The role of the psychiatric social worker at the Children's Unit of the Metropolitan State Hospital as seen through a study of fifty-four cases

Graffeo, Grace C

Boston University

http://hdl.handle.net/2144/8011

Boston University
THE ROLE OF THE PSYCHIATRIC SOCIAL WORKER AT THE CHILDREN'S UNIT OF THE METROPOLITAN STATE HOSPITAL AS SEEN THROUGH A STUDY OF FIFTY-FOUR CASES

A Thesis

Submitted by
Grace C. Graffeo

(B. S., Simmons College, 1952)

In Partial Fulfillment of the Requirements for the Degree of Master of Science in Social Service

1954
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION, PURPOSE, METHOD, AND SCOPE</td>
<td>1</td>
</tr>
<tr>
<td>I THE CHILDREN'S UNIT OF THE METROPOLITAN STATE HOSPITAL</td>
<td>4</td>
</tr>
<tr>
<td>II THE SOCIAL WORKER AT THE CHILDREN'S UNIT</td>
<td>15</td>
</tr>
<tr>
<td>III GENERAL STATISTICS OF THE FIFTY-FOUR CASES STUDIED</td>
<td>33</td>
</tr>
<tr>
<td>IV CASE PRESENTATIONS</td>
<td>42</td>
</tr>
<tr>
<td>V SUMMARY AND CONCLUSIONS</td>
<td>61</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I  AGE AND SEX FREQUENCY</td>
<td>33</td>
</tr>
<tr>
<td>II TYPES OF COMMITMENT AND FREQUENCY WHICH USED</td>
<td>35</td>
</tr>
<tr>
<td>III MENTAL DIAGNOSES</td>
<td>36</td>
</tr>
<tr>
<td>IV SOCIAL SERVICE COVERAGE</td>
<td>38 &amp; 39</td>
</tr>
</tbody>
</table>
INTRODUCTION

I. THE PROBLEM

Purpose of the Study

The Children's Unit of the Metropolitan State Hospital is a public institution in Massachusetts offering in-patient care and treatment for severely disturbed children. In a mental hospital, the psychiatric social worker is a member of the professional team—that of social worker, psychiatrist, and psychologist. It is hoped this thesis will show how the psychiatric social worker through the utilization of her special skills contributes to the treatment offered the children in the hospital and their better adjustment.

Scope of the Study

In discussing the role of the social worker, the following questions have been formulated:

1. How does the social worker function as a case-worker in the therapeutic team?
2. Is the work of the psychiatrist, psychologist, and social worker co-ordinated?
3. What is the role of the social worker in relation to intake, reception, treatment, discharge planning, and follow-up?
4. What treatment methods are utilized by the worker?
5. Does the social worker have any part in education, training, and community relations.
6. Is there a need for more psychiatric casework?

This study concerns fifty-four cases of patients admitted to the hospital from January first to April 30th of 1953.

Method of Study

This study is based upon fifty-four cases of patients admitted from January 1st to April 30th of 1953. The presentation of the data will include statistical material obtained from the records and five cases which were studied more intensively to further clarify the preceding material.

The sources of the data for this study include the hospital and social service records and interviews with the staff. Historical data and theoretical material were obtained from reports, articles, and studies.

Limitations of the Study

Due to the pressure of the work caused by the number of patients seen during this period and the fact that there was only one social worker at the Unit, some of the records give insufficient material on which a complete study could be made. Moreover, the writer realized the reports on which this study is based are somewhat subjective.
II Organization of the Thesis

A brief outline by chapters may be helpful in understanding the organization of the thesis. Chapter I will include a brief history, the organization, the function of the Children's Unit. In Chapter II the role of the psychiatric social worker at the Unit will be discussed. Chapter III is devoted to a statistical description of the cases studied and the social services offered. Chapter IV will include case presentations, and Chapter V will summarize and present the conclusions reached.
CHAPTER I

THE CHILDREN'S UNIT OF THE METROPOLITAN STATE HOSPITAL

A. BACKGROUND

Psychiatric hospitals for children are few in number, although the need was recognized as a result of an awareness of the large numbers of children admitted to state hospitals. The Annual Report of the Commissioner of Mental Health in the year ending September 30th, 1939, revealed there were admitted to state mental hospitals approximately two hundred nineteen children under seventeen years of age and one hundred children under fifteen years of age. Therefore, the Department of Mental Health in 1940 designated the Metropolitan State Hospital, Waltham as the hospital which would care for all psychotic children in Massachusetts. It was intended that a separate building be erected for the Children's Unit, but due to the war and the restrictions on buildings, this plan was impossible. However, in January, 1945 all children up to sixteen years of age who were under care in mental hospitals throughout the state were transferred to the Metropolitan State Hospital.

At the present time, physical facilities, which have not changed substantially since the Children's Unit opened, are located in the medical and surgical building of the Metropolitan Hospital.

State Hospital and consist of two fifty-three bed wards, the
overflow from the boys' wards housed on the male admission
ward, a small solarium utilized for group psychotherapy, two
small rooms used as classrooms, a basement playroom, two play-
grounds located between the medical and surgical wings, tennis
courts, bowling alleys, and a gymnasium, the last three being
shared with the adult patients. A five room suite located
between the wards contains an examining room, psychologic
testing room, doctor's office, and two small recreational
therapy rooms.

As was originally planned, a separate building to house
the children has been erected on land adjoining the hospital
and will be opened within several months. The physical set-up
of the new hospital is as follows: on the basement floor there
is the central bathing unit, a boy's shop, a girl's shop, the
dentist's office, and electroencephalogram room, and an infra-
red light therapy room; on the first floor are the Out-Patient
Department offices - the Out-Patient Department lobby, two
doctor's offices, two psychologists' offices, two social
service offices, an admitting room, an examining room, a
clerk's office, a barber's room, the kitchen and two dining

2. Thaddeus P. Krush, "The Need for In-patient Care and
Treatment of Mentally Ill Children in the Commonwealth of
September 22, 1949, p. 442.
rooms, six rumpus rooms and two canteens; on the second floor above the Out-Patient Department offices are the admission's offices, the clinical director's office, two for the doctors, two for the psychologists, two for social service, one for the director of nursing, a staff room, a clerical staff room, two examining rooms, eight dormitories, a gymnasium, and four group therapy rooms with adjoining observation booths; on the third floor is the medical unit - an x-ray room, and accident room, four single rooms, four seclusion rooms with an adjoining day hall, a doctor's office, a nurse's office and eight dormitories; on the fourth floor there are four school rooms, a school library, a teacher's room, a chapel, a staff library, and a suite for the doctor on call. In addition, there are two playgrounds - one for the boys and one for the girls.

It is the hope of the present clinical director, Doctor Thaddeus P. Krush that patients will come from the community within a radius of five to ten miles of the hospital to the Out-Patient Department. If treatment in the hospital is necessary, the child will be admitted and treated. When the child is ready to return to the community, the child will return to the Out-Patient Department for treatment.

The boy's shop will be set up, so that the boys can find out what they can do with their hands and the limits will be set by the individual boy. The girl's shop will be for the
girls to learn about personal grooming. The sleeping quarters are eight and ten bed dormitories which will be closed during the day, since the children will be off the wards at various activities. In the larger dining room the staff will eat with the children and in the smaller dining room will be for children who have to be fed.

It is obvious from this description that the facilities of the new unit will be superior to those facilities under which the unit has been functioning for the past eight years.

In the future, the clinical director also hopes that there will be an increase in personnel which judged by any standards is subminimal. The medical staff of the Unit includes one full-time psychiatrist who is also the clinical director, a full-time assistant physician, two psychiatric residents, and four part-time in training psychiatrists who each have several children in therapy. Social Service coverage was mainly provided by the head of the department and a full-time worker from 1948 until November of 1953 when another worker was added to the staff. There will be a third worker in May when a listing of workers available will be compiled as a result of


the State Civil Service Examination given recently. In addition, there are three nurses, thirty-five attendants, a laboratory technician, three teachers, an occupational therapist, an assistant librarian, and a clerk-typist. Services of the two hospital psychologists are available for testing. Vacant positions include a senior physician, a psychologist, and a social worker.

In spite of the limitations, the staff is continually improving and advancing the care and services provided for the children.

B. ADMISSIONS

Children up to sixteen years of age are admitted for observation, study, and treatment at the request of physicians, parents, general hospitals, social workers, probation officers and courts. The types of admissions will be presented to point out the legal requirements which effect admission to the Children's Unit. All laws relating to commitment procedures of patients to the hospital are contained in Chapter 123 of the 4 General Laws of Massachusetts. The selection of the admission procedure seems to be a more or less arbitrary decision and in no way designates the nature of the problem except in Section

100 where the child is brought to the attention of the court.

Section 100: This statute allows for the preliminary or out-right commitment of any person under complaint or indictment for a crime, with a legal limit of thirty-five days. The certificate which accompanies the patient must be signed by two qualified physicians and the Justice of the Court. The patient must be removed from the hospital if not found insane at the end of the period of observation. When released, the patient must be returned to court for disposition.

Section 77: This statute specifically provides for commitment for observation for a period of thirty-five days, pending the determination of the patient's sanity upon application of an interested person. The medical certificate must be signed by two qualified physicians and the order must be signed by the Justice. Observation must be completed by the thirtieth day if the patient is found insane. If not insane, the patient must be discharged at the end of the thirtieth day.

Section 79: This is a ten day paper authorizing temporary care for a person considered to be in immediate need of care and treatment in a mental hospital because of mental derangement. This paper may be signed by a physician or a police officer. This type of commitment is least preferred by the hospital staff.

5. Ibid., pp 34-35
6. Ibid., p. 25
since ten days is too brief a period for observation in the average case.

Section 86: This statute provides that any child under the age of sixteen who is suffering from psychosis, neurosis, psycho-neurosis, behavior disorder or other mental disability may be admitted to the hospital upon application of the parent, guardian, natural guardian, or person having custody of the child. This paper must be signed by a qualified physician. Also, included in this section is a specific paragraph for observation, study and treatment for a person not exceeding sixty days upon written application as stated above. In no case can the child be retained at the hospital more than seven days after the applicant for admission requests release, unless the patient is considered by the hospital to be dangerous to the community.

Section 51: This statute provides that a person may be committed to a state mental hospital for treatment if he is deemed insane. This certificate must be signed by two qualified physicians and the order signed by the judge. The judge shall see and examine the alleged insane person, or state in his final order the reason why it is not considered necessary or

7. Ibid., p. 26
8. Ibid., pp. 38-40
C. FUNCTIONING OF THE UNIT

On admission each case is assigned to one of the staff psychiatrists for study. Psychological examinations are given each child and include an intelligence test and other tests depending upon the nature of the problem in the individual case. In addition, each child received a physical examination, laboratory tests, and an electroencephalogram. The child's behavior on the ward is observed by the medical, nursing, and ward staff and records are kept. A medical-social history may be obtained by the social worker from parents or community agencies.

At the end of the observation period, which varies according to the section under which the child is admitted, each case is presented at a staff conference. At this time, the diagnosis and recommendations for treatment are made. If the child is found to be "insane", steps are taken for the child to be regularly committed. If the child was admitted under Section 100 and is not found to need hospitalization, the child is returned to the court for disposition and the clinical director informs the court in writing of the recommendations of the staff as a result of the child's being studied and observed. With the last group of children who do not fall into the above mentioned

9. Ibid., p. 22.
categories, the staff recommendations are discussed with parents or agencies.

In 1949 an Out-Patient Clinic, the Halloran Clinic, was established at the hospital for diagnosis and neuro-psychiatric treatment. Referrals come directly from the community mostly from social agencies but gradually some in-patients were and are treated in the Clinic, after these patients leave the Children's Unit. Moreover, the psychiatrists and social workers at the Clinic provide consultative services to other agencies in the community. The Clinic is held two afternoons a week and the staff - the psychiatrists, social workers, and psychologists, includes the regular Children's Unit staff.

An electroencephalogram is given each child attending the clinic as well as psychometric examination. Generally, the psychiatrist treats the child while the psychiatric social worker sees the parents.
CHAPTER II

THE SOCIAL WORKER AT THE CHILDREN'S UNIT

The psychiatric social worker in a mental hospital collaboration with the psychiatrist, brings certain skills to the understanding and treatment of mental illness.¹

In this chapter will be given a description of the social worker's role in relation to the patient's period of hospitalization and follow-up.

A. ADMISSION

The children coming to the Children's Unit for admission are generally accompanied by their parents, by social workers from agencies, police, or court personnel. Since the admitting physician is often unable to devote much time to the accompanying adult, the social worker has important responsibilities to these people. Admission of a child to a mental hospital represents a major crisis in the life of the family involved and sometimes conflicting emotions in the mind of the social worker escorting the child to the hospital, since in most cases admission to the hospital is used as a desperate last resort. The accompanying adult or relative may feel guilty,


². Information on the admission procedure was obtained from the following unpublished article-Thaddeus P. Krush, M.D.-Ruth Emma Roman, Social Service in the Children's Unit.
angry, or both and is always extremely anxious. If the adult is allowed to express his feelings, the worker can assist the accompanying adult with these feelings and can ameliorate the parents' anxieties in relation to the threat of having a mentally ill child. Also, the social worker can interpret to the accompanying adult the facilities, program, and operation of the Children's Unit. During this interview, the worker can acquire insight into the emotional interaction with the family constellation, and this information will be helpful later in allowing other members of the staff to evaluate the problem.

The worker's initial contact with the parents can be the beginning of the worker's establishing a relationship with the parents for future work with them and will encourage the parents to maintain a positive non-rejecting attitude throughout the period of care. Ultimately, it may help the parents to receive the returning child with understanding and acceptance. It is the policy of the Unit to have the social worker who has the first contact with the parents either at intake or when gathering information for the medical social history to continue casework services with this particular family.

B. RECEPTION

Reception is the process of helping the patient accept the fears and threats inherent in the experience of compulsion and restraint, of allowing him to respond to the therapeutic potentialities of
living under psychiatric supervision and direction.

The social worker's function at this time is to participate with other hospital personnel in the explanation of routine hospital and medical procedures and to help the patient understand that the worker serves as a link between him, his family, and the community. In this way, the worker assists in maintaining and preserving the child's family and community ties. At the Children's Unit the worker attempts to arrange a meeting with the child the day following admission.

C. THE MEDICAL-SOCIAL HISTORY

Another major function of the social worker is securing the medical-social history.

To understand mental illness one must know the environment (past and present) of the individual and his reactions to it, for these stresses have usually played an important part in the patient's breakdown. The patient's relationship within the family situation, both current and earlier, as well as his social relationships are especially important. The obtaining of such material is one of the functions of the social worker.4

Parents, social agencies, and others who have had experience with the patient are the prime sources from which the


social history is obtained. The social history data is organized according to a specific formal outline and is made a permanent part of the patient's medical record.

When securing information for the history, the worker should evaluate the facts given and know how much hostility, guilt, or anxiety from various causes has colored the informant's story. In addition, while taking the history, the social worker can do much to help the child's family to accept his illness, to allay their fears and anxieties about his care in the hospital, and whether or not they have done the wise thing in following out the physician's advice in regard to the patient's family, the worker can help the families with their feelings regarding mental illness, since few families go through the commitment of a relative to the hospital without a great deal of emotional strain. Due to the stigma which still exists to some extent regarding mental illness, relatives hesitate to discuss the problem or need help in understanding the malady. Moreover, relatives have fears for the mental health of other members of the family and certain attitudes of

5. See the appendix for the medical-social history outline.

their own toward mental illness. At this time, relatives need reassurance and help in handling these feelings. However, history taking, instead of being a routine search for facts about the patient's life to help in psychiatric diagnosis and treatment, may be of great assistance and have far-reaching results in the improvement of the environment to which the patient will return.

D. CASEWORK TREATMENT

After the period of observation, a staff conference is held during which a total study of the child is made according to the data obtained. The social worker as well as other members of the staff - the clinical director, doctors, teachers, nurses, psychologists, and occupational therapist - attend these conferences. At this time, the diagnosis is determined, the treatment plan is decided upon, and recommendations are made.

During the period of hospitalization, the social worker gives service to the patients, relatives, and/or agencies.

PATIENTS

In working with emotionally disturbed children, it became apparent to the staff that the worker knew only a small part of the children's personalities, if the worker confined her relationships with the children to interviews in the office or playroom. The children act so differently when with a group of
their contemporaries, it became essential to observe the children in groups and for this purpose many different projects were tried. Some workers have gone on the wards to share meals with the children, others have run dances or card parties for the adolescent boys and girls, and many group therapy projects of an interview type (for adolescents) or activity type (for pre-adolescents) have been held.

Until this time due to the lack of staff, the social worker's contacts with the children have been mainly confined to these group therapy sessions, but with an increase in staff, it is hoped more individual casework with the children will be undertaken. In addition, many of the children are receiving individual therapy from the psychiatrists but some of the children are organically damaged, so that they would not benefit from casework help. Therefore, the group therapy sessions conducted by the social service staff as well as other disciplines-the medical staff will be discussed.

In the interview type group therapy that is carried on with adolescents, it was found that there are certain types of children benefited by group therapy. With adolescent boys, it is those who come in conflict with the law because of stealing,

7. Information on the group therapy at the Children's Unit was obtained from an unpublished article written by Ruth Emma Roman, social worker at the unit, and is entitled, Group Therapy in the Children's Unit of the Metropolitan State Hospital, August, 1948 - August, 1950.
running away, or being "stubborn children" and with adolescent girls those who have run away, been promiscuous, or "stubborn children".

The goal of group therapy with these adolescents is to make the group member aware that he has a problem, that others have problems, and that the solution to the problem lies, to some extent, in his or her hands. This insight of other members of the group and through the exchange of similar experiences.

Since "contemporary insight" is the chief goal of inter-view therapy with adolescents, it becomes necessary to structure a situation in which the adolescents will communicate meaningful material to one another. The group therapist should allow the group to set its own tempo rather than directing the discussion herself. However, there are certain situations in which it is useful for the therapists to interrupt the discussion and these instances include: when group behavior becomes too aggressive so that injury or destruction would be the result, when the discussion reverts to endless repetition, and when there are long periods of silence and the therapist is justified in interpreting the nature of the resistance to the group. If the therapist prods the members into speaking and becomes too active, she gets certain results at the expense of group interaction which tends to diminish. To allow useful
interaction between group members, certain physical limits must be set such as: if the room is large, none is allowed beyond a certain point and not too far from the circle formed by the members, and if there is a telephone in the room, the therapist sits between the telephone and the group to avoid tinkering with the telephone.

It is understood by the members of the group that during the meeting no administrative questions will be answered by the therapist. When a new member enters the group, a member of older standing usually tells the new member the purpose of the group. Moreover, the new member is not pressed to join the discussion until he or she has been accepted by the group and feels sufficiently comfortable within the group.

If one of the members is so disturbing to the group that he or she is an obstacle to the group meeting, methods used vary according to the situation. Either the other group members reprimand the disturbing member or if necessary, the therapist will intervene.

During group sessions, members may tell untrue and fantastic tales. It is not helpful if the therapist shows up the group member as a liar but the therapist must indicate what she sees as reality and return to the statement of facts and relationships as she sees them, since it has been observed that all children, particularly adolescents, are testing reality and
and trying to find out how consistent and truthful adults are.

Within these groups, various observations were made regarding group interaction. The progress of the group is often impeded by the addition of a new member, as if a new sibling arrived in a family and stirred up resentments and jealousies. At times, hostility between the members of the group becomes too intense, particularly in boys' groups, that it seemed useful to let the antagonistic members have an exchange of blows and encourage the group to interpret the fight. When a difficult problem confronts the group and no member can or wishes to offer an opinion, the group may attack the therapist and challenge her to give an answer. However, it seems wisest to turn the question back to the questioner who, in most cases, knows the answer himself but wished to find out how much the therapist knows. It was observed that when a group member so identifies with the therapist that he or she tends to take over the role of the therapist, this member usually has gained some insight and this assumed role of leadership frequently indicates the child is ready to take his or her place in the community. Frequently, a newcomer will assume the attitude that he has no problem, and this attitude is invariably handled by the other group members. At this time, the therapist can re-affirm the aim of therapy - to remove the screen that keeps the individual from seeing his problem.
A certain amount of shifting of roles - a modest form of psycho-drama has been tried with some success in cases where some individuals are blocking. However, the silence of some members may not mean these members are not participating, since there are many forms of non-verbal communications which must be observed and may indicate considerable emotional participation.

With the younger group (boys from eight to twelve years), where these boys play, build models, and draw, the activity-type of group therapy is used. The types of boys who seem to benefit from these groups are the passive children who do not care to fight, are afraid, are somewhat feminine, and have a tendency to withdraw, and the aggressive type whose behavior is so belligerent that they cannot be accepted in the community. The goal of this type of therapy is to bring to the child an awareness of his relationship to the group - more through experience rather than by verbalization.

Since these therapists were inexperienced in leading therapy sessions, these first group experiences invariably caused feelings of inadequacy and insecurity among the therapists. Therefore, weekly meeting with the psychiatrist have solved these difficulties, since through these meetings the therapists gain new insights into what they are doing as well as gaining much needed reassurance.

Therefore, it is apparent that the psychiatric social
worker utilizes methods and principles of social casework in group therapy. Since the psychiatric social worker is trained in understanding and promoting inter-personal relationships, she is especially equipped for group discussion. In some groups, the worker finds that although patients want to talk to the therapist, they can help the patients talk to each other and thus establish inter-personal relationships. As mentioned previously, the worker refrains from expressing personal opinions but encourages patients to discuss subjects freely. At times, the worker helps to relate the experiences of one patient to those of another.

There are certain qualities as warmth, responsiveness, and consistent interest, which are necessary in working with individuals and groups, and these are apparent in the worker's attitude. Permissiveness toward feelings and actions is demonstrated by accepting and respecting the individual in the group, no matter what he says or does.

Since the social worker is skilled in interviewing, she can help people talk and is aware of the patient's needs even though the patient does not express them well. Moreover, because of the worker's knowledge of families and social back-

---

8. Information for this section was obtained from the following paper. Doris Menzer, M. D., mental, "The Role of the Social Worker in Group Therapy," Journal of Psychiatric Social Work, 20:4, June, 1951, pp. 158-159.
grounds, she can feel with the patients when they discuss family problems. However, the worker can also be objective and thus help the patient discuss his problem.

As the social worker's job is to find out why people do things and to use these attitudes in building a treatment plan, the worker learns to listen and observe in the group. By her own attitude, she helps the patient learn to relate to her and to other patients. In this way, the patient is helped to relate better to the hospital personnel and people outside the hospital.

In groups as in individual therapy, various types of psychiatric casework as manipulation of the environment, psychological support, and clarification of the patient's attitudes and their consequences can be used.

In the group, the patient's environment includes the other members of the group and the therapist. The worker can manipulate the other members of the group into a more cohesive one by encouraging group interests.

The social worker gives psychological support by listening, showing interest, and encouraging patients to express their feelings by discussion, by interacting with each other, and accepting each other.

The therapist helps the patient understand his own attitudes toward his environment (including other patients and hospital personnel), and helps him to see how he may provoke
hostility, aggression, and vexation in other people by his own behavior of which he may not be aware. Since in groups this behavior is more obvious than in individual therapy because the patient displays such behavior toward members of the group, the therapist can clarify attitudes and demonstrate the consequences of behavior.

Therefore, in group therapy the social worker deals mainly with problems in the patients' inter-personal relationships and with social environmental difficulties. The worker deals with reality problems; how the patient feels about his present environment, how he feels toward hospital personnel, what he feels he can do better, and how he can deal with people in a more mature way.

RELATIVES

Working with parents or relatives is an important part of the social worker's job, since it enables the patient to return to a situation that will help rather than hinder his convalescence. Moreover, it takes time to prepare adequately for the patient's return to the community. When family relationships inevitably play an important part in the continued improvement of the patient, the worker needs to understand them, just as the family needs to understand their effect upon the patient. In addition, the worker helps relatives with their feelings, attitudes, and conflicts; interprets the patient's illness, its
treatment, and problems growing out of the patient's illness.

The treatment methods used by the caseworker may include environmental modification, psychological support, and clarification. 9 Brief definition of these treatment methods will be given.

Modification of the environment includes any steps or direct action taken by the worker to change the environment in the client's favor. These modifications are undertaken by the worker either when environmental pressures upon the client are beyond the client's control but can be modified by the worker or when the pressure will yield to change when handled by the worker rather than the client.

Psychological support refers to support of the ego. The worker is accepting, interested, and permissive, so that the client is able to ventilate his feelings regarding the situation. Moreover, where these attitudes are warranted, the worker gives reassurance to the client by acceptance and appraisal or approval of steps taken by the client or steps the client is planning to take.

Clarification involves an understanding by the client of himself, his environment, and/or people with whom he is

9. Information for this section was obtained from the following paper. Florence Hollis, "The Techniques of Casework", Journal of Social Casework, 30:4, June, 1949, pp. 235-244
associating. The method is directed toward increasing the ego's ability to see external realities more clearly and to help the client understand his emotions, attitudes, and behavior. Moreover, the quality may range from a simple intellectual process of thinking through matters to a deeper comprehension of attitudes and feelings of considerable emotional content.

The nature and duration of the contact of the worker and family during the patient's period of hospitalization depends upon the circumstances of each case. In certain types of mental disease the social conditions may reveal only a slight relationship to the progress of the disorder or may hold little hope in aiding recovery. In others, family relationships may have played an important part in the patient's breakdown. Under the latter conditions, social service treatment can be invaluable. However, the important factors are that the treatment which the situation demands is given and that this treatment is based on the diagnosis of the patient at the time he enters the hospital, a diagnosis resulting from medical and psychiatric examinations, and a study of the social situations.

AGENCIES

Various agencies in the community as the Youth Service Board, state and local child welfare agencies, guidance clinics, study homes, private children's institutions, and the Department of Mental Health agencies as schools, clinics, and hospitals
refer children to the hospital for observation, study, and treatment. In these cases, the worker also interprets the patient's mental illness and discusses with the agencies the recommendations of the staff, so that a satisfactory plan and if necessary, future treatment for the patient can be arranged.

E. FOLLOW-UP

Sometimes a child is discharged after a short period of observation with the referral of the family to a family agency or psychiatric clinic nearer the home of the patient than the hospital, but often the follow-up phase the worker spends her time with the parents rather than the child who is seen by the psychiatrist.

The worker's role at this time is to help the parents express their feelings regarding the child's adjustment in the community and to help the parents become more aware of how they affect the child's adjustment in the community and how they can assist the child in his adjustment.

In addition, the staff of the clinic act as consultants to other social agencies in the community. Mental Health Consultation is a special process of personal inter-action between two professional people, the consultant and consultee, so that

10. Information for this section was obtained from the following article: Gerald Caplan, M. D., Principle of Mental Health Consultation.
the former helps the latter to solve more effectively a specific problem in his work which has implications for the mental health of the client. The purpose of consultation is to help the consultee make more effective use of his existing knowledge in respect to individual problems, in which his efficiency may be interfered with by his own emotional sensitivities. Successful consultations often results in increasing the consultee's general knowledge regarding mental health aspects of his work but also may lead to personality growth and more effective handling by the consultee of his emotional problems. Although its aim is to help in specific cases, the knowledge gained may carry over to similar cases and may have beneficial effects on the consultee's general attitudes to the emotional problems of his clients.

F. STAFF CONFERENCES AND SUPERVISION

The social worker at the Children's Unit attends and participates in various staff conferences during the week. A brief description of these staff conferences will follow.

On Monday morning there is a one hour Social Service Conference at which the head of the Social Service Department and that workers of the adult and children's services work on common projects. This year the Social Service Staff had discussed ways to take a medical-social history, have revised the outline used in taking medical-social histories, and have
revised the form letter sent to relatives at the time of the patient's admission.

On Wednesday morning, there is a two hour staff conference attended by the clinical director, the doctors, social workers, teachers, nurses, occupational therapist, and psychologists of the Children's Unit. At this meeting, material is present regarding the children whose periods of observation are ending shortly, so that diagnosis, dispositions, and recommendations are made.

On Thursday the head of the Social Service Department and members of the Social Service Staff at the Unit meet for one hour with the clinical director and doctors at the Unit to discuss social service problems in various cases.

On Friday there is an Out-Patient Department Staff Conference at which a case is presented either for discussion or for assistance with any difficulties which have arisen in the case.

Lastly, on Friday there is a group therapy conference which is attended by various disciplines within the hospital that are therapists for group session with the children. Each person in turn presents material on his group, so that the group can be discussed; comments can be made, and the therapists can learn to improve their methods.

As a result of the close cooperation between Boston Psychopathic Hospital and Metropolitan State Hospital, the workers at
the Children's Unit each have an hour conference with a psychiatric casework supervisor from Boston Psychopathic Hospital. At this time, the worker discusses one of the cases and received supervision.

G. TEACHING WITHIN THE HOSPITAL

Every six weeks a new group of student nurses affiliate with the hospital for their psychiatric training. During the student nurses' period of training, the social worker of the Children's Unit spends two hours with the student nurses to orient them to the role of the psychiatric social worker at the Children's Unit. The emphasis is on the role of the social worker at different periods during the child's hospitalization and the importance of the team concept especially between the psychiatric caseworker and the psychiatric nurse. In order to make the material more meaningful, specific cases are presented and there is a question and answer period. In addition, various mental hygiene resources and agencies in the community providing services for children are discussed.

Once a month the social worker meets with the Volunteer to discuss with them the children with whom they are working, how far along in treatment the children are, and in what ways the Volunteer could be of assistance to the children.

H. COMMUNITY RELATIONS

The social workers at the Children's Unit are engaged in
community interpretation. The psychiatric social worker has at times spoken to various church and club groups upon the set-up and philosophy of the Children's Unit.
CHAPTER III

GENERAL STATISTICS OF THE FIFTY-FOUR CASES STUDIED

The writer will present in this chapter statistical tables which will give a picture of the fifty-four cases studied. Moreover, social service coverage at the Children's Unit during this period will be revealed.

AGE AND SEX

Table I

<table>
<thead>
<tr>
<th>Age</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
<th>Percent</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>2:1</td>
</tr>
<tr>
<td>5-8</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>17</td>
<td>8:1</td>
</tr>
<tr>
<td>9-12</td>
<td>14</td>
<td>4</td>
<td>18</td>
<td>33</td>
<td>5:1</td>
</tr>
<tr>
<td>13-16</td>
<td>20</td>
<td>4</td>
<td>24</td>
<td>44</td>
<td>5:1</td>
</tr>
<tr>
<td>Totals</td>
<td>44</td>
<td>10</td>
<td>54</td>
<td>100</td>
<td>4.4:1</td>
</tr>
</tbody>
</table>

Of the fifty-four patients the youngest patients were in the one to four age group of which there were three patients; the oldest patients were in the thirteen to sixteen age group of which there were twenty-four patients. The largest numbers were in this thirteen to sixteen age group and included forty-
four percent of the total number of patients admitted. Between the ages of nine to twelve a total of eighteen patients which is thirty-three percent of the patients in this sampling are noted.

These results coincide with those of Dr. Thaddeus P. Krush who found that more patients were admitted in the thirteen to sixteen age group and the next largest number of admissions was in the nine to twelve age group.

It should be noted that there is consistently a larger ratio of boys admitted than girls with the largest ratio 8:1 being in the five to eight age group and the smallest ratio 2:1 being in the one to four age group. In the thirteen to sixteen age group there is a ratio of 5:1 and the average ratio of boys to girls is 4.4:1. Dr. Krush's findings also reveal a greater ratio of boys to girls. He also felt that the increase in the number of boys from eight to eleven years may be due to the fact that during this age range the more socially obnoxious and aggressive behavior of emotionally disturbed boys becomes more markedly apparent than that of girls. Therefore, Society's punitive attitude toward such aggressiveness thereby insures the early institutional recognition of mental illness.


2. Ibid., p. 819
In the last group two factors would appear to be involved in the lag in admissions regarding girls: the fact that many of the girl's symptoms only involve themselves and are of a rather passive character, and the fact that families usually tend to be more protective and supervising of girls.

**Types and Frequency of Commitment**

**Table II**

<table>
<thead>
<tr>
<th>Sections</th>
<th>Observation</th>
<th>Continued Observation</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>77</td>
<td>12</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>79</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>86a</td>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>100</td>
<td>22</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>54</strong></td>
<td><strong>5</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

| Percent   | 100 | 9 | 18 |

The largest number of patients (twenty-two) were admitted under Section 100 through the court and this large number is due to the fact that children are referred for study, observation, and treatment by the Youth Service Board and state and local child welfare agencies.

3. Ibid., p. 820.
The smallest number of admissions was under Section 86a and included five patients. It should be noted that the largest number of patients was under Section 79 and that twelve patients were admitted through Section 77.

Of the fifty-four patients five or nine percent were observed under Section 79 for a longer period, and nine or eighteen percent were committed under Sections 51, 77, and 86a for further treatment.

**Mental Diagnoses**

**Table III**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Brain Disorders</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Psychoneurotic Disorders</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Transient Situational Personality Disorders</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Mental Deficiencies</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>53*</td>
<td>100</td>
</tr>
</tbody>
</table>

* No diagnosis in one case, since child was in the hospital one day.

Of the fifty-four patients the largest number of patients (eighteen or thirty-four percent) were diagnosed as Transient
Situational Personality Disorders, and the smallest number (three or six percent) were diagnosed as Psychotic Disorders. The next largest group of patients was fifteen or twenty-eight percent and came under the category Chronic Brain Disorders. It should be noted seven patients or thirteen percent were diagnosed as Mental Defectives, six or eleven percent of the patients were considered as having Personality Disorders, and four or eight percent of the patients were diagnosed as Psycho-neurotics.

As can be observed from these findings only six percent of the patients were diagnosed as psychotic and the use of the term "psychotic" serves little purpose from an administrative standpoint. "It would be more feasible to sort out of the community for treatment children who have demonstrated repeated difficulty in adjustment to various individuals and/or agencies, either dealing with, or being a part of their problems." 4

---

4. Ibid., p. 821.
<table>
<thead>
<tr>
<th>Table IV: Social Service Coverage</th>
<th>Discharge Plans With</th>
<th>Referrals</th>
<th>ln-Patient Relatives</th>
<th>ln-Patient Referrals</th>
<th>ln-Patient Referrals</th>
<th>ln-Patient Relatives</th>
<th>ln-Patient Referrals</th>
<th>ln-Patient Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Service Coverage

Table IV

Social Service Coverage

Since there were no social service contacts during reception or admission in these cases, columns for these periods were not included in the chart. However, with the addition of another worker in the fall of 1953, social service presently takes part in the admission of the patient to the hospital.

In the fifty-four cases, the social worker obtained the medical-social history in forty-five cases. In thirty-four cases, the worker obtained information from relatives and in twenty-one cases social agencies.

It can be seen from this table that the social worker does little direct treatment with the patient except through group therapy. Of the total number of patients one was seen in individual treatment and three attended group therapy sessions directed by the social worker.

The social worker may have contacts with the relatives or agencies alone or both of them, depending on the case. In eighteen cases the social worker had contacts with relatives and in six cases with agencies.

Plans for discharge were discussed by the worker with the patients in two cases, with the relatives in fourteen cases, and with various social agencies in six cases.
It should be noted that in four cases referrals to community agencies were made, and three patients were seen at the Halloran Out-Patient Clinic with the social worker treating the parents and the psychiatrist the children.

In seven cases there were no social service contact, so that in forty-seven or eighty-seven percent of the cases the social worker contributes directly to the treatment of the patient.
CHAPTER IV

CASE PRESENTATIONS

The five cases presented in this chapter were selected because they represented some of the areas of treatment the social worker offers in her role as caseworker and group therapist. Moreover, these cases reveal the various types of emotional illness which are treated at the hospital as well as the manner in which children are referred to the hospital for observation, study, and treatment. The case abstracts vary in length according to the material in the medical and social records.

The case illustrations contain fictitious names.

CASE I

Margaret is an eleven year old white Catholic girl who was admitted to the hospital on January 24, 1955 under Section 79. The patient's father is a thirty-eight year old mechanical designer who completed high school and attended N. University. The mother is a thirty-eight year old woman who completed high school and two years of finishing school. At the time of the patient's admission, the mother was seven or eight months pregnant and has two other children - a nine year old boy and a seven year old girl.

Patient's birth and delivery were normal. Margaret walked at thirteen months and talked at eleven months. The mother and father seem happy and get along well. Margaret always was the most nervous and high strung of the children. She attended parochial school and did very well. She was on the honor roll but always was a little anxious about whether or not she was doing well enough.
Recently, the parents moved to H, where the patient did well but was a little lonely because she had not made many friends, since there were not many girls her age in the neighborhood.

In August of 1952, Margaret got anxious about her health and she thought she had heart trouble. The mother took her to the doctor and the patient was reassured.

Patient's menstrual period started in September of 1952 and since its onset, patient has been shy, self-conscious, and has become obsessed with feelings she is being poisoned by water, food, and varied inanimate objects. She cried hysterically and uncontrollably at the time of her last period. She was seen by a psychiatrist who recommended further treatment and study at a hospital.

On January 26, 1953 patient was given the Wechsler-Bellvue Intelligence Scale II by the hospital psychologist. She scored a verbal scale I.Q. of .155, a performance scale I.Q. of .93, and a full scale I.Q. of .106. The Draw-A-Person Test and Cowan Adolescent Adjustment Analyzer were also given. The psychologist summarized her report as follows: This initially tearful, pleading girl whose personal appearance was disheveled, welcomed this interview as a relief from the ward. Motivation was good but somatic complaints, erratic confidence, and concern with retention and disposal of mouthfuls of saliva appeared as interference factors to her in optimal ratings of average to bright normal intellectual functioning, free of bizarre responses. Personality tests suggest an openly fearful girl who is unable to compensate for unexpressed conflicts about body consciousness and glamor aspirations, since environmental security is lacking.

Patient was presented at Staff Conference on January 29, 1953 and it was felt that the patient represented an acute schizophrenic picture and the main feature is extreme anxiety. Patient has somatic fears and delusional ideas of poisoning which she realizes. Diagnosis was Schizophrenic Reaction - Acute Undifferentiated Type. Regular commitment was advised and the patient was committed under Section 51 on February 3, 1953.

Margaret was seen weekly by the psychiatrist and the social worker saw the patient's relatives. In addition, the patient attended group therapy sessions held by the social worker. The following are the worker's notes on the patient's progress.
during group therapy sessions.

Margaret attended approximately twelve meetings of the group. When she first came, she held her hand tightly over her mouth, her eyes were generally staring at the floor. The only thing the patient contributed to the first three sessions was in a vindictive tone the question, "Why must we come to group — — Nobody says anything anyhow."

At the fourth meeting, she complained rather bitterly about having to come to group because she had washed her hair and would have preferred to stay on the ward to dry it. In the fifth and sixth sessions, she became interested in some stories the other girls were telling, and during the sixth session, she asked the worker what refreshments would be served at the card party on Friday. After this, the ice seemed to be broken. Margaret sat increasingly closer to the worker and was interested in discussing part of her problem. At one point, when the others had said why they thought they were growing up and what had been their main difficulty, Margaret was asked by the group to speak about herself but she refused. Worker then proceeded to describe what she thought to be Margaret's difficulty with her mother due to the coming of the new baby and the fear of being poisoned. Margaret shook her head in acquiescence to what the worker was saying. After this, the bond between the worker and Margaret increased in friendliness. Since Margaret had difficulty in expressing feelings verbally, worker suggested patient play her Ukulele for the group and express herself in this way. At approximately the ninth session, patient brought her Ukulele and played and sang for the group. Before patient started going home on long week-ends, she was able to talk quite freely in the group sessions.

By June of 1954 patient was placed on Indefinite Visit and attended the Halloran Out-Patient Clinic where the psychiatrist saw the patient and the social worker the mother.

This case typifies the treatment process in some of the cases where treatment is continued at the Halloran Out-Patient Clinic, when the patient leaves the hospital.

During the patient's stay in the hospital, the worker saw the mother regularly and periodically would talk to the father over the telephone, when he called. The worker's first contact
with the mother was two days following the patient's admission
to the hospital at which time the worker obtained information
for the medical-social history. At this time and during
subsequent interviews, the mother was able to express her
feelings about her daughter's hospitalization. The treatment
methods utilized by the worker were psychological support and
clarification where the worker helped to clarify the changes
that occur in adolescence. Prior to the patient's leaving the
hospital, the worker prepared the mother for the patient's
return to the home. When the patient was placed on Indefinite
Visit, the patient attended the Halloran Clinic to see the
psychiatrist while the social worker treated the mother. The
worker offered the mother the opportunity to express and dis-
cuss her feelings about the daughter's adjustment in the
community and gave reassurance and support to the mother.

The group notes give an idea of how interview group ther-
apy with adolescents is carried on and in what ways these
sessions can be beneficial to the patient. In these group
sessions, the worker helped the patient to become part of the
group and to express her feelings in the group. Through
shifting of roles, the patient was able to discuss her problem
in one of the group session and thus to face her problems. As
a result of the therapist's understanding and acceptance, the
therapist was able to form a relationship with the patient and
to help the patient relate to other members of the group. In the last few sessions, it was apparent the patient was able to freely express her feelings and problems in group meetings.

From the material given in the abstract, the cooperation between the psychiatrist, psychologist, and social worker can be seen. The psychiatrist gave the patient physical and mental examinations as well as doing individual therapy with the patient; the psychologist administered various tests which contributed to the understanding of the patient and her problems; the social worker obtained information for the medical-social history, saw the patient's parents regularly and prepared them for the patient's return home, as well as helping the patient with her problems in the adolescent interview group therapy sessions. Moreover, the psychiatrist, psychologist, and social worker coordinated their findings at the staff conference where the patient's illness was diagnosed and treatment plans were formulated.

CASE II

Richard is an eleven year old Hebrew boy who was admitted to the hospital on January 30, 1953 under Section 79.

The family history indicates his parents are middle class people from whom no history of significant familial or hereditary causes could be elicited. There are two younger siblings - a ten year old sister and a two year old brother. Both are in good health and neither has suffered convulsions.

Patient's birth and developmental history are negative. It is stated that patient was an active, friendly child who had
always done well at school being successful socially, scholastically, and athletically. There has been no note of personality change in the past few months. Patient was said to have complained of occipital headaches for about six months and these occurred three or four times a month always localized to the occiput and only moderately relieved by aspirin. About three months ago, patient was fitted for glasses in an attempt to cure the headaches, but there had been no change in their nature and character. On January 4, 1953 patient was admitted to the Boston Floating Hospital. Richard had been perfectly well except for headaches until five days before when he had a sudden onset of cornical adenitis and malaise. The following day patient had a temperature of about 105 degrees and had one episode of vomiting. A doctor gave patient one injection of penicillin and prescribed sulfa pills. Patient's temperature fluctuated between 104 degrees and normal until January third when it was entirely normal. Patient's doctor stated he was treating patient for infected throat and ears.

On January third patient appeared to feel well and acted normally in all respects. He was heard to cry several times during the night and on entering his room in the morning, his parents found him on the floor with blood smeared about his mouth and totally unresponsive. Patient was taken to Boston Floating Hospital and was in status epilepticus for two or three weeks, gradually emerging from this state into a state of postictal confusion. Richard was then brought to the Children's Unit on a temporary care commitment paper which stated Richard was confused, belligerent, not capable of caring for himself, and needing constant supervision.

On February second, patient was seen by the hospital psychologist but was uncooperative so that testing had to be postponed. Two days later patient was presented at staff and a provisional diagnosis of Chronic Brain Syndrome with Convulsive Disorder (Deterioration Other) was made. Moreover, it was recommended the patient be placed on further observation and this was done on February ninth.

On February twenty-seventh, patient was given the Wechsler-Bellvue Intelligence Scale for Children. Richard scored a verbal scale I.Q. of .66, a performance scale I.Q. of .68, and a full scale I.Q. of .64. The Bender Visual Motor Gestalt Test was also given. The psychologist summarized her report as follows: a cooperative usually friendly boy who controlled his frustration and irritability very well. He knew he was failing in many instances and frequently reiterated, "I forget." Most of
what he learned in school has been lost and scores on general information and arithmetic were both very poor. Abstraction is at a dull normal level and all the manual items reflect some visual motor disturbance. Ability to form new associations is very limited. Understanding of social situations remain relatively good. The Bender Test is added evidence of his impairment. A speech defect was noted but there were no bizarre responses. Intellectually, he functioned at moron level, doing slightly better on performance that on verbal.

Electroencephalograms were given four times and these records are consistent with a diffuse form of epilepsy.

On March fourth, patient was again presented at staff for diagnosis and disposition. Patient's diagnosis was Chronic Brain Syndrome with Convulsive Disorder (Idiopathic). It was felt patient's behavior had improved and that he should be discharged on his present medication. Therefore, patient was discharged on April fourth and was to return to the Halloran Clinic in a month.

Patient was seen at the clinic but was not adjusting in the community. Patient was stealing money from his mother and the Five and Ten Cent Store. Patient was disobedient and occasionally refused to take his anti-convulsive pills. Moreover, patient was suspected of setting fires and finally broke into a gasoline station. The family physician recommended re-admission to the hospital. Therefore, patient was re-admitted on September twenty-seventh under Section 79. Patient was staffed on the thirtieth and further observation was recommended. Patient was re-staffed on October twenty-first and Richard's problem was discussed. It was felt Richard is a dangerous epileptic who should be committed to Monson State School. Patient was discharged on October twenty-ninth for commitment to Monson State School.

During the patient's first admission, the worker's only contact with the mother was to obtain information for the medical-social history and to help the mother with her feelings regarding her son's hospitalization.

During the second admission and as a result of a series of interviews, the worker helped the mother with her feeling about
the boy's hospitalization at Monson State School. Although the
mother felt that Monson was the place for the boy since he
could not adjust in the community, she feared relatives and
her husband's disapproval of this plan. The mother felt that
she had failed as a mother and feared that her relatives and
husband would consider her a "bad mother". The treatment method
used by the worker was psychological support and the worker
helped the mother express her feelings about the plan, so that
the mother was able to accept the boy's institutionalization
at Monson and realized she was not a "bad mother" in doing so.
Moreover, the worker also made arrangements with the court for
the boy's placement at Monson and this activity on the part of
the worker would be considered environmental manipulation.

This case also brings out the collaboration between the
psychiatrist, psychologist, and social worker. It also repre-
sents the caseworker's role in dealing with relatives - partic-
ularly around plan for the patient as well as working with
other agencies in the community.

CASE III

Dana is a twelve year old Catholic boy who was admitted to
the hospital on January twenty-third under Section 79.

Patient's mother is a thirty-seven year old widow and his
father was fifty-five years old at the time of his death in
1949. The father's death was sudden and the result of a blood
clot on a main valve. The father was a truck driver. Patient
has an eleven year old sister who is doing well in school.
At birth, high forceps were used and as a result, Dana's forehead was badly cut and his head was out of shape. He started walking at the age of six months and talked at two years. He entered school at four and one half years and although he missed a great deal of school, he was promoted.

The father's death seemed to have marked the beginning of the boy's instability. The father died in 1949.

In 1950 the mother became ill and the family was evicted from their apartment. The children spent several months in Cleveland with an aunt who was nervous and the children were under a great deal of stress and strain. On his return from Cleveland, Dana became worse. He started pounding walls and cabinets whenever annoyed or crossed in any way. He was jealous of his sister because she never got in trouble. He accused his mother of not loving him and wanting to get rid of him. The mother definitely preferred the girl and patient was jealous.

In July of 1952 patient was at Boston City Hospital with rheumatic fever and acute nephritis. While there, he adjusted very well whereas at home he was extremely difficult and had episodes of violence after which he complained of pains in his head. Moreover, he cried hysterically and the neighbors complained. He threatened his sister with a carving knife and on one occasion, attempted to choke her. It was suggested that Dana be seen at Southard Clinic but there were no appointments available. The mother was advised to take the boy to the Catholic Guidance Center but the doctor there felt the patient should be studied at the Children's Unit. The patient subsequently was admitted to the hospital.

On January twenty-sixth, patient was given the Wechsler-Bellvue Intelligence Test Scale II by the hospital psychologist and achieved a verbal scale I.Q. of 101, a performance scale I.Q. of 114, and a full scale I.Q. of 110. The Bender Visual Motor Gestalt and the Cowan Adolescent Adjustment Analyzer were also given. The psychologist summarized her report as follows: A friendly, eager, strongly motivated, tense, confident, left-handed boy who rated average to bright normal intelligence, free of bizarrities and organic markings. Yet some mild visual motor disturbance was suspected on another test. A personality questionnaire indicates a highly neurotic physically mature boy with repressed fears. Escape is his adaptive device with pronounced inadequacy feelings and open expression of disturbed family feeling including acceptance of authority from that area.
Patient was staffed on January twenty-eighth and diagnosis was Adjustment Reaction in Childhood - Conduct Disturbance. It was felt that placement for the boy should be considered, since there is considerable stress in the home and patient behaves much better out of it. Further observation and study were recommended. Patient was again staffed on February twenty-second and a Catholic boarding school was recommended. Therefore, patient was discharged on March third and patient and his mother were seen at the Halloran Clinic. However, patient was re-admitted to the hospital on March twenty-fourth, since patient had frequent fights with his sister and the family physician felt the patient potentially dangerous. Patient was presented at stagg on April first, and it was felt patient should remain in the hospital until he entered boarding school.

During the first admission the psychiatrist worked with the patient and the social worker saw the boy's mother to obtain information for the medical-social history and to help the mother with her feelings regarding the boy's admission to the hospital. Worker also tried to help the mother understand the boy's behavior. The causes of the boy's difficulty - his feelings of inadequacy, his missing his father, and the mother's preferential treatment of the sister - were also discussed during interview. Between admissions, the worker helped the mother with her feelings about the recommendations of the staff that the boy attend a boarding school. The worker assisted the mother in obtaining the money for the boy's education through Catholic Charities since the mother could not afford this expense. Moreover, the worker discussed Dana's situation with Catholic Charities from whom the funds for the boy's education were obtained. Since the mother could not cope with the patient prior to his entering school, the worker suggested the mother
return Dana to the hospital. The treatment methods used by the worker include psychological support and clarification in terms of the various factors which resulted in the patient's symptoms. In addition, environmental manipulation was utilized in view of the worker's obtaining financial assistance for the boy's education through Catholic Charities.

This case also demonstrates the cooperation between the psychiatrist, psychologist, and social worker as well as the utilization of a social agency in the community so that the plan recommended by the staff could be arranged.

CASE IV

David is a fifteen year old Protestant boy who was admitted to the hospital on February second under Section 77.

The family history indicates that the patient's father is forty years old, has always earned a good living, but has been a poor provider, being sent to the House of Correction for non-support recently. He is described as being an alcoholic and a gambler - this behavior being precipitated by patient's mother's running away with another man in 1945. He had no court record until that time, but since then has had thirteen charges for drunkenness and two for non-support. He does not display interest in his family but did appear in court for the patient and visited him regularly at home, much to patient's mother's dissatisfaction.

David's mother is forty years old and is employed part-time. She has poor moral reputation and attempts to place the blame onto the patient's father whom she married in 1936 and separated from in 1946. She has rejected the patient completely, compares him with his father, and frequently told him to get out of the house. Thus, the mother caused two runaways. She has offered the patient no emotional warmth or acceptance.

Patient is the oldest of five children and has two sisters and two brothers, the youngest boy is in foster home placement.
David's birth was normal and development was slow. At the age of one, he fell on his head and at two years, he was bitten on the shoulder by a rat. No medical attention was given in either instance. Patient has not been a serious behavior or school problem prior to this year when his behavior rapidly deteriorated and it was felt he was approaching a complete mental breakdown. He was neither truant nor aggressive but refused to study. When spoken to in class, he would simply get up and walk out. He became unmanageable at home, had run away twice, and finally was judged delinquent in January of 1953, as a stubborn child. Patient was sent to the Youth Service Board Reception Center where he complained of various aches and pains, showed erratic behavior traits, became exclusive, suspicious, and resistant. It was felt that patient was in the early stages of a schizophrenic process and that he should come to this hospital for observation, study, and treatment.

On March second, patient was given the Wechsler-Bellvue Form I and scored a verbal I.Q. of .78, a performance scale I.Q. of .85, and a full scale I.Q. of .71. The Draw-A-Person Test and the Cowan Adolescent Adjustment Analyzer were also given. The psychologist summarized her report as follows: The patient functioned at a high borderline level, almost all normal, doing better on performance than verbal. Rapport was difficult to establish and the patient was very evasive. He seems blocked and was not doing his best, it was felt. No bizarre responses were elicited, though some of the patient's remarks did suggest the possibility of paranoid trends. Other psychological tests indicated many repressed fears, disturbance in maturity, marked feelings of inadequacy, and overreliance on escape. Also he appears to have much difficulty in social relations, is sexually preoccupied, and is showing withdrawn tendencies.

An electroencephalogram was given and the record was borderline abnormal.

Patient's behavior was a little odd during the first part of an individual interview - he kept his eyes averted and was really withdrawn. Patient stated he thought Dr. N. suspected him of doing something more serious than he had done. David said he did not get along well with the children, and is in the eighth grade, since he repeated the first and the fourth grades. He said he was getting "F's" but felt he was doing fairly well. He came here, he said, because he was stubborn. He went to New York because it was lonely in his home town and claims his mother told him to go and packed his suitcase. He felt it
would be embarrassing to his mother to say this, so that he said he ran away; and he was sent to Westboro. He was rather evasive during the interview; there was no effect; it took him quite a while to get to the point. He was quite surprised when his mother came to see him at the hospital and said he never knew his mother cared so much for him. Patient has hallucinations which he talks about rather casually and has a feeling of withdrawal.

David was presented at staff on March eleventh and his diagnosis was Schizophrenic Reaction - Chronic Undifferentiated Type. Shock treatment was recommended as well as regular commitment which was done on March eighteenth under Section 77.

The patient was seen in individual therapy by one of the psychiatrists and his condition improved, so that he was sent to camp during the summer. In the fall, the patient went to the Hayden Goodwill Inn for six months and then returned to his mother. After patient left the hospital, he was seen at the Halloran Out-Patient Clinic.

In this case, there were no contacts with the patient's family by the social worker. In addition, information for the medical-social history was obtained from the Youth Service Board and the Society for the Prevention of Cruelty to Children. However, the caseworker did work closely with the Youth Service Board and the Hayden Goodwill Inn. With the Youth Service Board, the worker interpreted the boy's illness, and since David had progressed so well in the hospital, the worker convinced the Youth Service Board of the progress the patient was capable of making, so the Youth Service Board accepted placement at camp for David. With the Hayden Goodwill Inn, the worker also interpreted the patient's illness and worked on a consultative basis with this agency. The treatment method mainly used by
the worker, therefore, was environmental manipulation.

Although the worker did not see the patient on a regular basis, the patient would frequently talk to the worker at the dances held for adolescents. At these dances, the worker helped the patient to participate with the others in social groups.

This case is typical of cases referred by social agencies in the community where the worker interprets the patient's illness, works out future plans with the referring agency, and sometimes does consultive work.

CASE V

Mark is a twelve year old Catholic boy who was admitted to the hospital on April twenty-fifth on a Section 79 paper, since he had taken his father's gun, snatched a woman's handbag, and on being approached by the police used a five year old girl as a shield, threatening to shoot her if the police did not keep away. He was finally apprehended and brought to the hospital.

On April fourth the Wechsler-Bellvue Intelligence Scale Form II was administered and he achieved a verbal scale I.Q. of 92, a performance scale I.Q. of 75, and a full scale I.Q. of 83. The Draw-A-Person Test and the Cowan Adolescent Adjustment Analyzer were also given. The psychologist summarized her report as follows: There was easy rapport with this tense little boy who was given to frequent looking over his shoulder which he said, "It's a habit. It happens every summer. It happened last summer." Poor sense of failure, little or no autocriticism characterized this psychometric work with performance results a little below average verbal findings. No bizarries but there is a question of aggressive signs. Personality test suggest an immature, neurotic, fearful boy who has identified with the female sex. Acute inadequacy feelings cause him distress and he is in open escape from all authority.

An electroencephalogram was also given.

Patient was staffed on April twenty-ninth and a provision-
al diagnosis of Psychoneurosis - Type Undetermined was made. Further observation under Section 77 was recommended and was done on May fifth.

The family history indicates that the patient's father is a fifty-one years old and a lieutenant in the state police. He was in World War I, having falsified his age, and after discharge, he worked in a paper mill for a while. He then re-enlisted and while in the service, he studied in order to complete grammar and high schools. He also studied law and then took the police examination, topping the list. Eventually, he joined the state police and presently investigates important cases for the police. Patient's mother is forty-nine years old, went to junior high school, and worked as a telephone operator until her marriage in 1924.

Mark is the youngest of two children: a sister, now twenty-one, graduated from high school attended secretarial school, and is presently employed as a secretary. She is said to have been nervous during adolescence. Patient had a full-term normal delivery, Fontennale was too large but cleared up without causing further difficulties. He walked when he was one year old and talked between the ages of two and three. At age four he went into prolonged episodes of loss of consciousness with twitchings on two occasions. He was studied at the Children's Hospital where it was felt that these episodes might have been due to hypoglycemia and it was recommended that he be given cheese and milk before going to bed. The episodes never recurred but following them his parents felt that Mark's behavior became different. He became destructive and could not get along with other children. Patient has had to repeat two grades in school - the teacher feels he lacks concentration and his parents believe he could do better. Two or three years ago, patient stole some money in the home and the father beat him with a strap. Patient ran away and the father resolved never to beat him again. He had continued to steal money from his parents and ran away another time following what he called an argument with his father. The father claims he craves the boy's affection but patient is said to prefer his mother. The night prior to admission to the hospital, patient broke into a barber shop and stole thirty-five dollars which he spent on a racer for the Soap Box Derby. His father did not know about this until after the incident preceding patient's admission here.

On April twenty-ninth patient was given the Bender Visual Motor Gestalt and the Rorschach. The psychologist summarized
her report as follows: The Rorschach suggests a poor intellectual potential, lacking drive, and functioning unevenly. There is temorous respect for reality, as well as a paucity of ego values, with personality weakness, in that there is no reserve strength for times of stress. There is a poor adaptation to society at large, together with some lack of close human ties. This is a vulnerable boy whose anxiety is deeply rooted and probably in relation to an adult figure. Feelings of inferiority are only mild and fleeting. There is some repression of aggressiveness but more impulsive outbursts, without regard for the environment. Inner living is better controlled with mild conscious wishes for recreation. Insight potential is a bit promising. Diagnostically, we find a psychoneurotic with hysterical coloring but nothing of an obsessive compulsive nature.

On April 30, 1953 and May 7, 1953 patient was given Thematic Apperception Test. The psychologist summarized her findings as follows: The prevailing tone of this boy's relatively defenseless Thematic Apperception Test stories is one of diffuse aggressions, externally and internally directed, personal and impersonal, verbal and physical with hosocialal drives, no super-ego demands, and gaining of superiority through the use of aggression. All personal relationships are poor. There is ambivalence toward the authoritative coercive mother figure and all female figures dominate males. Likewise, there is sibling hostility toward the authoritative physically aggressive father figure. Needs of achievement, recognition, and quietude are strong in this unhappy boy.

On May 26, 1953 patient was staffed and it was felt patient's constitutional inadequacy is marked with a history of fontenelle not closing, hypoglycemia episodes, speech defect, borderline electroencephalogram, plus psychological stresses. Patient's diagnosis was Psycho-neurosis - Convulsive Reaction. Since it was felt the family was interested in the patient, it was recommended that the boy be tried a home and that all three receive treatment at the Halloran Clinic.

The patient remained in the community for one month but was re-admitted on a Section 86a paper, since Mark was picked up by the police due to two complaints of cruel behavior. The father was apprehensive about what might happen in view of the fact that Mark was under suspended sentence to the Youth Service Board.

Mark was seen in individual therapy by one of the resi-
dents but due to the transfer of the doctor to another service, he was placed in an activity type of group therapy for which the social worker was the therapist. The following are notes made by the therapist on Mark's activity during these group sessions. Mark was attended twenty-one of twenty-five activity type group therapy with four other boys who range in age from eight to twelve years. The toys available for the boys are a plastic building box, a ball, and animal puzzles. In the beginning, Mark wanted to talk all the time whereas the other boys were interested in playing. This interest in talking, it is felt, was due to Mark's being in individual therapy. He would frequently, tease, kick, poke, whisper to, or provoke the other boys but always with an air of innocence. However, the other boys would not retaliate but have no respect for him. It was felt that perhaps the patient would buy protection from the other boys. He always wants to be the center of attraction and has to be first, when the group is doing something. At most of the sessions, Mark would throw the ball but would throw it at the other children. At about the fifteenth session, there was a doll house in the room and the boys spent their time arranging the furniture in the home. The boys were competing to see who arranged the furniture best. At first patient scoffed at playing with the doll house, since this is for girls. However, he picked up a plastic doll and said the doll was not wearing clothes. The other boys said to the patient, "That's all you think about". He then said it was a girl doll but he wanted a boy doll. He put the doll in a carriage and pulled it around. He soon threw the doll in the bathroom and assumed a female role by saying, "Look father the stork has left us a baby". His expression changed and he said, "Cook my dinner, wife". Another boy told him he was not a girl and patient said smilingly, "All right, I'll cook the dinner". Interpretation was at a minimum since patient resists and interprets by saying, "Bla, bla, I know". However, prior to this incident, patient was actively engaged in homosexual behavior on the ward but the patient with whom he engaged in this activity was transferred. Patient's activity with the doll house seemed to have revealed his conflict about his role. During this session, the therapist noticed patient's tie, which was quite pronounced and which was unnoticeable up to this time.

A few sessions later, the group asked permission to use the ediphone and this was granted by the therapist who explained to the group how to use it. The boys then assumed various roles - Mark was Dr. F., the resident on the service at the time, and other boy was Dr. K., the clinical director, and the
rest of the boys were patients. The boys took turns using the ediphone and the boys who had assumed the roles of staff doctors would ask questions as how the patients like the hospital and each patient would reply in turn.

In the last few sessions, patient refused to attend, but when with the group, his attention span was short, he was restless, and he went from one activity to another and from one person to another. Patient seems to have contributed to the progress of the group by initiating the plan whereby the group set rules and watched various fixtures in the room so that others would not tamper with them, and by assisting the other members in becoming more verbal. However, it is wondered whether patient has gained from this group experience, since he rejects interpretations from the therapist and other members of the group so that one wonders if he is ready to receive help, he is disrupting to the group, and does not relate well to people whereas the other members have progressed in this respect, and socialize. However, patient will continue in this group until it is possible for him to receive individual therapy.

In this case, a great deal of work was and is being done with this patient, since he is still in the hospital. The father is seen weekly by a student social worker, the mother is seen weekly by the social worker at the Unit, and the patient attends activity group therapy sessions.

The worker at the Unit obtained information for the medical-social history and interval history from the parents, as well as seeing the mother on a treatment basis. The treatment methods used by the worker was psychological support as the mother had difficulty in accepting the boy's hospitalization and clarification in terms of her relationship to the boy and how she would help her son.

The caseworker seeing the father used the same treatment
methods psychological support and clarification, and helped the father to understand the son's illness and his role in relation to treatment.

These group therapy sessions are typical of the activity type of group therapy that is carried on with pre-adolescent boys. It should be noted that a modified form of psychodrama was used in this group and that the group mainly engaged in activities with a gradual increase in the amount of discussion. As mentioned previously, it is wondered whether Mark had gained from this group, since he resists interpretations and does not seem ready to accept it. However, patient's activity has given a clearer picture of some of his problems and his pattern of behavior.

In this case, the coordination of the work of the psychiatrist, psychologist, and social worker should also be noted as well as the process of the patient's being seen in the hospital, then referred to the Halloran Out-Patient Clinic, and because it was necessary for treatment, the patient was re-admitted to the hospital.
Chapter V

Summary and Conclusions

The aim of the Children's Unit, since it was opened in 1946, has been to provide observation, study, and treatment for emotionally disturbed children in the state of Massachusetts. It is a public hospital that offers these services. It has constantly enlarged and expanded its services to keep abreast of the advancements made in the field of psychiatry. Recently, a new Children's Unit, which it is hoped will be opened in July of 1954, has been constructed.

It was the purpose of this thesis to describe the role of the psychiatric social worker at the Children's Unit of the Metropolitan State Hospital. The writer has attempted to show how the psychiatric social worker through the utilization of her special skills contributes to the treatment offered the children in the hospital and their better adjustment in the community.

Study was made of fifty-four cases of patients admitted to the hospital from January 1, 1953 to April 30, 1953. Statistical tables presented information on these cases and five of these cases were described in detail.

Because it was felt necessary to describe the role of the social worker in the setting, the structure and function of the
Children's Unit as well as the admission procedure were described.

Structure of the Children's Unit

In 1953 the staff includes one full-time psychiatrist who is also the clinical director, a full-time assistant physician, two psychiatric residents, and four part-time psychiatrists in training. To this may be added two psychiatric social workers, three nurses, a laboratory technician, three teachers, an occupational therapist, an assistant librarian, a clerk-typist, attendents, and two psychologists from the adult service.

The physical structure of the present and new Units were described in Chapter I.

Function of the Children's Unit

The Children's Unit functions as a hospital for the observation, study, and treatment of children who are emotionally disturbed and up to the age of sixteen in the state of Massachusetts. In addition to the in-patient services offered, there is the Halloran Out-Patient Clinic whose staff provide treatment for children and their relatives as well as serving on a consultive basis to agencies in the community.

The Admission Procedure

The legal requirements which affect the commitment procedures of patients to the hospital are contained in Sections 100, 77, 79, 51, and 86a of Chapter 123 of the General Laws of
Massachusetts and were presented in Chapter I.

As more people are becoming aware of the emotional problems of children and are more accepting of treatment, referrals to the Children's Unit come from both parents and interested social agencies.

**The Role of the Psychiatric Social Worker**

In describing the role of the psychiatric social worker, questions were formulated. The writer will attempt to answer these questions from the data obtained in the first four chapters of this thesis.

1. How does the social worker function as a caseworker in the therapeutic team?

In most cases, the social worker obtains information for the medical-social history from relatives and interested agencies. The worker is able to see the environmental influences which may be creating or causing emotional problems in children. In this way, she obtains diagnostic data about the patient which will be helpful in terms of future treatment plans and disposition of the patient.

Depending on the case, the caseworker with in-patients may work with relatives, agencies, or act as therapist for group therapy sessions with the patients, while at the Halloran Out-Patient Clinic, the caseworker may work with relatives, agencies, or provide consultive services to community
agencies.

2. Is the work of the psychiatrist, psychologist, and social worker coordinated?

It is felt that each member of the different professions at the Unit has a contribution to make to the total area of mental health.

In each case, the child is given mental and physical examinations by the psychiatrist and the psychologist administers various tests according to the individual situation. Moreover, the children usually receive individual therapy from one of the doctors or are in one of the groups for which the social worker is therapist. The social worker also treats relatives and works with various social agencies. The coordination of the work of the psychiatrist, psychologist, and social worker can be observed in the five case abstracts presented in Chapter IV.

All three members of the professional team present material at staff conferences. Each contributes his knowledge and skill for help toward the understanding, diagnosis, treatment, and adjustment of the patient.

3. What is the role of the social worker in relation to intake, reception, the medical-social history, treatment, discharge planning, and follow-up?

As was revealed from the statistics, no services were
offered by the caseworker at intake or reception from January 1, to April 30, 1953. However, with the addition of another worker in the fall, the psychiatric social worker has become part of the admission procedure and interviews the accompanying relatives or adults to help them with their feelings regarding the child's admission to the hospital. The worker can be of assistance at this time, since admission of a child to a mental hospital represents a major crisis in the life of the family and conflicting emotions in the mind of the accompanying adult.

During the reception period, the worker sees the child to help him with his fears around hospitalization, so that the child can respond to the therapeutic potentialities of living under psychiatric supervision and direction. Moreover, the worker assists in the explanation of routine hospital and medical procedures as well as serving as a link between the patient, his family, and the community.

The medical-social history obtained by the worker serves to help the staff understand the patient and his environment. It also allows the worker to have a contact with relatives or interested community agencies to help with their feelings regarding the child's hospitalization and perhaps to continue working with these people, so that the environment to which the child will return will be improved.

Treatment offered by the psychiatric social worker in-
cludes working with relatives, agencies, and with the children in group therapy. In the cases of Margaret, Richard, Dana, and Mark the casework done with parents was brought out and with the cases of Richard, Dana, and David work was done with various agencies as the court, the Youth Service Board, Hayden Goodwill Inn, and Catholic Charities.

Margaret's case demonstrates the type of work the caseworker does as therapist for groups of adolescent children while in Mark's case the activity type group therapy carried on with pre-adolescent boys is demonstrated.

The social worker also contributes to discharge planning by working with relatives and agencies.

In the follow-up phase, the social worker as a member of the staff of the Halloran Out-Patient Clinic works mainly with relatives of the children. This phase of the caseworker's services is shown in the five cases discussed in Chapter IV. In addition, the consultive work done by the caseworker is brought out in David's case.

Therefore, it can be seen that the caseworker contributes to the treatment of patients and relatives and works with various social agencies to help the child with his adjustment in society.

4. What treatment methods are utilized by the worker?

The social worker offers casework help in various areas as
it appears necessary for the improvement of the patient's emotional problems. This involves an examination of the interrelationships of inner and outer pressures and the using of both environmental change and psychological methods appropriate to the case.

The specific methods used by the worker were discussed in Chapter II and include environmental manipulation, psychological support, and clarification. The treatment method of psychological support was brought out in four of the five cases discussed - the cases of Margaret, Richard, Dana, and Mark. Environmental manipulation was used in three cases - those of Richard, Dana, and David. Clarification was brought out in three of the case abstracts - those of Margaret, Dana, and Mark.

5. Does the social worker have any part in education, training, and community relations?

The social worker assists in the training program of the student nurses affiliating at the hospital for their psychiatric training by interpreting the role of the psychiatric social worker at the Children's Unit and discussing the importance of the cooperation between the psychiatric nurse and psychiatric social worker in the treatment of the patients.

In addition, the social worker assists the Volunteers by giving them a better understanding of the patients and ways in
which the Volunteers could be of benefit to the patients.

Through her speeches to various clubs and religious groups, the social worker makes an invaluable contribution to the understanding of mental illness by lay people.

6. Is there a need for more psychiatric social work?

In this thesis it has been shown how the psychiatric social worker contributes her skills and knowledge to the care and treatment of the children admitted to the hospital with emotional disturbances as well as to their relatives and community agencies involved. This was described in five examples and by the use of statistics of fifty-four patients admitted to the hospital for observation, study, and treatment during the first four months of 1953.

This material has pointed out some areas where the social worker has been unable to offer service due to the pressure of time and energy. As is often the case where a social worker is serving in a hospital setting the demands are greater than can be met. It, therefore, is necessary for the worker as well as other professional staff to recognize this limitation so that casework skill is used where it is more effective or to provide more social workers, so that more casework services can be afforded.

Approved:

Richard K. Conant
Dean
APPENDIX
BIBLIOGRAPHY

BOOKS AND PERIODICALS


Department of Mental Diseases, *The Massachusetts Laws Relating to Insane Persons and Other Classes Under the Supervision of the Department of Mental Diseases*, Boston: January, 1930, Revised December 31, 1934.


REPORTS AND UNPUBLISHED MATERIAL

Annual Report of the Commissioner of Mental Health for the State of Massachusetts, 1939.


Caplan, Gerald, M.D., Principles of Mental Health Consultation.


Krush, Thaddeus P., M.D., and Roman, Ruth Emma, Social Service in the Children's Unit.

Roman, Ruth Emma, Group Therapy in the Children's Unit of the Metropolitan State Hospital, August, 1948-August, 1950.
IDENTIFYING INFORMATION
Name:
Age:
Sex:

ADMISSION TO HOSPITAL
Date:
Referred by whom:
Section under which admitted:

HOSPITALIZATION
History of patient:
Diagnosis and staff notes:
Testing done by psychologist:
Psychiatrists' activity:
Role of the social worker in the case:

TERMINATION OF TREATMENT
Discharge:
Reason:
OUTLINE FOR MEDICAL-SOCIAL HISTORY

FAMILY HISTORY

Paternal Side General background of paternal ancestors, social standing, nationality, and race.
Data as to following individuals:
Paternal grandfather, paternal grandmother, father.
Inquire about: insanity, feeblemindedness, epilepsy, neurotic manifestation, excessive alcoholism, instances of suicide, delinquency, etc. Also questions to any so-called "family diseases", including tuberculosis, cancer, migraine, etc. Where possible, secure for each individual full name, age if living, birthplace, condition of health, occupation, age at and cause of death if dead. With parents it is of value to know also educational and economic level, and outstanding personality traits.

Maternal Side Same material as for paternal side. If parents were related, mention this.

Sibling List in order all the mother's pregnancies, including those resulting in miscarriages or stillbirths and including the patient in his proper place. Give cause of death of any siblings which have died. For the living siblings, try to ascertain name, age, civil status, number of children if married, general health, occupation. Inquire about the same conditions as previously mentioned, e.g., insanity, feeblemindedness, etc.

PERSONAL HISTORY

Birth and Early Development Exact place and date of birth.
Develop mental history--feeding difficulties, age at walking and talking, convulsions, retarded development.

Childhood General description of childhood (up to about twelve years).
Illness and injuries and any after-effect of these.
Play-life--amount of activity, age of children preferred as playmates, patient a leader or follower, type of play preferred.
Neurotic traits--enuresis, nail-biting, thumb sucking,
chorea, finicky food habits, night terrors, etc.

**Educational History**  
- Age of entering school, general progress, repetition of grades, double promotions.
- Intellectual ability in school, outstanding achievements or difficulties.
- Conduct at school, and adjustment to school-mates and teacher.
- Effort and interest, attitude toward school.
- Grade reached, age at and reason for leaving school.
- Subsequent study or training, e.g., at night school, adult education courses.

**Settlement Data**  
If foreign born, date and port of arrival in this country; has he been naturalized? Length of residence in Massachusetts, history or local settlement.

**Military Service**  
State company or unit, position, length of service, injuries received, dates of entering and leaving service, type of discharge, compensation received since service.

**Habits**  
- Use of alcohol—amount and frequency of consumption, type of liquor taken, number of years of addiction, and circumstances of first report to liquor.
- Drinking habits—solitary or social, week-ends, occasional sprees, etc.
- Effect of alcohol on disposition, behavior and work.
- Use of drugs—type of drug taken, amount, frequency, alleged reason for its use.
- Effects of drugs and attempts to break habit.
- Use of tobacco, moderate or excessive.

**Court Record**  
Complete chronological history of arrests and sentences (best obtained at Massachusetts Board of Probation).

**Religion**  
Church connections and activities, regular or irregular in attendance, unusual religious interests, changes in religious practices or ideas.

**Personality and Interests**
1. Intellectual endowment, judgement, common sense, shrewdness, suggestibility, decisiveness, or lack of decision.
2. Social adjustments, sociable or seclusive, enjoyment
of crowds, number of friends, leader or follower, demonstrativeness, reserve.

3. Disposition.

4. Predomination moods--restlessness, hopelessness, over-optimism, depression, suspicion, irritability, brooding, introspection, tendency to mood swings.

5. Emotional reactions--fear, jealousy, suspicion, impulsiveness, tendency to temper displays.

6. Energy output, amount of activity, sustained or fitful, easy fatiguability.

7. Ethical standards, sense of right and wrong, tendency to lie or steal, strength of ideals.

8. Interests - use of leisure time, sports, movies, reading, music, handicrafts, clubs, etc.

Occupational History

Chronological statement of position held including, if possible, type of work, name of employer, wages, length of employment, and reason for leaving. Note resourcefulness, ability to manage others. History of difficulties with other employees or employers. Decline in wages or work efficiency.

Psycho-Sexual and Marital History

Attitudes--frankness, excessive modesty, disgust, conventional or unconventional reactions.

Pre-marital experiences--history of love affairs and apparent significance of these, broken engagements, illicit relations, homosexual interests or practices, bestiality. Courtship - length and circumstances of acquaintance, difference in ages, attitudes of relatives toward marriage, reasons for marriage.

Marital--date of marriage and name of spouse. Names and ages of all children, with school standing or occupation, any outstanding personality traits, problems or illnesses. List also any stillbirths or miscarriages. Success and happiness of married life, degree of sexual compatibility, cause of friction, periods of separation; if divorced, date and reason for divorce.

Family or Home Life

Sometimes desirable to use this heading when a good many details are obtained as to family relationships, changes in fiscal status, changes in residence, friction among members of the family, jealousies, etc. This heading may also be used to describe the mode of living of an unmarried person.

Physical set-up of home. Psychological factors with emphasis on relationships.
Medical History  
Chronological statement of all illnesses, operations, or accidents with exact dates of any hospitalization, if possible. Note sequelae or unusual reactions. Inquire specifically for any illnesses accompanied by high fever or any head injuries. Check by questions as to the various systems, i.e., cardio-respiratory, gastrointestinal, etc. Regarding menstrual history, note age at establishment of menses, frequency and amount of flow, any irregularity for cessation, symptoms of menopause, date of menopause, if past.

Fast Difficulties or 
Previous Attacks of Mental Disorder  
Chronological history of any previous mental illnesses with dates, apparent precipitation factors, description of symptoms, length and place of hospitalizations, extent of recovery, include hospital diagnoses if obtained.

Present Situation or 
Onset of Present Illness  
Describe first evidence of change of character or behavior and state when this occurred. Give a detailed description of symptoms as observed by informant, with possible causes or precipitating factors. Note changes in personal appearance, slovenliness in dress, failure to bathe or shave, untidiness, etc. Inquire as to bizarre behavior, grimacing, mannerisms, overtalkativeness or mutism, daydreaming, staring into space, failure to respond to questions. Note sensitiveness, suspiciousness. Quote accurately and in detail false ideas expressed and any indications of hallucinatory experiences. Inquire as to compulsive or obsession phenomena. Note changes in mood, depression, elation, boastfulness, instability, irritability. Note suicidal threats or attempts and note also any violence or destructiveness. Inquire as to memory loss, narrowing of range of interest, confusion, inability to concentrate, loss of orientation. Inquire as to moral lapses, changes in social habits, ideas, preoccupation with own physical or mental symptoms, etc. Note physical accompaniments such as marked loss or increase in weight, failure in appetite or peculiar eating habits, insomnia, headaches, dizziness, speech disorder or slurring, accompanying physical disease or debility. In giving onset, avoid diagnostic terms, describing rather what the patient actually did or said. Note final precipitating factor in bringing about commitment.