "crazy"; these militated against the acceptance of treatment. On the other hand, this very fear of being stigmatized also precipitated the veteran into treatment
in an endeavor to prove to himself that he was an adequate person. In this group were three veterans who accepted treatment in order to be able to reenlist, one of them succeeding by requesting the draft board to induct him although his discharge from the Navy specified that he was not recommended for reenlistment. The desire of the veteran to improve his health and insight was seen as the outstanding factor in the successes noted.

From the point of view of the worker, it is seen that she is strongly influenced by the recommendations of the medical officers as well as by the community interest in seeing these men referred for treatment immediately after discharge. The literature on veterans with psychiatric disabilities substantiates the writer's observation. In her zeal, the worker has, at times, lost her perspective as is seen in a failure to focus on the client's immediate situation which may not, of itself, have anything to do with treatment. This zeal also hampers the client as the worker is unable to allow him to move at his own pace. It was also seen from the evaluation of the interviews that where there was pressure from the worker, a relationship between client and worker was either non-existent or so frail that the referral was doomed to failure. In many instances it was observed that the worker's need to see the client move toward treatment prevented any participation of the veteran in the plan for treatment and often resulted in withdrawal. This was seen to be the case in Group I and Group II which the writer considers to be failures.

Where the veteran had insight, was already oriented toward treatment before coming to the Red Cross for service, success in terms of the continuity of treatment was observed. It was also seen that when the worker
was able to move with the veteran in a common plan, the referral was successful. Sensitivity to the nuances in relationships, understanding use of the available material about the veteran, simple explanation of the meaning of treatment, and beginning where the veteran is, namely, having the proper focus, were the essential factors in the successful cases.

The six case illustrations used in this study point up some of the many factors influencing the success and failure of referrals discussed above. Two cases from each group have been given to illustrate the techniques employed by the worker.

Letters to veterans were seen to be an important part of the case work plan. Illustrations of two letters, one formal and cold, and the other warm and personal, are given. Although the evidence from a study made at the Boston Red Cross points to the latter type as resulting in a better response from the veteran, this did not seem to hold true in the thirty-six cases under study here; the implication for the writer is that these veterans' needs were such that the letter in itself, whether poor or adequate, helped them to come to the Red Cross.

A review of the factors responsible for the success and failure of referrals for psychiatric treatment reveals that the referral is a process complicated by the fact that in the relationship of worker and client, there is an interplay of emotional reactions which make for the success or failure. The material seems to point to the fact that no one factor can actually be isolated as solely responsible for the outcome, but it has been seen that where pressure was used by the worker, the least positive results were obtained, that in the cases where pressure was employed, the objectivity of the worker could be questioned. The worker's need to see the
client move toward treatment can be said to be due not only to her own need, but also due, in part, to external influences, such as the recommendations of the medical officer and the general trend in literature on psychiatric disorders. The lack of focus seemed to go hand in hand with the worker's need to see the fulfillment of her plan for the veteran with little recognition of his objective. There seems to be an inclination to hurry the client into acceptance of treatment with little realization that an individual must travel at his own pace. In some instances the lack of diagnostic skill of the worker led to failure, where, in spite of a good relationship, the worker was unable to gauge the veteran's potentialities.

According to this study, half of the successful referrals came from the group of veterans already oriented toward treatment before coming for service to the Red Cross. This is important as it indicates that this is one of the areas in which workers need help.

From the above evaluation, the writer arrives then at the conclusion that a productive relationship can exist if the worker is aware of her own motivations and does not permit them to enter into the case work situation. In this connection, she must be alert to the signs of overzealousness for the client's welfare lest it destroy her objectivity so necessary in the treatment. The study seems to point to the need of more adequately trained personnel. One of the greatest weaknesses seems to be in interviewing which is of tremendous importance, since speech is the vehicle through which two individuals communicate with and understand each other.

Approved,

Richard K. Conant, Dean
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