The role of the psychiatric social worker in the mental hygiene clinic, Veterans Administration, Providence, Rhode Island: a study of twenty cases demonstrating the activity of the social worker as part of the clinic team

A Thesis

Submitted by
Natalie Margaret Post
(B.A., Emmanuel College, 1945)
In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service
1950
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CHAPTER I
INTRODUCTION

This thesis is a study of the role of the psychiatric social worker in the Mental Hygiene Clinic, Veterans Administration, Providence Regional Office, Rhode Island. The writer will attempt to illustrate, with case discussions, the activity of the psychiatric social worker as part of the clinic team. The clinic team in all instances which are discussed in the thesis will include the psychiatrist, the clinical psychologist, and the psychiatric social worker. The writer is concerned here with psychiatric social work as it is defined by the American Association of Psychiatric Social Workers as "social work undertaken in direct and responsible working relationships with psychiatry. It is practiced in hospitals, clinics or under psychiatric auspices, the essential purpose of which is to serve people with mental or emotional disturbances". 1

Purpose of the Study

The purpose of the study is to demonstrate how the social case worker in a psychiatric setting and as a member of a therapeutic team is able to contribute to the progress of the patient. It is hoped that the study will illustrate how the

psychiatric social worker, by providing services to other persons who are involved in the patient's illness, while the patient is under treatment with the psychiatrist, is able to help in alleviating some of the conditions which might be contributing to the patient's illness or situations which are made more difficult by the very existence of the illness. The writer will attempt to demonstrate the ways in which the psychiatric social worker can be of direct assistance to the treating psychiatrist by having regular contact with a member of the patient's family and during these contacts attempt to modify the behavior or attitude of that family member when this condition relates to the patient's illness and has some bearing upon it. In addition, it will be shown that these contacts and working relationships with family members can give to the psychiatrist in his contact with the patient a better picture of the patient in relation to his environment. The writer hopes to illustrate how the above-stated services, rendered within the clinic setting, contribute to the total progress of the patient. Through its services the clinic recognizes the Patient's ability to adjust within his own limitations by modifying his environmental difficulties and using individual psychotherapy. This is done through the combination of the three related disciplines which are available within the clinic, namely, psychiatry, clinical psychology, and psychiatric social work.
Scope of the Study

The study includes a review of the history of the Mental Hygiene Clinic of the Veterans Administration, Providence, Rhode Island, its purpose, and its function. The study further includes a summary of the services of the three disciplines: Psychiatry, Clinical Psychology, and Psychiatric Social Work within the clinic setting; and the individual purpose and function of each. The main body of the thesis centers around the function of the psychiatric social worker as a part of the clinic team. This aspect of the thesis therefore includes a review of cases which were referred to the Mental Hygiene Clinic. Cases were selected where psychiatric treatment was undertaken. Of the treatment cases only those which were assigned to a psychiatric social worker for case-work treatment in conjunction with psychotherapy were considered. The case illustrations do not always demonstrate the activity of the psychologist due to the fact that there was not always consistently a psychologist available while these cases were active. The study is focused upon a review of the problems which were presented by the patient, the techniques which were utilized by the psychiatric social worker in the handling of the problems, and some evaluation of the progress of the patient which was felt to be the result of the utilization of the combined services of the disciplines which are active within the clinic setting.
Sources of Data

The case records of veterans with service-connected neuropsychiatric disabilities, who had been referred to the Mental Hygiene Clinic for psychiatric treatment, were selected on an objective basis. In some instances it was deemed advisable by the writer to consult personally with the treating psychiatrist and/or the psychiatric social worker who had been or at this date still is active in the situation. These cases were not selected by the writer within any definite time limit. The selection was accomplished through a random sampling of cases which have been active since the clinic began functioning shortly following its inception on October 14, 1946 with a decision to select twenty which best demonstrated the utilization of the team concept.

Method of Procedure

The writer initially began the study by checking the monthly statistical reports of the Mental Hygiene Clinic in order that it might be determined which of the cases that were referred for psychiatric treatment received any continued service, both from the psychiatrist and the psychiatric social worker, and, in some instances, the clinical psychologist. Of the cases which were read by the writer, twenty were selected as a percentage which might demonstrate the activity of the three disciplines as stated in the purpose.
The twenty cases which were selected through a random sampling for further and more intensive study, were then reviewed as to the type of problem which they presented, the techniques which were utilized by the psychiatric social worker, and the activity of the team in relation to the problem. These techniques were then grouped under the general problem of the group as being characteristic of the entire group. The writer then selected one case situation, which she felt fairly well illustrated the type of problem noted in the group and the techniques utilized, and presented this case in a rather detailed manner as being representative of the group which is to be discussed.

**Value of the Study**

The writer hopes to illustrate by presenting the study, the values of the utilization of the team concept in specific casework situations. It is further hoped that this study will illustrate how the social worker in her capacity as a member of the clinic team is capable of functioning cooperatively with the psychiatrist and the clinical psychologist and how these three disciplines serve each other in their common goal which is the progress of the patient in his adjustment. The writer feels that the study will indicate the well-coordinated service which is made available to the patient through the utilization of the clinical-team concept in psychiatric treatment.
Although during World War I the mental hygiene movement received some impetus, large numbers of soldiers who developed acute psychoses and psychoneuroses were classified merely as having been shell shocked and an adequate treatment program was never developed. During World War II psychiatry came into focus almost at the onset. The number of civilians who were ineligible for military service during World War II, because of emotional maladjustment, created a serious limitation of manpower. The seriousness of the problem became even more apparent at the termination of the War when the large number of those who had been rejected or discharged from service because of psychiatric difficulties was disclosed.

Of the 15,000,000 men examined at the armed forces induction stations by June, 1944, a total of 4,217,000, or 28.1 per cent, were rejected for all medical reasons; of this group, 701,000, or 16.6 per cent, were rejected for mental and nervous diseases and 582,000, or 13.8 per cent, for mental deficiency. Thus neuropsychiatric disorders, accounting for 30.4 per cent of the men rejected, constituted the largest single reason for rejection. Since disability caused discharge from the Army of 320,000 men, or 41 per cent of all those granted
Mental hygiene emerged from the second World War as a proven and recognized service. Due consideration was given to the disastrous consequences of a lack of knowledge during the first World War and consequently during the post-war years considerable progress was made in relation to the recognition and treatment of emotional illnesses. In the Army there were extensive research programs for the detection and the management of the emotionally insecure. New and effective techniques for the treatment of mental and emotional disabilities were discovered and utilized. Mental hygiene orientation of medical officers, chaplains, and line men was initiated and the most effective clinical attack was found to be in the teamwork approach of the psychiatrist, psychologist, and the psychiatric social worker. Following the termination of the War, it was discovered that many of the principles relating to emotional illness, which had been utilized during the war years, could be adapted to treatment of civilians.

The Veterans Administration was established by the Consolidation Act of 1930. This Congressional Act authorized the President to consolidate and coordinate all federal agencies which were then dealing with veterans' affairs.

under a single control. The Administrator of Veterans Affairs is appointed by and is responsible to the President. The purpose is to administer certain benefits authorized by federal law for veterans of the armed forces of the United States. These benefits include medical, hospital, and domiciliary care; insurance; compensation or pension; vocational rehabilitation; education; loan guarantees for farms, homes, and business enterprises; and readjustment allowances for unemployment and self-employment. The Department of Medicine and Surgery in the Veterans Administration was authorized and established in January 1946. The Social Service Division of the Department plans and develops the social service program for in-patients in hospitals and out-patients at regional office clinics. In general, social service units assist in the preparation of hospitalized patients for discharge, supervise neuropsychiatric patients at home on trial visit, and furnish casework services for veterans receiving hospital or outpatient treatment.2

The results of World War II focused considerable attention upon the facilities which would be necessary to care for the emotionally disabled veteran. On September 17, 1945 a letter from the Medical Director, Veterans Administration, pointed out the great need of outpatient clinics for the

2 Ibid., p. 6.
treatment of individuals with neuropsychiatric conditions which was being demonstrated by the needs of the returning veteran. The letter is quoted in part:

Available statistics indicate that between thirty-five and forty-five per cent of the discharges from the Army for disability are because of neuropsychiatric conditions. Many of these veterans are still in need of treatment and in order to fulfill this need the Veterans Administration has embarked on a program to establish special Mental Hygiene Clinics for out-patients at a number of readily accessible facilities and regional offices . . . These clinics are being developed and will be operated in accordance with the latest information available from authoritative sources . . .

In July 1946 Circular Letter 169 was issued by the Veterans Administration. This circular letter indicated the nature, purpose, and responsibility of the Mental Hygiene Clinics. It further described the qualifications which would be desirable for the personnel of the clinics and gave some description of the routing and intake procedures which the clinics would follow. Extracts from this circular:

Mental Hygiene Clinics . . . will be established in regional offices when the Deputy Administrator, having jurisdiction determines that such clinics are necessary and can be properly staffed within the approved personnel ceiling.

3 Charles M. Griffith, Veterans Administration, Medical Director's Letter, September 17, 1945 (Unpublished).
Purpose and Responsibility. The need for treatment of the large number of veterans discharged from service with mental and nervous illness is evident. Experience in civilian practice before the war and in the armed service during the war indicates that the majority of these cases can be treated effectively in a clinic without hospitalization. The Mental Hygiene Clinics will render this treatment on an out-patient status and will be responsible for conducting the entire out-patient treatment program in the selected regional offices. This program will serve to alleviate a minor neuropsychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization.

Function of the Mental Hygiene Clinic. . . . treat the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization. The veteran may present himself or be referred by another component of the Veterans Administration, a public or a private agency, or an organization in the community . . . 4

The Mental Hygiene Clinic, Veterans Administration, Providence, Rhode Island, serves the State of Rhode Island and southeastern Massachusetts including Cape Cod and the islands of Martha's Vineyard and Nantucket. The Clinic began functioning on October 14, 1946. The purpose of the Clinic was to treat, on an out-patient status, veterans who are experiencing nervous and emotional illnesses. Eligibility for treatment would depend on whether the veteran's neuropsychiatric disability was incurred in Service,

4 Veterans Administration, Circular Number 169, July 15, 1946, p. 1.
aggravated in Service or was interfering with the veteran's rehabilitation under Public Law 16. There was no estimate of the number of veterans who would require out-patient treatment at that time.

At the time of its origin, the staff of the clinic included psychiatrists who were approved by the Dean's Committee and psychiatric social workers who were trained in psychiatric casework. In addition, a medical consultation service with certain local specialists and the Veterans Administration Staff was available. Shortly after the Clinic's origin a statement was published in a Providence newspaper stating that the Clinic had opened and giving the regulations regarding eligibility for treatment. The statement further indicated that cases requiring treatment could be self-referred, referred by community physicians and agencies, and from Veterans Administration Out-Patient Departments and other sections of the Veterans Administration. At that time it was decided that Social Service would evaluate and orient the patient at the time of intake. Following intake, interviews would be arranged by appointment only and would be adjusted to the convenience of the patient if he were in training or in school. A further arrangement was made in that fee-basis psychiatrists and contract clinics would supplement the Mental Hygiene Clinic facilities and attempts would be made to coordinate all activities involving
In March of 1947 the psychiatric staff of the Mental Hygiene Clinic was composed of seven members, five of whom were part-time and two full-time. The staff spent a total of 275 work hours. Of this, treatment consisted of 160 hours, staff conferences 18 hours, and the remainder of the time was devoted to administrative duties and individual conferences with workers. The psychological services were offered through a contract with Butler Hospital, Providence, Rhode Island. There was no full-time psychological staff. The social work staff consisted of three full-time staff members and two students from accredited schools of social work located nearby.

The Clinic opened in October 1946 and the statistics on the cases treated through December 31, 1947 were as follows:

**TABLE I**

<table>
<thead>
<tr>
<th>NUMBER OF CASES TREATED OCTOBER 1946 THROUGH DECEMBER 1947</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Referred to Mental Hygiene Clinic by Various Sources 1549</td>
</tr>
<tr>
<td>B. Referred to Fee-Basis Physicians by Mental Hygiene Clinic 68</td>
</tr>
<tr>
<td>C. Referred to Contract Clinics by Mental Hygiene Clinic 92</td>
</tr>
</tbody>
</table>
The estimated case load on December 31, 1947 was as follows:

**TABLE II**

**ESTIMATED CASE LOAD -- DECEMBER 31, 1947**

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Mental Hygiene Clinic (99 active, 9 inactive)</td>
<td>108</td>
</tr>
<tr>
<td>B. Fee-Basis Physicians (approximate)</td>
<td>45</td>
</tr>
<tr>
<td>C. Contract Clinics (approximate)</td>
<td>28</td>
</tr>
</tbody>
</table>

In December of 1947 the staff consisted of the Chief, a full-time psychiatrist, two psychiatric social workers, the position of casework supervisor being vacant, three clerks, three attending specialists, five fee-basis neuropsychiatrists, and two contract clinics. Contract clinics are those public or private clinics which have a contract with the government to treat a specified number of individuals for a specified fee and in turn render reports as to the progress of these individuals to the government. In November of 1947 a position had been established for a full-time clinical psychologist but it had been impossible to fill the position.

In January of 1948 the following recommendations were made by the Acting Chief to the Branch Medical Officer:
1. The addition of another full-time psychiatrist.
2. Employment of a full-time or part-time clinical psychologist.
3. Recruitment of a social service case supervisor.
4. Additional clerical personnel.
5. A closer working relationship with Butler Hospital.
6. The possibility of using the Mental Hygiene Clinic for training purposes.

On February 11, 1948 a special conference was scheduled to discuss the policies, problems, and future plans for the Mental Hygiene Clinic. Present at this conference were representatives from the Branch Office, the Chief Medical Officer of the Regional Office, the Chief of Hospitalization, representatives of the Examination Section, and Butler Hospital.

On April 7, 1948 Doctor Harry Rand was appointed "Psychiatrist-in-Charge of the Mental Hygiene Clinic". On July 27 of that same year a psychiatrist was designated as "Assistant Psychiatrist-in-Charge". On November 16, 1948 Doctor Rand was appointed "Chief Psychiatrist" of the Mental Hygiene Clinic and during that same month a Clinical Psychologist was appointed to the Clinic. With these data the writer points out that actually it was not until November 1948 that the clinic team per se could be utilized in the clinic setting.

A Survey Report of the Mental Hygiene Clinic, which was submitted to the Chief Medical Officer in December 1949,
indicated many progressive changes within the Mental Hygiene Clinic. The Clinic is located geographically approximately one mile and one-half from the center of the city in a former school building. Corresponding medical services for veterans are located within the same building. The staff presently consists of the chief psychiatrist, three full-time psychiatrists, four attending psychiatrists, and one full-time psychologist. The social work staff consists of the casework supervisor, two full-time social workers, and two second-year social work students majoring in psychiatric social work. Two of the members of the psychiatric staff are presently in analysis and one psychiatrist is engaged in group therapy with two separate groups.

Monthly reports indicate that an average of approximately 165 individuals is treated each month with a sum total of approximately 485 treatments per month. Of the latter, 107 of the total number of treatments are by social workers. The majority of the patients are referred from the Out-Patient Neuropsychiatric Examining Section where the screening is done. Secondary sources of referral are from Veterans Administration hospitals and agencies, community social agencies, private physicians, relatives, and self-referrals.

Following the referral, the patient is seen by the social worker at which time information relative to his condition is secured. In some instances this is accomplished
in one interview and in others more than one, depending upon the patient and the nature of his problem. Since a large number of patients who are referred from the Neuropsychiatric Examining Unit, have presented somatic complaints and feel strongly that their condition is an organic one, considerable interpretation of the clinic, its function and purpose, as well as the meaning of the patient's symptoms, is required. The social worker attempts to use some guide in relation to the intake process. However, this is flexible and can be geared to what the patient is willing and able to give at the time of the initial interview. Generally, it would include the following factors:

- Source of Referral
- Eligibility
- Complaints
- History of Illness
- Present Adjustment
  - a) Work
  - b) Social
  - c) Family
  - d) Marital
- Military Service
- Attitude Toward Treatment
- Recommendations

In some instances an appointment with a psychiatrist is arranged for the same day and in others the appointment is scheduled for a later date. This again is dependent upon
the patient and the acuteness of his problem. In some instances a psychological interview is also arranged. Final responsibility for diagnosis and treatment is with the psychiatrist who has contact with the veteran. Treatment is carefully planned with due consideration given to the needs of the patient, his limitations, and the facilities which can be made available to him through the Clinic. Following the initial psychiatric interview, a staff conference is held in most instances at which intake problems are discussed as to diagnosis, evaluation, and therapeutic recommendations are made.

The Mental Hygiene Clinic is presently operating two evenings each week for veterans who are unable to keep appointments during the day-clinic hours. The monthly report reveals that at the present time the use of contract clinics has been reduced to approximately six cases per month. The patient is seen on the average of two and one-half times per week in the Clinic for extended interviews with the treatment orientation being dynamically analytical. The team concept is utilized in the clinic setting and weekly seminars are conducted by the Chief Psychiatrist which are largely for the purpose of orienting the social workers and the social work students.

The following is a monthly report of Mental Hygiene activities as it is submitted to the Chief Medical Director,
Washington, D. C., for the attention of the Medical Administration Statistics Division. The report selected was the latest which had been completed at the time of this section of the study. The report includes in the left column the figures to date for the fiscal year; the monthly total is in the last column.

**TABLE III**

MONTHLY REPORT OF MENTAL HYGIENE

MONTH ENDING JANUARY 31, 1960

<table>
<thead>
<tr>
<th>Total fiscal year to date</th>
<th>Section A - Current Case Load</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1733</td>
<td>1. Case load end of last month</td>
<td>254</td>
</tr>
<tr>
<td>138</td>
<td>2. New cases received this month</td>
<td>29</td>
</tr>
<tr>
<td>71</td>
<td>3. Cases reopened this month</td>
<td>13</td>
</tr>
<tr>
<td>1942</td>
<td>4. Total case load during month</td>
<td>236</td>
</tr>
<tr>
<td>1598</td>
<td>5. Cases active this month</td>
<td>262</td>
</tr>
<tr>
<td>344</td>
<td>6. Cases inactive this month</td>
<td>34</td>
</tr>
<tr>
<td>198</td>
<td>7. Cases closed this month</td>
<td>32</td>
</tr>
<tr>
<td>1744</td>
<td>8. Case load end of this month</td>
<td>264</td>
</tr>
</tbody>
</table>

Section B - New and Reopened Cases

By Referral

<table>
<thead>
<tr>
<th></th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Total new and reopened cases this month</td>
<td>42</td>
</tr>
<tr>
<td>10. Self-referral</td>
<td>5</td>
</tr>
<tr>
<td>11. VA Regional Office Medical Division</td>
<td>34</td>
</tr>
<tr>
<td>12. VA Vocational Rehabilitation</td>
<td>0</td>
</tr>
<tr>
<td>13. VA Hospital</td>
<td>1</td>
</tr>
<tr>
<td>14. Other VA Sources</td>
<td>0</td>
</tr>
<tr>
<td>15. Non-VA Sources (excludes self-referral)</td>
<td>2</td>
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</tbody>
</table>
TABLE III (continued)

<table>
<thead>
<tr>
<th>Total fiscal year to date</th>
<th>Section C - Disposition of Closed Cases</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16. Cases closed</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>17. Treatment completed</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>18. Transferred to hospital group</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>19. Treatment incomplete</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>20. Discontinued by veteran</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>21. Discontinued by Mental Hygiene Unit</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>22. Medically not feasible</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>23. Legally ineligible</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>24. Other</td>
<td>0</td>
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</tbody>
</table>

Section D - Personnel and Man Hours

Section E - Examination Summary Staff

<table>
<thead>
<tr>
<th></th>
<th>42. Total number of individuals examined</th>
<th>26</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>43. Neurological (total)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>44. Epileptics</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>45. Aphasics</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>46. Other Neurological</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>47. Psychiatric (total)</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>48. Psychotic</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>49. Psychoneurotic</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>50. Other Psychiatric</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>51. Other (total)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>52. Total number of examinations</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>53. Neurological</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>54. Psychiatric</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>55. Other</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>56. E.E.G. Recordings</td>
<td>0</td>
</tr>
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</table>

Section F - Treatment Summary Staff

<table>
<thead>
<tr>
<th></th>
<th>57. Total number of individuals treated</th>
<th>206</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>58. Neurological (total)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>59. Epileptics</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>60. Aphasics</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>61. Other Neurological</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>62. Psychiatric (total)</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>63. Total number of treatments</td>
<td>576</td>
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<tr>
<td></td>
<td>64. Psychiatric (total)</td>
<td>564</td>
</tr>
<tr>
<td></td>
<td>65. Therapeutic interviews</td>
<td>524</td>
</tr>
<tr>
<td></td>
<td>66. Psychiatric</td>
<td>408</td>
</tr>
<tr>
<td>Total fiscal year to date</td>
<td>Section F - (continued)</td>
<td>Monthly Total</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>67. Psychological</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>68. Social Service</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>69. Group therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70. Number of sessions</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>71. Number of treatments</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>72. Hypnoanalysis</td>
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</tr>
<tr>
<td></td>
<td>73. Narcosynthesis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>74. Other Psychiatric Therapies</td>
<td>0</td>
</tr>
<tr>
<td>84</td>
<td>75. Neurological (total)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>76. Aphasia</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>77. Language Therapy</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>78. Medical Treatment</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>79. Epilepsy</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>80. Other</td>
<td>10</td>
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</tbody>
</table>

Section G - Individuals treated and Fee Basis

| 547 | 81. Individuals treated by fee physicians | 87 |
| 1561| 82. Treatment rendered by fee physicians  | 241|
CHAPTER III

PSYCHIATRIST, PSYCHOLOGIST, PSYCHIATRIC SOCIAL WORKER - THEIR RELATIONSHIP IN THE CLINIC SETTING.

Having discussed the Mental Hygiene Clinic, its history, purpose, and function, the writer will consider the three disciplines which function within the clinic setting and their relationship to each other. This study will be preceded by information relative to the growth of these professions in order that the reader may acquire a better picture of the factors which led to the utilization of the three disciplines in a specific setting for the purpose of giving the best in service to the patient.

The concept of the clinic team was first developed in Child Guidance Clinics. This occurred in the 1920's during a period when the mental hygiene movement began to develop the preventive program.

Prior to 1900 there were only four psychiatric clinics in the whole country; today there are 688 mental hygiene clinics, of which 285 are for children only.1

This movement closely followed the period which saw the beginnings of social work as a profession at the turn of the

1 Lucas, supra.
twentieth century. During this period helping people was the primary consideration and the awareness of a need to understand people and their problems grew out of the experience which was gained in the helping process. The objective, from the beginning, was to assist and foster personality adjustment, but the attempts of the profession did not become more organized until they were influenced by Mary Richmond who gave to the field its first definition of social casework. The essence of this definition was that social casework consisted of those processes which developed the personality through adjustments between man and his environment. Her "Social Diagnosis" led to the utilization of data and the main emphasis in early casework was placed on modification through the environment.

Following World War I with the return of the disabled veterans, there was an apparent need of recognizing and understanding the personality of the individual. Social Work was first established as a profession with a body of knowledge during this period. Some clarification of the treatment role in casework became apparent with the new relationships between casework and psychiatry beginning to develop. During this period social work turned to psychiatry and there was a lessening of interest in social data with considerable emphasis beginning to be placed upon the importance of collecting psychological data and an attempt to integrate the
findings of both medical psychology and social work.

The reformulation in Freudian theory in 1933 gave a new understanding of the ego, the role of anxiety, and the nature of defense mechanisms. The two professions, psychoanalysis and casework, began to draw closer together in their aims. The United States Army's acceptance of military psychiatric social work and the ensuing problems which occurred as a result of World War II gave considerable impetus to the recognition and utilization of both services today.

Since this study is primarily concerned with the clinic and the team concept, some consideration has been given to each discipline and its relationship to the others. Service to patients in a clinic setting requires the collaborative efforts of all three disciplines. It is an integrated, well-coordinated functioning with the training and techniques of one discipline supplementing the other. Each discipline has within its professional equipment, skill which complements that of the other and facilitates the achievement of their common objective. It is the experience of the Mental Hygiene Clinic, Veterans Administration, that although the focus is different, the three disciplines can function concurrently with each offering its particular service as it is best adapted to meet the needs of the patient.

Since psychiatry is a branch of medicine, the medical training and experience of the psychiatrist influence his
approach and understanding of the patient in the clinic setting. The psychiatrist brings a knowledge of medicine which is steeped in individual pathology and which is oriented to the treatment of mental illness. He has the potentials to treat the patient through a variety of techniques which exist in the area of his professional competence. His psychoanalytic training qualifies him to use the techniques of free association which differ from the techniques used by the psychiatric social worker. The primary responsibility of the psychiatrist is to help the patient directly with the resolution of intrapsychic conflicts. The method of free association is used as a basis for further procedure. The technical handling of material is accomplished through interpretation and manipulation.

... Interpretation, in the psychoanalytic sense, refers to the unconscious meaning of and the unconscious conditions between, the patient's thoughts, attitudes, dreams, symptoms, and tendencies in the present and in the past... the cure is based on the patient's comprehension of the unconscious roots of his symptoms and consequently on the more adequate disposal of his pathogenic, infantile conflicts.

... Manipulation, in the psychoanalytic sense, is based on an intimate knowledge of the various aspects of the patient's personality and refers to the therapist's attempts to influence the patient in immediate ways, verbal and non-verbal, by making use of his actual or habitual emotional systems for the purpose of the cure... Manipulation may be a personal one or environmental one.
In his contacts with the patient, the psychiatrist must be aware of the social factors which may be preventing the integration of the patient. It is necessary for him to know as much as possible about the patient. He partially acquires his information through the patient's free association and observation of his conduct utilizing this for manipulation and interpretation. The psychiatrist attempts to remove the basis of the patient's disorder through insight and reorientation. Some of the curative factors are the insight which is gained into the resisting forces and methods of defense as well as the insight into the repressed material and the reorientation of both. The ultimate medical responsibility for the emotionally ill person remains with the psychiatrist.

Each member of the clinic team contributes, from his own area of competence, to the total understanding of the situation and all three participate in planning for treatment under psychiatric leadership. The second member of the team whom the writer will discuss is the psychologist.

... psychology as the systematic study, by any and all applicable and fruitful methods, of organisms in relation to their behavior, environmental relations, and experiences. Its purpose is to discover facts, principles, and generalizations, which shall increase man's knowledge, understanding, predictive insight, directive wisdom, and control of the natural phenomena of behavior and experience, and
of himself and the social groups in which and through which, he functions. . . .3

With a growth of dynamic psychiatry there also occurred a shift of emphasis in psychology and studies appeared which involved personality lists.

The contributions of the psychologists have been primarily in the area of psychodiagnoses. The procedures which are employed include verbal and nonverbal intelligence tests, tests of sensory, perceptual and motor functions, tests of memory, reasoning and learning, tests of special disabilities, vocational aptitude tests and situational tests. Diagnostic tests gain in value as they become oriented more toward an analysis of the dynamic and motivational forces which are involved not only in the testing and interviewing situation but in the more fundamental psychopathology in a given patient. The psychological test does not make a psychiatric diagnosis but only contributes toward it.

In some clinics psychotherapy is carried on by the clinical psychologist but the type which he does is determined by his training and individual competence, the conditions under which the training is accomplished, and the type of patient who is being treated. The psychologist who works in close continued association with the psychiatrist has someone who

can assume professional and legal responsibility for him.

The term "clinical psychology" was first used by Witmer who established a psychological clinic at the University of Pennsylvania in 1896. In 1906 Goddard at Vineland established the first psychological laboratory in an institution for the feebleminded. In 1909 William Healey established the Cook County Juvenile Court Behavior Clinic in Chicago for the study of delinquency. His chief emphasis as a psychiatrist was on the motivational aspects of personality and social pathology. The psychologist, whether employed in an institution, hospital or clinic, was concerned with the emotional and motivational factors. It eventually became necessary to control or evaluate those factors and consequently personality tests and detecting devices for various types of maladjustment were developed.

The clinical training program is a graduate program of four years which leads to a doctoral degree. At least one of these years is devoted to concentrated field training.

... this committee believes that to make his [psychologist] most effective contribution to the total area dealing with mental health and emotional adjustment if he works in direct association with a psychiatrist. In such a relationship his maximal effectiveness to persons in need of help will be assured. ... 4

4 Ibid., p. 9.
The third and final consideration of the writer will be given to the psychiatric social worker and her relation to the other members of the clinic team as well as some consideration of other responsibilities which she has in the Veterans Administration setting.

When social work becomes psychiatric social work, it is practiced in a direct and working relationship with psychiatry. When the professions join they do so with the understanding that each has a special contribution to make which will serve in an effectual manner the patient with emotional problems.

The psychiatric social worker is equipped to treat certain emotional problems of individuals. Her knowledge comprises an understanding of the psychological development of personality, the development of personality types, and the main mechanism of these types, an understanding of the basic sources of conflicts and failures, and the possibilities for success and adjustment, as well as some realization of the role of sublimation. In addition, she should be aware of the main structures of the patient's symptoms and his personality and gain some understanding of him in relation to his environment and knowledge of the important factors of his infantile background. This knowledge is acquired through interviews with the patient and observation. Casework is a process to help the patient achieve a better acceptance of himself, his
limitations, and his reality situation.

The first situation in which the training of the psychiatric caseworker is utilized is at intake. During this process the ego strength of the patient is evaluated and the acquisition of specific information is an aid in estimating the meaning of the patient's present symptoms and in determining the type of therapy which will be the most advantageous to him. One of the purposes of casework contacts in a mental hygiene clinic is to make the services of the clinic more available and usable to the patient. As a member of a therapeutic team, the social worker helps to contribute to the therapeutic progress of the patient.

At intake the psychiatric social worker is able to help the patient in his decision to accept or reject treatment as well as help him to assume some responsibility for his part in the illness and in his activities preparatory to treatment. During this process, the patient is allowed to express his attitude toward the treatment which is suggested as well as his doubts and resentments. The psychiatric social worker in this process gives the patient the time to decide whether the treatment which is offered is something that he wants at a specific time. It is important that this first interview be organized sufficiently to reach the most pertinent of the social and psychological facts.
The social worker brings to this relationship acceptance and a non-judgmental attitude toward the person who has come for help. In addition, she brings an understanding of what she contributes to the treatment relationship in terms of the patient's past living experience and his current problem.

During treatment, the case worker attempts to help the patient mobilize his inner health, ego strengths, and gives him warmth and support, thereby enabling the patient to understand his inner problems which have caused him difficulty. The social worker attempts to alleviate the patient's anxiety and so channel his energy into constructive activity in his present living situation which is both satisfying to himself and useful to the community in which he lives. The relationship which is offered by the case worker to the patient is a therapeutic experience for the patient because of its acceptance, understanding, and purposefulness.

The goals of treatment are set by the patient, the nature of his problem, and the degree to which he wants and is able to utilize help.

In a clinic setting the availability of psychiatric consultation for the psychiatric social worker is important since this creates a controlled situation in which the psychiatric social worker can function with a minimum of anxiety around problems that may be difficult. Consultation is also
utilized in establishing and defining the goals of the team.

All activity in the clinic setting is geared to the patient's illness. The over-all responsibility for the patient remains with the psychiatrist who may suggest that the skills and techniques of the psychiatric social worker be employed. Following the intake interview, the psychiatric social worker refers the patient to the psychiatrist who frequently will have all continuous contact with the patient. If certain social problems are presented, the worker and psychiatrist will decide upon the services which the worker will offer. Quite often this service will be to provide continuous service to other persons who are involved in the patient's illness. In working with these associated problems, the function of the case worker may be to explain the operation and function of the clinic, handle their attitudes toward treatment of the patient, and help them through difficult periods which occur as the patient progresses in treatment. In addition, she offers family members opportunities for discussion of the meaning of change in the patient and even changes at times on their own parts. This help is sometimes more effective when the case worker is able to see the family member regularly and thus she may focus her casework treatment on some member of the family.

The psychiatric case worker carries the treatment responsibility under the supervision of a casework supervisor
and consults with the psychiatrist as this is indicated by the nature of the situation and the treatment plan. This may include casework treatment of a patient supplementing the treatment of the psychiatrist who is treating the patient or casework treatment with the patient who in some instances may not require regular contacts with the psychiatrist. In addition, the case worker has contact with other community resources and utilizes these as they facilitate the treatment of the patient.

When the social worker is undertaking direct treatment with patients who present serious emotional problems, she turns to the psychiatrist for help and guidance. She utilizes psychological reports to further her understanding of the individual patient. In the clinic setting some patients are able to benefit from the supportive techniques of the psychiatric social worker. These techniques aim toward bringing about re-orientation to the immediate reality situation. This supportive work, in some instances, might result in the patient's becoming more accessible to psychiatric treatment through direct help with the social problem. The case worker must be aware of the intrapsychic conflict present and have some skill in handling it.

In staff conference and individual consultation, the psychiatric social worker contributes to the clinic's total understanding of the patient's needs. This contribution is
made possible by her knowledge of the social, environmental, and familial forces as they may have influenced the patient's attitude, behavior and general adjustment. From her contacts with the family members, the worker is able to contribute her estimate of the degree to which they can be helped to achieve more desirable attitudes toward the patient and his problems.

The function of the psychiatric social worker is directed, as a whole, toward contributing to the psychiatrist's diagnostic and treatment efforts and toward helping the patient and his family make the maximum use of the services of the clinic. She supplements rather than duplicates the work of the psychiatrist. This is a service to the psychiatrist and the patient. While the psychiatrist treats the illness of the patient, the psychiatric social worker helps the patient use the strengths he has at any particular time as effectively as possible in his social situations. The worker deals primarily with the reality situation and interpersonal relationships and uses social work insight and skills to bring about a better adjustment. She utilizes social agencies and community resources that are available. There must be a clear differentiation of the objective with the psychiatrist and social worker each using his own appropriate skill to bring about the combined objective. In general, the aim of casework is not to eliminate the patient's character disturbances but is to help him find a satisfactory form of social
adjustment. Treatment involves the use of the worker-client relationship and this relationship is the medium through which the client can state his problem and through which attention can be focused on the reality problems. The elements of this treatment consist of helping the client secure and make use of social services, creating an opportunity for better contacts with reality and changing some of the negative factors in the environment.

It is possible to recognize a distinct separation between psychiatric social work and psychiatry while realizing that they are interdependent in a clinic setting. While the area of each discipline may differ, each must be aware of what the other has to offer and at times each takes on the function of the other. Each profession learns from the other, possesses skill acquired through training and background, and facilitates the achievement of their common objective. Each should be completely informed about everything that promotes a better understanding of human nature. If the problem which is presented is predominantly a social one, or when it is the only type of help that the patient can accept, then the psychiatric social worker will, with psychiatric consultation, assume the major responsibility. However, if the problem presented is predominantly one of intrapsychic conflicts, then the psychiatrist will assume the major responsibility. The ultimate medical responsibility for the patient remains with the
psychiatrist and the decision as to whether or not the skills and techniques of the psychiatric social worker will be employed is his. This is determined by joint conference when the objective of social work help will be mutually agreed upon. The methods and techniques which will be utilized by the case worker fall within the scope of the casework supervisor and this is integrated with the continuing psychiatric over-all supervision and responsibility.

Within the clinic setting the training program consists of weekly staff meetings, weekly seminars in psychiatric theory, in addition to individual psychiatric consultation. The close relationship between the casework supervisor and psychiatric social worker is widened to include the psychiatrist.

Within the function of the clinic the psychiatric social worker has a variety of responsibilities. Skillful recording is important and it is important that the emotional quality of the interview be shown in the recording.

The following services which are stated are in regard to services rendered by the social worker to the veteran. These functions are listed in paragraph 2 of the Veterans Administration Technical Bulletin 10A-198.

2. Social Service Function. The Veterans Administration has established social service functions, in the recognition that effective medical treatment in-
factors involved in illness and disability. As an integral component of the Medical Division, Social Service carries out the following responsibilities in collaboration with the various out-patient medical clinics, mental hygiene clinics, hospitals and other VA services in cooperation with the community. (a) Social casework services to veterans directly within the Medical Division; also in relation to the vocational rehabilitation programs; (b) services to other components of the VA: case consultation; and (c) corollary responsibilities of equal importance with (a) and (b) and essential to their adequate accomplishment.

**a. Social Case Work Services to Veterans Directly Within the Medical Division; Also in Relation to the Vocational Rehabilitation Program.**

... The purpose of Social Service is to enable the veteran to cope with those factors and inter-relationships which are destructive and develop those which will be constructive, in his effort to recover from his illness, lessen handicaps, adjust to remaining disability, and re-establish himself. The following illustrate the general area of these casework services:

1. **Assistance to the Veteran in Relation to Entering Upon a Medical Care Regime.**

2. **Assistance to the Veteran Under Medical Care in Out-patient Clinics or Hospitals.** The purpose of this service is to help the ill or disabled veteran to use constructively and without undesirable interruptions, the treatment opportunities and benefits provided through out-patient clinics and hospitals. In close coordination with the physician, assistance is given to the disabled veteran in coping with emotionally charged situations and personal maladjustments which are hindering his rehabilitation.
(3) Assistance to the Veteran in the Process of Leaving Hospital or Domiciliary Care.
(4) Assistance to the Veteran on Trial Visit.
(5) Assistance Through After-Care to a Veteran Discharged From Active Medical Treatment.
(6) Assistance to the Physician in Securing and Evaluating Social, Environmental, and Emotional Data.
(7) Assistance to Veterans Receiving Vocational Rehabilitation Services.
(8) Referrals to Other Agencies.

b. Services to Other Components of the Veterans Administration...

The above listed are the specific functions and services as defined by the Veterans Administration.

CHAPTER IV

TWENTY CASE STUDIES WHICH DEMONSTRATE THE ACTIVITY
OF THE PSYCHIATRIC SOCIAL WORKER AS A PART OF THE
CLINIC TEAM.

As was stated in Chapter I, the writer first selected cases at random which indicated the activity of one or more of the three disciplines. The second step in the process was for the writer to select, from the random sampling, case situations which best demonstrated the function and the role of the psychiatric social worker in relation to her various responsibilities in rendering service to the patient in the clinic setting: those case situations which gave some indication of progress as a result of the utilization of the team concept.

Twenty case situations were selected for study and these were primarily classified as to the most outstanding problem which they presented following some contact with psychiatrist, psychologist or psychiatric social worker.
TABLE IV
OUTSTANDING PROBLEMS PRESENTED IN CASES STUDIED

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Non-emancipation</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>II. Marital problems with coresponding job adjustments</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>III. Environmental difficulties</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>IV. Inadequate Personalities</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Following this classification, the case situations were studied according to the techniques which were utilized by the psychiatric social worker during her contacts with the individual case situation.

The writer then illustrated each group considered through a case presentation which she felt best indicated the type of problem presented and the techniques utilized which were peculiar to that group.

**GROUP I**

A. Number of Cases  
6

B. Problem  
Non-emancipation
C. Techniques Utilized

1. acceptance
2. recognition
3. transference
4. insight
5. reassurance
6. alleviation of financial problems
7. utilization of community resources
8. emotional relief
9. emotional support
10. interpretation
11. establishment of a working relationship

Case Illustration - Group I:

Frank R: Mr. R was referred to the Mental Hygiene Clinic on November 6, 1946 by the Veterans Administration Out-Patient Department neuropsychiatrist. The veteran had a disability of psychoneurosis, anxiety, and was receiving thirty per cent disability compensation. His chief complaints during the intake interview were enuresis five to six times weekly, headaches, backaches, and general feelings of depression and sadness. His history of illness, which was taken by the social worker, indicated that the veteran had been enuretic since childhood and that the condition had been aggravated while he was stationed in the Pacific and continued until the end of the war. While the veteran was able to verbalize his own understanding of the emotional basis of his illness, he expressed considerable feeling regarding the stigma which he felt was attached to an illness of this sort and the psychiatric treatment which was involved. The social worker interpreted the clinic and discussed with him his need for psychiatric help in an attempt to help him accept psychotherapy with a psychiatrist. The veteran was unable to make a decision until a later date when appointments were
arranged for him to see a psychiatrist on Saturdays since he was employed during the week.

There were no additional contacts with the social worker until January 1948 when a request for a social and industrial history was received from the Adjudication Division. During this interview, the social worker learned that the veteran had been having continued contacts with the psychiatrist and he felt that he was benefitting from these. The veteran kept his appointments with the psychiatrist until a few weeks before the next referral to the Mental Hygiene Clinic.

In June 1949 the veteran was again referred to the Mental Hygiene Clinic for psychiatric help by the Out-Patient neuropsychiatrist. During the interview the social worker found that he was not keeping his appointments with the psychiatrist "because he did not feel he was receiving any help". However, it was discovered, at a later date, that Mrs. R., the veteran's wife, had been partially responsible for this. The veteran's complaints were comparable to those cited previously but, in addition, he complained of an inability to get along with his wife. Consequently, in October 1949 the treating psychiatrist requested a home visit by the social worker since he felt the veteran's wife was having a negative effect upon the veteran and was emotionally involved in his illness. The psychiatrist felt that Mrs. R. needed assistance in understanding the veteran's behavior and some assistance in accepting the changes in him which were occurring as a result of treatment.

Mrs. R is twenty-seven years old and is the mother of two boys aged four and three years. The first interview was concerned mainly with the veteran's illness, his period of service, and Mrs. R verbally expressed understanding of the problem of enuresis and informed the social worker that she was
accepting of the condition. She expressed considerable concern about the veteran's background, his family relationships, and his difficulties in Service, and was seemingly in need of an opportunity to express her feelings toward the entire situation, receive assurance that she is a good mother and wife, and the social worker, with her consent, planned to visit again at a later date.

Following this initial home visit, the case was discussed with the treating psychiatrist and it was mutually decided that the social worker would visit Mrs. R on a weekly basis and would attempt to alleviate some of the tension in the home, interpret to Mrs. R the type of treatment which the veteran would be receiving, and what reactions she might expect as a result of treatment. It was also hoped that the social worker would be able to interpret to Mrs. R the part she plays in the veteran's treatment as well as give her assurance that she is handling the situation properly.

Mrs. R related well to the social worker and over a period of several visits to the home a good working relationship was established. Mrs. R was given an opportunity to express her feelings toward the marital situation and the home conditions, which she strongly felt were the results of war and the fact that the veteran had a difficult childhood which he could never completely forget. Mrs. R later amplified this during several interviews, telling the social worker that the veteran was the oldest of five children, all of whom were completely dominated by an extremely aggressive, domineering mother. The veteran is a native of a southern state and this has entered into the situation in that he has never felt completely at home in Rhode Island. During her contacts with the social worker, Mrs. R was able to verbalize many of the difficulties which had accumulated over a period of six years during their married life. Specifically, these were her ambivalent feelings
about her husband's illness, her own needs, which she felt were not being met, namely, her desire for praise and simple affection. She could recognize, at least verbally, that the veteran could not meet these needs, partially because of his background and partially because of his illness. The social worker attempted, during the interviews, to give Mrs. R recognition to assure her that she had done well to withstand the pressures that had been inflicted upon her and attempted to interpret her husband's behavior to her.

Conferences were held between the social worker and psychiatrist at least twice each month and the psychiatrist felt that the home situation would become more intensified as his treatment of the veteran progressed. He suggested that the social worker attempt to discuss with Mrs. R her own family backgrounds and relationships and attempt to discover why she reacts in the manner in which she does since it would seem that she is seeking something in her married life which she lacked in her own background.

During the interviews that followed, with continued reassurance and interpretation, Mrs. R seemed somewhat more objective and understanding of her husband. She was able to recognize some progress in his attitudes in the home, could recognize that the enuretic problem was an emotional one and felt that a large amount of his difficulty could be traced to his impoverished early childhood relationships with his mother. During this period, the veteran's enuresis increased and shortly after this time, the veteran began asserting himself as a father and husband in the home and this resulted in a considerable amount of marital conflict. Mrs. R had difficulty accepting the passive feminine role into which she was being forced, stating that the home conditions were intolerable, that her own personal needs were not being met, and that the veteran was showing all of his hostility toward her. The social worker attempted to interpret
this to Mrs. R by explaining that as the veteran recognizes the dependent person he has been, he is resentful of her independence and strong family relationships in contrast to his own. During this period, the veteran's enuresis ceased completely and Mrs. R was able to recognize the connection between this and his growing independence.

During these interviews the social worker attempted to work through some of the difficulties which appeared obvious in regard to the children. Mrs. R continually showed preference for the older child and was rejecting of the younger one. She placed a good deal of emphasis upon their care and served them abnormal amounts of food. Although her excessive care of them and their reaction to the marital conflict were discussed frequently, Mrs. R seemingly was unable to see their emotional needs and would discuss these only on an intellectual level referring to her use of child psychology books, etc.

The situation in the home increasingly became more difficult, partially because of Mrs. R's inability to accept the treatment of the veteran and partly because of the financial complications with Mrs. R's family since the couple had become involved in several loans to back her father in business and he was presently threatened with bankruptcy. Mrs. R informed the social worker that she was cancelling her husband's appointment with the psychiatrist. This matter was discussed with the psychiatrist who felt that for the present no attempts should be made to force the veteran back into treatment but that the social worker should continue her contacts with the veteran's wife since Mrs. R had expressed a wish for this. During one of the most current visits with Mrs. R, the social worker learned that Mrs. R had used the psychiatrist as a threat to the veteran and consequently he had decided against treatment. As the veteran has matured as a result of his treatment by the
psychiatrist and has partially given up his symptom of enuresis, as he is able to be more independent, Mrs. R has not been able to accept this and so has contrived to manipulate the situation in such a way that he has again broken off treatment.

The following points will illustrate the important factors of this case:

1. As the veteran has become less dependent upon Mrs. R, as a result of his treatment with the psychiatrist, he has given up some of his former behavior patterns, i.e., bed wetting, and has become more the father and husband and so has forced Mrs. R into a feminine, passive role which she has great difficulty in accepting.

2. Mrs. R may eventually need direct treatment with a psychiatrist but at the present time is unable to see this and consequently the social worker will continue to function in the case.

3. The social worker has been able to relieve some of the pressure on the veteran by helping Mrs. R to express her feelings. She has also been able to interpret to the veteran's wife his behavior and also the role played by her relative to the situation. The social worker's goal is to help the veteran's wife to accept the growth in the veteran and to help him to go back into therapy. In addition, the social worker would hope to help the veteran's wife either to change sufficiently through casework help or accept psychiatric help for herself.

The above case is representative of the group of six cases which were grouped under the heading of non-emancipation problems. It is noted that with the exception of utilizing community resources, each of the techniques which are listed under Group I was utilized by the social worker. In three of
the cases studied in the group it was necessary to use other community resources primarily for the purpose of temporarily meeting a financial need which was affecting the veteran's problem. There was an element of support noted in each of the case situations and in all six the social worker's contact was with a family member while the psychiatrist treated the veteran directly. The writer felt that these six case situations demonstrated the progress of the patient in treatment that included the cooperative services of the social worker and the psychiatrist.

GROUP II

A. Number of Cases

B. Problem

Marital problems with corresponding difficulties making job adjustments.

C. Techniques Utilized

1. acceptance
2. recognition
3. transference
4. reassurance
5. interpretation
6. emotional support
7. clarification
8. utilization of community resources
9. utilization of other V.A. facilities
10. establishment of working relationship
Case Illustration - Group II:

John J. Mr. J was referred to the Mental Hygiene Clinic on October 22, 1948 by the social worker in the Regional Office.

At the time of the intake interview, Mr. J was receiving fifty per cent compensation for an anxiety condition. His complaints were not of a physical nature and he informed the social worker that he suffered from periods of amnesia, which built up slowly over a period of a few days and which rendered him incapable of working for a period of time. Information which was secured during the initial interview indicated that the veteran's family background was an unstable one, his parents were divorced and the veteran had left school at the age of fifteen years. He expressed considerable feeling about the fact that he is not able to read or write and informed the social worker that he had left school when he was in the fifth grade at the age of fifteen. He brought out considerable hostility regarding this and during the course of the interviews stated that he felt his wife was superior to him because of his "abnormal inabilities". With assurance from the social worker that she could understand his situation has been difficult because of these handicaps, the veteran was able to verbalize many of his fears and anxieties which he felt existed because of his feelings of inferiority. He informed the social worker that more specifically he fears losing his wife and eventual insanity, adding, that although he had been able to hold a responsible job at one time, he is unable to do so now and is fearful of the insecurity which faces him. He accepted the social worker's interpretation of the clinic services and expressed an interest in having an appointment arranged with a psychiatrist.

The psychiatrist, following his initial interview with the veteran, felt that it would be advisable for the social worker to initiate a contact with Mrs. J since so much of the veteran's insecurity seemed to be in
the area of losing his wife. He explained further that the veteran had felt arrested in his development since the age of seven and that his present condition began to develop during military combat and consists of a slow building-up condition which after a period of a week culminates in anxiety which is manifested by sweating, periods of nausea, severe headaches, shakiness, and confusion. This condition begins to recede after a few days and occurs at least twice each month. The psychiatrist felt that it would be helpful to have Mrs. J's picture of the situation and also to attempt to interpret the veteran's illness to her.

The social worker began having weekly contacts with Mrs. J who willingly gave information relative to the veteran's education and family background. She expressed concern because of the noticeable change in his attitudes and behavior since being in Service. Intellectually, she expressed some insight as to how his present situation could be the result of unpleasant and upsetting experiences that have occurred during his life; however, she had little understanding as to why this should have affected their marital relations and expressed fear of the ultimate consequences. Mrs. J was apparently very much attached to her husband but was intimidated by the changes that had taken place and seemingly was in need of considerable reassurance, interpretation, and an opportunity to talk with someone who would be understanding.

During the course of these interviews, while the psychiatrist was engaged in the treatment of the veteran, the social worker attempted to interpret to Mrs. J the veteran's illness, its meaning, and the treatment involved. In addition, some emphasis was placed on alleviating some of the pressure within the home, specifically, working through the financial situation by referring Mrs. J to another social agency for temporary financial relief. A large amount of the focus was centered on the veteran, his reading and writing difficulties and the meaning which
this had for him, and eventually Mrs. J was able to cooperate with this in a realistic way by helping the veteran in these areas.

Upon the request of the psychiatrist, the social worker had some direct contact with the veteran in an effort to help him think through the possibilities of training for a job under the benefits available through Public Law 16 since he had expressed an interest in this. During December 1948, the veteran began employment and was enthusiastic about it. Mrs. J did not share this enthusiasm and the social worker found that she was fearful that it would be a temporary enthusiasm and that she was certain that the veteran could apply himself for a short period of time only, would not be able to withstand the supervision, and would relinquish the job. Both the veteran and his wife seemed in need of a great deal of support and encouragement during this period.

The veteran continued his contacts with the psychiatrist. An electroencephlogram and psychometric examination were given and both were negative. The neurological examination yielded no abnormal findings except for an absent gag reflex which was suggestive of hysterical anesthesia. The veteran reached a point in his treatment where he could accept the explanation that his difficulties were basically emotional and this, in turn, was interpreted to Mrs. J, who during this period had gained a great deal of insight into her husband's situation and the role which she played in relation to it. The veteran's mood continued to be flexible and he was increasingly able to verbalize his difficulties and relationships at home and at work and could recognize that his own problems were basic to these situations. He showed little improvement in managing his reading and writing difficulties but was obviously less insecure with them as a result of his insight and the encouragement and cooperation which his wife was able to give him.
In the case which is cited, as well as in the five other cases which were studied within this group, the writer found, in addition to the element of support which was very important, that the techniques which were utilized most frequently were, acceptance of both the veteran and his wife in regard to the hostility they were able to express to the therapist, interpretation of each other's behavior, and interpretation of the meaning of the illness, as well as attempts to alleviate collateral conditions which had some relation to the existing problems. Both the psychiatrist and the social worker played an active therapeutic role in each situation and the psychologist contributed to the treatment of the situation within the group. It is noted that five of the techniques that are utilized in Groups I and II are similar and since the problem differs, these are necessarily supplemented by additional techniques to meet the problem of marital difficulties which is peculiar to this group. The writer found that the problem of non-emancipation also related to this group.

**GROUP III**

A. Number of cases

3

B. Problem

Environmental Difficulties

C. Techniques Utilized

1. Reassurance
2. Support
3. Utilization of community resources.
4. Utilization of other V.A. facilities.
5. Clarification of client's problem in terms of needs.
6. Treatment of medical conditions.
7. Interpretation.
8. Reality situations.
10. Assistance in inter-relationships.

Case Illustration - Group III:

David S: Mr. S was referred to the Mental Hygiene Clinic on July 25, 1949. His complaints during the intake interview were chiefly those of insomnia, tremulousness, and inability to sit still. The veteran seemed very much concerned because his wife had informed him that she was disgusted with his numerous treatments and periods of hospitalization for an ear condition. The veteran informed the social worker that he felt his ear condition was responsible for his nervousness and explained that at times his ear aches so badly that the pain causes him to bite his fingernails and forces him to hold his hands to his ears to relieve the pain.

Mr. S at the time of the intake interview was receiving a fifty per cent disability compensation for "Chronic, Purulent, Otitis, Media, Bilateral, Superative" and had been receiving treatment for his condition since his discharge from Service in January 1946. He had been hospitalized for this condition and prior to this initial contact with the Mental Hygiene Clinic had been known to the Social Service Department. He was referred to the Mental Hygiene Clinic by the Out-Patient Department neuropsychiatrist at this time because of his extreme nervousness.

During the initial interview, the veteran informed the social worker that he has been
married for thirteen years. With some feeling
he explained that although he had been employed
for sixteen years by one company prior to his
Service experience, that he has been unable to
work for any length of time since his discharge.
The financial situation in the home seemed
particularly upsetting to the veteran and the
social worker found that they are dependent
upon his disability compensation and unemploy­
ment compensation as a source of income. With
this the veteran expressed a feeling of help­
lessness about his future security. He de­
scribed his wife as being a "chronic asthmatic"
and himself as having "chronic ear trouble",
adding that as a result of these disabilities
they irritate each other and the home conditions
are consequently very unpleasant. The social
worker during this interview attempted to in­
terpret the services of the Mental Hygiene
Clinic to the veteran, assuring him that she
understood that his situation had been diffi­
cult and accepting the resentment which he ex­
pressed about the Veterans Administration be­
because they had not been able to cure his ear
condition. The veteran explained that he would
submit himself to anything "as long as it would
help" and evidenced interest in a psychiatric
interview. The social worker felt that psy­
chotherapy was indicated and that, in addition,
supportive casework with the veteran's wife
during his treatment might be of some assist­
ance, as well as some cooperative work with
the Vocational Rehabilitation Division.

Following the psychiatrist's initial inter­
view with the veteran, the psychiatrist felt
that the social worker should concentrate all
effort toward establishing a relationship
with Mrs. S in order that the environmental
pressures might be lessened for the veteran,
since he seemed so concerned about the finan­
cial situation and his ear condition.

During the home visits which followed, the
social worker was able to establish a sustain­
ing relationship with Mrs. S. The home condi­
tions were poor, the house was located in a
crowded neighborhood and Mrs. S obviously put
little time or had little interest in the home.
The first interviews were mainly concerned with the veteran's illness and the social worker found that Mrs. S was impatient with this and could think only in terms of hospitalization as a solution to the problem. The veteran had expressed an interest in a hobby and Mrs. S was unable to share his enthusiasm about this. She seemingly was in need of an opportunity to express her feelings towards the situation. During the contacts, the social worker was able to relieve some of the pressures, as well as interpret the veteran's condition, and attempt to help Mrs. S realize what her role could be in the veteran's adjustment.

Through the combined efforts of the psychiatrist and the social worker, occupational therapy was arranged for the veteran, as well as authorization for him to attend lip-reading classes. Since the financial problem was such an important factor, a referral to Soldiers' Welfare was arranged and this was acceptable to both the veteran and his wife.

The psychiatrist and the social worker saw the veteran and his wife consistently over a period of several weeks and the veteran gradually developed enough self confidence to apply for a job and was employed by a small jewelry factory. The veteran continued his interest in his hobbies and with encouragement from the psychiatrist was able to put his hobbies on display and consequently received recognition through the local newspaper. The social worker was able to make arrangements for the veteran to attend evening classes and learn simple drafting.

During one of his psychiatric interviews, the veteran had informed the psychiatrist that his wife was an alcoholic. This was later discussed with Mrs. S who was only able to state that she was nervous. During the succeeding interviews she was able to release some of her own feelings about the home situation, her difficulties in relation to the veteran's illness, and the part which she
has played in relation to the illness. The social worker had, upon the request of the psychiatrist, some direct contact with the veteran. This was on a supportive basis and her role was a passive one during which she attempted to talk through some of the financial problems with the veteran, encourage him in his work and hobbies, and explored with him the possibilities of occupational therapy. During this period the veteran was also having contacts with the psychiatrist.

The veteran's relationship with the psychiatrist improved remarkably during these contacts. He appeared to look less dejected, discussed the future with some hope and animation, and began to talk in terms of forgetting physical treatment for his ear condition, informing the psychiatrist that he would try to lick the condition himself. The veteran seemed to gain self-respect with his job and reached the point where he could show hopefulness for the future and was able to verbalize his appreciation to the Clinic. The home conditions improved considerably and at this date both the veteran and his wife are continuing their contacts with the Mental Hygiene Clinic.

The above case is typical of one in which interpretive therapy is carried on at a minimum and the focus is placed almost entirely on those realistic problems which make adjustment a difficult process for the veteran. The techniques which were utilized in all three that were found in this group were comparable. The writer feels that it is of significance that this group which is most conditioned by external factors is the smallest of those studied.

Two of the techniques that were used by the social worker in this group, reassurance and support, were utilized in the two previous groups studied, while the remaining techniques
differed as they were geared to meet the problem. In working with this group, the social worker and the psychiatrist related their activity in an effort to assist the veteran in his reaction to many environmental pressures.

GROUP IV

A. Number of cases 5
B. Problem Inadequate personalities
C. Techniques Utilized
   1. Acceptance
   2. Recognition
   3. Transference
   4. Reassurance
   5. Emotional support
   6. Interpretation
   7. Utilization of other V. A. facilities
   8. Emotional relief
   9. Assistance in acceptance of illness
   10. Alleviation of financial problems

Case Illustration - Group IV:

David B: This situation was referred to the Mental Hygiene Clinic on February 25, 1948 by the Out-Patient Department neuropsychiatrist because of the complaint the veteran presented of "generalized fatigue". Hospitalization was recommended by the psychiatrist at the time of the intake interview but Mrs. B, the veteran's wife, could not accept this but could think in terms of Mental Hygiene Clinic treatment.

The psychiatrist began treatment of the veteran and since Mrs. B had verbalized a need for counseling, casework contacts were initiated. The veteran's behavior, because of his illness,
was extremely antagonistic, both toward his wife and child. During the social worker's contacts, the seriousness of the veteran's illness was constantly discussed with Mrs. B. Since she seemed unwilling to consider hospitalization, the focus of the social worker's interviews was toward assisting Mrs. B to accept her husband's behavior and interpret the chronic aspects of his illness to her. Mrs. B seemingly gained some reassurance from the contacts and was able to verbalize her hostility toward the veteran. As his condition became progressively worse and the home conditions more chaotic, Mrs. B consistently required more support from the social worker. A temporary financial plan was arranged with another agency since the veteran could not accept the fact that his wife had to be the breadwinner for the family. With assurance from the social worker, Mrs. B made an effort to remain detached from the veteran during his more antagonistic periods and gained some intellectual insight into her husband's illness.

The veteran received psychiatric treatment for three months. During April the psychiatrist felt that there was some improvement and Mrs. B informed the social worker that she had noticed this in that he was becoming less aggressive in his sexual demands and she felt that they were less tense with each other. The social worker constantly reminded Mrs. B that treatment was a matter of time and that she should not expect too much from him at one time. During this period the veteran began employment on a part-time basis and relations between them continued to improve. Mrs. B verbalized that she felt that this change might be attributed partially to the fact that she, too, had become less antagonistic; with her new insight concerning the veteran's behavior, she did not rise to the defense as often and as energetically as she had previously because she realized that his behavior could not be helped and was actually not directed toward her as she had previously thought.
Both the psychiatrist and the social worker felt that the goal should be one of assisting the veteran and his wife in their personal adjustment since there was little hope for the veteran to show any real change as a result of psychotherapy and Mrs. B was still unable to think in terms of hospitalization for the veteran.

Following this brief period of improvement, the veteran's behavior again changed for the worse. He became extremely difficult to control especially in relation to the child who consequently was becoming enuretic, nervous, and tremulous. Mrs. B expressed extreme hostility about this, found the social worker accepting of this hostility, and reacted by becoming defensive of her husband. Following this period, the veteran secured employment as a laundry truck driver. Mrs. B continued her weekly contacts with the social worker, informing the social worker that the veteran's condition seemed much improved. During these interviews, Mrs. B was able to verbalize some of her own inadequacies of the past and how they affected the home situation. The social worker attempted to clarify for Mrs. B that although the veteran had improved, that his improvement was far from being a stable, permanent thing and Mrs. B acknowledged that she could understand that he would probably regress periodically.

Following the veteran's employment, the interviews with Mrs. B were held less often and she gradually stopped coming to the office. On September 7, 1949, the Mental Hygiene Clinic received word that the veteran had been a patient at Veterans Administration Hospital, Bedford, for a period of six months. He was allowed to go home on two trial visits and was returned to the hospital because of his inability to adjust and his continued aggressive behavior. Mrs. B presently resumed her contact with the Mental Hygiene Clinic. She is intellectually able to realize that her husband's condition is a chronic one and the social worker is, during her contacts, attempting to reassure her that hospitalization is
the best plan and is helping her to accept and work through the difficulties which are consistent with her situation.

This situation is typical of those in Group IV where the focus is in helping a relative of the veteran accept the fact that his condition is a chronic one. In this group the therapy indicated for the veteran was hospitalization but because this was not immediately feasible, the Clinic assumed a supportive role until the patient's hospitalization could be accepted by the veteran and his family. Seven of the techniques that were utilized in Group IV were similar to those utilized in Group I. Much of the responsibility fell upon the case worker in this group of cases and frequent team consultations were required.

TABLE V
CASEWORK TECHNIQUES UTILIZED IN STUDY GROUP

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Groups Where Techniques Were Utilized</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. acceptance</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>2. recognition</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>3. transference</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>4. insight</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>5. reassurance</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>6. alleviation of financial problems</td>
<td>12</td>
<td>60.0</td>
</tr>
</tbody>
</table>
TABLE V (continued)

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Groups Where Techniques Were Utilized</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. utilization of community resources</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>8. emotional relief</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>9. emotional support</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>10. interpretation</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>11. establishment of working relationship</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>12. clarification</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>13. treatment of medical conditions</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>14. utilization of other V.A. facilities</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>15. assistance in acceptance of illness</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>16. assistance in interrelationships</td>
<td>3</td>
<td>15.0</td>
</tr>
</tbody>
</table>

The above table demonstrates the number of techniques listed that were found to be utilized by the social worker in the entire study. It was noted in the study that although the role of the social worker was fitted into the team-work concept and her focus and goal were geared to the individual problem and the role which the psychiatrist was playing in the treatment process, the techniques which were utilized were frequently similar and appeared in various combinations in the four groups which were studied.
CHAPTER V

SUMMARY AND CONCLUSIONS

The writer attempted in this study to demonstrate the activity of the social worker as part of the clinic team. The four cases which were illustrated as being typical of the four problems selected for discussion were intended to give some picture of how the psychiatric social worker can be of direct assistance to the treating psychiatrist and to the patient.

The writer found that of the twenty case situations studied, or fifteen per cent, could be classified as Environmental Difficulties, while six, or thirty per cent, could be classified as Non-Emancipation Problems, and six, or thirty per cent, as Marital Problems with corresponding difficulties in making Job Adjustments. The remaining five were classified as Inadequate Personalities.

With regard to the techniques which were found to have been utilized in the twenty case situations considered, it was discovered that recognition, reassurance, emotional support and interpretation were utilized by the social worker in all twenty cases and that all of the techniques cited in Chapter IV were frequently similar and appeared in various combinations in all four groups which were studied. Both the psychiatrist and psychiatric social worker were active in each situation and their degree of activity was dependent upon the
problem and the needs of the patient. The responses of the patient and the families in the situations studied may be indicative of what can be accomplished by the utilization of the team concept.

Although there have been many progressive changes in the clinic setting since its inception in 1946, the writer feels that a better and more complete service could be rendered to the patient in relation to his total problem if the team concept could be utilized more frequently. The matter of time and staff still are a limitation and during part of the time of the study there was not a psychologist available.

The writer feels that the study illustrates the impossibility of treating the patient in a vacuum and the value of considering all factors relative to the patient's environment. A keen awareness of all the factors which are involved in the patient's problem and an understanding of these factors assist the therapist in aiding the patient in his adjustment.

Through the utilization of the team, the patient and his illness may be seen and treated not simply in relation to himself but to his entire environment and those factors which may be contributing to his illness are understood. With skilled psychotherapy and a well-integrated clinic setup, the veteran suffering from neuro-psychiatric disorders which do not require hospitalization may be expected to respond favorably, gain insight into his illness, and be restored to healthy
relationships with his community or family.

The study indicates that services to patients in a clinic setting require the collaborative efforts of the psychiatrist, psychologist, and psychiatric social worker. Although the focus is different, the three disciplines can function concurrently and can be aware of the factors of the other. Each discipline is influenced in its approach by its specific training and experience; each offers its particular service as it is best adapted to meet the needs of the patient. Each member of the clinic team contributes from his own area of understanding to the total understanding of the situation, and all three members participate in planning for treatment under psychiatric leadership. When the professions join, they do so with the understanding that each has a special contribution to make which will serve the patient with emotional problems.

The psychiatric social worker in the Mental Hygiene Clinic has numerous responsibilities and the study indicates that the chief one of these is to make available and usable to the patient the services of the clinic and, secondly, as a member of a therapeutic team, to contribute to the therapeutic progress of the patient.

All activity in the clinic is geared to the patient's illness, the goals of treatment are set by the patient, and the nature of his problem and the over-all responsibility for the patient remains with the psychiatrist.
An adequate training program is in operation within the clinic setting and this consists of weekly staff meetings which are attended by the Social Service and Mental Hygiene staffs, weekly seminars in psychiatric theory which are conducted by Doctor Harry Rand, Chief Psychiatrist, and individual consultation periods with the psychiatrist in relation to specific case situations. The close relationship between the casework supervisor and psychiatric social worker is widened to include the psychiatrist and carries through the theme of the team concept.

Approved,

Richard K. Conant
Dean
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