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Treatment of five patients diagnosed neurotic depression or depressive reaction at Briggs Clinic.

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TREATMENT OF FIVE PATIENTS
DIAGNOSED NEUROTIC DEPRESSION OR DEPRESSIVE REACTION
AT BRIGGS CLINIC

A thesis

Submitted by
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(B.S., Simmons College, 1952)
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CHAPTER I
INTRODUCTION

Purpose.

The purpose of this paper is to learn what techniques of casework are used in the treatment of five patients with the diagnosis of neurotic depression or depressive reaction at Briggs Clinic. By case study and analysis, the writer will endeavor to find how these techniques were used and how, if at all, these patients were helped. The cases will be examined with reference to five casework principles listed and defined in Chapter III of this paper.

Scope and Limitations.

The writer will present five cases in detail. These cases will vary in terms of age, sex, background of patients, and number of treatment hours. Because of the limited number of cases used and because this study was made in one setting only, the findings of this study will be valid to this setting only. All of the cases were selected as of February, 1954. Three of these cases had been closed at that time, and the remaining two were still in treatment.
Method of Procedure.

All of the cases selected had the common diagnosis of neurotic depression or depressive reaction. Out of all of the cases examined, the writer found twenty-nine with this diagnosis.

The cases selected had a minimum of twelve interviews, as anything less than this would be considered insufficient treatment for the purpose of this study. The patients had been treated by social workers rather than by psychiatrists or psychologists. Treatment was on an individual and not a group basis. The recording had to be in process form, not in summary form, as process recording only allowed sufficient material for the writer to reconstruct the interplay between patient and worker.

Five of the twenty-nine cases were found to satisfy the above criteria. One of the cases had been treated by a social worker who was no longer at Briggs Clinic. This case will be studied entirely from the material available from the record. The remaining four cases have been treated by social workers who are still at the Clinic. One of these is a student worker. With these cases the writer will consult with the workers who treated these patients as well as use case records.

The cases will be examined within the framework
of the five casework principles proposed by Doctor Arthur F. Valenstein. These are a modification of those principles of Doctors Edward and Grete Bibring. The principles are: suggestion, abreaction, manipulation, clarification and interpretation.
CHAPTER II
THE CLINIC

Background and Purpose of Briggs Clinic.

Briggs Clinic is the outcome of the ambitious and experimental thinking on the part of Boston State Hospital administrators. It has long been realized that there are those people in the community who could not or would not visit a state hospital on an outpatient basis but who would use such facilities if they were available out of the hospital. Briggs Clinic is just such a source of psychiatric treatment within the community. It is appropriately named after Dr. L. Vernon Briggs, a pioneer in the field of mental health.

The Clinic is an affiliate of Boston State Hospital and was established in February, 1950. It was forced to operate within the hospital until September, 1950, when office space was secured in a newly-built Health Unit on Blue Hill Avenue in Dorchester. This present location enables the Clinic to be apart from the hospital yet close enough to make use of all of the hospital facilities and personnel. The Clinic operates from 8:30 A.M. to 5:00 P.M., Monday through Friday. There are no evening or Saturday hours available to
patients.

The purpose of Briggs Clinic, as stated in its Manual is as follows:

to give guidance and direction to those who have emotional and psychological illness, preferably early in the course of such illness in the hope that more serious problems may be prevented and hospitalization rendered unnecessary.¹

The Clinic is designed to treat:

those people suffering with emotional problems to the extent that their efficiency as productive members of society and their social adjustment have either diminished or threaten to become diminished. The Clinic will not accept those individuals whose need is for direct help in a solution of realistic family and/or environmental problems. Such problems would be more efficiently administered by specific agencies within the community which deal exclusively with problems of this type.²

In accordance with the above, age limits for patients are sixteen to fifty-five years of age, since the community offers other treatment facilities for children, and since those above fifty-five years of age are generally not so amenable to psychotherapy.

Electro-shock therapy is available on an outpatient basis at Boston State Hospital for selected cases

¹ Boston State Hospital, Manual of Practice and Procedure, The Briggs Clinic, unpaged.

² Ibid.
of depression.

A sliding scale of fees is used at the Clinic ranging from no payment to two dollars and fifty cents per treatment hour, the amount depending on income and number of dependents. The purpose in setting a fee is primarily to maintain the patient's self-respect, independence, and will to move toward health. Those earning over seventy-five dollars a week are not eligible for this Clinic since it is felt they can obtain treatment privately. All of the fee collections are turned over to the Commonwealth of Massachusetts and cannot be used by the Clinic.

Patients not eligible for treatment at Briggs, besides those mentioned above, are those suffering from cerebral arteriosclerosis and senility, those already receiving psychiatric treatment elsewhere, those suffering from drug or alcoholic addiction, and veterans with service connected difficulties.

The total number of patients in treatment now is two hundred and forty-four. There are many more applications received than the Clinic can handle with its present facilities. The waiting period for an intake appointment is six weeks at the present time.

Personnel.

The Clinic has as its full-time personnel a
psychiatrist, a clinical psychologist, two psychiatric social workers, and two secretaries. This nucleus is augmented by four students coming from two schools of social work, each of whom spends twenty-four hours a week at the Clinic, and ten psychiatrists from Boston State Hospital and from private practice, who spend an average of half a day per week at the Clinic. The latter see patients in treatment only.

The full-time psychiatrist is also the Director of the Clinic, and, as such, he must spend much of his time in administration and supervision. He interviews all patients seen at intake to determine the diagnosis, the eligibility of the patient for treatment, and to indicate the area of treatment, when the patient is accepted. Since he has little time to spend in the treatment of patients, the bulk of the cases are treated by the other members of the staff.

The psychologist gives psychological tests and interprets the results in cases where this is indicated. He also sees patients in treatment both on an individual basis and in groups.

The caseworkers in this setting are considered in the role of psychotherapists performing treatment within the limits of their own capabilities, closely supervised. They are involved in treatment of patients
both individually and in groups, and they see patients for intake interviews. Besides being in the role of therapists, they are also supervisors, each supervising two students.

The Psychiatric Team.

The psychiatric team at Briggs Clinic brings to treatment the varied contributions of each discipline. Staff conferences are held each morning at which cases are presented informally and problems of treatment are discussed. These meetings are a learning experience for all members. Since the professional staff is small, these meetings promote free and informal discussion by all.

Supplementing these meetings are weekly individual conferences for the permanent staff members with the Director. In the case of the students, they have two-hour weekly supervisory conferences with the caseworkers. Also the Director meets with all of the students and supervisors once a week for an hour at which time the students present a case throughout the year. This provides the students the opportunity of following the process of continuous treatment with their own cases.

In this setting the majority of cases are treated by the social workers. It is felt that casework has a valid and distinct contribution to make in the treatment
of adults with emotional problems. The distinguishing factor in the approaches of the psychiatrist and social worker is that the former deals with genetic, unconscious material whereas the latter deals with the current situation. However, the worker must understand the dynamics of the unconscious in each case although avoiding working with it directly. This knowledge is gained from the psychological reports and from the diagnostic evaluation of the patient by the psychiatrist. The doctor's recommendations suggest how the worker may use this knowledge to help the patient on the conscious level.

**Intake and Treatment at Briggs Clinic.**

The impressions of the Clinic upon the patient at intake are considered of great importance, since these are lasting first impressions, which can help or hinder treatment. Thus the Clinic strives first to give a warm, accepting atmosphere. What is wanted at intake is, not history, but how the patient feels now (in the sense of his current distress), how long he has been feeling so, and how it came about in terms of his current life experience. The worker's goals at intake are threefold: first, to find how the patient sees his problem; second, to interpret the Clinic's function to the patient, making sure the latter understands and
desires such treatment as the Clinic offers; third, to agree upon an appropriate fee with the patient.

After this interview, the worker presents to the psychiatrist a brief resume of what occurred in a short meeting between the two. The patient is then seen by the psychiatrist, who explores the situation more intensively and demarcates further the areas for treatment. The patient is advised at this time as to whether or not he can receive treatment at Briggs Clinic. Referrals are made when appropriate.

On the basis of his interview, plus the information received from the worker, the psychiatrist makes the diagnosis and suggestions as to the area for treatment. Or he may defer diagnosis and recommendations pending the results of psychological testing, which may be necessary. Psychological tests are not given routinely, but rather are done with a specific aim; such as, to test the degree of depression, the nature of the conflict, and so forth.

When treatment begins, the patient will usually come once a week for fifty-minute interviews. Where necessary, interviews can be arranged more or less frequently. Interviewing is conducted on a vis-a-vis basis. Treatment is done according to psychoanalytically oriented concepts of therapy. Accepted casework
techniques are used. Length of treatment varies with the individual.

In the following chapter the writer will present the casework techniques under discussion in this study.
CHAPTER III
THEORETICAL CONSIDERATIONS

A Discussion of Neurotic Depression.

Freud was the first to distinguish between a normal mourning state and a pathological melancholia in his *Mourning and Melancholia*. The main symptoms of the former are sadness, dejection, hopelessness, a withdrawal of interest in the world, and some degree of retardation of functioning. A common precipitating cause is the loss through death or some other cause of someone whom the person has loved. The main factor is an unwillingness to renounce the loved person in whom so much love was invested. Rather than re-invest love into other objects, the person may withdraw. However, the reality of the loss is worked through, and after some time, the symptoms leave. In the pathological state, the symptoms are generally the same except for an additional self-abasement or self-criticism. Freud explained this from the melancholic's basically ambivalent relationships to love objects.

The self-accusations usually fit not the speaker but, with slight modification, the lost love object. He can speak against himself because, although part of what he says is true, at bottom it related to some-
In regard to the ego functioning in this case, Freud says:

The libido when withdrawn from the lost object is not transferred to a new one. Instead it is withdrawn into the ego. In the ego, it identifies the ego with the lost object. The shadow of the lost object thus falls on the ego so that the latter can be criticized like an object (the lost one) --- The conflict between the ego and the loved object becomes a cleavage between the super-ego and the ego as altered by the identification.

Thus in the melancholic, the latent hostility toward the lost object is turned against the self. The loss constitutes the opportunity for the ambivalence in the relationship to make itself felt. The illness serves a two-fold purpose; it is a punishment for the hostility and an indirect expression of it, revenge by self-punishment.

Freud considered that such a process necessitated certain predisposing conditions. The choice of object, the self, reflects an existing narcissistic component within the personality. The reaction to loss implies a regression from one type of object choice to narcissism.

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1 Sigmund Freud, Collected Papers, Volume IV, "Mourning and Melancholia", p. 69.

2 Ibid, p. 72.
Another important factor here is that the melancholic not only identifies with, but introjects the lost object. The melancholic is an example of the oral, narcissistic phase of the ego.

In summarizing, Freud says:

There are three conditioning factors in melancholia:
1. loss of object
2. ambivalence toward the lost object
3. regression of libido into the ego based on the predisposing narcissism.

Abraham based his later investigations of melancholia on Freud's findings. He found that symptoms of depression occurred in conjunction with other personality disorders, particularly with the obsessive-compulsive. He further noted that the obsessive-compulsive personality is often the pre-psychotic counterpart of the manic-depressive psychosis. He explained the similarity in the ambivalence of both.

Ambivalence is one of the dynamic factors in depressions as well as in the compulsion neuroses. The compulsive patient relieves his guilt by rituals of expiation; the melancholic, by inverting his hostility.

Alexander later agreed with these findings:

3 Ibid., p. 73.

We find overlapping symptoms in depressions and obsessive compulsives— The amount of regression in depression is greater than in the obsessive compulsive.5

Abraham gave the following formula for depressions:

Formula: I cannot love people; I have to hate them. People do not love me because of my inborn defects. Therefore, I am unhappy and depressed.6

He considered that the depressive wants revenge but cannot act on this desire because such activity is paralyzed by repression of hatred and revenge. What remains conscious is a feeling of guilt which is connected with the hatred and revenge. The depression and self-reproach arise from this repressed sadism. Suicide is explained as a result of these hostile impulses which have been repressed and turned inward.

The writer will confine this study to those patients who have been diagnosed by a psychiatrist as neurotic depression. This implies that the disorder would be psychoneurotic rather than psychotic. The chief characteristic of the former is anxiety. This anxiety may be directly expressed or may be unconsciously controlled by the use of the various defense mechanisms. The depression would be then a defense mechanism. Further-

6 Karl Abraham, op. cit., p. 420.
more, the life history of an individual with a psycho-neurotic disorder would show evidence of periodic or constant maladjustment of varying degree. Special stress may bring about acute symptomatic expression of such disorders. Evidence for the existence of a psychosis would be gross distortion of external reality. With regard to depressions, the difference is held to be one of degree rather than of kind. Rado maintains the view that neurotic depression is based on the same mechanisms as psychotic depression.

The diagnoses made at Briggs Clinic are in accord with what is set forth in the Diagnostic and Statistical Manual of Mental Diseases. The following definition is taken from this manual.

**Depressive reaction:** The anxiety in this reaction is allayed and hence partially relieved by depression and self-depreciation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures or deeds. The degree of the reaction in such cases is based upon the intensity of the patient's ambivalent feeling toward the loss (love, possession) as well as upon the realistic circumstances of the loss. The term is synonymous with reactive depression and is to be differentiated from the corresponding psychotic reaction. In this differentiation, points to be considered are 1) life history of the patient with special reference to mood swings, to the personality structure (neurotic or cyclothymic) and to precipitating factors; 2) absence of malign-
nant symptoms (suicide, stupor, etc.).

Therefore, in this study, neurotic depression shall be considered synonymous with depressive reaction and shall be in accord with the definition stated above.

A Discussion of Casework.

Organized philanthropic agencies in Europe and America were a prelude to the social work of today. The individualizing of social problems began mostly with persons who needed relief. Before human behavior and motivation were understood, caseworkers recognized that there were forces within the individual which contributed to economic stress. Social work for a long time had been involved in giving help with outer stresses. As it became evident that every problem is psychosocial, casework treatment inevitably acquired a psychosocial approach. It remained for psychiatry to contribute an understanding of the inner stresses. Today social casework involves "a combination of psychological understanding and social services in an integrated, participating experience with the client." The social worker at Briggs Clinic works primarily with the social and emotional problems and does only a minimum of en-

7 American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, p. 37.
Social work is a process of helping another to help himself. The focus is no longer a "doing for" but a "doing with." It is summed up in the familiar phrase: not alms, but a friend.

The distinct contribution of social work is the emphasis on the total person; the social, emotional, the environmental forces which contribute to the adjustment of the individual. The aim of social work is always the creation of a better social adjustment for the individual and for society.

Casework Techniques.

In 1947, Doctors Edward and Grete Bibring presented a proposition that all methods involved in human relationships of a psychological nature could be reduced to five basic principles. The techniques used in this study are based on these five principles, as modified by Doctor Arthur Valenstein. They are given with the same idea that any therapeutic procedure can be considered as either one or a combination of these techniques.

A. Suggestion involves the conveyance or insinuation of beliefs, ideas, sensations, or actions within the patient to the exclusion of logical thinking by the pa-
tient. This technique is most successfully used with patients who have a tendency toward submissiveness and are trusting of the therapist. It is used to lead the patient to believe something which will further treatment.

B. Abreaction signifies the release or ventilation of feelings or pent-up emotion which leads to relief. In its pure sense, it means only this expression of feelings. However, as a disturbing, emotional experience is relived within a positive relationship, the feelings become desensitized. The ego can then reintegrate the disturbing idea, which may have been avoided or suppressed previously.

C. "Manipulation consists essentially in making use of existing emotional systems and forces within the patient for the purpose of cure and promoting treatment." This technique is used in three ways: positive, or the increasing of certain existing emotions; negative, or the decreasing of certain existing emotions; a new experience. The therapeutic relationship itself is a new experience. The support, acceptance, and reassurance have a curative effect. This technique also implies modifying of the environment by the therapist or help-

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9 Dr. Arthur Valenstein, Unpublished Lecture Notes, Boston University, School of Social Work.
ing the patient to make such changes. Manipulation is based on the therapist's cognizance of what emotional systems within the patient he is using. Therefore, the therapist must have an intimate knowledge and understanding of the patient's personality.

D. Clarification involves pointing out objective and psychic realities and helping the patient to a better perspective of himself and of others. Clarification always deals with conscious and pre-conscious material, "the conflict as it is expressed by the patient; the conscious derivative experience."\(^\text{10}\) Clarification does not encounter resistance but rather has the effect of surprise and intellectual satisfaction, except with patients having special disturbances and except if it activates unconscious material. The aim of this technique is better understanding and self-awareness on the part of the patient. It usually involves a change of self-image and increased mastery by the ego as the patient becomes more objective.

E. Interpretation, as clarification, aims at self-understanding by the patient. The main difference is that interpretation always deals with unconscious ma-

\(^{10}\) Ibid.
terial. It also demands emotional participation of the patient whereas clarification does not demand so much involvement.

At the present time, there is much disagreement among social workers and psychiatrists as to whether or not interpretation is appropriate to casework.

The Casework Relationship.

The casework techniques listed above must be used within the context of a positive relationship to be successful. A relationship is something felt, an emotional experience. Because of this, it is difficult to put into words; a relationship is warm while words are cold. Nonetheless, relationship and some of its elements have been identified in an attempt to conceptualize and crystallize the meaning. The following is a definition:

The casework relationship is the dynamic interaction of feelings and attitudes between the caseworker and the client with the purpose of helping the client achieve a better adjustment between himself and his environment.\[11\]

In order to achieve a positive relationship, several elements are essential. The worker must be able to accept the client; that is, the worker must have a respect and liking for the client as a personality and

a huming being. The caseworker accepts the client "not as a 'problem' but as a person with a problem." This implies that the worker have a non-judgmental attitude. He listens, not to judge of guilt or innocence, but to understand. Further, the worker must always remember that the client is a free agent with the right to make his own decisions. Although the worker may help a client to make a decision, the client, in the final analysis, has the right of self-determination.

The relationship helps the client to express his feelings. In response to this, the worker also becomes involved. "At the center of the casework process is the conscious and controlled use of the worker-client relationship to achieve the ends of treatment." This involvement of the worker implies his sensitivity to the client's feelings, his understanding of their meaning. It is a purposeful, appropriate use of the worker's emotions in response to the client's feelings. It is the worker giving of himself, lending support to the client. Throughout the casework process, the relationship is an ongoing, continuous thing that grows and deepens.

12 Gordon Hamilton, op. cit., p. 38.
13 Ibid., p. 38.
The therapeutic effects of the relationship are many. It enables the client to reveal himself to the worker, to have confidence in the worker, to have the ability and strength to look at himself objectively, to do what is necessary for constructive change.

Since a relationship involves two people, the worker and the patient, it is necessary to consider the patient's ability to respond to such a relationship. The type of disturbance and the intensity of the illness influence the patient's participation in the relationship.
CHAPTER IV
CASE PRESENTATION

The following five cases shall be presented and discussed in reference to the casework techniques listed and defined in the preceding chapter. All of the patients have been diagnosed as neurotic depression. The number of treatment interviews varies from twelve to fifty-four. The length of treatment varies from three months to sixteen months. Other variables are age, sex and background of patients.

Case I

Shirley B. is a thirty-four year old married woman, mother of a daughter, aged six. She came to the Clinic in August, 1952, having been referred by Pastoral Counseling Service. Her presenting problem was her excessive concern for the salvation of people of various religions. She opened the interview by questioning the worker regarding the worker's religion and expressed concern for the worker's salvation. Knowing that the worker did not believe correct dogmas and so would not be saved caused her concern and a deep feeling of futility, she said. She usually questioned others about their religion, and although she said little, it always gave her "an awful feeling inside" to realize they would not be saved.

During the interview she was quite tense and fidgety, wiggled around in her chair, and held the chair arms in a vise-like grip. As the interview progressed, it appeared that her
religious problem was probably a defense against having to face her personal problem; i.e. her hostility to her mother, her guilt about leaving her mother, her wonderings if she loved her husband, her fears of pregnancy. She tortured herself and her family, especially her husband and daughter, with religious discussions.

The patient had many somatic complaints: nausea, vomiting, gagging, difficulty sleeping. Other complaints were inertia and loss of interest in caring for her home, The patient had a miscarriage about a year ago, and she was somewhat cognizant of the fact that her longstanding fear of pregnancy was a factor in the abortion. However, she also expressed a wish to have more children and to be pregnant, and it was of note that her stomach upsets and vomiting occur especially in the morning.

The patient came to the Clinic with some awareness that her basic problem was her relationship to her mother. Much of the interview time was spent in recriminations of her mother, especially how awful her husband thinks her mother is. Later, she described her mother as a tartar, who completely dominated the patient and who has been in a constant fury against the patient, ever since patient, her husband, and her daughter left her mother's home to live by themselves two and a half years ago. The patient was able to say she had never been able to emancipate herself from her mother and had never given all her energies to her family situation. Although she went to Florida with her husband, when he was in the service in 1943 to 1946, she was deathly sick and almost had a miscarriage. The only factor which saved the day was her mother's arrival. The patient and her mother have quarrelled bitterly since the time of the patient's marriage, and the patient's guilt about the mother relationship had been reinforced by her mother's accusation.
that the patient had deserted her. The pa-
tient noted that at times her mother was
definitely psychotic and was hospitalized
about three years ago.

The worker asked the patient if she thought
her mother would be saved; and with no
hesitation and no apparent anxiety, the
patient replied that, of course, mother
would be saved.

Throughout the first few interviews following in-
take the patient continued the theme of her hostility
towards her mother. The worker encouraged the patient
to express this hostility by sympathetic listening and
an accepting attitude. The patient described her
mother as demanding, critical, and irritating. As the
patient abreacted her depression symptoms diminished.

The worker encouraged the patient to verbalize
her own feelings toward her mother. The patient saw
herself in a vicious circle. She felt that, whenever
she contacted her mother, inevitably the patient felt
anger. On the other hand, she felt very guilty when
she avoided her mother. The worker handled this by
being permissive: "--- encouraging the patient to take
the reins and decide for herself when she would phone
her mother, the criterion to be obtainment of her own
maximum comfort." As the hostile relationship was
explored, the worker continued to focus on the patient's
involvement. She began to consider herself, what she
said, and what her reactions were. The worker encouraged this by questions and comments, thus clarifying the situation with the patient. This clarification was accepted by the patient. "She noted that her mother did not really say such irritating things to her, but rather that she herself felt more keenly about the little things her mother said."

Mrs. B. also complained that her mother did not get along with the patient's husband and daughter. Again the worker investigated this complaint with the patient in order to clarify the situation. It became clear that the patient did not permit any give and take between her mother and her husband or between her mother and her child, and the worker commented on this.

She feels she must get into the middle to protect either from hurting or being hurt by the other.— Actually it is the patient and not the others who feels hurt and guilty about the supposed hurt of others.— Mrs. B. finally could say she wished her mother had nothing to do with the B. family.

The patient had allowed herself to form a close and dependent relationship with the worker almost immediately. This was evidenced in the progressively more childish clothes which Mrs. B. wore at each interview. The relationship, while always ambivalent, was weighted positively at the outset but became gradually more
negative. She would frequently close the interview with such comments as, "Do you think we are ever going to get anywhere with this?" On the sixth interview Mrs. B. brought up her religious conflict for the first time since the intake. She did this in a hostile, attacking manner toward the worker, asking for the worker's opinions and advice. The worker clarified the patient's anger which was prompting this, but the patient consistently denied her angry feelings.

Throughout the interview the patient's anger was very evident; but no matter how many times the worker brought this up and pointed it out, the patient continually denied it. The only one for whom she can possibly admit angry feelings is her mother.

This clarification by the worker followed by the patient's denial occurred in five consecutive interviews. The worker commented, "I could do nothing but give up."

Concurrent with this rise of hostility the patient began to initiate termination. She first spoke of how she was improved in that she could stay away from her mother without feeling too guilty, and, at the same time, she checked herself from becoming verbally abusive to her mother. This new restrained comfort which the patient felt with her mother was continually emphasized by the patient until she terminated treatment. On the eleventh
interview she came with the purpose of terminating. The worker pointed out that the patient had a long way to go, and the patient agreed; but she wanted to do the rest herself. The worker resisted the patient's idea of terminating at this time. During this interview and the next, the worker questioned the patient's readiness to continue, and after a conference with the Director of the Clinic, termination seemed indicative.

This patient was seen for three months, a total of twelve interviews.

Discussion.

The main area of improvement in this patient was the lifting of the depression. Her conflict regarding religion diminished as a clarification of her real problem, her hostile relationship with her mother, was made. In this area, a slight and tenuous improvement seemed apparent in that the patient was making a conscious effort to control her hostile feelings and was finding a new, restrained comfort with her mother. Concurrent with the change in this relationship, the relationships between the patient's mother and her husband and daughter also improved.

The techniques used in this case were abreaction, clarification, and manipulation. Abreaction was important in the initial formation of the relationship
and in relieving the depression.

Clarification, when repeated, was accepted by the patient when it concerned the area of the patient's relationship with her mother. However, it was not accepted in the area of the patient's relationship with the worker.

Positive manipulation was used in that the worker encouraged the patient to express her hostile feelings. Manipulation in the sense of a new experience was the relationship itself, the medium for treatment. Mrs. B. showed movement while the relationship was positively weighted. As it became negative, the worker attempted to work this through by clarifying that the patient was angry with the worker and supporting the patient in recognizing this. The patient did not accept this. The patient's inability to continue treatment seemed related to her fear of her dependency on the worker. Generally, Mrs. B. showed a lack of readiness for further treatment. It would seem that a positive relationship was essential for the successful use of clarification and abreaction.

Suggestion and interpretation were not used in this case.
Thomas F. is a forty-nine year old married man. He has a son twenty-one and two daughters, ages sixteen and twelve. His chief complaint was feelings of nervousness, depression, hopelessness and insomnia. He first began to feel nervous twenty-seven years ago when he married; but since his father's death over a year ago, he felt much worse. Also within the last six to twelve months, his wife began to have menopause symptoms. Since then, his wife has become very irritable and quarrelsome. Although she always pushed him with the desire of making him more successful, she began to ride him hard on it. She always wanted him to be a successful man, whereas he never felt he could do this and actually settled for cab driving.

As a young man he studied violin and continued this on and off. As recently as two years ago, and at various times before this, he attempted auditions with various symphony orchestras. He had an offer of employment with one such orchestra two years ago, but at the point of success in his violin playing, he lost interest and went back to cab driving. Thus he was very much aware of his failure in life and felt that his wife made him even more aware of this than he ordinarily would be.

His mother had this ambition of violin playing for him, but he gave it up to marry. The patient almost cried when he mentioned his mother. She was ill, and he felt that she should do more for her. She has lived alone since the death of the patient's father and refused to live with her children. He found himself now frequently arguing with her, whereas he used to be closely attached to her.

The patient was a placid looking, soft-spoken man, who seemed to convey an impression of "live and let live," but this attitude was failing him now under pressure of these aforementioned influences.
The diagnosis was neurotic depression. Treatment was to be aimed at first giving him the opportunity to ventilate his resentment toward his wife. Also, there was to be an investigation of his peaceful attitude since behind it lay a great deal of resentment toward his wife and mother.

The patient began treatment a week after intake. Throughout the first few interviews, he talked a good deal about his feelings toward his wife and mother. He described them both as critical, demanding, and money-mad; and he complained that they nagged him and made him feel unsuccessful. The worker supported him in this by sympathetic listening. Gradually he was encouraged to consider his own role in this and his way of handling unpleasant situations.

He seems to have given up responsibility with the children at home and lets his wife cope with most of the discipline problems. He goes to bed early and later cannot sleep. He thinks his reason is to avoid any conflict in the evening hours. The patient was able to see that, at times, he has been very provoked with his mother and has left the house, not to return for a period of time.

The worker clarified the pattern of escape in this behavior, and this led him to speak of his fears of criticism from others. The worker related this to his own self-criticism and feelings of inadequacy.

Mr. F. connected his feelings of inadequacy with his mother. He blamed her for making him feel this way
because of her constant criticism and accusations that he did not care for her. He remembered how his mother used to prefer him to others in the family and made much of him. When the patient married, she grew away from him. Since his father's death, his mother was again making demands on him. The worker pointed out the patient's disappointment in no longer receiving support from his mother.

After four interviews in which the patient expressed much of his anger and resentment toward his wife and mother, his symptoms simultaneously diminished. He had no headaches and was sleeping better. He spoke of feeling better.

I made the statement that he might now feel he did not need to come here. He said he had reached there now. He felt that he was depending on me to make him feel good, and he wanted to see if he could feel better without coming here. We lengthened the visit to two weeks, and then we would see where we would go from there.

The patient complained that his headaches had returned the two week interval. The worker explored this with the patient. He connected this with his boss. Recently he had an auto accident with his cab, and his boss said nothing about it. The patient wondered if he provoked the boss. Whereas his boss used to give him much encouragement on the job, he was now silent. After
exploring this further with the patient, the worker clarified his feelings and the patient accepted this:

The patient was able to see that he was looking for comfort from others instead of trying to feel, when others are upset, it was not his problem. He was looking for someone to make him feel good and was blameful of others who did not give him this sense of wellbeing.

Apparently at no time did the worker relate the patient's desire to terminate with his feelings in regard to their relationship. This seemed indicated in that, during the previous interview, the patient said the worker was the only one who understood him. Then, in this interview the worker commented:

The patient seemed to have some difficulty in the transference and made the statement, as he was leaving, that, if he were with me continually, his headaches would not occur. I have not yet had the opportunity to go into this with him.

It would seem that the patient feared the growing intensity of the relationship and was using his typical mechanism of running away from the unpleasant. He continued to ask for two week intervals, and this was granted by the worker.

During the following two months, the patient spoke of his growing dissatisfaction with his job. The worker handled this, at one point, with suggestion:
The worker suggested that he would have liked to have been a musician but did not begin early enough. Now he has a job where he has friendly contacts with people and a good boss. Also he is considering the possibility of owning his own cab.

Primarily, the worker used clarification combined with support in regard to his feelings toward the job. She pointed out that the patient was looking to the boss to make him feel good, whereas the feeling of worth must come from within. She related this to the clarification which was made earlier in regard to his relationship to his mother; namely that he was angry when the boss was critical just as he was angry with his mother, who had once given him encouragement and now only criticism. Although the worker repeated this clarification, the patient reported more and more criticism and then arguments between himself and the boss. He made some attempt to act on his new knowledge by remaining on his job. At the same time, he found he could visit his mother weekly and have no arguments with her. However, he eventually quit his job but with some awareness of why he acted this way.

The focus of treatment changed when the patient's mother died.

The patient broke down as he entered the interview room and could hardly tell me that he had lost his mother. He was not so pained in the loss of his mother but
was upset because his two sisters were fighting over the settlement of the estate.

Because the patient was going through this trying experience, the interviews were held weekly, at the suggestion of the worker. In the following six hours, which were the last before termination, the patient continued to talk of the settlement. The worker handled this by relating it to his feelings regarding his mother's death.

He was interested in a fair settlement because that would be what his mother would have wanted. This would prove that she was equal in her affections for them all. He was further disappointed that his mother did not appoint him administrator.

As he had the opportunity to talk over the settlement with the worker, he was able to get a clearer idea of what he believed to be a fair settlement and, further, to engage a lawyer. At this time, he also bought his own taxi cab.

Since the worker was leaving the agency, she focused in the area of termination. The worker related the patient's feelings of being left by her to his feelings toward his wife and mother, who refused to support him as he wanted. The patient was unable to speak of his mother's death per se. The worker tried to verbalize some of his feelings. At the time of ter-
mination, the worker commented that this area still needed to be worked through. However, the patient refused further treatment. This may have been related to the apparent lack of clarification of the treatment relationship.

This patient was seen for six months, a total of eighteen interviews.

Discussion.

The main area of improvement for this patient was the diminishing of the depressive symptoms. Simultaneously with this, his relationships in the family improved. He came to realize his dependency feelings and anger towards those who failed to support him and make him feel adequate. He was able to initiate some actions toward independence in buying his own taxi cab and in procuring a lawyer to help in the settlement of his mother's estate.

The techniques used in this case were suggestion, abreaction, manipulation, and clarification. Abreaction was a strong element in the formation of the relationship. The depression symptoms diminished after the patient abreacted.

Manipulation in the sense of a new experience was the relationship itself. This patient formed a
swift, positive relationship with the worker. Treatment was a corrective emotional experience in that the patient found in the worker a female figure who was not critical and demanding and who gave him a reasonable and consistent amount of support. He responded to the support he was offered by acting for himself. However, this patient demanded excessive support from others due to his own feelings of inadequacy. This occurred in the treatment situation and was clarified by the worker. This was a combination of manipulation and clarification. Although the patient resisted this at first he gradually accepted it as it was repeated. Clarification was more readily accepted when it related to the patient's actions and feelings outside of the interview situation. It gave him some awareness of his behavior and feelings, but he was able to act in only a limited way on his new knowledge. Suggestion was used once to help the patient to accept his reality situation. The patient did not respond to this. This occurred at a time when the patient seemed to be fearful of his dependency on the worker, and this may have been relevant to his resistance to the suggestion. Other factors which may have been related to this were not evident from the case material.

While the relationship was comfortable for the
patient, he could use casework help. When the relationship became unwieldy for him, he used his characteristic method of withdrawing by asking for less frequent interviews. This seemed indicative of the ambivalence he must have felt toward the worker and toward treatment. It was curious that the worker complied with his request without exploring and clarifying with him further his reasons for this. The patient's response to treatment varied with the quality of the relationship. His inability to continue treatment seemed related to his fear of his dependence on the worker.

Interpretation was not used in this case.

Case III

Gretta B. is a forty-five year old divorcee, who came to the Clinic in October of 1951. Her chief complaint was a feeling of depression, with periods of insomnia. This depression existed throughout most of her life but was worse periodically. The most recent period began about eleven to twelve months ago. At that time, she and her parents were evicted from their home, making it necessary for the patient to live with her married brother and his family. Her parents lived alone in a single room. About three months after this, she learned that her father had an incurable cancer of the lung. Since then, she became increasingly depressed and always felt she would be happier dead. On the other hand, she took very good care to see that she, in no way, would harm herself.

As a child the patient was hypochondriacal
and always feared that she would be very sick. At the age of fourteen, she had a severe case of the flu and did almost die. She marks this as a turning point when she substituted for hypochondriasis a fear of going crazy and a wish for death. She often wished release from mental anguish by death but never made any suicidal attempts. Every time she felt the least bit unhappy, a voice inside her told her that it wasn't right for her to be happy.

The patient married at twenty-three years of age. She was quite unhappy and the following year she obtained a divorce. She was never pregnant. Following the divorce, the patient gave up fighting the feelings of depression and for the first time in her life, she quit work and cried a lot and moped around the house. After several months of this, she pulled herself together and obtained a job as salesclerk. She has held this one job for the past sixteen years. The patient returned to live with her parents after the divorce. Things went along smoothly until they got an eviction notice, which was when the present depression started. Living with her in-laws was a lonely time for the patient, as she did not feel part of the family. It was also a lonely time for her mother, since her father became ill then and required hospitalization.

The patient was close to tears during the interview but fought them off just as she usually does. Crying spells only leave her more worn out. She asked for reassurance that the Clinic could help her.

The patient was diagnosed as neurotic depression. Treatment was to focus on why the patient at present and all her life felt she was a bad person.

The patient was seen two weeks after the intake interview and weekly thereafter. In this interval she
acquired an apartment for herself and her parents.

In the beginning interviews the patient tended to avoid discussion of her feelings, yet she arrived very early for her interviews. She recalled childhood memories and material from her readings in psychology. The worker handled this by encouraging the patient to speak of her feelings regarding present day situations. The patient responded to this gradually by complaining of her miserable life and her family. Of her mother she said:

Mother is a strong, capable woman, who is able to operate efficiently and to be happy despite physical illness and mental worries. Over the week-end, she and mother worked at getting settled in the new apartment. Her mother took over the burden of the work, and the patient was her helper. The patient eventually gave up the work entirely because she began to feel depressed.

Gradually the patient could speak of herself, her feeling that she was submissive, weak, and worthless. The worker handled this by clarifying how strong, capable persons accent the patient's feelings of worthlessness and inferiority, and the patient envied them. This brought the patient to tell of experiencing a desire to kill that morning on the elevated train, when she saw so many superior, business-like people going about their business. It had emphasized her feelings
of inferiority. She felt these thoughts of killing people were bad and might mean she was going crazy. Worker clarified this:

We equated the words envy, resentment and anger, and the patient seemed quite accepting of this. She never lets out her anger, which she carries with her all the time. It pops out occasionally in her urge to kill.

After two months of complaining of her depression, the patient began to show some initiative in changing. She told of instances where she fought off the depression by talking herself out of it. It became a test of her own controls. At this time also, the patient was planning for her vacation, which was approaching. She wanted to visit a man friend in New York, whom she had visited on previous vacations. On the other trips, she could barely get through the week, because she got so depressed and had obsessive thoughts and fears of high places. The worker encouraged the patient to discuss these things fully before the next trip. When the patient returned, she reported how she had had a good time, free from fears and depressions.

Chiefly, her present method of overcoming these fears, which she sees are unreasonable, is by lecturing to herself about how silly they are, and how weak she is to give in to them. She was quite comfortable and free from depression, especially when she was in the company of her boyfriend, who made a lot of her.
On the following interview, the patient seemed more depressed, and she related it to her father's recent return from the hospital. Patient was encouraged to talk of her resentment in having to listen to and cater to his demanding, whimpering ways. She was further worried in that she thought she had replaced her fears of going crazy with the fear that she was becoming a drug addict from the sedation pills she was taking. After exploring this, the worker commented that the present fear was not so gripping and all pervasive but was confined to bedtime.

After five months of treatment, the patient phoned for an emergency interview. Her method of handling her depression was failing. The worker was very sympathetic and accepting of the patient's dilemma. Later, the worker clarified:

The talking to that she gave herself was so one the negative side, emphasizing the weak, disabling, feelings, that it amounted to kicking herself when she was down. She wondered about why it seems that she has to hit rock bottom before she can begin to go up again.

The worker, while realizing that this fit with the masochistic strivings of the patient, did not feel that the patient was ready to take a further investigation of this area then.
Soon after this, the patient's father died. The patient looked quite well in spite of it. The worker encouraged her to speak about this. The patient spoke of the events and then how she had handled herself by spending the whole day in front of the mirror, rearranging her hair, trying on clothes, etc., preparing for the funeral. As she reviewed the events, she began to cry for the first time since her father's death.

In the next few interviews, the patient concentrated on how she could no longer talk herself out of her depressions. The worker handled this by clarifying the patient's method of accentuating the negative and supporting the patient where the patient showed she could function.

A month after her father's death, the patient requested another emergency interview. She had felt all alone and panicky thinking of her father's death, and wondered what she would do if her mother died, too. Since she still seemed to be involved in the process of mourning her father's death, the worker encouraged her to talk about her father.

The worker began to focus on the patient's masochism when the patient seemed ready for this. The patient considered how she had never been able to have
a happy life, how she had always been afraid that her melancholy would swamp her. The worker explored this with the patient and then clarified that the feeling of melancholy was serving to put a distance between the patient and any wanted object. After repetitions of this the patient seemed fully aware that it was she who was denying herself happiness. She could see, by hindsight, that she was currently doing this, particularly on dates, when she would get depressed.

The patient showed marked improvement for several weeks and then asked for an emergency interview. The urge to kill was strong, and she was crying a good deal. The worker conferred with the Director, who suggested electro-shock therapy. When this was suggested to the patient, she was very resistive. "After some discussion around this point and a free expression of the patient's fears, the patient seemed to relax. By the time the interview was over, she looked better."

This was the most serious set-back during the treatment. The patient showed gradual improvement from that point. She began to show more ability to control her depressions. The worker encouraged and supported her. The worker explored the area of dates and social contacts with the patient when the patient showed
readiness for this. The patient described the tension and depression she felt before and during dates. The worker repeated earlier clarification regarding the patient's feelings of inadequacy. The worker also showed how this was keeping dates away from the patient.

The patient allowed herself to become excessively dependent on the worker until it began to impede treatment. The worker clarified that the patient wanted the worker to take over while the patient could enjoy a completely dependent state. The worker also offered encouragement to the patient by pointing out where the patient was handling her own affairs successfully, while not giving herself credit for her own strengths and resources. The patient responded to this by initiating ten, twelve, and fourteen day intervals between interviews. Termination plans were considered by the patient later, but she left treatment before this was fully worked through.

The patient was seen a total of thirty-eight interviews.

Three months after termination, the patient phoned the Clinic for an appointment. When she saw the worker, she told how she had gone downhill after treatment until, seven weeks ago, her brother had in-
sisted she go to a psychiatrist. She did this, and now she felt dissatisfied with him. He had advised her to give up work and prescribed medication. Since she was still seeing the psychiatrist, she was told to talk it over with him and then make a decision as to whom she wanted to see, since she could not see two people at the same time. She did not call back then.

Thirteen months later, this patient returned to the Clinic. At that time the depression symptoms were not apparent, and she was diagnosed as obsessive-compulsive. This portion of the record is in summary form and is not pertinent to this study in view of this later diagnosis.

Discussion.

This patient's depression symptoms diminished slowly during treatment. Her phobias disappeared, and she was able to ride on public transportation comfortably. Generally she seemed to maintain more control. The area of dates and social contacts improved somewhat, but it still remained a difficult area for her. She gained enough self-assurance to handle many situations herself. Her relationship with her mother improved.

These results were achieved through casework help. The techniques used in this case were abreaction, manipulation, and clarification.
Abreaction was used throughout the treatment process. It seemed to be an aid in the establishing of the relationship. Later, it was used in helping the patient to grieve over the death of her father. As the patient obtained sufficient relief, her symptoms diminished.

Manipulation was employed as the relationship itself. This patient was able to form a close and dependent relationship with the worker. A great deal of treatment was supportive, and the patient seemed able to use the support she was offered to become more self-assertive.

The suggestion of electro-shock therapy was intended to be a manipulative technique and not as the technique of suggestion. It was meant to diminish certain emotions in the patient by focusing the patient's fears and anxiety on electro-shock therapy. In this sense it was negative manipulation. By diminishing the anxiety, the worker helped the patient to exert controls.

Clarification, when repeated, helped the patient to some self-awareness. When it was used in conjunction with support from the relationship, it seemed effective in helping the patient to more adequate functioning. Later in treatment when the patient became excessively dependent on the worker, she appeared to
accept a clarification of this dependency. However, she eventually went to a private psychiatrist, who met more of her dependency demands. Her acceptance of this clarification seemed doubtful.

Suggestion and interpretation were not used in this case.

Case IV

This patient, Munro J., is a thirty-three year old, single man, who lives with his mother and sister. His presenting problem was that he felt anxious, restless, depressed, and he frequently vomited during the day. He was supporting his mother and sister both of whom had physical complaints. He expressed a great deal of resentment in having to support them. He blamed his mother for his problems; she did not let him grow up. He would have liked to be independent and live his own life. He would have also liked to become at ease in social situations, and thus get to know people so that eventually he could marry.

His desire for independence had been for as long as he could remember. This desire became stronger gradually. Along with it, violent cursing quarrels were increasing with his mother. The patient was staying with an engineer friend and was going home only once a day to light the furnace. The patient also resented his half brother, since the latter was no longer supporting the mother but instead has his own home and family. The patient's mother had remarried about thirty years ago.

Mr. J. reported that he had been drinking heavily during the past six months. He was now drinking one to one and a half pints of liquor daily. When he was working, he used to keep a pint in his desk drawer. At present
he is not working and does not have the de-
sire to do so. He described his position
as a vicious circle; if he drinks, he can't
work; but he can't work without a drink.
Today he has twenty dollars in his pocket,
of which he owes five, and nothing else.
When asked what he would do when that was
gone, he replied that he would think about
it when it happened. His attitude toward
therapy seemed not voluntary in the worker's
opinion. He spoke of receiving previous
psychotherapy and spoke as having been
through the same thing before.

The patient was diagnosed as depres-
sive reaction. Recommendations were that
treatment should be primarily aimed at al-
leviating his depression and eliminating
the possibility of his deteriorating into
a chronic alcoholic. This patient, who
was seen one week after intake, was point-
edly hostile to the worker. He expressed
a great deal of disappointment and anger
at being assigned to a social worker.
Social workers were limited in their ability
to be of any help to him. Also, he was un-
able to work with a woman because he at-
tributed his problems to the fact that he
could not get along with his mother and
sister in the home.

The patient continued to complain throughout
several interviews with the attitude that he was
right and the world was wrong. The worker encouraged
him to air his feelings by being accepting and by lis-
tening sympathetically.

His lack of employment was causing him consid-
erable discomfort, and the worker explored this with
him. He told how he was spending most of his time
alone, reading classics, listening to symphony records,
and drinking. His attitude was blase and hostile as he reviewed his situation. He tended to blame everyone for his dilemma. Worker repeatedly clarified his responsibility in being without a job, and his know-it-all attitude began to diminish. He was able to share somewhat with the worker his feelings regarding a job. He really did not want to work; he was afraid to be called to account for his spotty job record; he could not tolerate taking orders from anyone; he was ashamed that he was not a college graduate. Worker listened to this and clarified: "The worker pointed out that he was so concerned with the negative aspects that he was unable to evaluate the positive ones, which seemed to be his attitude in all situations." The worker also explored his feelings of inferiority when he was able to talk about this. Clarification was again used: "He sets up too high standards for himself, assumes others are doing it, too; and then he gets angry, feels he cannot meet them, and so does nothing at all."

After three months of treatment, the main area of which had been in regard to jobs, the patient reported that he had found employment. Generally he was unhappy and dissatisfied with it; it was only clerical work. The worker encouraged him to voice
his complaints. She also repeated clarifications she had made before, and they seemed to become more meaningful to the patient as they could be applied to the immediate and actual situation. The worker also pointed out the reality of how employers must set standards and give orders when the patient complained of this. Gradually the patient's fear of exposing himself and his inadequacies at work became apparent, and the worker clarified this with him. The worker continued to support him in his efforts to stay on the job. At this time the patient's depression symptoms diminished.

The patient turned his focus gradually to the area of social contacts and dates. Here again he complained and blamed others for his failures. The worker pointed out how his attitudes regarding the job carried over into his social life. His feelings of worthlessness were explored. The worker related this to his need to drink, which was particularly evident in this area. He had some awareness that alcohol was a crutch for him, and that without it he felt he could not face people, especially strangers. He also found that he could tolerate his mother's and sister's nagging ways when he was fortified with a drink. They, in return, were less demanding of him when they knew
he was drinking.

The patient was very critical of his friends. The worker clarified this with him. "It appeared that what he was doing was trying to find fault with his friends to bring them down to his level, which would make him feel more comfortable. The patient agreed that he felt inferior and therefore uncomfortable with them." Again in a limited way he could share his feelings with the worker. He had no self-confidence, could not make decisions, could not take the initiative in anything. Although he continued to blame his mother for this, the worker repeated his responsibility.

On the twentieth interview, the patient looked very tense and reported having spent an awful week. He seemed unable to shake the feeling of depression, which had returned. He related this to the death of his sister's dog.

His sister had called him at work to tell him of the dog's death. He reported feeling terribly frightened when he thought his sister had said Ma died instead of Pal. When he realized his mistake, he was relieved, but the sadness had continued. He also found himself breathing more rapidly. This was a familiar feeling, and in some way, it was associated with fear.

The worker explored this with him, and then pointed out how this feeling related to his grandmother's death.
and his early separation from his mother.

Following this interview, there were five interviews before the Clinic closed for a month in the summer. He did not return to the subject of death, but complained about his job and his mother's treatment of him. He was able to tell how he looked down on himself for trying to be a big shot. As the vacation drew near, he had less and less material for the interviews, and often his language was obscene. He did not accept that he felt anything but indifference in regard to the worker's vacation. His depression symptoms were in evidence up to the time of vacation.

Although the patient had always been markedly ambivalent toward the worker since the beginning of treatment, he was particularly hostile after the worker's vacation. At this time he did not seem depressed. He questioned the efficacy of treatment, the competence of the worker. The worker encouraged him to express this and clarified the way in which the patient was relating to her:

He had been testing the worker all along by handing her little jobs to do, which he thought she was capable of doing. Presumably this was done with the intention of building up his confidence in her. If she could handle these jobs for him, he could hand her a bigger job to do.

The patient seemed to be resisting therapy more
and more. He always kept his appointments but he had less and less to say. Since this was impeding treatment, the worker focused on this area. The worker clarified that what he was doing in therapy, he does in many other situations: he is angry and afraid to be found wanting. This led the patient to discuss his strivings to prove himself a man outside the interview situation. For awhile this remained the area for discussion, but the patient's resistance was still evident. The worker realized there was less and less affect accompanying the content of the patient's material. At this time also, depression symptoms returned. Although he had told how his drinking had decreased since the start of therapy, the worker now questioned him about this. It became evident that his drinking was increasing. The worker pointed out to him that he was putting his anxiety into liquor and not into the interviews. She encouraged him to decrease or stop drinking. The worker also focused on the dynamics of the interview situation in order to mobilize workable anxiety.

In exploring the most recent phase of depression, the worker related it to the patient's having been recently rejected by a girlfriend. The worker also pointed
out the positive element in this; namely, that the patient had taken the initiative to date this girl. This was the first time the patient had ever done this.

At the time of writing, this patient is still in treatment. The time covered thus far in this case is fifteen months, a total of fifty-two interviews.

Discussion.

This patient, who has never been able to hold a job for any length of time, was able to stay with one job for a year. At this time of writing, he still has this job. He has not been drinking on this job. He also returned to his home, where he has been living since shortly after the start of therapy. He was beginning to realize his dependency feelings towards those who support him, but he has been able to act in only a limited and sporadic way on this knowledge. The depression symptoms which were evident at intake, diminished and, later, returned. Fluctuations of this nature have continued during therapy.

Although the worker encouraged abreaction throughout therapy, this patient was able to share his feelings in only a cautious and limited way. Much of his complaining was intellectualized. Apparently where the patient allowed himself some degree of emotional involvement, his depression symptoms diminished.
Manipulation in the sense of a new experience was the relationship. This patient had in his worker a warm and accepting woman, who gave him a consistent amount of support. However, this patient did not allow himself to form a close relationship with the worker.

Positive manipulation or the increase of emotions in the patient was employed by encouraging him to recognize and verbalize his feelings. However, the patient seems to have done this mainly in an intellectual way and has avoided the accompanying feelings. Currently, the worker is focusing on the treatment relationship, which seems to be more effective in arousing workable anxiety.

Repeated clarification produced some sporadic change toward improved functioning, but it was not maintained. This patient's resistance to the treatment situation seemed of importance in his inability to make effective use of this technique.

Suggestion and interpretation were not used.

Generally, this patient's inability to use casework help seemed related to his limited acceptance of and participation in the relationship. The patient's improvement in functioning seems related to the support he received and his ability to make use of it.
Case V

This patient, Wilma C., is a forty year old widow with a nine year old daughter. They live with the patient's mother and father. When seen at intake, her chief complaint was her periods of depression. She also mentioned having phobias. Her depression began three years ago or even earlier. Her husband died three years ago in bed with her. She recalled how she had retired early that Friday night and blanked out completely so that she could not remember when he went to bed. She awoke the next morning to hear him in a death rattle and was pulled out of the bedroom by her mother. About three years prior to his death, Mr. C. had been suffering from subacute bacterial endocarditis. He had been unable to work, and his former good humor had turned into grouchiness. Since in the course of his illness, he had suffered from palpitations when they had intercourse, they discontinued having it. The patient complains now of having palpitations. The first occurrence was about a year ago. It occurred on a Wednesday night after a card game. She was very sick but refused to go to bed in the room she used to occupy with her husband. She hasn't slept in that room since. The only other palpitation occurred on a Friday night, although it usually comes and goes when she is in bed. Although she is always depressed, it gets worse on Friday nights, when she thinks back to that Friday night three years ago.

The patient worked from March to October of 1953. She lost this job, and this precipitated a depression that led her to come to the Clinic. She has dated men twice since her husband's death but considers them shabby, dull, uninteresting. Similarly she has rejected all her friends, feeling that when she is in the
company of married couples, she is out of place.

Her phobias are related mostly to the feeling that she is smothered in the elevated or in thick crowds. The phobias have actually been in existence since shortly after marriage at twenty-four. It has only been within the last three years that the phobias have increased.

This patient was diagnosed as Depressive Reaction. It was recommended that a warm relationship be established immediately. Then it would be important to make clear to her her jealousy, her need for revenge, her deep hurt at every sign of lack of appreciation, and especially her denials, which have become increasingly intensified since her husband's death.

This patient was able to form a close and dependent relationship almost immediately. She spoke of her husband, particularly of how wonderful he was and how unhappy she had been since his death. The worker encouraged her to bring her feelings into this material by interpretation.

I said it must be her feelings about me that wouldn't let her cry in my presence. She denied this, saying I was a pleasant sort of person. I said maybe that is just it; I am a pleasant sort of person, and she would like to cry in my presence; but like her relationships with other men, she would like it but keeps herself from it. The patient said nothing. She seemed very angry, so I remarked she seemed so. After a lengthy silence, the patient broke down and was racked with sobs.

The patient continued to talk about her husband
but the picture she portrayed of him was still idealized. The worker suggested that the years of caring for him when he was sick had probably made her angry. At first, the patient denied this vehemently. However, the worker repeated this suggestion in the following interviews, and gradually the patient recognized and verbalized some of her hostile feelings toward her dead husband.

In discussing these hostile feelings, the patient brought up her guilt. She felt that, if only she had responded quickly enough on that fateful night, he might be alive today. The worker handled this by pointing out the reality; namely that her husband's death was inevitable despite all her attempts and hopes that he would live. In connection with her guilt, the patient discussed her feelings of worthlessness. The worker supported the patient by reassuring her that she did have worth.

To encourage more abreaction, the worker clarified the patient's denial of feelings.

The patient wondered why people make fun of her for coming to the Clinic. She said she could see nothing wrong in doing this. I pointed out that she was denying. Perhaps underneath, she felt weak and worthless.

Repeated clarification of denial encouraged the
patient to express more negative feelings for her husband.

The patient said others have told her she got stuck in marrying her husband. I wondered how she felt about it. She thought the work stuck was rather harsh. I wondered if she were denying her feelings again, possibly because she would think it bad to have such thoughts. She finally admitted she felt stuck.

After seven interviews in which abreaction played an important part, the patient's depression symptoms diminished considerably. Concurrently her phobias disappeared. She reported she had been dating and was able to go in town alone on the street car. If anything, the patient seemed suspiciously happy. The worker clarified this new-found happiness as a denial of feelings. In order to increase the patient's emotional participation in treatment, the worker asked that she not go out on any more dates. At this, she became very angry and cried and pouted. The worker interpreted:

I mentioned these must be tears of anger. She agreed. I wondered if all her other tears had been of anger. She guessed they were. I said that was why, at the time of her husband's death, she had cried when alone only. To be angry at one's dead husband was wrong; hence the feelings of not being worthy and of guilt; hence the necessity to punish herself for being bad.
The patient's response to the interpretation was to resist it and to tell how, on the contrary, she was now standing up for herself and showing anger when she felt it. However, it appeared to achieve the goal of intensifying the treatment relationship. The worker continued to clarify the patient's feelings as they occurred within this relationship.

The patient appeared angry when there was no office space available to start immediately. Later I asked her why she was angry at this. She felt left out, she said. I pointed out how her quick hurt in situations such as this caused her trouble. When she does not get attention, she gets hurt. When hurt, she gets angry and then withdraws. We related this to her feelings of worthlessness.

This clarification was repeated at other appropriate instances during treatment, and the patient began to become aware of it.

After three months of treatment, the patient seemed ready to consider her relationship to her nine year old daughter. She was able to express her guilt in not being an adequate mother. The worker handled this by relating it to her more general problem of feeling worthless and inadequate.

The patient repeatedly told of feeling better. The worker noted that the patient was gradually becoming
excessively gay. It was the worker's opinion that the interpretations he made early in treatment were accepted by the patient as suggestions. In effect she wanted to be happy to please the worker. This was pointed out to the patient. At that time, the worker began to prepare the patient for transfer, since the worker was leaving the agency. The patient did not deny her negative feelings in this to the extent that she had been using denial. The worker handled this by relating the patient's feelings in this situation to her feelings of loss when her husband died.

At the point of writing, the patient was still in the process of being transferred, and the worker was focusing in this area in an attempt to work through some of her feelings in regard to this.

Discussion.

At the time of writing, this patient had been in treatment for four months and had been seen a total of seventeen hours. She is currently in treatment.

This patient has been helped through the medium of casework. Her depression symptoms greatly diminished, and her appearance improved. She was able to ride in public transportation and to be in crowds with some degree of comfort. She applied for a job. Recently she has begun to consider her relationship with her daughter,
which heretofore she had not done. Generally, she was functioning more adequately in that she became more active in outside interests.

The techniques used in this case were suggestion, abreaction, manipulation, clarification, and interpretation.

Abreaction was important in the initial phase of treatment in establishing the relationship. It was also effective in diminishing the depression symptoms.

Manipulation was the relationship itself. In treatment, this patient was given the opportunity to establish a close and dependent relationship with a male figure and was able to use this opportunity. She seemed to use the support and reassurance she received to improve her external situation. Therapy was primarily a corrective emotional experience in that the patient was able to relate to a man for the first time since her husband's death. She was able to recognize and verbalize the hostility she felt toward her husband from the encouragement and acceptance she received in the relationship. Positive manipulation or the increase of emotion was used when the worker asked the patient to stop dating. The patient tolerated this because of the relationship, and it proved effective.

The worker advised the writer that early clar-
ifications of the patient's functioning outside of the treatment situation occasionally proved to be accepted as suggestion by the patient. However, clarification of the patient's functioning within the therapeutic relationship seemed acceptable to the patient.

Suggestion was used to encourage the patient to abreaction. The patient's dependency on the worker seemed important in her willingness to incorporate his suggestions.

Interpretation, while offered as such, was accepted as suggestion. According to the worker, this was because it was used too early in treatment and the patient was not ready for it. Also she had not been prepared for it by preceding clarifications.

Treatment consisted predominately of a combination of the techniques of abreaction and suggestion used within a positive relationship.
CHAPTER V
SUMMARY AND CONCLUSIONS

This has been a study of the casework techniques used in the treatment of five patients with the diagnosis of neurotic depression or depressive reaction at Briggs Clinic. The writer studied how the techniques were used; and how, if at all, the patients were helped.

The cases were examined in reference to Doctors Edward and Grete Bibring's techniques of treatment as modified by Doctor Arthur F. Valenstein. These techniques are suggestion, abreaction, manipulation, clarification, and interpretation.

All of the patients had a common diagnosis. All had been seen for twelve or more interviews. They were seen in individual treatment by social workers. Of the five patients, three were females and two were males. All three women had married. However, at the time of treatment, one was living with her husband and three children; another was a divorcee living with her mother; the third was a widow living with her daughter and her parents. The ages of these patients were thirty-
four, forty-five and forty respectively. They were seen for twelve, thirty-eight, and seventeen interviews respectively. Concerning the two men patients, one was married and living with his wife and three children. He was seen for eighteen interviews. The other man was single and living with his mother and sister. He was seen for fifty-two interviews and was still in treatment at the time of writing.

The diagnosis of neurotic depression or depressive reaction used in this study is in accord with the definition stated in the Diagnostic and Statistical Manual of Mental Disorders. According to this definition, there are certain observable symptoms in this diagnosis. The depression symptoms evident in all of these cases varied in intensity and, occasionally in kind. The symptoms noted in all cases included a withdrawal, inertia, loss of interest in outside activities, feelings of worthlessness and hopelessness. Somatic complaints, where they were evident, were insomnia and vomiting.

In all of the cases, the patients found relief from the depression in that the symptoms diminished. In four of the cases, relief from the symptoms seemed to have been maintained. Of these four, one had recurrences of symptoms during treatment; but she was
free of these at termination. The fifth patient was still in treatment, and fluctuations in symptoms were apparent during treatment.

In all of the cases, the patients showed some degree of self-assertiveness and the ability to function more adequately. As the patients became less withdrawn, they were able to participate in relationships and activities. In three of the cases, there was improvement in family relationships. In the remaining two, the family relationships became openly hostile whereas, prior to treatment, these patients had been avoiding family contacts.

Manipulation seemed very important in all of the cases. Those patients who were able to show movement following casework treatment had a very positive and dependent relationship with the worker. In those cases where movement seemed not so evident, the patient was not so dependent on the worker, and the patient's ambivalence toward the treatment situation was more apparent. In the relationship, the patients found acceptance, support, and consistency; and they responded to this by becoming less self-deprecatory and more self-assertive.

Positive manipulation, or the increase of certain
emotions, was used in two cases by focusing on the patient's anxiety. This technique was used with the patients who were resisting treatment by denying the feelings which accompanied their problems. The response each time was an increase in the emotional participation of the patient in treatment.

Negative manipulation, or the decrease of certain emotions, was used in one case by focusing the patient's diffusive fears and anxieties onto electroshock therapy. The patient responded by becoming more relaxed and self-controlled. It was used with a dependent patient in a positive relationship.

Abreaction was used in all cases. It was used extensively at the beginning of treatment in every case, but it continued to be an important technique throughout treatment. The patients' response to the opportunity and encouragement for abreaction was to recognize their problems and ventilate their feelings. As this occurred the patients obtained some emotional relief; and, concurrent with this relief, the depression symptoms diminished. Also, as the patients shared their problems with their workers, the relationships became more intensified and positively weighted.

Clarification was used extensively in all of the cases. The effectiveness of clarification seemed de-
dependent on its repetition. When it was used in conjunction with the support from the relationship (manipulation), it seemed effective in helping the patient to more adequate functioning. Generally, it was used after the patient had abreacted to some extent. It was of particular importance in the treatment of depressions in that it enabled the patient to redirect the hostility from the self to the appropriate outside object, and thus diminish the depression. Generally the patients were more accepting of clarification when the relationship was positive.

Suggestion was used in two cases. It was used with one patient to encourage her to recognize and verbalize her hostile feelings for her dead husband. She accepted the suggestion after it was repeated in that she responded by doing just that. She was a dependent person, who tried to please the worker throughout treatment; and this may have been an important predisposing factor in the patient's willingness to accept this suggestion. In the other case, the patient did not respond to suggestion. It was used when the patient seemed to be fearful of his dependency on the worker, and this may have been relevant to his resistance to the suggestion. Other factors which may have been related to this were not evident from the case material.
Interpretation was used twice in one case. The patient's response to the first interpretation was to accept it as a suggestion. The patient resisted the second interpretation. The worker advised the writer that the patient may have responded by rejecting interpretation because it was used early in treatment and because clarification had not preceded the interpretations. Other factors which may have been related to this were not evident from the case material.

The most frequently used combination of techniques used with these five patients was abreaction, manipulation, and clarification. Abreaction was used to a great extent early in treatment; and after sufficient relief was obtained, clarification was used. The response of the patients to these techniques seemed to vary with the quality of the relationship. The more positive and dependent the relationship was between the patient and the worker, the more evident was movement in the patients.

Approved:

Richard K. Conant
Dean
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