1953

A study of twenty-two initial interviews with peptic ulcer patients.

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Boston University
A STUDY OF TWENTY-TWO INITIAL INTERVIEWS
WITH PEPTIC ULCER PATIENTS

A Thesis

Submitted by
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(A.B., Pembroke College, 1937)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1953
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>List of Tables</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Purpose and Scope</td>
<td></td>
</tr>
<tr>
<td>Sources of Data</td>
<td></td>
</tr>
<tr>
<td>Limitations of Study</td>
<td></td>
</tr>
<tr>
<td>Method of Procedure</td>
<td></td>
</tr>
<tr>
<td>II. The Setting</td>
<td>6</td>
</tr>
<tr>
<td>III. Survey of Literature</td>
<td>11</td>
</tr>
<tr>
<td>The Illness</td>
<td></td>
</tr>
<tr>
<td>The Role of the Social Worker</td>
<td></td>
</tr>
<tr>
<td>The Initial Interview and</td>
<td></td>
</tr>
<tr>
<td>Brief Contact Cases</td>
<td></td>
</tr>
<tr>
<td>IV. Presentation of Factual Data</td>
<td>21</td>
</tr>
<tr>
<td>V. Case Presentations</td>
<td>42</td>
</tr>
<tr>
<td>VI. Summary, Conclusions and Recommendations</td>
<td>64</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>74</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>76</td>
</tr>
<tr>
<td>A. Schedule</td>
<td>77</td>
</tr>
<tr>
<td>TABLE</td>
<td>PAGE</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>I.</td>
<td>21</td>
</tr>
<tr>
<td>II.</td>
<td>22</td>
</tr>
<tr>
<td>III.</td>
<td>23</td>
</tr>
<tr>
<td>IV.</td>
<td>25</td>
</tr>
<tr>
<td>V.</td>
<td>26</td>
</tr>
<tr>
<td>VI.</td>
<td>28</td>
</tr>
<tr>
<td>VII.</td>
<td>29</td>
</tr>
<tr>
<td>VIII.</td>
<td>30</td>
</tr>
<tr>
<td>IX.</td>
<td>31</td>
</tr>
<tr>
<td>X.</td>
<td>33</td>
</tr>
<tr>
<td>XI.</td>
<td>34</td>
</tr>
<tr>
<td>XII.</td>
<td>35</td>
</tr>
<tr>
<td>XIII.</td>
<td>36</td>
</tr>
<tr>
<td>XIV.</td>
<td>37</td>
</tr>
<tr>
<td>XV.</td>
<td>38</td>
</tr>
<tr>
<td>XVI.</td>
<td>39</td>
</tr>
</tbody>
</table>

**LIST OF TABLES**

**Statistical Data on Hospital Admissions**
from January 1, 1952, through December 31, 1952

**Ages of Patients Studied**

**Marital Status of Patients Studied**

**Education of Group Studied**

**Number of Siblings in Patients' Families**

**Present Economic Status**

**Occupations of Group Studied**

**Recreational Outlets**

**Length of Service**

**Length of Hospital Stay**

**Length of Time between Admission and Referral to Social Service**

**Accompanying Diagnoses**

**Reasons for Referral**

**Problems Seen in Ten Social Service Initiated Contacts**

**Causative Factors in Illness as Seen by Patient**

**Services Rendered by the Social Worker**
CHAPTER I
INTRODUCTION

Social work within a hospital setting is influenced by a multiplicity of factors which must be understood by the social worker, and accepted, if its practice is to be effective. Medical social work is unique in that it is practiced in a multi-disciplined setting with certain elements of authority inherent in the medical profession. In addition, the referral process is unusual in that it frequently does not start with a recognition of some need for service on the part of the patient. The doctor may request social service participation in treatment, often without preliminary discussion with the patient. Social service coverage may be extended to certain groups of patients, such as the terminally or the chronically ill.

Another important factor in the practice of medical social work is the tempo of the hospital, which necessitates quick handling by the social worker of a variety of social problems associated with illness, with all its implications for the patient. The medical social worker, therefore, in addition to being equipped with generic case work knowledge and skills, must be familiar with medical, psychosomatic and psychiatric concepts, and must be particularly adept at dealing with brief contact cases.
It is felt that the study of a group of peptic ulcer patients would be of value, in view of the enormous social implications of an illness which, according to estimates, affects about ten per cent of the adult population in this country. At the same time this group would afford an opportunity to study the contribution of the social worker in brief contact cases, which form a large portion of the medical social worker's case load and which may be a means of reaching out to larger numbers on a preventive rather than a curative level.

PURPOSE AND SCOPE

The purpose of this thesis is to examine twenty-two initial interviews with patients admitted to the medical service of the Veterans Administration Hospital at Providence, Rhode Island, with a diagnosis of peptic ulcer, with the aim of studying the nature of the social service contact and the way in which the social worker may utilize her skills to make a contribution to a total treatment program, despite the limitations of time and setting. In all but six cases the initial interview constituted the entire social service contact, and in no case did the contact extend beyond three interviews.

The specific questions which are posed for the purposes of this study are the following: What is the medical social
worker's approach and focus in the initial interview? What social work skills and techniques are utilized in the initial interview?

**SOURCES OF DATA**

The cases included in this thesis were selected from the social service files at the Providence Veterans' Hospital. The social service file cards were perused to obtain the names of all World War II and Korean veterans who had been admitted during 1952 with a diagnosis of peptic ulcer, designated on the cards as either gastric or duodenal, and who had been known to social service. The complete social service records were then examined and those in which the contact was sufficiently limited for the purposes of this study were reviewed. The final selection of cases was made on the basis of availability of recorded material in the folders.

The medical records of these patients were then reviewed to abstract additional information required for this study. These records contain medical history and running notes by doctors and nurses. Usually valuable personal and social information can be obtained from careful study of these records which are readily accessible to the medical social worker before interviewing each patient. A schedule was then compiled and completed on each case which was to be studied.
The statistical data on the number of hospital admissions of all kinds during the year 1952 and the number of patients admitted for treatment of peptic ulcer during the same period were obtained from the files of the registrar's office at the hospital.

LIMITATIONS OF THE STUDY

Because of the small number of cases included in this study, no valid statistical conclusions can be made. It is also recognized that to establish any conclusions reached by this study, follow-up contacts would be desirable, but for obvious reasons were not possible. Selection of cases was limited to patients between the ages of twenty and forty, as it was felt that a study of this age group would make the greatest contribution in terms of future treatment and prevention of illness.

METHOD OF PROCEDURE

Some background information regarding the Veterans Administration social service program is reviewed in Chapter II, together with a description of the social service department at the hospital where the study was made. A review of some of the pertinent literature is presented in Chapter III. This includes, briefly, medical facts, psychosomatic concepts about the specific illness, the functions of the medical social worker as part of a total
treatment program, and social treatment in initial interviews and brief contact cases.

The main body of the thesis is presented in two sections. Chapter IV gives factual data on the total group of twenty-two patients. The factual data serve to give an over-all picture of the kinds of persons involved in treatment, the problems presented, and services rendered by the social worker. Chapter V includes a presentation of six summarized, disguised cases with discussions. (The cases in this study are classified in three groups on the basis of source of referral, namely social service initiated, self-referrals and doctor referrals.) The final chapter contains a summary and conclusions based on the findings of this study.
CHAPTER II
THE SETTING

Veterans Administration hospitals are an important part of present day medical care programs. Veterans Administration today is the result of the consolidation on July 21, 1930, of three federal agencies serving veterans, namely United States Veterans Bureau, Bureau of Pensions, and National Home for Disabled Volunteer Soldiers. The Administrator of Veterans Affairs, appointed by the President of the United States, is responsible for administering all special laws enacted by Congress for the benefit of former members of the military and naval forces. In general, veterans of all wars in which the United States has been actively engaged who were discharged under conditions other than dishonorable are eligible for admission to Veterans Administration Hospitals. Those requiring treatment for service-connected disabilities are given preference. Others are eligible if they state their inability to pay for hospital care.

The construction of the Veterans Administration Hospital at Davis Park, Providence, Rhode Island, was completed in June, 1949. This modern, double-Y shaped structure, servicing 393 beds, provides much needed hospital facilities for veterans of World War I, World War II, the Spanish-American
War, and more recently the Korean Conflict. Patients come from Rhode Island and certain cities and towns in neighboring Massachusetts. This federal tax-supported hospital is staffed by civil service employees and maintains specific standards, in order to provide the best possible care to eligible veterans.

The hospital is classified as a general hospital for the care of the acutely ill, with the exception of a limited number of tuberculosis patients who come within the classification of the chronically ill. The usual procedure for admission is through application to the medical division of the Providence Regional Office of the Veterans Administration, where examining physicians determine the need for hospitalization. Main services at the hospital include medical, surgical, neuropsychiatric, and physical medicine which includes rehabilitation services. Functioning in the treatment of the veteran-patient are Nursing, Dietetic and Social Service Departments. Each department is responsible to a Chief of Professional Services and finally to a Hospital Manager.

There are several active programs, including weekly clinics and classes for diabetics, attended by ambulant patients, nurses, dietician and social worker. A weekly seminar, conducted by a visiting psychiatrist, is held for hospital personnel, including psychiatrists, nurses, social
workers, attendants, psychologist and electroencephalogram technician. Two weekly tuberculosis board meetings are held, one stressing medical therapy, the other the team approach (doctor, nurse, social worker, attendants, physical and occupational therapists and rehabilitation counsellor.)

Social Service at Davis Park Hospital was activated in November, 1949, in accordance with specific rules and regulations applicable to all other departments of Veterans Administration Social Service. The services of its workers are available to all hospital in-patients.

Veterans Administration has established social service functions in recognition that effective medical care includes treatment of the social factors involved in illness and disease. . . . The purpose of social service is to enable the veteran to cope with those factors and interrelationships which are destructive and develop those which will be constructive in his effort to recover from illness, lessen handicap, adjust to remaining disability and reestablish himself.¹

Present staff at Davis Park consists of a Chief Social Worker, three social workers, and two student workers. Referrals come from doctors, nurses, dieticians, relatives or interested friends, the patient himself or other agencies. Any social study or treatment is undertaken in close collaboration with the physician responsible for treatment of the veteran to insure that it constitutes an integral part of the physician's over-all plan for the patient. The

physician is constantly in control of social work activities relative to the patient. It is the function of social service to facilitate medical treatment by helping the patient with personal and social problems which may prevent his maximum recovery. This is accomplished both by working directly with the patient and often with his family, and also by furnishing the physician with data concerning the patient's history which will be of significance to him in diagnosis and treatment.

Patients selected routinely for social study as most likely to present acute social problems retarding response to medical treatment will include the following groups in their respective order - reception service, neuropsychiatric, tuberculosis, venereal disease, cardiac, gastric ulcer, diabetes, surgical, malaria, anemia.2

As yet routine coverage is not extended to ulcer patients at Davis Park Hospital, but it is the hope of this writer that this study may stimulate further thinking regarding the total needs of this group of patients and what can be done within the hospital setting to make treatment more effective. Routine coverage was tried on an experimental basis for a six-week period during 1952, but was abandoned mainly because of inadequate size of staff.

The social service staff holds weekly meetings at which a certain amount of time is devoted to administrative detail, and the remainder to discussion of case work procedures and

2. Veterans Administration Manual ML0-6, June 1,1947. Chapter VI. Social Service Procedures, Section 1.
current social work publications.

The department was instrumental in setting up a vocational counselling service in collaboration with the Department of Employment Security, whereby a counsellor is available one day a week to interview patients.

In addition to rendering services upon referral, the department arranges to interview all diabetic patients as soon as possible after admission and makes services available to them throughout their hospitalization on a team-work basis. An attempt is made also to interview all patients on the neuropsychiatric ward for purposes of a social study. All patients hospitalized over ninety days are seen for social study and evaluation.
CHAPTER III
SURVEY OF LITERATURE

The Illness. A peptic ulcer is an excavation formed in the mucosal wall of the stomach, in the pylorus or the duodenum, and is due to the erosion of a circumscribed area of its mucous membrane. Its etiology is poorly understood. It occurs with greatest frequency between the ages of twenty and forty. Its exact incidence in man is unknown, but it is estimated on the basis of autopsy statistics that approximately ten per cent of all persons suffer at some time in their lives from a chronic gastric or duodenal ulcer. Pain and vomiting are the outstanding symptoms. The four characteristic features of the ulcer pain are its chronicity, its periodicity, its quality and its relationship to food taking. Sudden hematemesis is a not uncommon complication of peptic ulcer. A large amount of blood, even two or three quarts, may be lost. The patient may become exsanguinated, and rapid blood replacement may be required to save his life. Perforation may likewise occur unexpectedly without previous indigestion, in which case immediate surgical intervention is indicated to close the perforation as quickly as possible. Recovery is the rule, but death may occur at any time, usually two to five days after onset of symptoms, and results either from exsanguination or from
intercurrent complications, such as pneumonia and perforation.

Acute peptic ulcer is treated most effectively by putting the patient at strict bed rest, sedating him comfortably, and neutralizing the gastric juice at frequent and regular intervals with milk drinks and alkaline powders.

It is a well-known fact that many patients with acute ulcer symptoms, due to proved ulcer, derive complete temporary relief from nothing more than severance of all connections with environmental anxiety-producing factors - unfavorable diet and hygienic conditions notwithstanding. Such a solution is rarely practicable, however, for environments, particularly internal emotional environments, are not easily shed. Ulcers are prone to recur, despite medical and surgical measures, if the patient must return to the same environment to face the same problems which earlier played a contributory role in their production.

It is thus apparent that, whereas peptic ulcer, the disease, can be discussed from purely medical and physical aspects, peptic ulcer, the illness, involves much more than physiological changes demonstrable by X-ray. The illness results from disturbed bodily function, and its character, duration and severity are dependent not alone upon the physical causes of these disturbances, but also upon the characteristics of the patient as an individual and upon the life situation. This concept of the illness is of particular concern to the social worker, but should be understood by all who are charged in any way with the care of the sick person.

Much has been written about peptic ulcer as a psychosomatic illness. It is more or less widely accepted that emotional and environmental factors play an important role in the pathogenesis of the disease, although constitutional and hereditary factors, particularly as related to choice of organ involved, are given varying degrees of significance. One study concludes that the role of emotional factors in peptic ulcer remains a moot question, although there can be no doubt that emotional disturbances aggravate existing lesions and there is good reason to believe that emotional strain may reactivate quiescent lesions. According to this same study, peptic ulcers occur in individuals whose make-up may be characterized by rigidity, over-conscientiousness, and even intolerance, in individuals who are overly honest and meticulous, usually dynamic and often aggressive.²

Statistical studies have shown that certain occupations which involve a great deal of mental stress and tension predispose to the development of peptic ulcers.

There is much to suggest that the increase in duodenal ulcers may be due to the increase in the stresses and strains of modern life. Of course constitutional factors are largely responsible for the equanimity or excitement with which we respond to a potential stressor. The personality features and emotional reactions of patients with peptic ulcer, gastritis

or duodenitis have been carefully analyzed from the psychiatric point of view and there remains no doubt that in the vast majority of the cases these can be regarded as psychosomatic disorders.

Statistical studies have shown, furthermore, that during times of war—presumably as a result of psychic strain—the incidence of peptic ulcer increases in various countries. Of course, the personnel of the armed forces, being exposed to particularly severe nervous strain, is even more subject to peptic ulcer in war time.³

Dunbar, who has written extensively on psychosomatic medicine, refers to four steps which go into the making of an ulcer. First, an unusually large number of impulses, caused by emotional disturbances, are transmitted to the nerve fibres running through the mid-brain to the intestinal tract. Second, these impulses are passed along to the stomach and the intestines where they affect the production of hydrochloric acid. Harm results when it is produced in larger quantities than necessary for digestion. The immediate result is hunger pangs. Third, tension develops in the smooth muscles and their contraction and relaxation is disturbed, interfering with the normal rhythm of the muscles which govern the traffic between mouth and stomach. Vomiting may ensue and food which is kept in the stomach instead of being passed along in the normal course of digestion also irritates the lining. Fourth, the victim may then eat something irritating to the mucous membrane lining the stomach or

³ Hans Selye, M. D., Ph. D., D. Sc., F. R. S., Stress, p. 703.
intestines. The hydrochloric acid and muscle tension combine to aggravate the slightest blemish on the wall of the digestive tract. The sore becomes noticeable, painful and infected, and can be seen by X-ray on the stomach wall, which is an ulcer. 4

Alexander is inclined to assume that in certain personality types gastric symptoms, even peptic ulcers, may more frequently develop than in others, but he finds characteristic not so much a certain personality type as a typical conflict situation which may develop in very different personalities. This conflict is between repressed receptive infantile wishes and the claims of a masculine ego - a protest between the wish to be loved and the wish to appear self-sufficient and independent. 5

Karl Menninger has the following to say about the peptic ulcer personality:

One can see . . . that it is as though such persons were obliged (as we all are) to love and be loved in order to live, but were unable to do this in a normal manner. Instead they regress, upon the occasion of some degree of thwarting to primitive, infantile (therefore "perverse") modes which entail a mixture of this substituted erotic quality, and of the rage and resentment (that is,


aggressiveness) which the thwarting and disappointment engenders. This aggressiveness, in turn, comes under the disapproval of the conscience and a punishment is demanded. All of these things—the oral craving (and the mediate and immediate "love" it obtains), the aggressiveness (both the original impulse and the aggressive uses of the illness) and the self-punishment are neatly gratified—"solved"—by the development of the stomach ulcer.  

The Role of the Medical Social Worker. The social case worker is a specialist who is trained to study, diagnose and treat social problems. All social workers are concerned with the problems of individuals and of society, but one group is especially equipped to deal with those problems related to illness. This is the field of medical social work. The medical social worker is a member of the professional medical team concerned with the welfare of the patient. She increases the effectiveness of care by helping the patient to make his own best adjustment to illness and by helping him to solve those social difficulties which may be factors in causing the illness or interfering with treatment. Although for each patient the social factors which affect the meaning of illness and the social problems related to illness are unique and must be studied individually, there are factors and problems which rather commonly are found among patients who have certain illnesses or are in certain social groups.

Improvements in the patient's general life adjustment and in his capacity to manage his problems not only enable him to adapt himself to the demands of treatment, but may actually reduce illness. "The patient who has gastric ulcer often profits more by case work designed to meet his underlying need for emotional dependency than by instructions about diet." 7 Often the patient's illness may constitute his way of meeting his life problems. It becomes important to evaluate the personal factors in illness. The individual's family and social relationships, deprivations, reality pressures, and social milieu may all give rise to emotional conflict which he may attempt to meet through illness. This approach to illness leads to an evaluation of both the emotional and physical factors present in any given illness.

"Most commonly in medical social work . . . we find emotional, intellectual and environmental factors rather evenly intermingled in a case." 8 The help offered by the medical social worker may prove more effective if it is focused on working out some of the patient's feelings around the medical problem, thus making progress that may indirectly


affect the deeper problem. The medical social worker is in a strategic position to assist the physician in sifting out early cases where emotional factors seem to play an especially large role.

The medical social worker must be clear as to her appropriate scope and focus . . . She is likely to find that much of her opportunity will lie in understanding the emotional needs in the day by day run of cases . . . We are now able to demonstrate rather impressively, I think, the far greater value of such service when psychologically oriented.9

The Initial Interview and Brief Contact Cases. During the initial interview it is important first to get into rapport with the patient's affect. This is accomplished by meeting him on his own ground and at his own level. Second, the worker must maintain an intellectually alert and active attitude, and be oriented to getting a factual picture. This will point up discrepancies in the material and will also define attitudes in conflict areas. An integration of the above will make it possible to get into rapport with the patient's affect, which is usually the keynote to good interviewing. Third, the worker must make use of this definition of the patient's situation to make a formulation of the presenting problem as soon as possible.10

9. Ibid.

10. Alice L. Voiland, Martha Lou Gundelach, Mildred Corner, Developing Insight in Initial Interviews.
In the medical setting, often the entire contact with a patient is limited to one, perhaps two or three interviews, making it necessary for the worker to operate within limited goals. A rapid diagnosis and evaluation must be made, and the worker must be equipped with a sound body of knowledge about human behaviour and illness, in order to make each contact as therapeutically effective as possible. In each situation, the worker attempts, within the framework of designated limits, to render some service directed toward helping each patient develop a degree of implementation with which to adapt more adequately to his life situation.

In a recent article on some implications of short term therapy, it was found that, despite the difficulty of establishing an emotional, meaningful relationship in one interview, the eliciting of history material with therapeutic emphasis, together with the focusing on dynamic factors which seem to underlie expressed needs, seemed to help clients to come to terms, to some extent, with an impasse and to grow constructively beyond it. It was suggested that there is dynamic value inherent in urgency and its concomitant of pressure both for the client and the therapist. Urgency might be a propelling force for both individuals toward action. The client might use urgency to come to grips more readily with his difficulty and to be motivated more quickly toward change. Pressure on the therapist might serve not only as a
prod toward action, but to sharpen diagnostic judgment and heighten therapeutic skills. It was concluded that short term therapy can offer specific gains to clients, that it requires reorientation, flexibility and discipline on the part of the therapist, that it seems to meet the requests for service by the majority who solicit help, and that it may contain some therapeutic potentialities for a large segment of the population.

CHAPTER IV
PRESENTATION OF FACTUAL DATA

The factual data presented on the twenty-two cases under study were gathered from the social service records and the medical records. All of the patients were male, white World War II or Korean veterans treated on the medical ward of a Veterans Administration General Hospital for peptic ulcer.

TABLE I

Statistical Data on Hospital Admissions
From January 1, 1952, Through December 31, 1952

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admissions</td>
<td>3,756</td>
</tr>
<tr>
<td>Total Admissions with diagnosis of Peptic Ulcer</td>
<td>343</td>
</tr>
<tr>
<td>Total Number of Ulcer Patients Known to Social Service</td>
<td>51</td>
</tr>
</tbody>
</table>

It has been stated that peptic ulcer patients comprise about ten per cent of total adult admissions to medical and surgical hospitals today.1 During the period January 1, 1952, to December 31, 1952, 343, or approximately eleven per cent.

of admissions, both medical and surgical, fell into this category at the hospital where this study was made. Fifty-one, or 6.72 per cent of ulcer patients during this period were known to social service, indicating that social service coverage under present system of referrals extends to only a small percentage, despite the evidence that most of these patients might benefit from some help to relieve either internal or external stresses. It should be added that approximately one third of these contacts were initiated during a six-week period of one hundred per cent social service coverage of ulcer patients.

TABLE II

<table>
<thead>
<tr>
<th>Ages of Patients Studied</th>
<th>Number</th>
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<tbody>
<tr>
<td>Years</td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>2</td>
</tr>
<tr>
<td>26-30</td>
<td>7</td>
</tr>
<tr>
<td>31-35</td>
<td>6</td>
</tr>
<tr>
<td>36-40</td>
<td>6</td>
</tr>
<tr>
<td>Over 40</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

Nineteen of the patients studied, or 86.3 per cent, were between the ages of twenty-six and forty. The youngest was twenty-three, the oldest, forty-one. The factor of age was not of significance, as only World War II and Korean
veterans were selected for study, so that they would be expected to fall within this particular age group. Review of literature regarding peptic ulcer does indicate, however, that the illness occurs most frequently between the ages of twenty and forty.²

### TABLE III

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
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<tbody>
<tr>
<td>Married</td>
<td>14</td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Of the total group, fourteen, or 63.6 per cent, were married. In the interviews with these patients, six openly discussed marital friction and maladjustment, five did not discuss their wives or marriage, although there seemed to be opportunity to do so, and three referred to themselves as happily married. Of the latter three, one said his wife waited on him "like a king," another praised the meals his wife prepared for him, and another attributed to his wife

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² Emerson and Taylor, *op. cit.*, p. 316.
qualities of a good mother and homemaker. The divorced patient said his troubles began after the birth of their child, when they began to quarrel over everything. Of the six unmarried patients, only one, the twenty-three year old who lived with his parents, had a girl friend and planned to marry her when financially secure. Another, aged twenty-eight, also residing with his parents, thought he might consider settling down to marry the girl he sometimes dated, now that he was on a special diet. Three were living with their aged mothers and had no girl friends. Another lived with both parents. Two never had time to think about marriage. One had had only one girl friend in his life, who had left him to marry another, and he still experienced "butterflies in his stomach" when he saw her.

Of the fourteen married patients, records did not reveal any previous marriages. Five of these patients had three children, two had four children and three had five children. Two had two children and one had an only child. One had no children. The divorced patient had one child living with the mother, and the separated patient had no children.
TABLE IV

<table>
<thead>
<tr>
<th>Grade Completed</th>
<th>Number</th>
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<tbody>
<tr>
<td>Grades 4-6</td>
<td>2</td>
</tr>
<tr>
<td>Grades 7-9</td>
<td>12</td>
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<tr>
<td>Grades 10-12</td>
<td>5</td>
</tr>
<tr>
<td>More than Grade 12</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Twelve of this group, or 54.4 per cent, left school between grades seven and nine. Five, or 22.7 per cent, left school between grades ten and twelve. Only two had less than seven years of formal education. One patient completed two years at business college, another spent three years in a religious seminary, and another two and a half years in a teacher's college. The seminary student left when the person whom he sought to please by his studies died and he no longer felt obliged to continue. The teacher's college student left because he could not stand the stress of practice teaching.

No significance can be attached to the fact that more than half of the group left school in grades seven to nine, as economic and cultural factors, in addition to the World War II draft, might have been causative.
In those interviews which contain sufficient information to determine attitudes toward school, there was a variety of reactions to the learning situation. It is to be noted, however, that the predominant attitudes were "eager to learn," an attitude expressed by five patients, and indifferent or disinterested, an attitude expressed by ten patients. Two patients openly stated they disliked school, while two implied that they were unable to learn because of limited intellectual capacities and had completed the equivalent of the fourth and fifth grades in a special class.

**TABLE V**

<table>
<thead>
<tr>
<th>Number of Siblings</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>5</td>
</tr>
<tr>
<td>4-6</td>
<td>11</td>
</tr>
<tr>
<td>7-9</td>
<td>4</td>
</tr>
<tr>
<td>10 or over</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Fifty per cent of the group were one of from four to six siblings. One came from a family of twelve siblings, one from a family of thirteen.

In seventeen cases there is definite evidence in the records of difficult or deprived childhoods, either because of early death of one or both parents, large families with
insufficient income, or poor marital adjustment of the parents.

PARENTAL PERSONALITIES AND RELATIONSHIPS

The early childhood relationship with parents has particular significance for the social worker in understanding individual personality development, in addition to its prognostic value in terms of probable worker-patient relationship. The interviews were studied to determine if it was possible to define these relationships from the content.

In analyzing the interviews, it was found that eleven mothers (fifty per cent) might be classified as domineering, seven as over-protective, three as rejecting. It was not possible to define the relationship in one case. Among the fathers, eleven might be classified as passive, ineffectual figures, four were referred to as alcoholic, three died early in the patient's childhood, two were described as domineering, and no mention of this factor was found in two cases.

In no instance did any positive discussion of the father come out in the interviews. Three fathers were frequently away from home on business during the patient's early years. One alcoholic father had deserted the family during the patient's childhood, and this patient spoke of always having been close with his mother, and was very upset over a recent quarrel with her. One patient spoke at length of being hurt
because his mother favored an older brother. Although the father in this same case was in a tuberculosis sanatorium, there was only a passing reference to him. This was clearly the pattern in the majority of the interviews - brief references to the father and evidence of strong emotional involvement with the mother, although there was equal opportunity to talk about either parent. Three patients called themselves "mama's boy." Three spoke of being looked after by their mothers. Another was overly upset because his mother was too old to travel the necessary distance to visit him at the hospital.

TABLE VI

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than marginal income</td>
<td>6</td>
</tr>
<tr>
<td>Marginal income</td>
<td>9</td>
</tr>
<tr>
<td>Moderate income</td>
<td>6</td>
</tr>
<tr>
<td>Greater than moderate income</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Nine of the group, or 40.9 per cent, were considered to be of marginal income and 27.3 per cent each of moderate or less than marginal income. Only one of the group had a better than moderate income. These classifications were set up arbitrarily on the basis of the writer's judgment.
from the total financial and social picture in each record, rather than on the basis of any standardized norms. No conclusion can be drawn regarding the incidence of ulcer cases among particular economic groups, partly because veterans with non-service-connected disabilities, which is the status of eight of these patients, are eligible for hospitalization in a Veterans Administration facility only if they are unable to pay for such care elsewhere. It is true, however, that the majority of these veterans were living under probable financial stress.

**TABLE VII**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled</td>
<td>6</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>6</td>
</tr>
<tr>
<td>Unskilled</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Ten of the patients, or 45.5 per cent, were unskilled workers. This included six factory or mill workers, three restaurant workers and one construction laborer. Of the remainder, an equal number were skilled and semi-skilled. Semi-skilled included four mill or factory workers, one truck driver and one self-employed person. Skilled workers
included three white collar workers, two interior decorators and one musician.

This study group is not large enough to permit any correlation between kinds of jobs and the incidence of ulcer symptoms. Studies have been done which would indicate that cases of ulcer are more prevalent among those engaged in certain occupations. It has been concluded in general that there is a definite correlation between "anxiety at work" and the frequency of ulcers. In this group of twenty-two patients all except three brought out discontent over employment in one way or another. Two felt their jobs were beneath their abilities, seven had never had a satisfying job experience, one considered himself underpaid and disliked his boss, three disliked taking customers' complaints, three had left jobs for higher-paying positions, two were experiencing anxiety and tension because of recent job changes, and one would do anything to make "big money."

**TABLE VIII**

<table>
<thead>
<tr>
<th>Recreational Outlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many recreational activities</td>
</tr>
<tr>
<td>Limited recreational activities</td>
</tr>
<tr>
<td>No recreational activities</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Two patients of this group were of the aggressive, "go-getter" type and boasted of having travelled, participated in sports and of having many friends. Half of the group said they had no time or money for play or that they were "stay at home" and that their lives were humdrum. The remainder, forty-one per cent of the group, spoke of having enjoyed occasional card games, watching T. V., or hanging around a few hours in neighborhood clubs, having a few beers with the boys. One had a woodworking hobby shop to which he retired whenever tense or nervous. He was unemployable because of a diagnosis of schizophrenic reaction.

There was a notable lack of satisfying or healthy outlets in all but two instances. It is possible, in the two cases where there were many recreational outlets, that these individuals may have been using them to compensate for basic feelings of inadequacy or insecurity.

### TABLE IX

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months or less</td>
<td>1</td>
</tr>
<tr>
<td>7-12</td>
<td>0</td>
</tr>
<tr>
<td>13-18</td>
<td>2</td>
</tr>
<tr>
<td>19-24</td>
<td>3</td>
</tr>
<tr>
<td>25-30</td>
<td>3</td>
</tr>
<tr>
<td>31-36</td>
<td>8</td>
</tr>
<tr>
<td>37-42</td>
<td>1</td>
</tr>
<tr>
<td>43 and over</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>
Nineteen, or 36.4 per cent, of the group studied spent nineteen months or over in service during war-time. All except two served overseas. Thirteen of the group saw considerable active combat, one as a paratrooper, five on navy ships, the remainder with the ground forces. Five of the entire groups referred to feeling "fearful" in service, three were "happy" in service, five spoke of being "resigned" to the situation, two spoke of enjoying recognition through promotions in service, one had fun and drank heavily when he hit port, two were "inwardly resentful" throughout service, two felt "nervous" all the time. In two cases it was not possible to determine adjustment in service.

Eleven of the group related the onset of stomach symptoms to their periods of service, three shortly after discharge, and in eight cases, symptoms first appeared within more recent periods. Four of the group had been rated service-connected for ulcers, one for schizophrenic reaction, one for psychoneurosis and back sprain, one for hysterical type, manifested by conversion symptoms and one for psychotic or schizoid episode. Two had filed claims for service-connection while in the hospital.
TABLE X
Length of Hospital Stay

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-20</td>
<td>11</td>
</tr>
<tr>
<td>21-30</td>
<td>5</td>
</tr>
<tr>
<td>31-40</td>
<td>1</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
</tr>
<tr>
<td>51 and over</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

Eleven patients, or fifty per cent, were hospitalized between ten and twenty days. All of these patients received medical treatment for ulcers only. Of the five who remained twenty-one to thirty days, two were transferred from the medical to the neuropsychiatric service prior to discharge and the others were under observation or received treatment for another condition. One patient who was hospitalized forty days was also transferred to the neuropsychiatric service. Of the two hospitalized forty-one to fifty days, one underwent surgery, the other was treated for anemia. One patient hospitalized from fifty-four days was treated for arthritis and transferred to the neuropsychiatric service. One remained seventy-four days because of an attack of pleurisy, and the patient hospitalized longest (eighty-six days) was treated for Laennic’s cirrhosis.
TABLE XI

<table>
<thead>
<tr>
<th>Length of Time between Admission and Referral to Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Days</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>1-5</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>11-15</td>
</tr>
<tr>
<td>16-20</td>
</tr>
<tr>
<td>Over 21 days</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

There was no indication that social service initiated referrals resulted in earlier contacts with patients. The two patients whose hospital stay exceeded twenty-one days had been hospitalized forty-nine and sixty-three days respectively before referral and both were discharged a few days later. Reasons for these two referrals were given as help with environmental factors and help toward better adjustment in the community.
TABLE XII

Accompanying Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>1</td>
</tr>
<tr>
<td>Laennic's cirrhosis</td>
<td>1</td>
</tr>
<tr>
<td>Hysterical type with conversion symptoms</td>
<td>1</td>
</tr>
<tr>
<td>Schizophrenic reaction</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety state</td>
<td>4</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>4</td>
</tr>
<tr>
<td>Back sprain (chronic)</td>
<td>1</td>
</tr>
<tr>
<td>Gastritis</td>
<td>2</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>1</td>
</tr>
<tr>
<td>Somatization reaction</td>
<td>2</td>
</tr>
<tr>
<td>Malingerer</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Periarthritis</td>
<td>1</td>
</tr>
<tr>
<td>Urticaria and dermatitis</td>
<td>2</td>
</tr>
<tr>
<td>Pleurisy with effusion</td>
<td>1</td>
</tr>
<tr>
<td>Stuttering</td>
<td>1</td>
</tr>
<tr>
<td>Chronic constipation</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

Eighteen patients in the group had other diagnoses in addition to peptic ulcer. Some had more than one other
accompanying diagnosis. With the exception of anemia which was related to excessive hemorrhaging of the ulcer, and pleurisy with effusion, each diagnosis listed above implies problems related to emotional disorders.

**TABLE XIII**

Reasons for Referral

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social service initiated</td>
<td>10</td>
</tr>
<tr>
<td>Financial problem</td>
<td>5</td>
</tr>
<tr>
<td>Vocational problem</td>
<td>1</td>
</tr>
<tr>
<td>Personal or social problem</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Ten patients were seen during a period of routine social service coverage of ulcer patients. Reasons for referral of the other patients are given as nearly as possible as they seemed to be presented by the referral source and do not necessarily coincide with problems as seen by the social worker. The five patients presenting a financial problem were self-referred. The six referred for help with personal and social problems, exclusive of financial problems, were referred by the doctors. One self-referral was for help in locating more satisfying employment. Financial problems related mainly to concern over support of families during
hospitalization. Requests for casework help with personal and social problems included referrals for help toward better adjustment in the community after discharge, help with environmental factors, more satisfying job experiences, casework treatment in the area of personal problems.

**TABLE XIV**

Problems Seen in Ten Social Service Initiated Contacts

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal and social</td>
<td>10</td>
</tr>
<tr>
<td>Psychiatric follow-up treatment</td>
<td>3</td>
</tr>
<tr>
<td>Vocational help</td>
<td>4</td>
</tr>
<tr>
<td>Financial help</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
</tr>
</tbody>
</table>

The social worker saw problems in the area of personal and social adjustment in all ten cases. The more particular problems shown in the table emerged as the most urgent or most readily understood by the patient, and areas in which the worker felt help would be most effective. Of the ten social service initiated contacts, there were only two in which the worker did not see a specific need wherein she could offer immediate, practical service.
TABLE XV

Causative Factors in Illness as seen by Patient

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional factors</td>
<td>14</td>
</tr>
<tr>
<td>Organic factors</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Fourteen of the group, or 63.6 per cent, recognized emotional factors as causative in their illness, although they were either unwilling or unable, without direct guidance or support, to take any action to modify the external factors which led to states of tension or stress. Such factors as worry, "nerves," or "keeping things to oneself" were most frequently mentioned by the patients. Six of the group, or 27.2 per cent could understand their illness only on a strictly organic basis. The two cases classified under "other" were those in which it appeared that the patients believed that the kind of food they were accustomed to eating and alcoholic beverages caused ulcers.
More than one service was rendered in most cases. In twenty out of twenty-two cases supportive help was given by the worker. This implies that support was utilized consciously and purposefully within a professional relationship and that it was apparent in the record. Supportive help is meant to connote specifically the encouragement extended to the patient to talk freely, indication of the worker's interest and confidence that the patient will be able to improve his situation because of his own ego strengths, and the worker's accepting, permissive and sympathetic attitude. The two cases in which it was found there was no evidence of conscious use of supportive techniques were self-referred specifically for help with a financial problem shortly before discharge from the hospital.

Social studies in fifteen, or 72.8 per cent of the cases, were direct services to the medical staff and involved

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive help</td>
<td>20</td>
</tr>
<tr>
<td>Social study</td>
<td>15</td>
</tr>
<tr>
<td>Referrals</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>63</strong></td>
</tr>
</tbody>
</table>
inclusion in the permanent clinical records of a summarized social data sheet, designed to further the doctor's understanding of the kind of person he was treating.

Referrals to vocational counsellor, dietician, relief agency, mental hygiene clinic, psychiatrist and family agency accounted for twenty-one, or 33.3 per cent, of the total services listed and demonstrate an important aspect of the social worker's function in the medical setting, and particularly in brief contact cases.

Other services included interviews with the wives in four cases where there was apparent marital maladjustment or need for support and guidance to the wife during the patient's hospitalization. Cooperative casework was done with other agencies in two cases. One veteran who attached great emotional significance to obtaining a service-connected rating for the ulcer condition requested and was given practical services in filing a claim.

The services rendered by the worker give evidence of the needs, both internal and external, with which this group of patients might use help. Knowledge of community resources and quick diagnostic thinking and evaluation can result in effective use of the casework relationship, despite limitations of time and setting.

COMMENTS BY DOCTORS IN CLINICAL RECORDS

Comments frequently found in the clinical records
referred to these patients as follows: "a nervous, tense individual," "quiet, outwardly submissive," "not gregarious," "dissatisfied with work," "jittery and apprehensive," "tension and rush at work," "worried over domestic problems," "major financial worries," "needs to relax," "shy, poor mixer." Only two of the clinical records examined lacked such references. It can be concluded that the doctors are aware of the importance of social and economic problems and the need for services in addition to medical treatment with this group of patients.
CHAPTER V
CASE PRESENTATIONS

The purpose of this chapter is to present case studies to show the medical social worker's approach and focus in the initial interview and the social work skills and techniques, both generic and specific, which are utilized in the interview. The cases are further intended to show the possible contribution of the medical social worker in these brief contacts, as part of a total treatment program within the hospital setting. Six cases have been selected for presentation and classified on the basis of source of referral, that is, physician referrals, self-referrals, and social service initiated contacts. Two representative cases in each category are included in this chapter.

In presenting the material under study, a brief medical history and social data will be given, in addition to the social worker's activity and evaluation. Each case summary will be followed by a discussion by the writer, emphasizing the major points of this thesis.

Case A

This case was referred by the physician sixteen days after the patient's admission and ten days before discharge for the purpose of obtaining a social study and for case work help to the patient.

Review of the medical chart prior to the interview with the patient revealed that he had been
admitted for treatment of a service-connected duodenal ulcer, after treatment by a private physician had failed to relieve symptoms, primarily severe and constant abdominal pain. In the hospital, the patient was placed on total bed rest, gastric diet and medication, which included nembutol and amphojel. There was some improvement, except for the continued abdominal pain. The nurses' notes indicated that the patient was quiet, pleasant and helpful on the ward, but not gregarious. After approximately two weeks the physician ordered a psychiatric consultation because of the lack of sufficient organic basis for the continuing pain, and, as a result, transfer to the neuropsychiatric service was recommended. The psychiatric consultant saw family tension as the external precipitating factor in the patient's illness and felt that this outwardly submissive individual was caught in a situational difficulty. An accompanying diagnosis of somatization reaction was made. The patient accepted transfer to the neuropsychiatric ward as a means of "resting up" before returning to face family problems.

During the interview with the social worker, the patient appeared anxious to please and smiled frequently. He was a thin man, of less than average height, with a sallow complexion. He was thirty-two years old, married and the father of two children, a five-year old girl and a three-year old boy. His parents were both living. The mother, aged sixty-three, suffered from arthritis and was described by the patient as calm, good and the strength of the family. The father, aged sixty-five, a retired factory worker, was in ill health, but the patient could not name his illness. He was described as a heavy drinker during the past twenty years, with little interest in his family. The patient was the second in a family of four siblings, the eldest a brother.

During World War II, the patient spent three years and five months with the army signal corps and was overseas for months under danger of enemy bombing. He enjoyed the army after he got over feelings of loneliness during the first month away from home. Stomach symptoms started about a year before discharge when he was disappointed in not being sent home from overseas, as he had expected. He spent three weeks in army hospitals at that time. After discharge he was comparatively free of symptoms until two months before his marriage in 1946 when
exacerbation of ulcer symptoms necessitated another period of hospitalization. He was then well until the present attack.

Since their marriage, the couple had lived with the wife's parents. The patient spoke of his resentment because his in-laws treated him "like a son," instead of a grown-up person. He also mentioned feelings of frustration and resentment because his mother treated him the same way and he referred to himself as "mama's boy." As a youngster he avoided fist fights and always tried to be friendly. The protecting attitude of his younger brother was a source of inward irritation.

The patient had never been serious with girls although he enjoyed their company and had his first steady girl friend when he was sixteen. At twenty-six he married a girl eight years his junior, whom he first met when she was twelve, at which time she immediately reminded him of his mother "with her long, flowing hair."

The patient completed grammar school at sixteen, and later attended night school for two years. He started to work at sixteen on a milk delivery truck. A year later he obtained work as a stock boy, which lasted until he was drafted. After discharge from service he "relaxed" for three months, then went to work in a rubber factory. A few months later, he married and changed to a city job which his father-in-law got for him. Less than two months later, he lost his job due to a reduction in forces and subsequently felt depressed and unhappy. He tried to reenlist in the army, but did not pass the physical. He later secured a job as a production dispatcher at a government installation where he was currently employed at a weekly salary of sixty dollars and entitled to sick leave pay.

The patient's recreational activities were limited to an occasional movie. He had no hobbies or outside interests.

The patient was considered to be a conscientious, passive individual who, during this period of illness, was beginning to sense some conflict within himself, which heretofore he had been unable to express. His long-standing dependency needs were unmet in his marriage to a child-like, dependent person. Until
this time he had rationalized that "diet" was the main cause of his stomach trouble.

The worker arranged for an interview with the wife who was considered to be incapable of understanding her husband's basic needs, and appeared to be an immature person, emotionally dependent upon her mother.

As the worker felt this patient would profit from long-term therapy, a referral was worked out with him to a mental hygiene clinic. The worker also encouraged him in plans to move into his own apartment as interfamilial relationships were contributing to a state of tension in this patient.

In discussing with the patient the reason for transfer from the medical ward, which was poorly understood by him, the worker used this as an opportunity to introduce some clarification of emotional components in his illness.

The worker compiled the facts elicited in the interview with both the patient and the wife, together with a social diagnosis, into a social study to be included in this patient's permanent medical records.

Discussion. In this case the worker combined with case work treatment the function of obtaining social history for the doctor. Social diagnosis was formulated on the basis of facts brought out in the interviews, implemented by information from the clinical chart, the patient's behavior during the interview, the worker's understanding of the development of personality and theoretical knowledge about the illness.

The patient was afforded an opportunity to express his feelings and to view them as normal, reasonable reactions. At the same time the worker focused on some clarification of the tie-up between physical and emotional factors. The
patient was freed to talk within the medium of an accepting, professional relationship. Continuous diagnostic thinking and evaluation, together with a knowledge of other treatment resources, enabled the worker to focus on social and personal factors related to the illness and to set clearly defined goals, despite the limitations of time and setting. The techniques of psychological support and clarification were combined during this brief contact.

The history revealed this patient's typical pattern of behavior, namely internalization of resentment, hostility or frustration which would result in periodic exacerbation of ulcer symptoms. The referral to a mental hygiene clinic was part of a social treatment plan which could eventually mean a more satisfying, healthier future for this patient. The encouragement and support aimed at mobilizing his strengths toward positive action to relieve a tense family situation could result in minimizing external pressures in the patient's life situation. The interview with the wife implemented both the worker's and the doctor's understanding of the patient and further served to assess the wife's capacity to participate in future treatment of the patient.

Case B

This thirty-six year old World War II veteran, who served in the Pacific theater of operations as a rifleman from 1943 to 1946, was hospitalized after an acute attack of bleeding ulcer. He responded quickly to medical treatment, consisting of bed
rest, diet and medication, including banthine and amphojel.

Seven days after admission and five days before discharge, the doctor referred the case to social service, mainly because he detected a note of dissatisfaction in the patient's attitude toward present work. He described the patient as "emotionally flat."

When the patient was interviewed, the worker interpreted the function of hospital social service and reason for referral as part of a total treatment program. The patient was a tall, extremely thin, homely man, soft-spoken and shy, who at once indicated his desire to cooperate. He felt flattered by this concern for his welfare and displayed a quick interest in the kind of help the worker was prepared to offer. He said he was never much of a talker and lived a very ordinary existence. He lived with his sixty year old mother and twenty-eight year old sister who was unmarried and currently out of work. His mother, "a big, healthy woman," worked part-time in a laundry. She had always been strict with the children, although the patient added quickly that it was for their own good. His father, a semi-skilled factory worker, who died fifteen years earlier of cancer, was easy-going and quiet. His work took him away from home for days and the mother ran things. The patient never felt close to either parent, nor to his four siblings, although he was always on good terms with them. He had never had a girl-friend, as he felt he should wait until economically secure before marrying. This state of security never seemed attainable, for one reason because his mother and sister were partially dependent upon him for support.

He left school at seventeen to go to work and never learned a trade, working usually as a heavy construction laborer. He decided at the last minute to attend a technical school under the G.I. bill thirteen months prior to hospital admission and had two more months to complete the course. He had not enjoyed the experience and found it difficult to keep up with the class because of his poor mathematical ability, although he loved to read. He attended class regularly and was conscientious about his studies. He could now see how the constant stress and strain had contributed
to his illness which might now keep him from completing the course. These were things he had never before told anyone and it was a tremendous relief to be able to unburden himself.

The patient was under constant financial pressure also, because the government subsistence allowance was less than he used to earn, but he was driven to this step because of the desire to better himself.

The patient had hated service, too, but never before told anyone, and, above all, he had resented the unnecessary rigidity and the way regular army men took all the glory. He had never complained and had been a good soldier.

Recreational activities were limited to an occasional movie with male associates. Within the past few months he had gone nowhere and had lived in constant fear of nocturnal pain, a fear he had lost since he understood the cause.

He saw himself as a retiring person, with no close relationships, dissatisfied but uncomplaining, constantly striving inwardly, but unable to share his feelings with anyone.

The worker arranged an interview with the vocational counsellor. Social findings were interpreted to the doctor who now felt that the patient was ready to return home, but who cooperated by extending hospitalization until social treatment could be carried out.

Discussion. The case work contact with this patient came about because the doctor was aware to some extent of needs other than medical, the treatment of which fell within the area of competence of another professional person within the hospital setting. The information elicited during the interview helped the doctor and the worker to understand better the patient's basic personality. At the same time the patient received the benefit of a total approach to his
illness, which included medical and social treatment. It would seem that the worker gave a clear and effective explanation of social service function and that a professional approach and attitude helped the patient to enter into the relationship with considerable freedom. This resulted in at least temporary relief of tension from the opportunity to share long-repressed feelings. Even though the contact was limited to one interview, there is the possibility that the patient received some degree of self-understanding and acceptance which might tend to reduce any basic conflict associated with his illness.

Because of his quick response to the worker's permissive, accepting attitude, he may have profited from discussion of certain internal pressures and the way they contributed to his illness. The worker, however, was functioning under obvious pressure of time and maintained the primary focus on external factors and the specific request in the doctor's referral statement. The patient was shown a way of ameliorating his social situation through the counselling referral. This, in turn, could bring some release from stress and strain in the future with accompanying improvement in his physical functioning.

The social work techniques of psychological support with some clarification were utilized in this case. Constant diagnostic thinking, quick evaluation and a knowledge of
other resources were important social work tools. The worker avoided any interpretation of dynamic material to the patient, but showed an awareness of the patient's needs which probably stemmed from an understanding of dynamic factors.

In order to accomplish treatment goals, the worker did some interpretation of social needs with the doctor who cooperated by extending hospitalization beyond the period required for completion of medical treatment.

Case C

This patient was self-referred to the social service department for help with a financial problem on the seventh day of hospitalization. Medical history indicated a twenty per cent disability rating for service-connected duodenal ulcer and psychoneurosis. There had been many previous hospitalizations. Three weeks before admission he had been rushed to a private hospital from work after a coughing spell, when he almost died and had to be placed in an oxygen tent. He had been admitted to this hospital on an emergency basis after an acute ulcer attack during which he was not himself and which resulted when he failed to receive an unemployment check which he had expected.

From the medical ward he was transferred to the neuropsychiatric service to attend group therapy sessions as an adjunct to treatment of the ulcer.

When he came to the social service office, he appeared restless and anxious and tried to hide his anxiety by cracking jokes throughout the interview. He was a nice-looking, somewhat obese individual. His immediate concern was over support for his wife and two small daughters, ages four and two. He was finding hospitalization intolerable because of external pressures, aggravated by his wife's habit of bringing troubles to him at the hospital.

This patient had spent one year and five months with the Naval Air Forces during World War II. He
disliked guard duty to which he had been assigned. He was kept from going overseas because of the onset of ulcer symptoms.

His early history was one of insecurity and deprivation, both material and emotional. He remembered no relatives and for reasons which he did not understand had gone from one foster home to another until the age of sixteen when he left school and went to a CCC camp. He was an average student with no real desire for learning.

Most recent employment had been as an unskilled factory worker, a job he had recently lost because of prolonged absences due to illness. Previously he had worked as a general farm-hand, but left this job because of the low pay, although he enjoyed the work. He was now worried because he would have no job when he left the hospital within a few days.

This patient had few friends and no recreational outlets, other than to watch T. V. and attend occasional baseball games. He had time for work only. His emphasis was on being a good provider for his family, so that they would not know the deprivations he had experienced as a child.

He considered himself happily married. He had always managed household affairs and spoke of his wife's complete dependence upon him, to the extent that he could not see remaining in the hospital any longer. He was concerned, too, about how they would manage his special diet, partly because of the expense, partly because his wife did not understand the diet.

This patient was confused and anxious because he apparently had not accepted the reason for his transfer to the neuropsychiatric service, which to him meant that he was a "mental" case.

A meeting was arranged with the wife, although the patient at first resisted the plan on the basis that she would not profit from it. When she came in, it became clear that basically she was an immature person who, during her husband's hospitalization, was transferring her dependency needs to an overprotective father. The latter accompanied her to the interview. Despite her intellectual
limitations, possibly due to some mental retardation resulting from an early accident in which she sustained a head injury, the worker recognized a deep affection for both husband and children. She showed some ability to take some initiative of thought and action when treated as a responsible, adult being, rather than as a child, as her husband and father were apt to do. She appeared anxious to learn about her husband's illness and to participate in the treatment plan for him.

During the interview with the patient, the worker discussed and arranged for a meeting with the vocational counsellor to alleviate the patient's concern about the lack of a job. The patient was reassured about the fact that he was still being treated in the hospital as an ulcer case and some discussion of a total treatment program and emotional components in his illness was introduced at this point.

A referral to a community agency for financial assistance was worked out during the interview with the wife who was able to make the application in person. A meeting was also arranged with the hospital dietician, during which she displayed alertness and a willingness to learn.

Since the worker felt that both the patient and his wife might benefit from a sustaining relationship in the future and that the patient might gain further insight into his illness, a referral to a mental hygiene clinic was made before the patient left the hospital.

Discussion. This patient and his wife presented a picture of two dependent persons whose main strengths lay in their affection for each other and their willingness to change to adjust better to each other's needs. The history obtained from this striving, overly-conscientious individual revealed a pattern of developing ulcer symptoms in response to frustration or stress. Previously he understood his illness from a purely organic point of view. The
case work situation in the hospital was the beginning of a new orientation which might bring to an entire family greater security and satisfaction in daily living.

From a simple request for financial help for temporary support for a family, the worker moved into other problem areas as the total situation unfolded in the interview. Practical services, consisting of referral to the vocational counsellor, relief agency and dietician were given at the same time that a supportive relationship was afforded both the patient and his wife. Some limited clarification of emotional components in the illness was done mainly as an exploratory procedure to determine this patient's readiness for referral to a mental hygiene clinic.

A social study was made available for the permanent medical records as a result of the social service contact.

In order to make the contact with this patient and his wife meaningful, it was necessary for the worker to make a quick diagnosis and evaluation of the total situation. A sound knowledge of medical and psychiatric information, knowledge of community resources, and above all an accepting, understanding approach within the medium of a skillfully handled interview is demonstrated.

Case D

This case was self-referred to the social service department on the second day of the patient's ten day hospitalization for help with a financial problem. The medical chart revealed that this was
the first hospital admission for peptic ulcer symptoms which began about six months earlier. The private physician had recommended hospitalization for complete X-ray study after a strong abdominal pain persisted for two weeks. The patient was placed on the usual medical regime, but was ambulant on the second day. Five years earlier this patient sustained a knee injury at work which incapacitated him for a year and a half. A similar injury had occurred to the other knee two years earlier. The ward physician felt that this patient was not sick enough to remain in the hospital and thought he exaggerated his symptoms. The patient made many requests for care for his teeth and a chronic back pain shortly after his arrival on the ward. The doctor became impatient with him and stated that he suspected "malingering."

The patient was tall and underweight, with a swarthy complexion and small, beady eyes. He wore a sad, somewhat hurt expression and spoke in a whining tone. He was thirty-five, married and the father of four children, ranging in age from eleven to two, the youngest a boy to whom he seemed particularly attached. The patient was the youngest of four siblings. His parents were both living, the mother in good health, the father a patient in a tuberculosis sanatorium for the past six months.

Despite the original request regarding financial help, uppermost in the patient's mind was the strained relationship with his parents as a result of a quarrel six months earlier. He was hurt because his mother always had favored his older brother, although the patient had always been good to his parents. He tied in the onset of symptoms with family trouble and saw it as a culmination of years "of keeping it all in."

Early childhood had not been unusually difficult, although he had always felt emotionally deprived. He went through the fourth grade in school and explained this by the fact that he would not pay attention, but looked out the window, wishing he could be at play.

He said he had always been a hard worker since the age of sixteen when he was actually earning more than his father at his first job in a machine shop. After service he did seasonal construction work
which often took him out of town and away from his family for several days. He liked this work, but had recently changed to an inside job in a mill for the security and regular, though smaller, pay. He disliked indoor work, but had taken the job against his better judgment at the insistence of in-laws.

This patient had served four and a half years with the army in World War II, was proud of his promotions from private to sergeant, and considered those the happiest days of his life. He had tried to reenlist not long ago, but was rejected because he had too many dependents.

He had no recreational interests because of lack of funds and usually fell asleep after dinner, which made his wife feel rejected, while he in turn felt misunderstood. Within the past year since they had moved near in-laws, they quarreled constantly and had talked of separation. He longed for things the way they used to be, when they may have had to ask for relief from time to time, but were happy with each other.

This patient enjoyed talking about his illness, his "pain," and his family troubles. He did not believe, however, that there could be any real connection between his physical symptoms and emotional states.

At the patient's request, an interview was arranged with the wife, and the patient accompanied her to the office. In the joint interview, it became apparent that they were seeking help with their shaky marital situation which two weeks earlier had almost led to separation. The wife's manner was more mature and sensible than the patient's child-like, "fix it, mother" attitude.

The worker questioned this patient's capacity or real desire to change, but felt that continued case work help was indicated. There were complicating factors of interfering relatives, medical needs for other members of the family, and many debts.

Referrals were worked out to both a relief and a family agency. Social study was prepared for the medical records and some direct interpretation was
done with the doctor regarding the kind of person he was treating.

Discussion. This apparently immature, dependent individual developed an ulcer attack after an acute marital situation, preceded a few months earlier by a quarrel with his mother, toward whom his feelings were extremely ambivalent. He had always been in rivalry with an older brother, who was favored by his mother. This patient displayed the typical conflict between the wish to appear self-sufficient and inner cravings for love and dependency.

This patient was given practical help through suitable referrals, at the same time that he was given the opportunity to bring out his feelings about his illness, his family, in effect, his total life situation. A warm, friendly relationship was offered this "misunderstood" patient who could be expected to respond quickly to a kind mother figure.

The referral to the relief agency was seen as a way of relieving urgent financial pressures. The worker realized that the marital problems was beyond the immediate goal and made a referral to a family agency. The interview with the wife provided an opportunity for the worker to attempt to assess the wife's strengths and weaknesses, as well as to include her in the social treatment plan. Through sympathetic listening and suggestions for future help, the patient and his wife were offered support and guidance during this hospitalization, despite limitations of time and setting.
The interview presented a possible means of relieving both internal and external pressures and constituted part of a total treatment program, which took into consideration both medical and social needs. Social information was made available for inclusion in the permanent medical records and was shared with the doctor to increase his understanding of his patient. The case illustrates the worker's ability to combine quick diagnosis and evaluation with social treatment within limited goals because of knowledge about illness, the dynamics of human behavior and community resources.

Case E

This patient was seen one week after admission during a period of one hundred per cent social service coverage of ulcer patients. The doctor introduced the worker to the patient, but gave no interpretation of function.

Admission diagnosis was bleeding duodenal ulcer (non-service-connected). The patient had been in good health until ten years earlier. The doctor's notes made mention of tension and rush at work. Medical course during his sixteen-day period of hospitalization was satisfactory. He was placed on the usual regime of bed rest, diet and medications.

This twenty-eight year old World War II veteran was the second youngest of four male siblings. His parents, with whom he lived, were both in their early fifties and in good health. The patient was pale and thin, and of average build. His manner during the interview was outwardly relaxed and free.

He came from a family of somewhat higher than average cultural standards. All his brothers had completed college and were well established in business. The patient did not enjoy close familial relationships, but spoke positively of his relatives.
He appeared to be in rivalry with his siblings. He felt that being away in service had broadened the gap between him and his family.

He had been in the Army Air Corps over two years and had attended gunnery school. He enjoyed classes, but was extremely fearful of flying. At the time of final tests, he became air-sick and flunked out. He interpreted this as a "subconscious reaction" to the whole situation. He was disappointed over his failure, but happy not to have to fly again. He had always been prone to car and train sickness.

After discharge from service he enrolled in a teacher's training college, but left after two and a half years because of recurrence of gastric symptoms, resulting from the stress of classroom practice teaching. He was reluctant to leave college, but still glad to get away from the tension-producing situation. He thought of transferring elsewhere, but decided he would lose too many credits. He then took a job as a postal clerk, which he had done part-time before, and remained at this job two and a half years until his present attack of illness. He felt the job was beneath his abilities, resented the superior attitude of older, less educated co-workers, and, whereas his duties were enjoyable, he felt he should have a more responsible position, although he did not mean to appear egotistical.

Recreational activities were limited. He attended an occasional movie with a girl friend. He had never taken girls seriously, but now thought he might consider settling down to marriage, since he required a special diet.

He had read extensively when he first learned his diagnosis. He still felt, however, that he would always have to adhere to a strict diet to remain well, at the same time that he gave verbal recognition to the importance of tension and stress factors.

This patient's understanding of the emotional aspects of his illness were on a strictly intellectual level. He eagerly accepted referral to the vocational counsellor after discussion of this program and how it might lead to work which would be more gratifying to him.
Discussion. This patient had a ten-year history of exacerbation of ulcer symptoms in response to stress situations. Although he spoke glibly of emotional components on the basis of extensive reading, he was considered to have no real insight into the use he was making of illness, its "secondary gains" for him. His limited acceptance of emotional elements was further evidenced by his discussion of future dietary needs.

This individual appeared to be striving to prove his personal adequacy and to display the typical conflict between his desire to be independent and his longings for a comfortably dependent state. As a result of the worker's clearly defined, accepting approach, he may have obtained considerable relief from the opportunity to share his underlying feelings with a kind and understanding parent figure. With support from the worker, he was helped to face his limitations and to accept the help and guidance of a vocational counsellor. The worker did not attempt any clarification of underlying emotional factors in the illness and seemed to recognize strong defenses which could not appropriately be handled within the present scope of treatment.

The worker focused on an area in which it was possible to render practical help within the limited time available, namely referral to the vocational counsellor, which hopefully might lead to a more satisfying job experience for this patient. This service resulted from the worker's quick
diagnosis and evaluation and because of the worker's knowledge of other resources and supportive, understanding approach in working out the referral.

This social service initiated contact may have been a unique experience for the patient which might eventually lead to a better understanding of his illness. As a by-product of this contact also, more complete social information was available for inclusion in the medical records.

Case F

This patient was seen during a period of one hundred per cent social service coverage of peptic ulcer patients. The worker had asked the doctor to prepare the patient for social service contact, but no actual interpretation of function was given. The patient was seen on the eighteenth day of his twenty-eight day period of hospitalization.

A private physician had recommended hospital treatment after a three-month period of illness and inability to work. The patient gave a history of intermittent epigastric pain and vomiting of four years' duration. He responded well to medical regime of diet, bed rest and medications. Complicating diagnosis of severe constipation was present.

He was a tall, slender man of twenty-nine, married and the father of two boys, aged nine and three. His wife was to be confined any day. His mother, aged sixty-five, was living and well. His father had died of pneumonia when the patient was six, leaving the mother, "a good woman," with full responsibility for four children, of whom the patient was the youngest, although this made no difference, as the oldest boy was still her favorite. All the children stuttered and the patient believed he had acquired the habit by imitation, at the same time admitting that he stuttered only when nervous. In the army, he had been sent to school to try to correct this habit without success. As a result he was kept from becoming an officer, despite his high I. Q.
This patient's manner during the interview was pleasant, but he made obvious attempts to impress the worker with a "man of the world air" and frequent references to influential local figures.

He spoke of his children only when asked for factual data. He expressed concern over his wife's condition and awaited confinement and implied that marital adjustment was good.

He had spent nineteen months overseas with the army engineers during his three years in service during World War II. He said he did well in service and thought the army was a "good deal." He had had attacks of jaundice and dysentery while overseas.

He left school in the ninth grade to go to work out of financial necessity, but said he was reasonably fond of school and quite smart. He had always worked in mills, many of which had closed down, so that he often had to seek new employment. He now travelled several miles to work daily and each morning hated to get up to report to a job he disliked intensely. He resented his bosses, had refused supervisory promotions, and preferred to work alone, perhaps as a painter. For years he had been seeking better work without success, although all his influential friends were on the lookout for something suitable.

He was concerned about how his family would manage financially while he was in the hospital, although he preferred not to ask for help. They had managed well when his wife had been able to work and he expected that as soon as possible after the new baby was born, she would return to her job.

In discussing his illness, he could not understand why he had ulcers, as his wife prepared plain, wholesome meals for him, although she was brought up to cook spicy foods because of her different nationality. He had never thought about emotional factors being related to this particular illness.

This patient's attitude toward his illness was organically oriented and placidly accepting. He did admit he was always the nervous type, but
could not see how this would cause an ulcer. It was not felt that he had the capacity to change his orientation at this point.

A referral was worked out to a community agency for temporary financial assistance after the patient had been afforded the opportunity to work through his feelings about this step. A referral was also made to the vocational counsellor after explanation of this program. The worker's doubts about this patient's intellectual capacity were confirmed when he did poorly on the aptitude tests and came out with a low average I. Q.

Discussion. In this social service initiated contact it was necessary to give a careful explanation of the social worker's role in the hospital setting, as neither the doctor nor the patient had requested the service.

The worker recognized this patient's strong defenses early in the interview and assumed a non-directive, permissive role, in order not to disturb the facade of self-sufficiency. Thus the patient was free to discuss his anxiety about his financial situation and his employment. The worker maintained her focus in those areas which seemed important to the patient and offered services of a practical nature.

From the social history and the patient's behavior in the interview, it seemed that the patient's need to impress the worker hid strong feelings of insecurity and personal inadequacy. In the face of failure at work and increasing family responsibilities, he developed ulcer symptoms. It apparently was inadvisable to introduce any discussion of the emotional components of the illness, which this patient probably would promptly deny.
The worker limited goals to modification of stress situations by referrals to the relief agency and the vocational counsellor. The technique of psychological support was used to enable the patient to make constructive use of the case work relationship. This case illustrates the possible advantages of the social service initiated contact when the worker interprets social service function as part of the total treatment program and tries to assess the strengths and weaknesses of a particular individual and situation. In addition this case illustrates the possibility of increasing and improving services to the ulcer patient by including social treatment and evaluation in the hospital setting, even though the social service contact may be limited to one interview. The usefulness of such a plan of treatment would depend to a large extent upon the worker's understanding of the illness and knowledge of other resources, in addition to the worker's ability to diagnose and evaluate psychosocial factors within the limitations found in the hospital setting. The availability of social data for the medical records might result in greater individualization of medical treatment, even if no other service resulted from the social service contact.
CHAPTER VI
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study of initial interviews with twenty-two patients admitted to the medical service of a Veterans Administration General Hospital for treatment of peptic ulcer was undertaken with the aim of determining the nature of the social service contact and the way in which the medical social worker utilizes generic and specific social work skills to make a contribution to a total treatment program, despite limitations of time and setting. To achieve the broad purpose of this study, specific questions were posed as follows: What is the medical social worker's approach and focus in the initial interview? What social work skills and techniques are utilized in the initial interview?

After setting forth in the introductory chapter the purpose, scope and method of study, Chapter II included a description of the physical and administrative set-up in the hospital where the study was conducted, in addition to some explanation of the philosophy which led to social service within the Veterans Administration and the manner in which social service is administered in the Providence Veterans Administration Hospital, in accordance with this philosophy.

In Chapter III, the writer compiled a brief review of some of the literature consulted in preparation for the
writing of this thesis. There are three sections, devoted respectively to the illness, the role of the medical social worker, and initial interviews and brief contact cases. In the first section, medical and psychosomatic concepts were presented. No attempt was made to apply any specific psychosomatic concept, of which there are many, as this was considered beyond the realm of the medical social worker. As the initial interview in all but six of the twenty-two cases constituted the only contact with the patient, it was felt that some discussion would be pertinent on brief contact cases, as well as initial interviews, since all of the cases clearly fell within this category.

The presentation of factual data on all twenty-two cases in Chapter IV brought out some interesting facts regarding these patients and the problems they were confronting. The data showed that only a small number of peptic ulcer patients at this hospital were receiving social treatment, combined with medical treatment, although all of the literature reviewed recognized the important role played by personal and environmental factors in the development of ulcer symptoms. Although it was recognized that the findings of the study could not be considered statistically valid because of the small number of cases examined, nor applicable to any other hospital setting, they do compare favorably with the opinions expressed by most writers on the subject of the ulcer personality and psychic conflicts
found in ulcer sufferers, particularly in view of the many common characteristics of the group and the high incidence of personal and social problems. There was actual evidence of satisfactory heterosexual or marital adjustment in only three of the entire group, while it was likely that the others may have been experiencing some sort of marital conflict or difficulty in establishing satisfying heterosexual adjustment. Another common characteristic was the presence of a strong mother figure and a passive father figure in the patient's background. In seventeen cases out of the twenty-two, there was definite evidence of an emotionally and/or materially deprived childhood.

In the current life situations of these patients, there was evidence of financial pressures in the majority of cases. There was also little doubt that most of the patients were experiencing anxiety at work or dissatisfaction with their jobs. There was a notable lack of satisfying or healthy recreational outlets among the entire group.

Although this study did not focus specifically on any correlation between length of war time or combat service and the development of ulcer symptoms, it was seen that the majority (86.4 per cent) of this group served a relatively long period of time (nineteen months or more) in the military forces during war time. Half of the group related the onset of ulcer symptoms to war time, three shortly thereafter, and eight to more recent periods.
The length of hospital stay for half of the group was ten to twenty days. Those remaining longer were either transferred to the neuropsychiatric service or were treated for some other physical ailment. One of the most interesting facts brought out was the presence of accompanying diagnoses in eighteen patients, of which all except two definitely implied the presence of problems related to emotional disorders. Fourteen of the twenty-two patients recognized emotional factors as causative in their illness, although they may not have been ready to accept help in this area.

An analysis of the social work services to the twenty-two patients revealed that supportive help was given in all but two cases, fifteen social studies were compiled for inclusion in medical records, representing direct services to the physician, while twenty-one referrals were made to other hospital personnel or community resources. Among the seven "other" services, four were interviews with wives who needed guidance, support or information during the patient's hospitalization. Two cases involved cooperative case work with other agencies and one case included practical help with a pension claim.

The final section of this chapter was included to show how the doctor saw the individual patient. Comments were extracted from the clinical records which are accessible to the worker before each interview. Only two records lacked some written observation by the doctor which would indicate
his awareness of the presence of stress factors, both internal and external, in the patient's make-up or life situation.

In Chapter V, six case summaries were presented, separated into groups of two on the basis of source of referral, that is, physician referral, self-referral and social service initiated contacts. When the study was started, it was thought that some difference might be found in the worker's approach and focus, depending upon the source of referral. As the study progressed, no significant findings emerged in this respect and categories were retained solely for the purpose of clarity and systematic presentation. The summarized cases are intended to demonstrate the worker's approach and focus in the initial interview, and the social work skills and techniques utilized by the worker.

The worker's approach and focus in the initial interview was seen to have certain common elements, regardless of the source of referral. Even when a specific request for a social study was not made, the worker saw this as a basic function within the hospital setting and made social information available for the medical records in each case. Even when the interview came about through the authoritarian medium of the medical specialist, the worker offered a unique professional relationship to each patient. Although the
worker was mindful of responsibilities to the rest of the professional staff, each patient was still treated as an individual with the right of self-determination. The worker was able to obtain medical, as well as some personal, information regarding the patient from clinical charts and discussions with doctors and nurses before seeing the patient. Although this information can be helpful, it may contain some prejudicial, judgmental elements. In some of the case presentations, it was seen that the worker, rather than incorporating these views, can compile social data which may modify the doctor's attitudes, and perhaps effect some improvement in the doctor-patient relationship and greater individualization of medical treatment.

The main social work technique utilized was psychological support which was evident in each of the six interviews, while some limited clarification was done in three cases. The social work skills included quick diagnostic thinking and evaluation, a sound knowledge of the illness, both medical and psychiatric, and familiarity with other available services within the hospital or the community, and ability to accept and function within limited goals. In addition, the workers used both medical and personal data available in the clinical records, which is a particular advantage in the hospital setting and which largely explains why brief contacts with hospitalized individuals can be uniquely helpful and effective experiences.
It can therefore be concluded on the basis of the findings of this study that the medical social worker has a definite professional contribution to make to the total treatment program of peptic ulcer patients, despite obvious limitations imposed by the hospital setting. It can also be concluded that this contribution is not being made available to the majority of patients at this particular hospital, who are suffering from this illness which in most instances has clearly definable emotional components and which often develops in response to life situations characterized by chronic stress and tension states. The number and kinds of services rendered by the medical social worker in the cases presented for study indicate that the social service contact can be useful to doctors and patients alike.

It would seem that more emphasis should be placed on planned and thoughtful handling of the initial interview, and brief contact cases, since it is only in this way that the needs of the majority of persons seeking social services can be met. The worker has a unique opportunity to help those patients who are able to accept dependency resulting from illness and thus are freed within the medium of an accepting, permissive case work relationship to discuss their conflicts and dissatisfactions and to mobilize their strengths to take steps to cope more successfully with their problems, whether financial, vocational or interpersonal.
I am convinced that when the social aspects of illness are given the consideration they demand in hospital practice by the medical staff, the functions of the medical social worker will become clarified. The medical social worker forms the link between the hospital and the community from which the patient comes and to which he returns. It is her duty to investigate the social status of the patient and to evaluate the significance of adverse social conditions in relation to his particular kind of illness. She is then called upon to use her professional skill and knowledge in efforts to effect desirable changes in the relationship of the patient and his human and physical environment.

Whereas ideally this writer is of the opinion that no hospitalized individual suffering from peptic ulcer should be discharged before his individual social status is evaluated and, when practicable, social treatment started, realistically it is admitted that such a procedure is not feasible in most hospitals because of limitations of staff and time, and because of the undisputed precedence of medical over social treatment. When the matter of economy of time and money is considered, both from the patient's and the hospital's point of view, however, it would seem advisable to devise some substitute method of coping with this total problem. Furthermore the broader public health aspects of a chronic type of illness which at some time or other afflicts an estimated ten per cent of the population in this country cannot be ignored.

Fully cognizant of the fact that administrative and technical details involved in setting up a new, perhaps somewhat revolutionary, program present obstacles and difficulties, this writer would still hope that the professional staffs within the hospital setting, including medical and social services, could combine their thinking with the aim of making total treatment of all peptic ulcer patients an actuality. In reviewing the findings of this study, certain suggestions and recommendations have evolved in the writer's mind. First, it might be possible to open to all peptic ulcer patients group therapy sessions now held on the neuro-psychiatric ward in the hospital, or perhaps separate group sessions might be instituted for these patients on the medical wards. Second, the social service department might participate in these sessions, or might conduct separate group meetings in which social aspects would be emphasized. Third, there is a peripheral area to be considered, namely the wives of some of these patients whose attitudes have a direct bearing upon the individual patient's progress. They might profit from participation in occasional group meetings planned specifically to include and help them. Fourth, it might be possible to compile information on the illness, its relation to internal and external stress situations, community resources where help is available with various problems after hospital discharge, dietary needs and some general discussion
on preventive aspects of the illness into pamphlet form for distribution to the patients and their families.

Any attempt to put into effect one or all of these proposals would, of course, require the cooperation of all professional personnel concerned with any phase of the treatment of the peptic ulcer patient. Any such attempt might result in increased understanding of function among the professional staffs and greater coordination of all services, in addition to the potential benefits which it might bring to all patients, whether they are being treated for peptic ulcer or some other disease which carries with it the added complications of personal, emotional or social problems.

Approved:

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BIBLIOGRAPHY

Books:


Pamphlets and Periodicals:


Bibliography (continued)

Government Reports:

Veterans Administration Manual M10-6, June 1, 1947, Chapter VI, Social Service Procedures, Section I.

APPENDIX A

Schedule:

REFERRAL:

Number of Days after Admission
Source
Reason

IDENTIFYING DATA:

Age
Marital Status
Number of Children
Number of Siblings

APPEARANCE:

SERVICE RECORD:

Length
Overseas Service
Adjustment in Service

MEDICAL HISTORY:

Onset of Symptoms
Course in Hospital
Length of Hospital Stay
Prior Hospitalizations
Significant Familial Medical History

FAMILY BACKGROUND AND PARENTAL RELATIONSHIPS:

EDUCATION:

Attitude toward Learning

EMPLOYMENT:

Present
Past
Attitude toward Work

FINANCIAL SITUATION:

RECREATION:
Appendix A (continued)

MARITAL ADJUSTMENT:

MEANING OF ILLNESS TO PATIENT:

Causative Factors
Effect upon Present Life Situation

PSYCHOSOCIAL DIAGNOSIS:

SERVICES RENDERED BY WORKER:

SOCIAL WORK SKILLS AND TECHNIQUES UTILIZED IN INITIAL INTERVIEW.