1954

Intake at the out-patient department of the Washingtonian Hospital as shown in twenty-seven cases

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Boston University

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Boston University
INTAKE AT THE OUT-PATIENT DEPARTMENT
OF THE WASHINGTONIAN HOSPITAL
AS SHOWN IN TWENTY-SEVEN CASES

A Thesis

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

1954
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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study is to examine the intake process of the out-patient department at the Washingtonian Hospital, with special emphasis on the attitudes that clients have toward beginning treatment for their alcoholic problem. Through understanding of these attitudes and the general intake process at this Hospital, it is hoped that the social worker will be better equipped at intake to meet specific needs of the applicant. The study will deal with the following questions:

1. What is the number of interviews necessary for intake?
2. What happens to patients after intake?
3. What attitudes do patients have toward their alcohol and toward treatment?
4. What is the role of the social worker in meeting these attitudes?

Scope of Study

This is a study of twenty-seven cases which were active in the out-patient department during the period April 1, 1953 to December 6, 1953. This period was chosen because in April, 1953 cases seen in the out-patient department were selected for a special file where interviews with clients were kept separate from the medical record. The latter date represents the beginning of this study.
The writer surveyed seventy-seven cases, which were the total number active during this period, but only twenty-seven cases were finally chosen. Many had no intake interviews recorded. Others had insufficient recording. Cases where the patients were seen at least once, while they lived outside the hospital, were chosen. Those who were on a living-in-plan for several months numbered four. Those who began treatment before, but who remained continuously inside the hospital on a living-in-plan, after the December 6, 1953 date, were surveyed, but are not included in this study. Family and friends, as well as interested persons seen, were not studied.

Sources of Data

The cases used in this study come from the general files which contain the case records of the Washingtonian Hospital. All identifying information regarding the patients has been thoroughly disguised. Additional information was obtained from current literature in the field of social work and psychiatry, as it related to the intake process and understanding of alcoholics. Included in this study, especially in the chapter on the setting, is material gained in discussion with the Director of the Social Service Department.

Methods of Procedure

The twenty-seven cases are viewed as a whole in chapter four. The basic material, which is presented in chapter five, is a qualitative analysis. It has been grouped according to two major groupings:

1. Those patients who show resistant attitudes to treatment.
2. Those who accept the need for help.
The first group is further broken down into how resistance is manifested. The second is handled as a whole group. A rather detailed chapter is devoted to the out-patient department. The literature will be reviewed and related to the major questions the study poses.

Limitations of the Study

This study covers a limited number of cases over a limited period of time and, therefore, no definite statements about all out-patient intake can be made. Also, the material used is from a selected group, and does not deal with all those treated in the out-patient department, such as wives and families of alcoholics, as well as those patients who are currently using the living-in-plan as an adjunct to treatment. Recording was studied to the point where it ended, or if there was much of the case recorded, several interviews after intake were surveyed. No valid conclusions can be made regarding the effect of intake upon treatment, therefore.
CHAPTER II

THE SETTING

History and General Setting of the Washingtonian Hospital

The history of the Washingtonian Hospital is best summed up by one writer who says:\(^1\)

The Washingtonian Hospital . . . is the oldest hospital in the country devoted exclusively to the treatment of alcoholism. It was incorporated in 1859 as the Washingtonian Home; it was promoted and financed by the Washingtonian Movement, which was a nineteenth century society of men and women who came together, signed abstinence pledges, and proselytized its cause (somewhat analogous to the Alcoholics Anonymous society of today.)

The early therapy for alcoholic addicts was moral suasion, a sympathetic assurance of equality, confidence and brotherly love, plus detoxication of the alcoholic patient.

The home survived the movement itself, which disappeared after eight or nine years of existence. The hospital changed locations several times, until in 1873 the present home was built.

In 1910, the name was changed officially to the Washingtonian Hospital and the present medico-psychiatric regime of patient care was instituted.

Structurally the Hospital is divided into departments. There is the in-patient department, the social service department and the out-patient department. Actually these are not three separate isolated departments within the Hospital. Patients who are considered out-patient have been in-

patients, while some of those being carried as out-patient cases use the facilities of the in-patient department.² The social service department has sole responsibility for intake in the out-patient department, as well as for providing casework services in the in-patient department.

History of Out-patient Department

With the growth of the Hospital over the past years, there has been a change in the place of the out-patient department. It was formed when the Hospital was reorganized in 1939 and granted funds from the Community Chest. The department had its ups and downs with the war practically depleting its staff.³ At present the out-patient department of the Hospital has on its staff four part-time psychiatrists who are exclusively its own. Approximately two and one-half years ago the out-patient department became a unit of the State clinics for alcoholism. Thereupon, it received State funds which have helped it develop and take on greater responsibilities for services.⁴

The Washingtonian Hospital's out-patient department has never been defined clearly. The following is an attempt to present a picture of this department of the hospital.

Administrative Lines

The Medical Director of the hospital is basically head of the out-pa-

² Discussion with Director of Social Service, Gladys M. Price.


tient department. However, responsibility is delegated to the Director of Social Service, who supervises the out-patient department.\(^5\) The person who employs the four psychiatrists is the Medical Director.

**Source of Patients**

Patients reach the out-patient department by many avenues. "State patients" (paid for by the State Division on Alcoholism) are exclusively outpatients. There are also direct referrals from agencies within the community, such as family agencies, protective agencies, courts, prison associations, etc. Another source of referral is the in-patient department of the hospital, and this can work through several different routes. Patients who come to the hospital for detoxication can indicate a wish to have out-patient treatment. This can be expressed to a nurse, resident physician or Medical Director, as well as to any staff person. Or the social worker can initiate contact or be requested by a patient to provide some service, and discussion can be brought around to out-patient treatment for the problem. Those patients who are referred directly into in-patient care from an agency, usually are contacted by the social service worker to see if they are interested in out-patient treatment.

**Who Constitutes Out-patient Cases**

Those patients who live outside of the hospital in the community are not the only ones considered out-patient cases. There is a group who live

in at the hospital, using the working-protection plan; 6 those who are living in on a full-time basis for detoxication as a part of treatment as well as those in the beginning stages of conditioned reflex treatment are out-patients. 7 Wives and family members of the alcoholics who are seen for treatment are also considered out-patients.

Another group are those who are given in-patient service when they are patients in the hospital. When they are ready to leave or to accept some treatment plan, they then become out-patient. There is no continuance in in-patient care once the patient leaves.

Treatments Offered

In general, the treatments offered to the patient are summed up by:

The Washingtonian Hospital attempts an individualized and scientific approach to the treatment of the alcoholic patient, employing an eclectic system of study and therapy. 8

Basically there are three kinds of treatment offered to patients: psychiatric, medical and environmental. The psychiatric service includes social casework, which is provided for by the Director of Social Service (who is the only full time social worker at the hospital), and the two


student social workers, who are from the Boston University School of Social Work. Only the social workers work with families of alcoholics, however, but they also do casework treatment with the alcoholics. Because of the belief that treatment of relatives of alcoholics was important, the Director of Casework described the function of the caseworker as:

1. The greatest proportion of time and service is afforded to relatives who need help in understanding the patient, the nature of his illness, the treatment prescribed, and their own part in his recovery. Social histories obtained from the relatives, also, are of aid to the physicians in planning treatment.

2. Patients are helped to use the resources of the hospital, steering them to appropriate members of the staff, assigning them, in making adequate financial arrangements, planning living quarters upon discharge, and guiding them in their attempts to find suitable employment. An explanation of the patients' problems to prospective employers has often been necessary.

Since this report, the social worker in later years has taken on more responsibility for direct treatment in the out-patient department with the alcoholic patient.

Psychotherapy, both individual and group, is given by four psychiatrists and the Medical Director. Some attempts were made in the past at hypnosis, but this has been discontinued. The patients seen for psychotherapy are seen once a week. Group therapy of conditioned reflex treatment patients has been going on for many years under the direction of the Medical Director. Patients who are taking conditioned reflex treatment are seen by the Medical Director for individual psychotherapy.

9 Discussion with Director of Social Service Department, op. cit.

The drug treatment offered in the out-patient department consists of Antabuse.

It provides disagreeable symptoms which follow the ingestion of alcohol by individuals... However, there should be two phases of treatment. (1) Administration of "Antabuse" which induces the patient to shun drinking; and (2) psychotherapeutic care, which supports the patient in his desire to continue medication, to readjust himself socially, and finally to make necessary changes in his habits.\[11\]

Adrenal Cortex Extract is also used as an adjunctive treatment,\[12\] as well as the conditioned reflex treatment. With the conditioned reflex treatment, Dr. Thumann states that with patients whose

... alcohol addiction is their only outstanding difficulty... the conditioned reflex treatment is the therapy, or at least the main therapy. In the third group of patients who are overly tense, restrained, oversensitive, exclusive and inhibited, high strung... with compulsive drinking developing relatively early, and the drinking is a mere expression of underlying neurotic traits, psychotherapy becomes the main treatment and has more chance of success, if the drinking is eliminated.

Environmental change is also offered to patients who are seen in the out-patient department. This is called the Working Parole Plan which...

... is a system of working patients, that is to say, the patient while still under treatment returns to his former occupation (or finds a new job), but spends all his spare time at the hospital. This arrangement has a number of advantages. The patient is in a protected environment during his free time. His evenings and nights are spent at the hospital if he is working in the day time or vice versa if he is working at night. He is under shelter of the hospital over the weekends, time difficult to bridge if he is living outside, be-


\[12\] Schwartz, op.cit., p. 11.
cause of the temptation to seek the conviviality of a tavern in his loneliness, and because he has nothing to do. He is, moreover, removed from the emotional instability of a home environment in which wife and mother may have little understanding of his problem, and from the company of drinking companions. It has been found that such a protective environment should be continued ... by ... other therapies.\textsuperscript{14}

\textbf{Intake}

At the Washingtonian Hospital, intake can take place while the patient is an in-patient or comes in off the street. Intake continues at the hospital until the patient and social worker reach the point where the patient and worker agree that there is a problem and the patient wishes to do something about it.\textsuperscript{15}

\textsuperscript{13} Joseph Thimann, "The Conditioned Reflex Treatment for Alcoholics," reprinted from Current Therapies of Personality Disorders, edited by Bernard Glueck, M.D.


\textsuperscript{15} Discussion, Gladys Price, \textit{op.cit.}. 
CHAPTER III

SURVEY OF THE LITERATURE

This chapter will concern itself with a discussion of the literature as it relates to the purpose of this study. Alcoholics as a group related to their sex and marital status will be discussed. There will also be a discussion of alcoholics as a group, pointing up similarities and differences with clients who do not have this as a major problem. This will be followed by a discussion of the purpose, the problems and the value of intake. The final part will discuss the role of the worker in the intake process.

As one writer states it, "Excessive drinking is largely a masculine affair."¹ In some of the latest statistics published in Massachusetts this is further brought out in that four times as many males as females are admitted to clinics for alcoholism sponsored by the state's Department of Public Health.²

Regarding alcoholism and marriage, studies show the largest group to be unmarried. One writer states the underlying reasons for this as -


... (2) the institution of marriage has become more important as an association for establishing intimate, affectional relationships of a reciprocal nature; (3) certain types, such as the immature man, the aggressive individualists, the unsocial dreamer, are afraid of the close associated ties of marriage: the pressure on them to marry is less; and ... (5) such types are very susceptible to alcoholism. It makes close interpersonal relations - in fact any personal relationships - far more difficult; it increases suspicions; it provides a safe retreat, temporarily, from the world of reality; it allows immaturity, cynicism, aggressiveness, egoism and self pity a fuller play.3

However, a large group are married and since we consider it a strength of personality to seek treatment, we can expect that the alcoholics seen at intake have reached a higher level of cultural adjustment than the group referred to above. No studies of marital relationships of alcoholics who have sought treatment have been reported. However, the alcoholic does marry and has his own family group. Statistics show that the group as a whole have unstable marriages with divorce and separation quite prevalent.4 The surprising part is that there remains intact marriages. This problem is handled by the wife in that:

Some wives find ways of handling this problem. Some women have been able to help their husbands get appropriate treatment. ... Others, however, remain in a constant state of indecision and anxiety. ... When the wife requests help we could see that it was rarely, if ever, the drinking per se ... the drinking usually was no more marked then it had been for years, but something in the man's behavior towards his wife had shaken her customary equilibrium.5

The wives do not want the husband to stop drinking and seem to derive

3 Seiden D. Bacon, op.cit., p. 229.

4 Ibid., p. 229.

satisfaction from the husband's alcoholism.

Some General Considerations of Intake with Alcoholics

In any interview, whether it be in intake or in later treatment, the actions of the worker must be based on sound diagnostic understanding. "The caseworker who is thoroughly familiar with these different syndromes is more likely to recognize early the client's pattern of adjustment."\(^6\)

This understanding can influence the worker's initial response to what the client says in the intake interview. With some patients the worker takes a more active role while with others the worker must remain absolutely neutral.\(^7\)

The alcoholic is described as an "impulse neurotic."\(^8\)

They get into difficulties through acting out their impulses to steal, to assault, to "have a good time" \(\text{at any cost}\) and above all to run away. Such persons present many of the same difficulties in establishing relationships.\(^9\)

While alcohol is the major symptom which brings patients for treatment at the Washingtonian Hospital, it is basically "only one factor in the sum total of the personality disturbance."\(^10\) The approach is to respond quickly


\(^7\) Ibid., p. 71.


\(^10\) Ibid., p. 297.
and decisively to the needs of the patient, and it is out of the situation of "giving and receiving", where something is given, either tangible or intangible, that communication can be established. However, other agencies do not meet the need of the client immediately, and the alcoholic wanders from agency to agency, "weeded out" of the caseloads. With the alcoholic there are special problems. He may be intoxicated and need immediate hospitalization. He may need living-in care, which is impossible in a family agency. Because of his special kind of problem, he needs care with only other members of his group.

When met at intake, the alcoholic is usually under a great deal of pressure as the result of his disastrous drinking. He sees himself slipping into acts which he is so fearful of as to what the results will be. He may be asking for an interview just on an impulse. He is also an extremely dependent person, who has a self image which is born of the constant nagging, berating, punishing world in which he lives and upon which he is so dependent for his existence. With an environment which makes him look at himself in this way, he is also going to be very suspicious of what will be offered to him by the caseworker. However, persons with extreme dependency needs, fearfulness, suspicions, and impulsiveness, are seen in other agencies.

11 Ibid., p. 298.
12 Ibid., p. 298.
Since the alcoholic comes to a clinic for treatment after there has been some catastrophe in his life due to his drinking, he may come referred by a social agency where he has sought help because of divorce. He is likely to come from a court, placed on probation or after being released from a prison. His drinking may have caused the community to take action against his children. Usually he comes referred, but he may also find his way because he has heard from others about the place where he can get help to relieve the extreme pain he feels.

Purpose

In the current literature, concerned with the purpose of intake, there has been some change in thinking, especially in psychiatric clinics. In the past, the social worker was used at intake as a gatherer of a history for the doctor. However, this is no longer looked at as the role of the social worker. In all latest communications, the social worker has sole responsibility for intake. Its purpose depends upon two factors, the client and the agency.

People come to social agencies with a wide variety of requests, problems and needs. Some persons select a particular agency because they know that agency’s function; some are referred for specific services because of special knowledge about a given agency; many come not knowing much about the agency and are unclear about the help they seek or whether this agency is the appropriate one. How the potential client is met initially, and how the agency responds to his request, his problem, his needs, or to a

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combination of these depend on the philosophy of intake.\(^\text{17}\)

The same writer then continues:

Some \ldots\) are concerned chiefly with the presenting request \ldots\) To some the important factor is the specific problem as seen in the request and its attendant ramifications. \ldots\) Others attempt through understanding the request, problem and need, to see the relation of these to their social resources and to the skills of their case work staff. \ldots\) Others \ldots\) understanding of the person and his need, regardless of the specific request as problem, or whether or not they have particular social resources or certain skills to meet the need. These agencies accept the concept that the primary focus of intake should be on the person, his family and their needs. \ldots\) In a broad sense an "open door policy".\(^\text{18}\)

The purpose is, then, clearly to ascertain the needs a person has and in which way they can be met. Intake is not the same in all respects to treatment. There are similarities in that the same approach by the worker is used, but the focus of intake generally is not treatment focused. A therapeutic gain can be experienced by the client, but this is basically a by-product. However, this view is not the only one in the field. One writer uses intake to make interpretations and to do "Short Term Therapy".\(^\text{19}\)

Whichever view is taken, its major focus "should revolve around the individual's need and the ability of the service to meet this."\(^\text{20}\)


\(^{18}\) Ibid., p. 234.


Problems of Intake

"Initial resistance is usually born of insecurity, fear of the unknown as of terms to be met, and may be increased due to cultural unfamiliarity with the procedures."\(^{21}\) Another important part of resistance comes from the defenses that the client has set up in order to help him face the world. When a patient comes into an agency, he must have laid aside some of these defenses and in general overcome part of his resistance. This does not mean that the patient will have neither defenses nor resistances, but on the contrary, because some will be in operation, they will present a problem to the worker in meeting the client.\(^{22}\) Resistance may be shown by refusing to give information or giving so much material to the worker that it overwhelms him, or by not being able to arrange a time, etc. However, each point the client makes should be looked at not only as resistance, but as having a reality basis also.

Value of Intake

As many writers have put it, intake provides a reality experience for the client on which to gauge what treatment will mean with another person. Also, it:

1. Brings into focus and clarifies the problems for which the client is seeking help.


\(^{22}\) I do not want to indicate that defenses are undesirable for clients and for workers to work with. However, sometimes they can propel a person out of treatment.
2. Evaluates what he has already tried to do about his problems.
3. Assesses the client's motivation for utilizing help and identifies some of his resistance to entering treatment.
4. Decides whether the service he wants is available under conditions he can accept.23

Intake also provides some diagnostic understanding on which to base a treatment plan.

Some Considerations on the Role of the Worker at Intake

The interviewer must strike a balance between the nuances of feeling and gaining factual material. At intake feeling tones and areas of distress for the client must be noted, but not plunged into. The relationship at intake is one where the patient can feel free to tell the worker his problem, but not be as intense as a treatment relationship.24 Support is given whether it is done through a direct statement or more subtly by "recognition of the client's own attempts at solution, discussion of his plans for the future and encouragement to self sufficiency."25 Sometimes it is necessary, especially with alcoholics, to think of meeting a need for hospitalization or to provide a resource for food and shelter, etc. The worker always focuses through the chief complaint and into the initial request. It is through this that diagnostic understanding can be gained and clarifica-

25 Ibid., p. 152.
tion of the problem made. The worker must be able to recognize the defenses and not break into them, as well as evaluate the ego strengths for diagnostic purposes. Another important role of the social worker is, in clarifying the problem, to point out the next step for the client to make.
CHAPTER IV

PRESENTATION OF FACTUAL DATA

This chapter will concern itself with an analysis of the sex and marital status of the patients as well as the sources of referral, the disposition of the cases, and the number of intake interviews the patients had as shown in the twenty-seven cases studied.

Grouped as a whole, there were nineteen male and eight female patients. Over seventy per cent of the cases studied were males. This, of course, can be expected since the alcoholic population as a whole has many more males than females.

TABLE I

MARITAL STATUS OF PATIENTS SEEN AT INTAKE

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4</td>
</tr>
<tr>
<td>Married</td>
<td>18</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

Sixty-six and two-thirds per cent of the patients were married and living with their wives at the time they were seen at intake. Some of them
indicated that they were having marital difficulty, while others felt that there was no problem with their wives at all.

The one widowed patient was the oldest of the group, sixty-five, and had lived with her husband prior to his death. Several of those who were married were divorced and remarried, but the great majority of them were living with their wives.

**TABLE II**

<table>
<thead>
<tr>
<th>SOURCE OF REFERRAL TO OUT-PATIENT DEPARTMENT</th>
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</thead>
<tbody>
<tr>
<td>Hospital: in-patient</td>
</tr>
<tr>
<td>Social agencies</td>
</tr>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Other hospitals</td>
</tr>
<tr>
<td>Community person</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The largest single group, or thirty-seven per cent of the total number of patients, was referred from social agencies. However, if we combine those who were sent from other hospitals, since they were all sent from the social service department of these hospitals, we find that by far the largest group came to the hospital after contact with another agency. This amounted to almost sixty per cent of the group studied. The social agencies who referred were Prison Associations, court referral and, of the ten, five were referred from a children's protective agency.
Those referred to out-patient service from the in-patient department had spoken to either the Medical Director, or to one of the resident physicians, indicating they wished help with their problem of drinking.

The community persons referring were physicians and clergymen. In general, there are very few who come to the out-patient department without having been referred from some source.

**TABLE III**

**NUMBER OF INTERVIEWS AT INTAKE**

<table>
<thead>
<tr>
<th>Number of Interviews</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

The criterion used in the agency for deciding where intake ended was when the client wanted to do something about his problem and the agency could meet the client's request for help. In almost fifty-two per cent of the cases this was possible in the first interview. In thirty-three and one-third per cent of the cases this decision was reached in the second interview. With all patients who needed more than one interview, they fell into two groups: those who were unsure about continuing treatment, and those who were so anxious to begin that clarification of the agency's role
had to be very specific.

TABLE IV

DISPOSITION OF PATIENTS
IMMEDIATELY AFTER INTAKE

<table>
<thead>
<tr>
<th>Continued With</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td>11</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>2</td>
</tr>
<tr>
<td>Did not return</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

Of the cases studied, forty-four per cent of the patients were referred to a psychiatrist after intake. Forty-one per cent were seen by a social worker. Three of those cases seen by the psychiatrist were jointly seen by a social worker also. Of the two who entered the hospital after intake, one was seen by a social worker and psychiatrist during hospitalization, while the other's record was insufficient to show what disposition was made after admission.

After intake there was a direct service offered to each patient, and by far the largest group was able to accept further services.
CHAPTER V

PRESENTATION AND DISCUSSION OF CASE MATERIAL

Four cases will be presented in this chapter which point up the problems the worker is faced with in the intake interviews with alcoholic patients at the Washingtonian Hospital. The focus of the case presentation will be on what attitudes patients have towards going ahead with treatment, and the role of the social worker in meeting these attitudes.

The cases studied fall into the following two categories:

1. Those who showed resistance toward treatment for their alcohol problem.

2. Those who showed no overt resistance to involvement in treatment for their alcoholic problem.

By far the largest group, nineteen, was composed of those showing resistance toward involvement in treatment. It was felt by the writer that since there were three distinct kinds of resistance shown, a further breakdown of this group should be presented. The resistance shown could be grouped into:

a. Those who focus resistance in the area of involvement in a treatment relationship.

b. Those who focus resistance in the area of accepting alcohol as a problem.

c. Those who focus resistance in a generalized way, even though they accepted alcohol as a problem and want help with the problem.
Group I: Case A
Those Who Focus Resistance in Area of Involvement in a Treatment Relationship

Mr. C.

This is the case of a forty-three year old white male who was referred by the Medical Director to the out-patient department after he had a week's stay in the hospital for detoxication.

Mr. C. lives alone, working and living in a State hospital. He has no children and is separated from his wife with whom he lived for a short time. His wife lives in another city. Very little is known of his relationship with his wife other than that they were in constant battles with each other, and he finally "outfoxed her" when he left. He told the worker nothing of his relationship with his family other than that when he left his wife, he returned to this part of the country and lived with one of his sisters for a while.

Patient is an alcoholic and has been a habitual drinker for the past twenty-five years. He had treatment for his problem of alcohol in a group, but broke treatment after eight months. His drinking has interfered with his jobs in the past, and he was recently worried that he might lose his current job as a result of this last drinking bout. He relates difficulty in eating and stomach trouble as causes in his drinking, adding to this that fear of what the future will bring causes tension which he reduces by drinking. He shows much unsureness as to what he wants from the therapist, both a person who tells him what to do and, on the other hand, a very passive person. His ambivalence focuses directly on treatment, looking at it as only drug treatment which he is very much afraid of taking.

Patient agreed to continue in treatment to "see how it goes". He maintains reservations and states that he does not want to talk about his past or to take any drug treatment. However, he is able to express areas which he wants help in, such as his current job crisis, his eating, and his recreation.

The worker listened passively to the client and accepted his defenses about talking of his alcohol and past situa-
tions. Exploration centered about his job, his past treatment, which were things he felt comfortable with. The worker also clarified with him his drinking in terms of his somatic symptoms and his tensions, against which the client defended himself. The worker also assured him that he did not have to take drugs.

Mr. C. was referred by the Medical Director for out-patient evaluation and intake. Intake was over two interviews and he is seen for treatment by a social worker.

Interpretation

Mr. C. is an extremely fearful patient who accepts quite readily that his drinking is a problem. However, he is quite ambivalent about getting help with it. His resistance to treatment centers around what it will mean to become involved in a treatment relationship with a therapist because of fears concerning what he will have to face in himself, as well as fears as to what will be done to him by the therapist.

By the worker's passivity in the interview, the patient is able to feel a measure of control which affords him safety. The worker's exploration is around areas in which he feels safe, which respect his defenses, and provides some diagnostic understanding on which to base a tentative treatment plan. Clarification and reassurance are used to show the worker understands the patient's problems, and respects the controls that the client needs over the worker.

This group of patients numbered five. The resistance ranged from a case where there was passive hostile resistance which was implied but not expressed to a patient who was really undecided and needed very little reassurance that he could control the interviews.

In all these cases the worker used exploration of the client's current reality situation. With some it was possible to explore through their
drinking problem, while with others it was not. However, the worker was able, through the areas which the client showed interest in, to explore through this. The worker's role was a passive one, and accepted the client's defenses, leaving it up to the client if he wanted to accept treatment.

In this group of patients all were males. Three were married, one separated, and one was single. Three were referred from the in-patient department and two came from social agencies. All had experienced dire consequences from their drinking. In three of the cases intake ended after two interviews, while with the other three intake was completed in one interview. Four were seen by a social worker for treatment, while one was seen by a psychiatrist.

Group I: Case B
Those Who Focus Resistance in the Area of Accepting Alcohol as a Problem

Mrs. L.

This is the case of Mrs. L., a thirty-nine year old white female who is a self referral to the out-patient department.

Mrs. L. has been divorced and is currently living with her second husband, who is five years her junior. She has a seventeen year old son who is of the first marriage. She divorced her first husband because of his drinking. Very little early history was gained except that her mother died when the patient was very young and she was extremely close to her father. Her father died several years ago. Patient also lost another child of her first marriage several years prior to the father's death. She and her husband work and the family income is adequate.

Mrs. L. has been drinking for a number of years, but has found she cannot control her drinking in the last two years. She has been to A.A., but this has not helped her.
Patient's initial major problem is her relationships with her son and her husband. Her son resents his step-father and her husband resents patient's relationship with her son, who he feels is a spoiled child. She finds herself in the middle, between her son and her husband. She also ties up the loss of her father and her son with her drinking, saying that she used to drink with her father and was happy; now when she drinks she finds herself grieving over the loss.

Mrs. L. wants the worker to tell her whether she is an alcoholic or not, and indicates that she has come because her husband has told her she is one.

Mrs. L. is able to recognize that she herself has a problem with her drinking, but is unable at intake to accept that she needs help with her relationship with her husband. She agrees to go on and work with the drinking problem and has become less resistant to facing her problems with her husband.

The worker explored the patient's drinking problem and also the relationship with her husband and son. The worker was passive only enabling the patient to tell him her problem, accepting the defense against the patient's seeing the drinking as a problem and then clarified her awareness and need for help. The worker accepted the patient's defenses against seeing that she in herself had a problem with her husband.

Intake was completed after two interviews and patient was seen by a social worker for treatment.

Interpretation

This is the case of a thirty-nine year old woman who comes to the outpatient department of the hospital to have clarified to her whether she is an alcoholic or not. She has resistance to accepting whether she has an alcohol problem, but behind this is the problem of her relationship with her husband. At intake, she is able to accept that she has a problem of alcohol, but is still unable to face the problem of her relationship with her husband. This patient agrees to continue on in treatment with a social worker. This was accomplished by the worker's acceptance of the patient's defenses
against her facing her drinking problem, and also accepting her defenses against her own involvement in her problem with her husband. The worker helped the patient to clarify the fact that alcohol was a problem and faced her with the need for treatment. Exploration of her drinking and the patient's relationships elicited an understanding of the client's situation, and also gave much diagnostic information.

The group of patients who initially showed resistance to accepting alcohol as a problem comprised the largest group of patients included in this study. There were ten in all.

There were variations in how strong the resistance was. The most extreme case was of a patient who openly denied any problem, and only came because he was literally dragged into the intake interview. In the other extreme was the patient who very passively denied that he had a problem of drinking but immediately after was able to lay aside this defense.

However, it was not clear in all cases just what the reason for this denial was because of the limited recording or that it did not become apparent. From what was apparent in the cases, reasons for this resistance were based upon a fear. Alcohol was used by some as a way of handling life situations which the patient found so hard to do. In two cases the patients felt extreme guilt over their drinking and had to deny it. In four cases it was unclear.

At intake with this group, the worker explored through the alcoholic problem. Defenses were respected, but the worker has to be more active in understanding with the patient, the drinking, and the consequences of it. Clarification was around agency function. With some of these patients the worker had to give them some support indirectly before they were able to
face with the worker the drinking as a problem. This was done through some tangible services such as a phone call, or having the patient tell of his accomplishments.

In this group there were three female patients and seven males. Eight were married and two were separated. Five patients were referred by a social agency, three from another hospital, one was a self referral, and one was a referral from in-patient department. Intake with seven cases was completed in one interview, with one case two interviews, and with two cases intake covered three interviews. Four were seen by a social worker, three a psychiatrist, one was admitted to the hospital, while two did not return for any further help.

Group I: Case C

Those Who Focus Resistance in a Generalized Way, Even Though They Accept Alcohol as a Problem and Want Help with the Problem

Mrs. M.

This is the case of Mrs. M., who is a sixty-four year old white female, initially seen while she was still an in-patient undergoing a period of detoxification.

Patient is of Irish birth and has lived in this country since her early twenties. She is a widow of eleven years. She lives alone in her own home, even though she has five daughters and one son in the community. All the children are married. Two of the daughters are nurses. Her son, the youngest child, drinks and the patient feels quite upset about this. The daughters want the patient to live with one of them, but patient wants to keep an independent home. The patient is working and paid for her own hospitalization, even though the family brought her into the hospital against her will.
Mrs. M. had been a habitual drinker a good many years. This was her second hospitalization, and she felt that her drinking was causing her to be hospitalized which interfered with her working. She also felt that once she began to drink she could not stop and feels the problem is out of control with no one in the family able to help her. Even though she sees the problem and feels that there is need of help, she is very suspicious of the worker whom she first identifies with her family and tries to provoke. She is faced with the problem of what to do about her drinking and tries every means to avoid this decision by focusing hostility on the hospital, her daughters, and also the worker.

Mrs. M., after four interviews, agreed to return to the outpatient department for treatment with a social worker. Her attitude changed from an openly hostile and suspicious one to one of passivity with an expression of real concern about the problems she faced. She indicated areas where she would want help, such as her relationship with her son and her indecision where to live.

The worker met this patient's hostility and suspiciousness by clarifying to her his role. Exploration was into the resistance around the hospital rather than into the relationships or her functioning outside the hospital. A firm stand by the worker was necessary and he faced the client directly with her resistance. Worker provided very tangible services such as telephone calls.

Interpretation

This is the case of a sixty-four year old white woman whose initial contact with the intake worker is during her detoxication period as an inpatient. When first seen by the worker she is extremely hostile and suspicious toward him, even though she admits quite readily to an alcoholic problem which she feels she needs help with. After four interviews, where the patient continuously tests out limits and focuses her hostility towards the hospital, her family and to the worker, she is able to accept treatment with her social worker.
This the worker was able to accomplish by acceptance of the client, clarifying his role, exploring into the resistance, doing things for the client, and placing limits upon her acting out.

This group comprised four cases of the study. There were two male and two female patients. Three were married and one was widowed.

All focused hostility towards the hospital and their outside environment. The differences were in that the amount of acting out tensions did not focus so much hostility on the worker as in the above case. Behind this kind of resistance was really the fear in the patients as to what kind of person they would be having a relationship with. They wanted to test out before they could feel comfortable in relating. One could speculate as to whether the testing the patient did had not elements of showing their bad part of themselves to see if they could be accepted as a total person.

In this group two patients were referred by a community person, one from a social agency and one from the in-patient department. Intake was carried on for two interviews with two patients, three for one patient, and four for another. After intake three were referred to a psychiatrist and one was seen by a social worker.

Group II

Cases That Show No Apparent Resistance to Treatment for Their Alcohol Problem

Mrs. B.

This is the case of a thirty-four year old woman who has been referred to the out-patient department by a local children's protective agency.
Mrs. B. was married at the age of nineteen and has three children. At the present time she is separated from her husband and there is a suit pending against him for neglecting the children. Mrs. B. showed much positive feeling to the children and while she was in a hospital, the husband neglected the children. Her husband is also an alcoholic, but does not want to accept treatment. Nothing is known of her earlier family relationship, other than reference to vague childhood problems.

Mrs. B. felt that her major problem was her alcoholism and she had to stop drinking, because she became abusive to her husband when intoxicated. This bothered her a great deal. She felt very mixed up inside and when she begins to feel pressure of home situations on her she begins to drink. The current problem which is causing her difficulty at this time is her relationship with her husband, since she really does not want to separate from him. However, he will come back to her if she places the children. She does not want to do this.

The initial request of the patient was to be able to see a doctor, because of her drinking and mixed up feelings.

Mrs. B. was able to tell the worker what her problems were and the areas in which she would want help. She was able to modify her initial request for someone to do something for her to a real involvement of herself with the social worker. She is able to see more clearly what her drinking means to her and agrees to accept drug treatment for it.

The worker used exploration of the drinking as it related to current reality situations. Also the worker controlled the interviews by refocusing the client from a preoccupation with the past into the current reality situation. Clarification of the patient's problems around her relationships with her husband and children was done and a contract agreed upon. The worker supported the side of the patient that wanted help by using reality reassurance.

Intake covered a period of two interviews.

Interpretation

This is the case of an extremely confused thirty-four year old mother of three children, who comes to the out-patient department clinic seeking help with an alcoholic problem which she is unable to handle. She relates
This drinking problem to a problem with her husband. After two interviews with the worker, she is able to accept involvement in a treatment relationship which is focused upon her basic problem with her husband.

This is accomplished by exploration by the worker of the drinking problem; clarification of her problems and support on a reality basis. Suggestion is also used by the worker in order to begin the treatment process.

This group of patients numbered eight in the study. All of them accepted, and quite readily, that they needed help with an alcoholic problem, but there was some variation. Four of the cases which include the above all related a problem of relationships, which was the area they needed help in, since these relationships caused them anxiety and they began to drink. In three of the cases the central anxiety was focused around the consequences of their drinking which caused them so much pain. In one case the central anxiety is not clear, because the interview was used just as a stopping point to make arrangements to see a psychiatrist and recording was scant.

In all of these cases other than the one where recording was scant the social worker controlled the interviews, keeping the exploration of the request for treatment in the current reality situation of the client. The worker had to assume a rather active role in pointing out to the clients just what the clinic could do for them in order to meet their requests for treatment.

Clarification and support were used in six of the cases with the worker clarifying the problems of the patients so that both patient and worker would understand where they both would work. Also, clarification was used
when referral to psychiatrist was the plan. Support by the worker of the part of the client that wanted treatment was done and concrete steps made with them to begin treatment with a social worker, psychiatrist or as with one of the patients to enter the hospital.

In this group there were five males and three female patients. Three were single and three were married. One each was separated and divorced. They were referred from many sources with two coming from social agencies, three from other hospitals, two from community persons and one from the hospital in-patient department. The number of interviews necessary for intake was one for five of the patients, two for three of the patients, and three interviews for one patient. After intake three saw a social worker, four saw a psychiatrist, and one was admitted to the hospital in-patient department.
CHAPTER VI

SUMMARY AND CONCLUSIONS

The purpose of this study was to examine the intake process of the out-patient department of the Washingtonian Hospital with special emphasis on the attitudes clients have toward beginning treatment for their alcohol problem. In order to do this, several questions were raised. They were focused around what the number of interviews necessary for the intake process was; what happened to the patients after intake; what attitudes do patients have toward their alcohol and toward treatment; and what was the role of the social worker in meeting these attitudes.

Twenty-seven cases from the files of the hospital were surveyed out of the seventy-seven seen at intake in the out-patient department during the period April 1, 1953 and December 6, 1953.

The out-patient department is one of the three departments of the hospital. It has a staff exclusively its own, as well as using staff from the two other departments, namely, in-patient and social service. Even though the out-patient department has an exclusive staff of its own it is directly responsible to the Medical Director, and administered by the Director of the Social Service. The service of the out-patient department is all focused in the direction of treatment for the problem of alcoholism and both families and the alcoholics are seen there. The department offers three basic kinds of treatment: medical, psychiatric, and environmental. However, the main treatment is psychiatric with psychotherapy, casework and group therapy the
three main types. The medical treatment such as conditioned reflex, antabuse, and adrenal cortex hormone are considered adjuncts to psychiatric treatment. Also included in the adjunctive category is the environmental plan for the patients (living in on a working parole plan), as well as detoxication.

The literature was reviewed and it was found that males by far exceed the number of female alcoholics. The alcoholic group in the population are mostly unmarried, but a large number do marry but have unstable unions.

Many alcoholics are impulsive character disorders. While the alcohol is the most glaring problem, there are also other basic problems. However, there are special needs to be met in the alcoholic which do not characterize patients coming to other social agencies. The role of the social worker functioning at intake has changed from the fact gatherer for the psychiatrist to the enabler in helping the client into treatment. The worker is there to meet a client's call for help and functions within the limits which the agency defines. Clients will show resistances and defenses against involvement in treatment, but the patient does come because he feels a need for help and workers must be prepared to meet the client as he presents himself.

The twenty-seven cases were surveyed as a whole with the focus of what was their sex, marital status, the source of referral to the out-patient department, the number of interviews necessary for the intake process and the disposition of the cases. It was found that the males exceed the females, that by far the greatest number of patients were married, and the patients came from a variety of referral sources but mostly from social agencies. Others came from community hospitals, referred by a community person with only one a self referral.
The number of interviews necessary for intake varied from one to four. However, the majority needed but one with the next largest group needing two. After intake, by far the largest group were seen by either a social worker or a psychiatrist. Another small group entered the hospital and two did not return for any service.

It was found that the majority of the group studied had resistance to involvement in treatment for their alcoholic problem. However, a large group had no resistance to their involvement in treatment for their alcoholic problem. Of those who did have resistance, it was focused in three areas: Those who were resistant to a treatment relationship, those who could not accept their alcohol as a problem, and those who focused their hostility in a diffuse way.

It was apparent that there was something behind this resistance. Those who focused resistance in the relationship were fearful of what would be done to them by the person whom they would see, the other group who could not face the alcohol as a problem were fearful of what would happen to them if they did accept treatment for it. In the third group it was not clear what was behind the hostility but from the quality of it one could assume that the patient wanted to test out whether he could be accepted, even though he were so "bad".

With those who accepted treatment for their alcohol problem, they had either attributed the drinking to another problem which caused anxiety or they were overcome with the pain due to the consequences of their drinking.

In working with some of the cases studied the worker had to assume a very passive role, while in others it was necessary to be active. The passivity was necessary to allow the client to control the interviews, while
the activity was necessary to set up limits. The worker always explored
the patient's drinking patterns initially and through this got valuable
diagnostic information and an understanding of what the client's basic
problem at the time was. The worker had to clarify the problem to the cli-
ent and define in what way the agency could help to meet the problem.

Intake at the out-patient department is representative of intake in
any social agency. The patients come from both sexes and they represent a
variety of marital backgrounds. Intake is done by the social worker, whose
task it is to understand what the client's problem is and then to see in
what way the agency can meet this request for help. It provides the client
with an experience but does not attempt to do any treatment. The intake
process is geared to the needs of the client. There is no limit placed upon
the number of interviews and to meet the needs of the client for treatment
different resources are used which the hospital provides. The clients who
come for treatment all have the symptom of alcohol addiction. While there
is resistance to going on with treatment, there is still a large segment of
their personality which can be worked with and the resistance does not nec-
essarily make movement into treatment impossible. Behind this resistance
are fears.

With those who do not show resistance to treatment for their alcohol-
ism there are other problems which must be recognized with the client.

The worker who does intake must be able to meet the resistance of the
client, understanding what is behind it. He also uses the techniques of
social work, such as exploration, support and clarification. In this set-
ting the worker must also be active in meeting a specific request of the
client and doing some tangible service for him.

Approved:

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Dean
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