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The transfer of patients from one social worker to another related to the patients' response to further treatment

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THE TRANSFER OF PATIENTS FROM
ONE SOCIAL WORKER TO ANOTHER
AS RELATED TO THE PATIENTS'
RESPONSE TO FURTHER TREATMENT

A THESIS

Submitted by
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CHAPTER I
INTRODUCTION

Purpose of the Study

The purpose of this study is to ascertain in what way the transfer from one social worker to another influences the subsequent life and conduct of the case. It is generally accepted by authorities to which the author has referred that the transfer of a case does have profound significance for the client or patient. The author wishes to learn if there are definite ways in which the first worker can aid the patient to a successful therapeutic relationship with his second worker—contrasted to a negative transfer where a patient either leaves treatment altogether when it has been deemed more helpful for him to continue, or the relationship with the second worker is most tenuous and fraught with ambivalence.

The author wishes to learn also if the transfer tends to reinforce existing resistances to treatment, if preparation of the patient for the transfer appears to make any difference in the subsequent conduct of the case, and if so, in what way does it manifest itself.
Scope, Method of Procedure, Sources of Data

This is a study of twenty-five cases transferred from one social worker to another during the calendar year 1949. During this period there were 122 such transfers.

It is recognized that variations in the skill of the worker will influence the handling of a case. In order to reduce this variable to a minimum, cases transferred to students have been eliminated. Consequently, from the balance of cases a random sampling of twenty-five cases was studied by the author for this thesis.

Case records have been examined for evidences of preparation of the patient for transfer, patients' reactions to the anticipated transfer, and patients' subsequent attitudes toward treatment. In addition current thinking on the significance of the transfer as revealed in the literature has been presented.

Consideration of influences has been limited to the transfer situation itself, though it is recognized that external circumstances, degree of illness of the patient, the interplay of emotional needs which one worker might more easily fulfill for the patient contrasted to another worker, etc., are important factors.

All these veterans of World War II were receiving case work treatment and the transfer was from one social worker to
another. Cases of transfer from one department of service to another are not being considered, though all patients are seen once by the intake psychiatrist.

It is the policy of the clinic according to the Manual (see Appendix) to have the workers make definite references in the case record as to the transfer of the case and the reason why this is taking place. Although it is realized by the writer that recording of case material may sometimes leave much to be desired and at times many feelings of the patient are actually explored by the worker with little or no mention of this activity on the typewritten pages, in this thesis when no mention is made of the transfer or exploration of the patients' feelings, the author could not assume that such was done.

For each of these twenty-five cases an abstract was prepared. (see Appendix)
The History, Organization, and Operation of the Mental Hygiene Clinic of Boston

Because so large a number of men were rejected from military service and so many disability discharges from the armed services were by nature psychiatric, a great need for a psychiatric clinic was demonstrated. It has been estimated that 475,397 men were medically separated from the armed forces due to a psychiatric disability. Another 100,000 medical discharges suffered from associated psychiatric difficulties, and an additional 400,000 men completed their services but received psychiatric treatment. Also there is an additional unknown number of men who were administratively discharged because of behavior difficulties or general inaptness. Many men in the armed forces carried on without psychiatric help but who nonetheless were handicapped by emotional symptoms or poor character formation. In the year following demobilization, there were approximately 17,000 veterans in Massachusetts alone who were receiving pensions for psychiatric reasons.

The Mental Hygiene Clinic of the Boston Regional Office

of the Veterans Administration was established in March, 1946 to provide ambulatory treatment for the large number of psychiatrically ill veterans from the Metropolitan Boston area. The function was officially defined, "Primarily, to treat the veteran suffering from a service-connected neuro-psychiatric illness not requiring hospitalization." ¹

From the small beginning as an Out-Patient Department with a staff of five full-time psychiatric social workers, three full-time psychologists, three full-time psychiatrists, and four part-time psychiatric consultants the clinic has grown proportionately to attend the needs of the more than 10,000 veterans who have been admitted to the clinic. At present the clinic has grown to such an extent that there now exists an additional subregional clinic in another city with plans underway for establishing others.

It has been the experience of the Boston Mental Hygiene Clinic that the problems of a preponderant number of veterans who come for treatment are primarily neurotic in nature. ² In this clinic the patient-therapist relationship is regarded as the most important element in treatment.

² Morris Adler, Arthur Valenstein and Joseph Michaels, op. cit., p. 520.
At present it is generally necessary that the veteran applying for treatment be receiving a pension award for a nervous disability. If he is, he is then deemed eligible for treatment. As explained above, he is then seen briefly at Intake by a social worker whose main purpose is to determine the patient's motivation for coming, to learn how he was referred, and to give the patient some idea of the clinic as a whole. Seventy per cent of the referrals come from within the Veterans Administration itself, the main source being the Out-Patient Department at 17 Court Street.

After his initial contact with the social worker the veteran is then seen by the intake psychiatrist. The latter makes a brief psychiatric evaluation, and makes his recommendations as to the type of therapy believed most beneficial. The veteran is then given an appointment for this treatment.

There are three types of treatment available; namely: psychotherapy, case work, and group therapy. A patient may receive all three types at one time or another. For instance, he may be assigned to a psychiatrist for psychotherapy and he may be tested by the psychologist at the same time. It might then be determined that group therapy would also be helpful. However, generally a patient is not seen by the psychiatrist concomitantly with the psychiatric social worker since treatment then tends to be diffused.
The psychiatrist in psychotherapy gives emphasis to the current reality situation but the patient's problems are assessed with regard to unconscious factors and motivations. His therapy is carried on at an insight level. The social case worker tries to explore the current reality problems with the patient on a conscious level and tries to help with the adjustment of the patient to his environment or help change the environmental situation by, for instance, helping the patient work through his feelings of changing to a more comfortable job, etc., thus avoiding the uncovering techniques of the psychiatrist. At present the clinical psychologist has been utilized mostly to date in the group therapy program at the clinic and testing. In group therapy the patient's conscious feelings about his current situation are discussed; deep uncovering techniques are avoided. Group therapy has been used by the clinic since its inception and its main value thus far seems to lie in preparing the patient for psychotherapy or as an adjunctive service to the patient already in treatment with a therapist. It must be kept in mind however, that much service is rendered to both the psychologist and psychiatric social worker by the consultant psychiatrist.

Constant research projects of varying purposes are being made by staff members. The staff has weekly meetings at
which all staff members of the varying disciplines are encouraged to present cases and evaluate services rendered. The social work staff has in addition separate weekly meetings where policies of the social service staff are discussed to learn what policies of the social service staff might be improved so that the clinic's aim of being kept up to date is strictly maintained. Cases of social workers are presented so that the staff may endeavor to learn ways of improving skills and thereby be more helpful to patients.

Various men and women renowned in their fields of psychiatry, psychology, or social work have frequently been invited to speak to the entire staff so that the staff may have its horizons of greater understanding expanded.
CHAPTER II

FACTORS TO BE CONSIDERED IN A TRANSFER

To understand what it might mean to a patient in case work treatment to be transferred, the case work treatment itself must be looked at thoughtfully. Today it is realized that there is a very definite relationship between dynamic psychiatry and social case work:

A deeper psychological knowledge is essential in a field that deals with individuals in their needs and failures, in their maladjustments or conflicts. There are obviously many cases where, beyond the social problems involved, the social worker in his planning faces complications and difficulties not related to outer circumstances but presented by the personality of the client. There the social diagnosis has necessarily to be combined with the personality diagnosis.

The psychiatric case worker then drawing greatly upon psychiatric concepts can more fruitfully aid the patient in his adjustment. Her aim is not to eliminate the internal causes underlying the character disturbances, but to help the patient find a satisfactory form of social adjustment on the basis of psychological understanding. Dr. Bibring feels that the environmental approach i.e., treating the personality disorder of the patient "from without" rather than changing the structure within the patient as a trained psychiatrist may endeavor to do through analysis, is the "genuine contribution of case work". In all the problems at the Mental Hygiene Clinic the patient's dynamic structure as well as the

patient's actual environment is considered by the therapist. It is therefore agreed that in social case work the personal relationship between the patient and the social worker is both the means and the method of therapy. Because the social worker functions to the patient as a constant, secure friend, the patient reacts in various ways expressing fear, guilt, hate, love or other emotions. The handling of the patient's feelings must be dealt with constructively if treatment is to proceed.

It is evident then, that when a worker departs from the clinic, the patient loses this constant person upon whom he has been able to depend. The patient is left then not only with the weight of his own problems once more, but is also bereft of the person in whom he confided and believed to be helping him with his burden.

His problem may then assume greater proportions to him and the departure of the worker may be of the greatest significance. The patient perhaps for the first time in his life had trust in his social worker. When he learns of the worker's leaving, his anxiety may well be mobilized and even heightened. These feelings can be expected even when the patient realizes

1 Regina Flesch, "Treatment Considerations in the Re-assignment of Clients," Family Service Association of America, 1947, p. 42.
2 Annette Garrett, "Transference in CaseWork," The Family, April, 1941, p. 42.
from the beginning that the current relationship will be brief and another worker will resume contact with him.

The patient's attitude toward a reassignment is greatly influenced by the current relationship to his case worker. When the relationship has been established and the change is necessary, invariably the patient has deep feelings about the change even though he may not always verbalize them:

We cannot assume that the significance of the relationship is determined solely or even chiefly by the length of time we have known a particular client. Clients may feel a real sense of loss when transferred after only one interview, as many intake workers already know. If the client has received considerable solace in the first interview, the referral to a new worker is a disappointment and may depress the client even though from the first he was aware that another worker would be assigned. The client's feeling about a reassignment is related more to the emotion invested in the relationship than to its duration.

Therefore, it can be assumed that as a consequence, the patient's sense of loss will be in proportion to the amount of emotional attachment he had to the worker.

Another phase which should be mentioned is the therapist's reaction to the transfer. Although this study is concerned with the patient's reaction, it must be stated that the social worker, being the other human being closely involved in the case work situation, has her own feelings in regard to the transfer and frequently these feelings may be un-

1 Flesch, op. cit., p. 7.
consciously adopted by the patient. Thus, if a female worker inwardly feels the patient should be transferred to another female worker after her departure from the clinic, this may subtly be picked up by the patient. Then when under the pressure of schedules, etc., the patient is perhaps assigned to a male therapist, this is an additional hurdle in the second relationship to be overcome.

The worker therefore has to be attuned to the patient's underlying feeling which he may not be capable of expressing. The worker must recognize the patient's feelings with him, allowing him self-expression, but letting the patient know too that this planned transfer could not be avoided and this plan for his welfare is of major concern to her.

It is important too that the second worker be "ready" for the patient and schedule an early appointment for him. This means that no more than a month should be allowed to elapse before the patient begins treatment anew. If the patient has been seen on a weekly basis for instance, his appointment with the second worker should be scheduled as closely as possible to the time of his regular appointment. The reason for this is that if the patient is allowed much time to himself following his first worker's leaving, he is apt to feel

1 Ibid., p.8.
"unattached", unwanted and broods over his "rejection." His first worker's plan of having him continue treatment and encouragement of the second worker's "interest" in him are apt to be fruitless indeed if no one indicates concern for him in this difficult period.

The practice employed by some of the social workers of the Mental Hygiene Clinic of introducing the patient to the second worker prior to the first worker's leaving, gives the patient something to "hang on to"; at least he has the name of a worker who has indicated pleasure at meeting him and he has some indication that the first worker actually showed her continued interest in his welfare by arranging the introduction. It should be kept in mind that however it manifests itself there will be a reaction at time of transfer.
CHAPTER III
SOME GENERAL CHARACTERISTICS OF THE GROUP

So that the reader may obtain a general picture of the men with whom this thesis is concerned, it is well here to present some background material.

Seventeen of these patients were classified as having psychoneurotic disorders while the remaining eight were diagnosed as having character and behavior disorders. All of the veterans as stated above were male veterans of World War II. There was only one veteran who had seen service in both World War I and II.

Thirty-three was the average age of this group when in treatment; they ranged from nineteen to fifty-one years of age. According to Alexander and French, "Advanced age is not an absolute contradiction—but prognosis is better for the young who have a much greater opportunity for change and who therefore usually respond more readily to treatment." Sixty-four per cent of the veterans were married. One veteran married while in treatment and was classified in this group. The married veterans averaged 1.25 children each.

As to race, twenty-three were Caucasian and two were Negro; eighteen were professed Catholics, six professed Protestants, and one veteran was of the Hebrew faith.

1 Franz Alexander and Thomas French, Psychoanalytic Therapy, p.97.
Concerning sources from which these veterans were referred to the clinic, only one was a self-referral, i.e., having learned of the clinic's services he came directly for aid; twenty-two were referred from within the Veterans Administration itself, as the Out-Patient Department or the Rehabilitation Division, and two were referred from hospitalization at veterans hospitals; namely: the West Roxbury Veterans Hospital and the Bedford Veterans Hospital, for follow-up out-patient care.

Seventeen of these men had served in the Army, the highest rank obtained being a Technical Sergeant. One was a veteran of the Army Air Corps who had secured the rating of Captain. Five were veterans of the Navy where the highest rank was BM 2/c. One was a veteran of the Seabees (no rank stated), and lastly, one was a veteran of the Coast Guard having risen to the rank of Chief Petty Officer. As an average each veteran had served 2.68 years, the mean being 2.9 years. However, thirty-six per cent of the men in this study were medically discharged from the armed forces, the balance being discharged because of accrued service points.

These veterans received pension award ratings from ten to eighty per cent for disabilities deemed "occurred in or aggravated by service." The mean average was a thirty per cent award.
The complaints verbalized by the patients upon their beginning treatment ranged from two complaints as "nervousness and headaches" expressed by one veteran, to eleven complaints given by another, naming "nerves, startle reaction, feelings of depression, rumbling stomach sensation, headaches, moody, confused feelings, loss of memory, eyes not focusing, excessive perspiration, and a general feeling of irritability." On the whole the three major complaints were: "nervousness," "headaches," and "insomnia".

While many veterans coming to the clinic actually have insight into their conditions and know that there is no organic basis for their complaints, most of those in this study found it difficult to accept the fact that their problems were emotional rather than physical. However, once these veterans commenced treatment with the psychiatric social worker, some help was extended to them to verbalize their feelings with the social worker there to listen, support, try to give them acceptance of their personalities and with warmth and understanding try to help them work through their conscious difficulties.
CHAPTER IV
PRESENTATION AND ANALYSIS OF DATA

Introduction

These twenty-five cases seemed to group themselves into two classifications; namely: the unsuccessful transfer and the successful transfer. The writer designates an unsuccessful transfer to mean the situation where it has been felt by the psychiatrist, social worker, and possibly verbalized too by the patient, that he continue in treatment with a second therapist due to the first worker's leaving but for some reason has not been able to keep his appointments with the second worker. The result is that the worker closes the case. In all these cases so closed the term "unimproved" was applied.

In a successful transfer the writer means a case where it has been fully agreed by the psychiatrist, social worker, and patient that the patient continue in treatment. The patient then adjusted to the new treatment up to the time when it was mutually agreed that he be discharged as improved. The writer has termed the transfer successful also where the patient has continued to keep regular appointments with his second worker and is now obtaining current help for his problems.

Tables have been drawn by the author to indicate the
the way the transfers took place and the patients' reactions to these transfers in the unsuccessful group (Tables I and II). Some case material has also been selected to exemplify the above. There were eleven cases termed unsuccessful.

The author has presented in this chapter a similar set of tables to illustrate the manner in which the transfers were handled by the social workers and the patients' response to the transfers in the successful group (Tables III and IV). Case material from the successful group of transfers has been quoted to indicate more fully the meaning the transfer has to some patients. There were fourteen cases categorized as successful transfers.
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In presenting the following material from four case records of the unsuccessful group of transfers, the writer wishes to illustrate how these transfers were handled by the two workers involved and how the patients themselves reacted to the transfers.

In the case of Mr. X., forty-one year old, married veteran diagnosed as a psychoneurotic - anxiety reaction and receiving a ten per cent rating, the patient related quite well to his male worker. He complained of being "nervous", "irritable", and spoke of "body pains". In the three interviews he had with his worker an assurance had been given him of the worker's interest and desire to see him weekly. The patient began to unfold some of his insecurities and feelings of dislike about his employment. On the third interview the worker wrote:

Worker then informed patient his case was being transferred to another worker whom the patient would find extremely helpful. Worker also informed him that he enjoyed meeting him and rendering him what little assistance he could in such a brief contact. Since patient had already received an appointment to see Miss Y. Tuesday, no further arrangements are to be made.

There followed a brief transfer summary. Apparently from the record, Mr. X. received an appointment with the second worker prior to his knowledge of the first worker's leaving!

A few days later worker II in her first interview with Mr. X. commented that Mr. X. seemed "resistant" and "kept his
coat on all during the interview."

When I asked him to tell me about his difficulty, he referred me to worker I's record. . . Patient stated that worker I told him his back pains were due to nervousness but he doesn't believe him. . . It took a considerable amount of questioning and encouragement to get him to express his feelings.

Then followed a lengthy description again of the patient's pains and nervousness which was more a repetition of earlier symptoms. Also was added the patient's hostility toward worker I claiming he did not "believe" the worker and further he showed resistance toward the second worker. Although it was agreed the patient then would continue treatment with the second worker, he did not come for his scheduled appointments and the case was closed unimproved.

In the case of Mr. S., twenty-seven year old married veteran diagnosed as a character disorder, with a ten percent disability rating, the patient here too seemed to relate quite well to his female worker. He spent much time in the three interviews with his worker discussing his many symptoms of "nervousness, sleeplessness, irritability and headaches. In the last interview prior to the worker's leaving, the patient was just beginning to express some of his problems concerning his addiction to alcohol which he had stoutly ignored up to this time. No mention was made of the worker's leaving but the case record did have a rather complete transfer summary.
At the time of the patient's next appointment he was met by his second worker:

We introduced ourselves to the patient and explained that the former worker had resigned and that he was to see us. Patient smiled pleasantly and said he was a little angry with the clinic because he'd had to wait a month after his initial contact with the psychiatrist before he got his appointment with us. . . . and now this. Worker regretted this and said it was due to the crowded conditions of the clinic. We said it seemed important to him to come here and the patient denied this saying that he made very little improvement since he did start to come. He still is very nervous and the patient felt bad about this. We wondered in what way he was nervous and the patient said he can not control his impulses to be angry and to throw things, etc.

The worker then stated this in her impression:

As can be seen from the interview, it was difficult for the worker to relate to this patient. Although he complains of nervousness, he seems to be completely happy in his present state.

Mr. S. was interviewed three times following this contact but then CKA'd (Ceased Keeping Appointments). His case was therefore closed as unimproved.

This patient, as others, might have been so discharged had no transfer ever taken place but from the material in the record stating that the patient expressed an interest to continue treatment with the first worker and seemed for a while to be obtaining some relief in bringing out to the worker his feelings about his drinking, a problem he did not discuss with the second worker, it would indicate that he felt following the transfer only more hostile toward the clinic and treat-
ment as a whole even though worker II tried to help him express this.

In Mr. L's case, a single, thirty-five year old veteran with a character disorder and disability rating of fifty percent, can be seen another reaction. This patient when first seen by the social worker, talked extensively about his headaches. By the third interview the patient had begun to talk of his work and of his hopes to better his condition. He also expressed a longing for a family. This man lived with friends but always felt the urge to move about as he never felt happy or satisfied. Up to the third interview the patient had discredited any thought that his living conditions were not meeting all his needs. At the third interview:

Patient was told of worker's leaving shortly.

'Oh, no! I'm not going to see anyone else!' He then laughed embarrassedly. The patient was then told this would be discussed in the next interview.

However, in the next interview no mention was made of the worker's leaving. Apparently from the record the patient left this interview not daring to ask about the transfer or possibly was hoping that the worker had changed her mind about leaving the clinic. The last interview scheduled prior to the worker's actual departure, the patient did not come for his appointment. A transfer summary was in the record.

The second worker sent the patient another appointment in
two weeks' time and the patient came early. The patient conversed of many things and then brought out the fact verbally that he hadn't definitely known of worker I's leaving. He said he had "liked her", meaning his first worker, and asked his second worker questions about the first therapist. It was then agreed that treatment would be continued thenceforth with the second worker. Due to repeated CKA's following this initial contact with the second worker however, the worker closed this case as unimproved.

Although the second worker was "ready" for this patient in a short space of time following the transfer, it is evident that the patient was not ready to accept the transfer. Even though the second worker tried to explore somewhat of the patient's feelings about the transfer and listened to the eulogizing of the first worker, this was not enough for this patient who could not work through his feelings. His questions to the second worker indicated his loss of worker I and his longing to see her. Although it can be seen from the record that the patient had in fact been told of the original therapist's leaving, although it was not mentioned after the first time, he remarked to the second worker that he did not know of her leaving, indicating his own confusion in the matter but also his refusal to accept the fact of her departure.

In the case of Mr. P., a married, twenty-six year old
veteran diagnosed as a character disorder and receiving a
disability rating of thirty per cent, the relationship between
Mr. P. and his male therapist seemed warm and friendly. The
patient's complaints were all listened to sympathetically by
the worker. By the fourth interview the patient began ex-
pressing anxiety about his work and some feelings of hostility
regarding the pressures which he felt were irritating to him
in the home.

Between the time of the patient's fourth interview and
the scheduled fifth bi-monthly interview the record states:

Worker telephoned patient since he felt he would be
transferring from the clinic within a few days. When
the worker informed the patient of his transfer, the
patient remarked, 'That's not too hot, is it--but if
you've got a transfer, I suppose there's nothing that
can be done about it.' At this point the worker in-
formed him that he had enjoyed talking over his prob-
lems with him and assured him he would find his new
worker most helpful. The patient expressed his appre-
ciation to the worker for having informed him of the
change and he thanked him for his sincere interest in
assisting him with his problem. Told patient next
appointment would be mailed to him.

The record contained a transfer summary wherein was
stated:

Patient felt that treatment he had received thus far
had been beneficial to him and he was desirous of
continued treatment.

Approximately one month later the patient had his first
interview with his second worker where the patient was allowed
some expression of feeling:

Patient said he had liked coming here to talk with
Mr. W., even though they never seemed to get anywhere special. Apparently the patient had very little difficulty in relating to the worker and spoke without any apparent effort or anxiety.

The next three appointments were missed by the patient however, and the case was closed as unimproved. This patient's ambivalence toward treatment is evident. He told the original therapist that he wanted treatment, yet gave the second worker a feeling that at the clinic he did not feel he was getting "anywhere special."

It is apparent from the above material that some needs of the patients concerning the transfers were not met by the two social workers involved. Five of these patients were given no warning of the first worker's leaving but were informed by the second worker that the first worker had left the clinic.

The average number of regular appointments prior to the patients' transfers was six. The average number of weeks' notice given to the patient by the worker prior to the transfer was 1.4 weeks. The average number of appointments kept by the patient in treatment with the second worker following the transfer was three. In only three of the cases in this group was the reason for the worker's leaving clearly stated to the patient. Six of the patients were encouraged by the second worker to express their feelings about the transfer.

Prior to the transfer four of these patients had a re-
currence of symptoms when informed by the first worker of the transfer to take place. Two patients increased their talkativeness and one patient did not keep his last appointment with the first worker prior to the transfer, thus demonstrating some of his hostility toward the transfer and resentment toward his first worker.

Following the transfer one patient asked for a change in appointment time which demand was met by the second worker. Seven patients expressed a recurrence of symptoms when in treatment with the second worker. One patient increased his reticence with the second worker while two patients' talkativeness increased. Three patients failed to keep the appointment for the first interview with the second worker even though one patient had the name of his second worker. Four of these patients kept only the first interview following the transfer. In no case listed as discharged unimproved was there a definite introduction of the patient to the second worker.
The second group, the successful transfers, consisted of fourteen cases.

**TABLE III**

**SUCCESSFUL TRANSFERS**

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Contacts Prior Transfer</th>
<th>No. of Weeks' Preparation for Transfer</th>
<th>Introduction to New Worker</th>
<th>Reason Given For Transfer</th>
<th>Contacts After Transfer</th>
</tr>
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<tbody>
<tr>
<td>12.</td>
<td>3</td>
<td>1</td>
<td>X</td>
<td>-</td>
<td>Cont. Tr.</td>
</tr>
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<td>3</td>
<td>1</td>
<td>X</td>
<td>-</td>
<td>Cont. Tr.</td>
</tr>
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<td>-</td>
<td>Cont. Tr.</td>
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<td>X</td>
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<td>-</td>
<td>-</td>
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<td>X</td>
<td>Cont. Tr.</td>
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<td>-</td>
<td>Cont. Tr.</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>16 Dis. Imp.</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>Cont. Tr.</td>
</tr>
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<td>31</td>
<td>9</td>
<td>X</td>
<td>-</td>
<td>4 Dis. Imp.</td>
</tr>
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<td>31</td>
<td>9</td>
<td>X</td>
<td>X</td>
<td>Cont. Tr.</td>
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</table>

Total 198 51 6 5
**TABLE IV**

**PATIENTS' REACTIONS TO TRANSFER**

**IN SUCCESSFUL GROUP**

<table>
<thead>
<tr>
<th>Prior Transfer Reactions Toward First Worker</th>
<th>Transfer</th>
<th>After Transfer Reactions Toward Second Worker</th>
</tr>
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<tr>
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<td>X</td>
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In presenting the following material from four case records of the successful group of transfers the writer wishes to illustrate how these four transfers were handled by the first and second workers and how the patients themselves responded to the change.

In the case of Mr. F., this single, twenty-four year old veteran diagnosed as a character disorder with a fifty per cent disability rating, came to the clinic and presented his many symptoms to his sympathetic female therapist. Within his sixteen treatment hours the patient began to express some feelings of dissatisfaction with his work and began to indicate some desires to "slow down" a bit on his job. He even began to have some amount of social life which since his discharge from service he had felt incapable of enjoying. In these hours of treatment it was evident to the worker and her consultant that the patient had had many difficult problems, a major one being in the patient's suffering emotionally over the past years because of a rejecting and rigid mother. The patient at his sixteenth treatment hour began to express some feelings of hostility toward his rigid mother whose high standards had been a source of difficulty to this young man.

No indication was made in the record of the worker's departure but when the veteran came to the clinic for his
seventeenth appointment, he was met by the second worker. There was no transfer summary.

However, when I explained that worker I had resigned and I would be seeing him, he immediately launched into some new symptoms which involved arms and stomach. This he feels is brought on by certain pressure at work.

No mention was made in the record of exploring the patient's feelings regarding this transfer. However, he did plan to continue treatment with the second worker. It is significant to note that this patient asked for a change in his appointment time which is a request frequently demanded by the patient at the time of transfer, when he had not given any notice to his first therapist of being dissatisfied with the schedule.

Mr. F. then kept sixteen regular appointments with his second worker during which he gained a great deal from the relationship. During this time the patient told of new methods he was introducing at work (thus gaining some recognition by his superiors at employment and displaying his growing feelings of self-confidence). The patient at the end of treatment had even become engaged to marry a girl who seemed well-suited to him. This case was then closed when it was mutually agreed by therapist and patient that the patient had improved by treatment but that he could return whenever he felt in need of such help again.
Although there were indications that this case might easily have become an unsuccessful transfer when the patient had no notice of the change etc., still it proved a successful one. This case therefore indicates that not all cases follow the same pattern; that there are other factors operating which in this case proved strong enough to keep the patient in treatment and counteract the negative effect of the transfer. It is significant that this patient had been in treatment for sixteen sessions before the transfer took place. Too, this patient's ego was strong enough to adjust to the change. The second worker was skillful also in being willing to wait with the patient. This was evidenced in her listening sympathetically to the enlarged number of complaints and also her willingness to change her schedule to coincide with the patient's time.

Mr. R's case concerned a single, fifty-one year old veteran having a ten per cent award for a character disorder condition. He came to the clinic depressed, nervous, and in great financial debt. His female therapist in the thirty-one weekly treatment hours finally helped the patient to realize that much of his feeling of being depressed was caused by his belief that the white people in this area were prejudiced against him because of his being a Negro. The worker tried to point out the patient's positive aspects and achievements
which were in fact quite numerous. The patient was slowly gaining in confidence due greatly to the relationship thus established with his worker and was even bettering his financial status in quite a remarkable fashion. Two months prior to the worker's leaving the record states:

Worker told patient that she would be leaving the clinic some time in the near future. The patient's reaction was, 'Oh, you're going to dump me, are you?'

In the next interview the worker wrote:

The patient looked rather pathetically at the worker at the end of the interview and asked if she was going away next week. When told that she would not be going until the last two weeks in October (due to her marriage of which the patient was cognizant) so would be seeing him twice more before that, he expressed relief. He was pathetic and somewhat childlike as he smiled feebly in leaving the interview.

In the next three interviews the patient brought out some questions he had of obtaining outside psychiatric help (i.e., a private psychiatrist). All his former symptoms seemed to recur and now he had an additional symptom of "breathlessness."

In the last interview this previously prompt patient was one-half hour late:

He was very depressed. . . acted much more as he had when first seen at the clinic sitting long periods of time saying nothing. He remarked he guessed the worker would be glad when she no longer had to see his face. When the worker denied this, his eyes filled with tears. He went on describing how discouraged he felt. . . He won't be responsible for anything that happens. The worker wouldn't have to listen to him anymore.
The interview terminated here and the patient was still in a rather depressed mood. He remarked that he was glad for the worker's sake that she was leaving. He was glad that someone could be happy even if he could not. Worker again pointed out what strides she thought he had made; told him she had already talked with Mr. R. about him and that he was very much interested, and introduced the patient to worker II.

There followed a transfer summary. A week and one-half later, worker II made these comments following the first interview with Mr. R.:

The patient was forty-five minutes late for his appointment and was sloppily dressed. . . He hadn't worked the past week due to a new eye complaint. . . He complained of treatment and the worker tried to obtain a clearer picture of what he expected as treatment. Worker felt this was part of his resistance and partial hostility directed toward me in his feelings of worker II's leaving.

In the worker's impression was stated:

Mr. R. certainly seemed to be taking worker II's leaving quite hard. . . . made him quite depressed. He seemed to be projecting most of his difficulties on his environment and is actually testing me too.

It is significant in the above case also that Mr. R. seemed to get into more financial difficulties at the time of the transfer, thus attempting to act out some of his inner anxiety. However, the patient has now been able to continue regular treatment with his new therapist after first changing his appointment time. In this case the second worker, aided by the interpretation of the original worker regarding the transfer, was able to help the patient with his feelings and accept his hostility as a part of his total personality.
Having survived this test well, the patient could then allow his positive feelings to be brought out concerning the relationship, and thus treatment with the second worker is begun on a firm foundation.

Mr. G's case concerned a married, thirty-three year old veteran with a psychoneurotic disorder rated at fifty percent. The patient expressed much anxiety, feelings of nausea, irritability and "jitters". This patient was seen regularly for eight weeks by a female social worker during which hours the patient was able to bring out some negative feelings toward his ill wife for whom he had to "do" so much. He was also concerned because after three years of marriage there were no children. The social worker tried to help this patient discuss his feelings and ease his own inner tension which, if left alone and allowed to "fester" would be more burdensome for the patient, and consequently the wife too would likely suffer emotionally.

After the eighth interview was recorded:

Worker said she was glad he was feeling better and then proceeded to tell him that she would be leaving the clinic in a couple of weeks and that she was arranging for someone to see him after she left. The patient looked crestfallen and said that he did not want me to leave. He said that he had gotten used to me and that I was kind to him. Worker agreed that she did not want to leave either. The patient asked the worker where she was going and the worker replied that she did not know. The patient said that he hoped he would not 'get a snob' for another worker. Worker assured him that he would not
and proceeded to ask him if he had ever come in contact with any snobs here. Patient admitted he had not but hoped he would not get one. The patient was practically crying by this time. He said, 'Mrs. J., I want to pack my bag and go with you.' Patient said he hoped new worker would be interested in him as coming here had meant so much to him and helped him.

At the next interview:

Patient told me that he had cried all the way home last week because he was so upset at my leaving. Unless he got a worker like me he would not come to the clinic. Worker told patient he could meet and see new worker for himself.

At the final interview with the first worker:

Worker introduced patient to second worker. Patient expressed his and wife's thanks for all I had done and again expressed sorrow at my leaving. At the termination of the interview, patient looked shyly up at worker and said, 'Goodbye, Mrs. J., I'm sorry not to be able to see you again.' Worker said she was sorry too and wished him luck. Patient said he would remember appointment arranged with worker II.

However, the patient called the second worker and changed his appointment time. At the first interview the patient repeated all his previous symptoms. The patient also extolled the virtues of the first worker to the second worker and the latter listened understandingly.

The patient stated he felt better already to know he could continue here. He thanked us very warmly for our help and made another appointment for next week.

The patient has since remained in treatment coming for his appointments regularly and is benefiting from this service. The home situation at present seems less anxious and the relationship between the husband and wife is now more comfortable.
In the case of Mr. P., a thirty-one year old married
veteran with a thirty per cent disability for psychoneurosis,
the relationship between the patient and his female therapist
was developing well. This patient feared his lack of control
over his own temper and feared therefore the loss of his job
and harmony of his family. He feared in a burst of temper he
might do physical harm to his young daughter. He expressed
much concern about his irritability and with the worker’s
help, was beginning to see some gains in releasing his irrita-
ability at the office thus gaining a release of tension, but
saw also the value of trying to keep control while outside
the office.

At the fifth interview the record states:

Worker then informed patient she would be leaving soon
to be a housewife. Patient appeared to take this lightly
but still planned to return to the clinic. Patient said
worker was smart leaving the city of Boston and would
tell her more next week.

At the next interview the patient was one-half hour late
and informed the worker he had to leave early for a
physiotherapy appointment. It was planned at the next
appointment the patient would meet his new worker.

However, the patient missed the last appointment.

There followed a transfer summary. The second worker had
no reply for two weeks to his appointment letter sent to the
patient. Then when the patient did come for his first appoint-
ment, he renewed again all his previous ailments. He expressed
anger at a recent transfer in his work unconsciously per-
haps expressing his anger at the clinic too.

We talked in the interview about the fact that there had been a change in workers and also that I would try to see him regularly and we would try to work something out.

The patient then began again coming to the clinic regularly and is still being helped currently by the therapist in talking out his feelings and endeavoring to help his own situation.

In three cases the patient was not told of the worker's plan to leave the clinic. Also of this successful group the number of regular appointments prior to the transfer averaged fourteen. The average number of weeks' notice given to the patient by the worker prior to the transfer was 3.6 weeks. The average number of appointments kept by the patient in treatment with the second worker and then actually discharged as improved was 2.6 interviews. The rest of these patients are considered by the therapists as progressing in current treatment. In only five of the cases was the reason for the worker's leaving clearly explained to the patient.

Prior to the transfer five of these patients had a recurrence of symptoms when informed by the first worker of the transfer to take place. Four patients increased their talkativeness.

Following the transfer four patients asked for a change
in appointment time which demands were acceded to by the second worker. Twelve patients expressed a recurrence of symptoms when in treatment with the second worker. One patient increased his reticence with the second worker while two patients increased their talkativeness.

In six of these successful transfers the original therapist introduced her patient to the second therapist who continued treatment. No patient in the successful group CKA'd (Ceased Keeping Appointments) with the first therapist prior to the transfer i.e. missed an appointment with the worker without any word of planned cancellation. As the reader can note, one patient cancelled his last appointment prior to his transfer but this is not termed a CKA.
CHAPTER V
CONCLUSIONS

The figures showed of the two groups studied that Group A being the Successful transfers and Group B the Unsuccessful transfers were alike in that the average disability rating was thirty per cent for each. In Group A there were nine psychoneurotic and five character disorders to a corresponding eight psychoneurotic and three character disorders in Group B., which is a slight variation proportionately.

In the successful group the average number of complaints per veteran was 1.7 symptoms more than in Group B., again a slight variation. The average age difference between the two groups was 3.5 years; the older group being Group B.

The salient conclusion warranted on the basis of statistics in terms of the transfer however, is the following: prior to the transfer the patients in the successful group averaged 7.3 more treatment hours than Group B. This successful group averaged 2.2 more weeks' notice of departure by the therapist prior to the transfer so that time was allowed for feelings to be discussed. In addition twelve patients were actually encouraged to express their feelings regarding the transfer in Group A while this occurred in only six cases of Group B.

It is significant too that in Group A six introductions
of the patient to his new worker were effected by the original therapist while no introductions were made in the unsuccessful group. Five patients in Group A knew the reason for the worker's leaving in contrast to three in Group B.

It can be seen generally that there is a definite relationship between the patients' reactions to the transfer and their general patterns of behavior as exemplified by material cited in the case work interviews. It can be concluded then too that when the patient has been in treatment a long enough time to feel that he can be helped, and he desires continued contacts with the clinic, and further, when that patient actually relates to his second worker, he can more successfully continue treatment. This excludes of course the environmental factors which would have to be studied further.

The change in the sex of the therapists at transfer was not indicated as being a major obstacle to treatment. In the successful Group A, forty-two per cent were cases where the patient was transferred from a male to a female therapist or vice-versa and effected the change well. In the unsuccessful group only eighteen per cent changed to a worker of different sex from the original therapist, the majority being transferred to a worker of the same sex as the original worker but still the patient could not transfer successfully.

It can be concluded therefore, that a planned transfer with the patient plus the workers' sharing some of his feelings
of loss and working this through with him, makes for a better relationship between the patient and worker II. A planned introduction has proven a helpful thing for the patient and the skill of the second worker in helping him through this difficult period has proven beneficial in therapy. The worker thus endeavors to aid the patient to regain the status he had in treatment prior to his emotional setback in being transferred. It can be concluded too that a transfer can be a very traumatic event to a patient when as shown in just this study apart, forty-four per cent of the twenty-five cases were listed as discharged unimproved or unsuccessful transfers, because the patient broke treatment following his transfer.

In summarizing the writer found what could be listed as five varying reactions of patients to the transfer:

1. The loss of the worker caused the patients to feel insecure and unloved thus rejected.

2. The patients hence made frequent demands for change of appointment time.

3. These patients frequently developed more physical symptoms during reassignment as well as rediscussed complaints expressed in early contacts with the clinic; some were expressed to the original worker but the majority of patients expressed these to worker II.

4. Frequently hostility was expressed to the first worker just before the relationship ended. Also the patient tended to reject the second worker after having felt rejected by the first. Some carried this hostility to such a degree that they could not even come to the clinic for a first appointment, or cancelled treatment altogether after a brief contact with
the second therapist.

5. Resistant clients who previously talked little about themselves suddenly became most communicative when it was learned that the first worker was leaving.

Further study is indicated on the problem of transiency of professional personnel. It is a large question but it is very evident that social workers and agencies should give careful thought to the question of transiency of personnel and the effect upon the client.

Approved

Richard K. Conant
Dean
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BIBLIOGRAPHY


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APPENDIX
APPENDIX A

Criteria for Transfer and Closing Summaries

(in Manual)

For the greatest economy of time, the transfer and closing summary should include enough pertinent information concerning the case so that the worker taking the case (as in transfer situations) and the next person reading the record (as in the event of the reopening of a closed case) need read only transfer or closing summary to get the essentials.

With this in mind, the following elements are suggested for inclusion in such summaries:

1. Identifying data.

2. Date of opening and/or reopening.

3. Source and reason for referral to clinic.

4. Source and reason for referral to Social Service with date first seen by social worker.

5. Statement of initial problem as presented by the patient and evaluated by the worker and psychiatric consultant.

6. Statement of the plan and goal of treatment, and evaluation of progress, showing worker's focus and patient's response.

7. Brief discussion of work with collaterals and evaluations of the personalities involved in the patient's environment.

8. Objective evaluation of the case work handling of this situation, including additional problems presented during the contact—how they were handled or not handled and the reasons.
9. Total number of hours patient was seen in the clinic with a breakdown as to the number of hours patient was seen by members of each discipline.

10. Reason for closing (or for transfer) with date.
   a. Diagnostic impression at time of closing (or transfer).
   b. Recommendation for future activity (in the case of transfer situations), or for reopening (for closed cases).