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Casework with veterans who request medication: a study of twenty-five cases at the Lowell Veterans Administration Mental Hygiene Clinic in which medication was requested at intake

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Boston University

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CASework WITH vETERANS WHO REQUEST $MEDICATION: A STUDY OF TWENTY-FIVE CASES AT THE LOWELL vETERANS ADMINISTRATION MENTAL HYGIENE CLINIC IN WHICH MEDICATION WAS REQUESTED AT INTAKE

A Thesis

Submitted by
Robert Holmstrom Krosek
(A.B., University of Massachusetts, 1952)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1957
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CHAPTER I
INTRODUCTION

Many veterans who have come to the Veterans Administration Mental Hygiene Clinic in Lowell, Massachusetts, sought medication. The number of veterans seeking medication is sufficient so that every caseworker in this organization hears the request many times and has some understanding of the problem. The general impression is that many of these patients are seeking relief of symptoms by asking for medication rather than psychological treatment. One might expect that the emotional aspect of receiving something tangible, if there is this need, would take the form of a request for medication in this setting. There may be varying impressions concerning social service casework with these veterans which research can clarify.

Purpose of study

Learning more about these patients and finding out what happens to them as a result of treatment may lead to an approach which is more understanding and of greater service. To give or deny medication is a medical decision, yet the decision concerning medication can be influenced by the psychological state of the patient as well as physiological reasons. Also in casework treatment with these veterans, physiological conditions must be taken
into consideration.

Thus, in an attempt to obtain a clearer picture of the casework problems involved in this type of case and keeping in mind that "Psychological and somatic phenomena take place in the same organism and are merely two aspects of the same process," this study seeks to answer the following questions:

1. What are the social and personal characteristics of these patients?
2. What are their complaints and problems at intake and how do they change during treatment?
3. What are their initial attitudes toward casework treatment and how does this change in the course of treatment?
4. How does the social worker handle the repeated request for medication?
5. What is the caseworker's evaluation of treatment at closing?

Method of study

Commencing in January of 1952 and ending in September of 1955, twenty-five cases met the requirements for this total population sample. Each case record meeting the requirements of a request for medication at intake, a

closed case, and five or more casework interviews was selected with the exception of one case in which the interview records were missing. The data source is case records from which information was gathered in accordance with the items in the schedule which is included in the appendix.

Limitations

In gathering data for a study one cannot expect all known information to be recorded and available in compact form because efficient agency functioning does not require this. The following points are made to show what limitations present themselves in this study. Taking a sample over a four year period seems unreasonably long in that many more patients must have requested medication at intake and thus, the sample would not be the total population. The referral, for purposes of this study, is not fully recorded. Statistically, all referrals are listed as medical referrals and any further information must come from the case records. The intake process was not consolidated during the period over which the sample was taken. It was only natural for many patients to stop at the Out-Patient Department located in the same building on the first floor before arrival at the Mental Hygiene Clinic on the second floor, and so, it would be difficult to distinguish where the referral process ended and the intake
process began. It was possible for medication to be given at the medical section which the casework records would not show.
CHAPTER II

DESCRIPTION OF THE MENTAL HYGIENE CLINIC

The Mental Hygiene Clinic of the Veterans Administration at Lowell, Massachusetts, an affiliation of the Boston Veterans Administration Out-Patient Clinic was established in September, 1949. Among several professions represented in this clinic is social service.

Social Service is an integral professional component of the Department of Medicine and Surgery. It was established on the recommendation that effective medical care and rehabilitation of necessity includes the treatment of the inter-related social and emotional factors. Social Service functions in VA Neuropsychiatric, Tuberculosis, and General Medical and Surgical hospitals, in Domiciliary Centers, and in regional offices.

More specifically the goals of this clinic are set forth:

The purposes of the Clinic are to provide early treatment to veterans on an out-patient basis, while there are elements of anxiety present and the symptoms are reversible, and before the anxiety becomes too well channeled into somatic symptoms with too much secondary gain and intractability, and when psychotherapy is likely to be most effective; to guide the severely mentally ill into suitable vocations and avocations; and to alleviate pressures from their environment and

in this way prevent repetitive and prolonged hospitalization.2

Intake is the initial process at the Mental Hygiene Clinic; it is also one of the first phases of social case-work.

The intake interview probably requires the greatest interviewing skill in case-work. It is characterized by a great variety of problems, and it calls for promptness in making formulations and reaching appropriate decisions... This first interview is of major significance because it is used to explore the presenting problem, the legal eligibility for treatment, the patient's motivation in coming to the clinic, and relevant social and medical factors in his background. The social worker summarizes the salient factors in the patient's history and concludes with a social-diagnostic evaluation and recommendation for treatment.3

This clinic has on its staff two full time psychiatrists who hold medical responsibility for patients referred to social service. The staff also includes three full time social workers and one full time psychologist. The patient first meets the receptionist who records essential information such as name, claim number, and eligibility status.


The social worker is the first member of the professional team to meet with the patient at intake. Next the psychiatrist who keeps the following objectives in mind meets the patient:

....to evaluate the motivation of the veteran, to make a dynamic diagnostic survey, to estimate the treatment potential and finally initiate a course of treatment.4

These two component processes can best be described as follows:

This dual intake procedure implies the teamwork of the psychiatrist and the social worker; the intake team becomes a clinic in miniature for the joint study of the veteran's motivation and of possible ways of meeting his problems. The mutual dependencies of the two disciplines working as a team serve to illuminate the areas not singly covered by each discipline, offers the veteran more effective and expeditious treatment, and results in a mutually educating experience for the psychiatrist and social worker.5

In addition the psychologist often gives psychological tests as an aid in understanding the patient.

If treatment is the plan of action, then the patient is seen by a staff member representing one of the three

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disciplines or a trainee in one of these fields. Treatment may consist of individual or group therapy. Policy pertaining to the function of the social worker in this setting follows:

The psychiatric social worker in the Mental Hygiene Clinic setting participates in the treatment of veterans with neuropsychiatric disabilities. His activity begins at the intake level through the acquiring of a dynamic social history, interpreting the clinic to the veteran and helping him to accept the treatment offered in relation to his problem. The worker also participates in the therapeutic activities of the clinic by bringing to the diagnostic and follow-up study an analysis of the factors of the patient's history and current circumstances which have significant bearing on the cause, development, and nature of his illness. Individual casework treatment under the direction of the Chief Neuropsychiatrist and Chief Social Worker is carried on in cases in which the emphasis is upon conscious material within current reality situations. Other duties include working with families or relatives when the clinic treatment plan indicates a need for collaborative treatment between psychiatric social worker and psychiatry or psychology.

The following chapters present a review of some of the material which relates to the overall understanding and treatment of the kinds of patients included in this study.

6 U.S., Veterans Administration, Dept. of Medicine and Surgery, op. cit., p. 6.
CHAPTER III
PSYCHOSOMATIC CONCEPTS AND SOCIAL SERVICE CASEWORK

A philosophy and framework of reference is necessary to understand and treat people. Psychosomatic phenomena in the personalities of these veterans are a concern of this study and a section will be devoted to this subject. The social worker observes, diagnoses, and treats psychosomatic phenomena. Since this study takes up these three aspects, social service casework will be considered in the second section of this chapter. The focus of information in this chapter is broad and does not necessarily apply to the specific content of this study other than in a general way. To more fully understand the data, however, one must apply some of these thoughts to the material presented.

The Psychosomatic Approach

Discussion of the psychosomatic approach is in order for a study which presupposes that many patients who request medication have somatic symptoms. All operations of the body are influenced in a direct or indirect way by stimuli of a psychological nature because the entire organism makes up a unit with each division interconnected.1 This idea can be broadened.

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1 Franz Alexander, op. cit., p. 12.
Personality can thus be defined as the expression of the unity of the organism. As a machine can only be understood from its function and purpose, the understanding of the synthetic unit which we call the body can only be fully understood from the point of view of the personality, the needs of which are served in the last analysis, by all parts of the body in an intelligible coordination.2

In each case or situation, the relative weight which can be attributed to emotional and somatic factors will vary. Since there is the variation and multi-causality between psychological and non-psychological elements, any validation of "psychosomatic disease" as a particular diagnostic group would seem unfounded. In theory all disease is psychosomatic since every body process is influenced by emotions.3 "The life history of everyone can be considered, therefore, a complex psychosomatic process..."4

How do psychosomatic patterns develop? Important is the early type of interaction between parent and child. These patterns can be separated from infantile reactions in its entirety before the development of words. The implication is that these primary experiences are most difficult to modify and that they occur before the beginning of verbal

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2 Ibid., p. 34.
3 Ibid., p. 52.
4 Ibid., p. 56.
memory. Furthermore, primitive and violent emotions go
with these early experiences and the psychosomatic pattern
amounts to a defense against the possibility of a re-
experience with the disagreeable situation and the
accompanying feelings.7 People tend to deal with crisis
situations through physical symptoms, but the difference
between the mature and the immature personality is that
with the mature these expressions do not persist while the
immature tend to rely upon them.6

Franz Alexander states: "It is well established that
emotional influences can stimulate or inhibit the function
of any organ... After the emotional tension relaxes, the
body functions return to their normal equilibrium."7
Actually there are many common responses. He also says:

Corresponding to every emotional
situation there is a specific syn-
drome of physical changes, psychoso-
matic responses, such as laughter,
weeping, blushing, changes in the
heart rate, respiration... these
psychomotor processes belong to our
everyday life and have no ill
effects..."8

5 John P. Spiegel, "The Psychosomatic Protest," 1:7,
Medical Social Work, October, 1952.

6 Jurgen Ruesch, "The Infantile Personality, Core
Problem of Psychosomatic Medicine," Psychosomatic Medicine,

7 Franz Alexander, op. cit., p. 41.

8 Ibid., p. 39.
At some point these responses can become a difficulty. If the emotional disturbances are prolonged, chronic somatic difficulties may result and become irreversible.9

Getting into the realm of treatment, one must keep in mind that each organic symptom has emotional significance through which the ego takes advantage in order to relieve emotional conflicts. When the ailment is cured, the ego attempts to fill the emotional vacancy created by the loss of the symptom. Therefore, the patient may consciously desire to get rid of the organic symptoms, but the needs which the illness serves may still be there.10 Now one can more fully understand that:

In a great number of cases the medical management of local symptoms and psychotherapy can be carried out simultaneously. In other cases, psychotherapy must be postponed until the patient's physiological disturbances are improved with the help of medical management. It is important to realize that penetrating psychotherapeutic measures which attack the fundamental emotional factors are apt to lead to transient increases of emotional tensions and may thus precipitate exacerbations of somatic symptoms. Close cooperation between the psychotherapist and the medical specialist is therefore imperative.11

9 Ibid, p. 144.
10 Ibid, pp. 269-270.
11 Ibid, pp. 266-267.
Pointing out some of the gaps in research will more fully delineate the scope of this study. There is a lack of understanding of the relationship between parent and child in the beginning development of psychosomatic patterns. Exactly what the "whole man" concept means is not fully known. Little has been done to separate cultural and sociological factors from purely psychological factors. Environmental impact on illness is often described in vague terms. Descriptions of emotions are often vague and this point is elaborated upon in the following statement: "Reference to emotions in such general terms as anxiety, tension, emotional unbalance is outdated. The actual psychological content of an emotion must be studied with the most advanced methods of dynamic psychology and correlated with bodily responses." Actually, there is no special treatment for illness of a psychosomatic nature and little is known about the exact mechanisms which transpire between the psychological system and the physiological operations of the body.

No one approach or view is the answer in understanding human behavior. Each discipline dealing with human behavior in a professional way has its own ways to observe and

13 Franz Alexander, on. cit., p. 11.
each means of measure has its margin of error. As a result, human behavior is not observed as a complete entity, but in part. Alexander maintains:

Psycosomatic research deals with processes in which certain links in the causal chain lend themselves, at the present state of our knowledge, more readily to a study by psychological than by physiological methods, since the detailed investigation of emotions as brain processes is not far enough advanced... Even when the physiological basis of psychological phenomena is better known, it is not likely that we can dispense with their psychological study. 15

Social Service Casework

The basic processes in social casework are study, diagnosis, and treatment. 16 These processes briefly will be described. They occur simultaneously and vary during the interviews. 17 Hamilton thinks of study in this light:

All exploration or investigation is for the purpose of coming to a better understanding of the person who has the problem, as well as the problem itself, in order to engage in effective treatment. Since the term 'investigation' which means 'steps inwards' (towards understanding), has

15 Franz Alexander, op. cit., p. 55.
17 Ibid., p. 60.
come to have unpleasant connotations
we prefer study for the overall con-
cept. 18

Study and observation serve as a guide for action, but they
also indicate that which should be left alone. 19 The case-
worker must try to understand the social situation as well
as the inner life of the patient. Human relationships are
unseen, intricate, and emotionally involved, but social
workers have one advantage in that people can talk and one
can learn to hear what they say.

Study is engaged in as long as the patient is known, 20
and all study is a psychosocial process. People, events,
and feelings toward them as they occur in real life
situations can be studied objectively and through the case-
work relationship. Before interviewing became accepted as
the principal technique for study, the social worker made
many first hand observations. Today one tries to maintain
a balance. It is here noted that intake is considered the
first phase of study. 21

Social work diagnosis is the worker's professional

18 Gordon Hamilton, Theory and Practice of Social
20 Ibid., p. 35.
opinion about the particular need or problem presented. Some theorists consider diagnosis and evaluation to be one concept, but Hamilton states they are concurrent and related. Evaluation implies a professional social judgment. Whether combined or concurrent, the goal is to understand the case and to make treatment effective. It is well to keep in mind that "No interpretation of the living human event can be final, no diagnosis can be complete."

The Hollis classification of casework techniques for treatment is widely accepted and very suitable for this study. The two broad divisions are intervention in the environment and employment of various psychological methods. All four classifications, each consisting of a number of techniques, may enter into treatment although one is usually dominant enough to characterize treatment by that name. These four broad classifications will be discussed: psychological support, clarification, insight, and modifying the environment.

Psychological support has a number of components. Among these components are encouragement of feelings and free expression and the promotion of helpful attitudes. The

Caseworker may express interest, show desire to aid, display confidence that there can be improvement, or give approval. Sympathetic understanding and acceptance are characteristic and positive feelings are often elicited on the basis of a warm parent type of relationship. The above aspects are based upon sound diagnostic thinking; and the aim is to reinforce the ego, but not to remove the cause. An equilibrium can be maintained by decreasing tension and guilt. Building self-confidence and promoting compensatory assets also support the ego.

The core of clarification is understanding. The subject may learn to understand himself, relationships, or the environment. The ego is aided to perceive more clearly. Clarification may simply amount to an intellectual thinking through with little emotion expressed. The intellectual component is high even if considerable emotion is involved. Clarification is on a conscious or preconscious level.

The development of insight is on a deeper feeling level than clarification and understanding may be impossible without this development. There is a reliving of present or past emotions in the interview situation whereupon emotions are discharged and material brought to the surface. The transference element is strong, and negative as well as positive feelings are present. Support and clarification always go
along with insight. One may even have to deal with repressed derivatives before insight is gained.

Modifying the environment is herein defined as direct changes in the environment made by the caseworker. This does not include all changes which may take place in the environment. One guide for taking this step is that the situation be out of control of the patient and that the caseworker be able to do something about it. When it is better for the patient to attempt the change, the caseworker may try to psychologically motivate the patient. However, there may be times when it is more suitable for the caseworker to take action even though the patient can.25

CHAPTER IV
A GENERAL STUDY OF THE PATIENTS AND
THE REQUEST FOR MEDICATION

Description of Patients
These veterans are similar in many respects. They are similar in age to each other and one might expect them to have much in common with the general population of the same age. For patients at a mental hygiene clinic, distinguishing characteristics are expected which do not fall within the average norm. For patients who meet the specific requirements of this thesis, possibly there are further distinguishing features. The age of these veterans appears to be significant.

At intake, the mean age of the twenty-five cases studied was 31.8. The breakdown by age follows:

TABLE I
DISTRIBUTION OF PATIENTS BY AGE AT INTAKE

<table>
<thead>
<tr>
<th>Age Group in Years</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30</td>
<td>6</td>
</tr>
<tr>
<td>31-35</td>
<td>15</td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
</tr>
<tr>
<td>41-45</td>
<td>0</td>
</tr>
<tr>
<td>46-50</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
</tbody>
</table>
Each man served during World War II and three men served during the Korean conflict as well. Thirteen men were known to have had combat experience. Before coming to the Clinic and the end of World War II almost seven years had elapsed, so that these veterans did not comprise an adolescent group. Neither were they an older group, for distribution was around a middle age norm.

Few veterans completed high school, as shown below, yet none left school prior to grade seven.

**TABLE II**

**SCHOOL ACHIEVEMENT OF PATIENTS**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school or trade school graduate</td>
<td>3</td>
</tr>
<tr>
<td>Left school during high school or trade school</td>
<td>6</td>
</tr>
<tr>
<td>Left school prior to high school</td>
<td>0</td>
</tr>
<tr>
<td>Left school prior to grade seven</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Education was completed beyond high school in one case and it seems that formal educational achievement may have reached a permanent level since only one veteran was a full time student. Of the three graduates, one graduated from high school and the other two completed trade school.

Educational information is incomplete in the present study.
because it was not part of routine recording procedure. In Ogden's study of thirty younger Korean veterans, only four of them left school prior to high school and fourteen were high school graduates.¹

In the occupational distribution table, four job categories are used. These categories are not a scale indicating wealth or status although these factors are involved. "Professional" includes the traditional professions as well as occupations requiring a superior education. In the "semi-professional" category were placed "white collar" workers not found in the first category. These persons are generally associated with professionals and include clerical workers. The "skilled, semi-skilled" category involved persons with special skills, special training, or prior apprenticeship. "Unskilled" included persons whose labor did not involve special skills, special training, or previous apprenticeship. The occupational distribution of these patients follows:

TABLE III
OCCUPATIONAL DISTRIBUTION AT INTAKE

<table>
<thead>
<tr>
<th>Job Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unskilled</td>
<td>15</td>
</tr>
<tr>
<td>Skilled, semi-skilled</td>
<td>6</td>
</tr>
<tr>
<td>Semi-professional</td>
<td>4</td>
</tr>
<tr>
<td>Professional</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Of this group, seven patients were unemployed and the full time student was working part time as an unskilled laborer. Most of the patients including the unemployed group were receiving monetary compensation from the Veterans Administration for neuropsychiatric illness.

To be eligible for treatment at the Clinic, the patient must have a rating of disability for service-connected neuropsychiatric disorders. This service connected disability entitles a veteran to monetary compensation designated by a per cent. Onset of the disability or aggravation of a disease or injury must have occurred during the period of service. Eighteen patients received up to thirty per cent compensation. Four patients received between forty and fifty per cent compensation which left three veterans receiving between sixty and eighty per cent compensation.
The marital status of these veterans is shown in the following table:

**TABLE IV**

MARITAL STATUS AT INTAKE

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>24</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

These men have family responsibilities. The married veterans were living with their wives, and there were children in twenty-two of the families. Five families had one child, and seven families had two children. Six families had three children, and one family had four children. Not included were the pregnancies or the recent births of nine wives. One veteran's wife took the children and filed suit for divorce during treatment. The single veteran was living with his father. In twelve instances it is known that parents, siblings, and in-laws lived in the same apartment or dwelling with the veterans. Generally these persons lived in separate apartments in the same dwelling. It seems likely that the immature reactions of these veterans center to some extent around their responsibilities to and relationships with the family.
The Request For Medication

The social worker and the psychiatrist each attempt to understand the request for medication. Although the psychiatrist holds medical responsibility and makes the decision in regard to medical needs, it is understandable that the patient may ask for medication from the social worker with whom he is meeting. The patient often sees the Clinic more as a unit, and therefore may not be able to easily differentiate the functions of Clinic personnel. Information gathered in accordance with the schedule about the request and the handling of the request furnished descriptive data although it was not always complete for correlative purposes.

The social worker noted that the patients asked for "pills", "medication", or "sedatives" in most cases and they requested the medication rather specifically for headaches, insomnia, weight loss, floor pacing, ulcers, the stomach, pains, a tense feeling, and gas.

Even more important are these facts. Eight patients received medication at intake and one person was denied medication. Medication was given at one time or another in fifteen cases and in eight cases, it was constantly given. Six patients used medication from sources other than the Veterans Administration during treatment. Seventeen patients had used medication in the past for their symptoms.
Two patients, not known to have used medication during treatment, left because they did not get it. At termination of treatment, six patients requested a return to the General Medical Section. There is an indication that these veterans relied upon medication which met some emotional or physical need. One must also consider that this data does not constitute a full description, and that the use of medication may be greater than shown here.

How often was the request for medication repeated? Eighteen patients ceased the request for medication after the middle third of the treatment interview. At least the records did not disclose a further request. Whether the request was resolved is not known, but after decision by the medical authority, one purpose of casework handling is to facilitate a shift to a focus which centers upon the more basic needs of the individual.

The caseworker appeared to use several approaches to the request for medication after exploration and understanding. Sometimes the patient had just seen the medical authority and it was quite evident that suggestion of some other course of action was in order. One patient was asked if the pills helped on previous occasions. The reply was in the negative and the caseworker then suggested that the patient try to get along without pills and come to the Clinic
instead. In some instances, the caseworker consulted the psychiatrist or arranged for the patient to make a visit. One patient did not accept the opportunity to visit the psychiatrist. Another patient who requested medication said the medication from his private physician helped. The caseworker pointed out to this patient that since the private physician's medicine was helpful and since he thought casework treatment was helpful, there did not seem to be any real need for medication from the Veterans Administration. In another situation, the request was explored and since the request was not repeated, no further consideration was necessary.
CHAPTER V

A DESCRIPTIVE SURVEY OF DIAGNOSIS AND TREATMENT

The Diagnosis

What are the complaints of these patients who request medication? Most of the complaints in the table below were presented and seen by the patient as somatic in nature. In some cases the patient did not complain, yet symptomatic features were observable by the social worker. A number of patients had some awareness that the bodily complaints were psychosomatic. The table follows:

TABLE V

PHYSICAL AND EMOTIONAL COMPLAINTS PRESENTED
FROM INTAKE TO CLOSING

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Anxiety, diffuse</td>
<td>17</td>
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<tr>
<td>Stomach disorders</td>
<td>15</td>
</tr>
<tr>
<td>Pain, pressure in the head</td>
<td>14</td>
</tr>
<tr>
<td>Irritability</td>
<td>12</td>
</tr>
<tr>
<td>Insomnia</td>
<td>7</td>
</tr>
<tr>
<td>Fatigue</td>
<td>6</td>
</tr>
<tr>
<td>Depression</td>
<td>6</td>
</tr>
<tr>
<td>Tremors</td>
<td>6</td>
</tr>
<tr>
<td>Dizziness</td>
<td>6</td>
</tr>
<tr>
<td>Pain or pressure within the chest</td>
<td>6</td>
</tr>
<tr>
<td>Breathing difficulty</td>
<td>5</td>
</tr>
<tr>
<td>Back, extremity, or neck pains</td>
<td>5</td>
</tr>
<tr>
<td>Weight loss</td>
<td>4</td>
</tr>
<tr>
<td>Gagging, dryness in throat</td>
<td>3</td>
</tr>
<tr>
<td>Paralysis</td>
<td>3</td>
</tr>
<tr>
<td>Constipation, diarrhea</td>
<td>3</td>
</tr>
<tr>
<td>Sweating, skin irritation</td>
<td>3</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3</td>
</tr>
</tbody>
</table>
Somatic complaints were noted in all cases during intake and in only two cases were they not presented afterwards. It is doubtful that in these two cases they disappeared because no mention was made in the closing summary. The multiple complaints presented were not temporary in nature and many of these patients very definitely wanted medication for them. Furthermore, records disclosed that twenty of these veterans received hospitalization apparently for symptoms similar to the complaints which brought them to the Clinic. Although the hospitalization was for diagnostic purposes in many cases, this fact must bear some relationship to the severity of the disorders.

What problems did the patient present from intake to closing? Current problems were chosen since these were the problems most often presented. The current situation has been the traditional concern of social service and the table follows:

**TABLE VI**
CURRENT PROBLEMS PRESENTED BY THE PATIENTS

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship with</strong></td>
<td></td>
</tr>
<tr>
<td>Wife, children</td>
<td>29</td>
</tr>
<tr>
<td>In-laws, relatives</td>
<td>10</td>
</tr>
<tr>
<td>Persons at place of employment</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
</tr>
<tr>
<td><strong>Concern over</strong></td>
<td></td>
</tr>
<tr>
<td>Employment, finances</td>
<td>25</td>
</tr>
<tr>
<td>Wife's pregnancy or recent childbirth</td>
<td>6</td>
</tr>
<tr>
<td>Physical handicap or illness in the family</td>
<td>7</td>
</tr>
<tr>
<td>Sexual difficulties</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>5</td>
</tr>
</tbody>
</table>
Adult living is a period of responsibility and these patients found it difficult to meet the adult responsibilities of marriage and the job. Although not included, many patients talked about their service experiences. A few talked about past relationships with their parents. The current situation is affected by this past history, so one cannot consider the current situation to be a total product of the present. The caseworker is able to work with the past through the current situation and unless the patient is enabled to solve some of these problems past or present, it is unlikely that the complaints will cease. Minor problems of little concern to the patient were not tabulated. Where problem areas are grouped together in this table, the numbers have been totaled in with each other.

A brief explanation of psychoneurosis will be presented since the majority of cases studied fell within this classification as the symptoms and problems partly indicate. Every human being has neurotic symptoms and conflicts from which anxiety results. The normal person gets along fairly well, but the neurotic person is not able to make a satisfactory adjustment. In the neurotic, this anxiety is usually beyond conscious understanding, yet there is often the feeling that something is wrong. Emotional states common to the neurotic are frustration, fear and hostility
which is repressed. Vomiting, diarrhea, fainting, weakness, and a quickened heartbeat may result along with the chronic malfunctioning of certain organs in the body. The neurotic in contrast to the normal person does not live comfortably with conflicts. The psychoneurotic still grasps reality and is able to relate to those persons in the environment. In a neurosis, the ego is no longer successfully able to integrate the demands upon it.¹

It has been pointed out that:

The patient's attitude toward treatment is an important factor for consideration in any setting. But it is particularly so in a mental hygiene clinic which for many people still carries a stigma characterized by a fear of being considered weak or inferior if not crazy or insane.²

These prevailing notions undoubtedly played a part in the following attitudes:


TABLE VII
PATIENT'S ATTITUDE TOWARD TREATMENT AT INTAKE

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pronounced reservations</td>
<td>12</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>11</td>
</tr>
<tr>
<td>Positive</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

For many veterans, it was their first visit to the Mental Hygiene Clinic. It is interesting that twenty-two veterans were known to have stopped at the medical section. Medical treatment is accepted by society and often considered a remedy for all ills. However, after referral upstairs to the clinic, a number of them asked: "What is this treatment they were talking about?"

Three terms were used to describe the patient's attitude toward treatment at intake. The writer applied these three terms to statements by the caseworker and quotations from the patient concerning attitude toward treatment. "Pronounced reservations" was applied to attitudes which were best characterized by few positive feelings, rejection, lack of knowledge, or suspicion. "Ambivalent" was used in the social work professional sense meaning the combination of two tendencies which are opposed to each other. The patient seemed to want treatment, but then again did not
want it. "Positive" attitudes contained few negative elements. There was an apparent motivation, willingness, and desire to make use of casework treatment.

What does it mean that in only two cases the attitudes were classified as "positive"? According to theory, emotional conflicts can be repressed into symptomatic forms which are less threatening than consciously facing the conflicts. If this be true, the patient may not look upon treatment with a favorable attitude. However, these difficult emotional situations must be worked through to some degree in order to improve. Perhaps attitudes are an index of the degree to which casework services were used.

The diagnosis of psychoneurotic illness is predominant in this study as shown in the following table:

TABLE VIII
INTAKE DIAGNOSIS BY PSYCHIATRIST

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoneurotic reactions</td>
<td></td>
</tr>
<tr>
<td>Anxiety reaction</td>
<td>7</td>
</tr>
<tr>
<td>Conversion reaction</td>
<td>6</td>
</tr>
<tr>
<td>Somatization reaction</td>
<td>4</td>
</tr>
<tr>
<td>Depressive reaction</td>
<td>1</td>
</tr>
<tr>
<td>Phobic reaction</td>
<td>1</td>
</tr>
<tr>
<td>Psychophysiological reactions</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis without known organic origin</td>
<td>1</td>
</tr>
<tr>
<td>Borderline psychotic reaction</td>
<td></td>
</tr>
<tr>
<td>Mental disorders, the result of impaired brain function</td>
<td>1</td>
</tr>
<tr>
<td>Post-traumatic encephalopathy, passive-dependency reaction</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
</tbody>
</table>
In this study there is a scattering of reactions as well as a few diagnostic formulations other than psychoneurosis. Only one diagnosis involved psychosis. Previous mention was made in Chapter III that psychosomatic disease did not limit itself to any particular diagnostic category, but in three-fifths of these diagnoses there is a somatic emphasis which is characteristic of psychoneurosis rather than psychosis. The psychotic patient usually has regressed to a point and in such a manner that somatic symptoms are not needed for such a level of adaptation. One must remember that these twenty-five patients were living in the community and they were dealing with reality situations although in a limited sort of way.

The definitions used in the psychiatric diagnosis table are standardized nomenclature employed in the Veterans Administration. They closely correspond to the nomenclature standardized by the American Medical Association. Since the diagnosis is considered to be the lowest subclassification, one must turn to the bulletin if more specific information is desired. Fundamentally, social work practice is no different in the Veterans Administration than in other social work settings. 3

Treatment Data

One might not expect these veterans to attend as many interviews as they did. The interview statistics follow:

TABLE IX
INTERVIEW STATISTICS

<table>
<thead>
<tr>
<th>Range of Interviews</th>
<th>Number of Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended</td>
<td></td>
</tr>
<tr>
<td>8-15</td>
<td>9</td>
</tr>
<tr>
<td>16-23</td>
<td>10</td>
</tr>
<tr>
<td>over 23</td>
<td>6</td>
</tr>
</tbody>
</table>

It is most likely the veterans attended enough interviews to gain some understanding of the casework process, but one might speculate in many cases that the treatment aspect of the process was just beginning. Twenty-one veterans cancelled appointments less than six times. In nineteen cases there were less than six absences for which no prior notification was given.

Supportive treatment was characteristic of every case except one in which the caseworker dealt primarily with resistance. Patients usually fail to associate symptoms with problem areas and look upon them each as separate entities because they need their symptoms. Yet in many
instances it was necessary to give some preliminary understanding of physical and emotional complaints through clarification, so that the patient would see a purpose in coming to the Clinic. Since casework treatment is not tangible like medication, it may have been necessary to interpret how "talking" might help. There often is a part of the personality which wants to keep the physical and emotional complaints and a part which wants to get rid of them. The need for complaints by these patients was probably one reason why they made as little use of understanding through clarification as they did. There were few examples of modifying the environment since the Clinic emphasis is upon manipulating the personality to change the environment. The records indicated some examples of insight therapy, but many examples were not expected because this form of treatment is not a primary technique used by social workers.

Changes brought about through treatment not only tell of results, but they further describe the patient. The intensity of somatic complaints decreased in nine cases and the intensity of emotional complaints decreased in nine cases. Problems became less troublesome in fifteen cases. In determining change in attitude toward treatment at closing, the writer compared statements by the caseworker
and quotations from the patient with the initial attitudes. Quantitative measurement of change in attitude seemed most practical in terms of "more accepting", "less accepting", and the "same"; the number of patients in these categories were seven, three, and thirteen respectively. Evaluation was not possible in two cases. These changes were noted primarily in the closing summaries.

The following evaluations show that many of these patients did improve:

TABLE X
CLOSED EVALUATION OF TREATMENT

<table>
<thead>
<tr>
<th>Caseworker's Evaluation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>16</td>
</tr>
<tr>
<td>Unimproved</td>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

However, fourteen of the improved patients listed in the above table were classified as slightly improved, while one patient was listed as considerably improved. The writer noted from the closing summary that one person not evaluated became worse. Five out of eight of the unimproved cases had attitudes best characterized as "pronounced reservations" at intake. Four out of eight patients evaluated
"unimproved" received medication consistently. It is interesting to note some of the reasons for closing. The caseworker terminated six cases and the factor of the caseworker leaving entered into eleven cases. In six cases the patient absented himself from treatment without notification. Two patients were hospitalized.
CHAPTER VI
SUMMARY AND CONCLUSIONS

The purpose of this study was to furnish a description of veterans who requested medication at intake and to learn something about treatment with them. Answers to the following questions were sought:

1. What are the social and personal characteristics of these patients?

2. What are their complaints and problems at intake and how do they change during treatment?

3. What are their initial attitudes toward casework treatment and how does this change in the course of treatment?

4. How does the social worker handle the repeated request for medication?

5. What is the caseworker’s evaluation of treatment at closing?

To conclude this thesis, a summary of information and trends will be presented.

The mean age of the twenty-five World War II veterans studied was 31.3 years at intake. The available information about school achievement indicated that schooling was generally completed up to grade seven, but only three veterans graduated from high school or trade school. Fifteen
veterans were unskilled laborers and the remaining ten were in skilled, semi-skilled, and semi-professional occupations. There was unemployment in seven cases at intake. Twenty-four veterans were married and there were children in all but three of their families.

It was found that the request for medication ceased in eighteen cases after the middle third of the treatment interviews. The medication request was for specific complaints and most of the veterans used medication for these complaints in the past as well as during casework treatment. Multiple complaints and problems were found in almost every case. The attitudes toward treatment at intake were those characterized as "ambivalent" and "pronounced reservations". In nineteen cases, the psychiatric diagnosis fell under the general heading of psychoneurosis with distribution fairly even among anxiety, conversion, and somatization reactions. Supportive treatment was the predominant form of treatment in most of the interviews. The closing evaluation by the caseworker in sixteen cases was "improved" and the improvement was slight in fourteen out of these cases. Eight were listed as unimproved.

One trend seems to be that these veterans came to the Mental Hygiene Clinic when responsibilities of adult life weighed heavy upon them. The principal difficulties were
with the family and the job. More specifically, relationships with the wife and children and concern over employment and finances were presented as difficulties. Again it will be mentioned that at the time of intake, nine of the wives were pregnant or had a recent childbirth. Most of the veterans were in a middle age norm and their accumulated burdens may have become so troublesome that there was enough motivation to seek help.

Another trend was that the multiple physical and emotional complaints did not disappear although their intensity decreased in about one-third of the cases. The intensity of the current problems decreased in about two-thirds of the cases. While the attitudes toward treatment at closing remained fundamentally the same in thirteen cases, it was encouraging to note that in only three cases were they "less accepting".

Another trend concerns medication. These patients seemed to acquire medication whether from the Veterans Administration or from some other source. Many patients ceased their request for medication, but whether it was because of casework handling or because they obtained medication is not known. Four out of the eight unimproved cases consistently received medication and five out of the eight unimproved cases had few positive attitudes toward treatment.
Perhaps the use of medication does affect the capacity of the individual for casework services. Yet interview statistics reveal these patients did come to the Clinic and many of them did improve. It seems they would not have continued to make use of casework services if the services were totally unsatisfactory to them. If these patients had a need for their complaints and if they wished to view them as separate from the emotional situations which caused them, it is not surprising that they used medication for relief.

One final area worth commenting upon involves the fact that these veterans had adjusted to reality for the most part although the adjustment may not have been mature and satisfactory. Only one personality was considered to be psychotic. They almost all were married, had families of their own, and held down a job. A number of them had skilled positions. They all had obtained at least a seventh grade education and this group spent considerable time in the service. Maintaining positive relationships and adjustments through the aid of casework services is an important goal.

What do other studies find about persons who request medication? One study found that patients who preferred medication for symptoms generally resisted the type of
treatment which the clinic offered. In a study of veterans with physical symptoms, none of the nine patients who requested medication were interested in psychiatric treatment. Only one study was found which dealt specifically with patients who requested medication. That writer, from six cases, observed that the patients generally asked for medication at intake or during the first two interviews. Five patients came because of symptom difficulties and one patient came because his medication source had been discontinued. The group seemed resistant to consideration of emotional matters and where symptomatic patterns appeared to be more entrenched, the focus on symptoms seemed to be even more pronounced.

Spiegel, in a comparative study of 1946 and 1952 World War II veterans receiving psychiatric treatment, concluded that among the latter group there was a greater demand for medication. It was felt that these patients were repressing


their emotional and personality differences through their physical symptoms and, in general, resisted treatment more than the former group. The median age of the 1952 group was thirty years in comparison to the median age of the 1946 group which was twenty-four years. Stearns in a comparative study of World War II veterans concluded that older veterans had more severe and more localized difficulties than the younger groups.

The conclusions from this and other studies seem to suggest there may be some progression of disorders with age and adult responsibilities, yet the suggestion could be misleading for no age group has a priority on symptoms and problems. Before any such conclusion could be reached, data about the onset and etiology of symptoms and problems would have to be gathered. Careful interpretations of scientific evidence must be made, but first, phenomena must be described which has been the primary purpose of this study.

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4 Edith Spiegel, op. cit., pp. 31-32.
5 Ibid., p. 11.
6 Mary Louise Stearns, "A Comparative Study By Age Groups Of The World War II Veterans Who Received Treatment At The Veterans Administration Mental Hygiene Unit, Boston, Massachusetts, From April 1, 1947 Through September 30, 1947," Unpublished Masters Thesis, Boston University 1948, p. 76.
BIBLIOGRAPHY
Books


Periodical Literature


Committee or Government Reports


Unpublished Material


Steens, Mary Louise, "A Comparative Study By Age Groups Of The World War II Veterans Who Received Treatment At The Veterans Administration Mental Hygiene Unit, Boston Massachusetts, From April 1, 1947 Through September 30, 1947," Unpublished Masters Thesis, Boston University, 1948.

Weinberger, Jerome and Eleanor Gay, "Intake Procedure," Unpublished Pamphlet at the Veterans Administration Mental Hygiene Clinic, Boston Regional Office.
Thesis Schedule

1. Case number
2. Sex
3. Age at intake
4. Marital status
5. Military service
   a. WWI
   b. WWII
   c. Korean
   d. Peacetime
   a. Combat
   b. Non-combat
6. Living arrangements (composition of household)
7. Occupation
8. Education
   a. Last school grade completed
   b. Other
9. Disability rating
10. History of prior illness, hospitalization, and medical treatment
11. Referral
    a. Source
    b. Reason for referral
12. Employment status at intake
13. Psychiatric diagnosis at intake
14. Complaints and problems of the patient at intake
15. Attitude toward treatment at intake
16. Complaints and problems of the patient during treatment
17 Request for medication
   a Content of request_______
   b At what point made_______
   c Whether met or denied_______
   d Worker's handling of request (explanation)_______
   e Patient's response to this handling_______

18 Number of casework interviews_______
   a Number of cancellations_______
   b Number of C.K.A.'s_______

19 Type of casework techniques used_______

20 Changes in complaints, problems, and attitude toward
treatment of the patient_______

21 Worker's evaluation of treatment at closing_______

22 Reason for closing_______

*Failure to keep appointment without notification