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The place of case work in handling the symptom of withdrawal in older people: a study of fifteen cases in the Department for Older People, the Family Society of Greater Boston, active within the five year period July 1948 to July 1953.

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THE PLACE OF CASE WORK IN HANDLING
THE SYMPTOM OF WITHDRAWAL IN OLDER PEOPLE:
A STUDY OF FIFTEEN CASES IN THE DEPARTMENT FOR
OLDER PEOPLE, THE FAMILY SOCIETY OF GREATER
BOSTON, ACTIVE WITHIN THE FIVE YEAR PERIOD
JULY 1948 TO JULY 1953

A thesis

Submitted by
Ellen Havelock
(B.A. Cambridge University, England, 1926)
In Partial Fulfillment of Requirements for the
Degree of Master of Science in Social Service
1954
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CHAPTER I
INTRODUCTION

With the launching of the Old Age Assistance and Old Age and Survivors Insurance Program of the Social Security Act of 1935 came tangible evidence that the American social conscience had wakened to the needs of a large and ever-expanding group in the population, namely those over the age of sixty-five. The depression had drawn attention to the plight of the older people who, by 1950, formed 8.1 per cent of the population in the U.S.A. and 10 per cent of the population in the State of Massachusetts. In actual numbers the population of this country has doubled since 1900, but the number of persons over age sixty-five had quadrupled. There are today thirteen million persons in this age group, and the number is increasing at the rate of four hundred thousand per year, an increase made possible by gains in the control of disease, in preventive medical care and through the rise in standards of living.

It is not surprising, therefore, that once interest was aroused, such a numerically large proportion of our voting population should continue to attract attention and that the effort should be made to lift the economic burden of this retired and largely unproductive element from the shoulders of the young and productive segment. For this reason the principles of self-support which characterized the Social Security Act of 1935 were extended. More and more categories within the working population were included in coverage until more than 80 per cent of our

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1Committee on Aging and Geriatrics, Fact Book on Aging, pp. 1, 2.
workers had old age protection under public programs in December, 1951.

Recognition of economic need was followed by further gains in the fields of health and recreation, and some public interest was shown in efforts to improve the housing of older people and to examine methods of retraining towards re-employment of older employees in occupations suited to their capacities. This interest was shown in state commissions set up to study the special needs of the aged. The New York State Commission on Problems of the Aging took the lead in this movement and has now been in operation for seven years, and other states are following this lead. The extent of public interest at the national level was demonstrated when President Harry S. Truman called the first National Conference on Aging in 1950.

Recent emphasis has been placed upon mental health. How serious a problem the mental ill health of older people has become may be seen from the statistics which reveal that 40 to 50 per cent of admissions to mental hospitals are people over sixty. The cost of care for the mentally ill is covered 80 per cent by tax funds.

One of the agencies in the community which has long recognized the mental health needs of older people is the Department for Older People of the Boston Family Society, which, through its case work service, has tried to meet the emotional and psychological needs as well as the environmental needs of clients. Accordingly, the records of the Department for Older People furnish material for the study of those emotional problems which are symptomatic of maladjustment in older persons.

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2Ibid., p. 23.
The symptom of withdrawal occurring in many older people about the time of retirement is an often-recurring problem with clients of this agency's.

It is the purpose of this thesis to study fifteen cases known to the Department for Older People, Boston Family Society, active within the five-year period July, 1948, to July, 1953, in which the symptom of withdrawal was a major problem. Cases were selected, from five years of intake, in consultation with the Associate Director of the agency, under whose supervision all cases in this district were handled.

The questions asked in this study are as follows:

1. How did the withdrawal manifest itself?
2. What other problems were evident?
3. What were the areas and types of social work activity?
4. What was the status of the withdrawal symptom at the close of contact or at the time of termination of the study?

In addition to the above source of data a survey was made of literature pertinent to the scope of this study.

**Method**

The fifteen cases were read and abstracts made of each. Findings were tabulated according to a Schedule (see Appendix, p. 54). The symptom of withdrawal and accompanying personality traits and symptoms were surveyed in further detail in Workchart A (see Appendix, p. 57). A summary of these findings is presented in Chapter IV.

Case studies are presented in Chapter V. These illustrate in greater detail the case material upon which the Schedule is based and the
adaptations in case work method used in these cases.

For purposes of juxtaposition and comparison, two groups are differentiated in the tables and charts.

Group I is composed of nine persons who were able to make a better adjustment to life, and in whom the symptoms of withdrawal had subsided when case work contact terminated, or at the time of the close of this study.

Group II consists of the six cases which showed little movement in the course of agency contact.

Scope and Limitations

All cases studied were active with the agency during the five-year period July, 1948, to July, 1953. Two cases remained open at the time of termination of this study. Informal contact was maintained by agency staff, through old age groups and brief informal interviews, in six cases which were formally closed at the termination of this study.

For the purpose of this study, those cases were eliminated in which organic disease or marked physical handicap or disability were apparent contributing factors in the development of the withdrawal symptom.

Certain minor physical limitations were however accepted as normal in this group of older people, their presence being attributable to the normal degenerative processes of old age.

As the cases were chosen on the basis of symptom formation alone, the proportion of men and women is not representative of the proportionate amounts of help given to men and women in this agency. As only five out of the fifteen cases were men, it would not be possible to determine
whether masculine and feminine characteristics are significant.

Findings in this study have limited applicability. They apply only to cases studied and cannot be considered as generally applicable in other settings.
CHAPTER II

AGENCY BACKGROUND: CASE WORK AND CASE WORK MODIFICATION IN WORK WITH THE OLDER CLIENT

The Department for Older People was at the time of this study a specialized department within the Family Society of Greater Boston, a non-sectarian case work agency and a member agency of the United Community Services of Greater Boston.

The offices of the Department for Older People are located near Boston's South End, an area of the city where a high proportion of the population is known to belong to the older age group, as exemplified by the fact that 47 per cent of the Old Age Assistance recipients of the city are located in this area. It serves also the city and suburban area given service by the Family Society's branch offices.

The Family Society was first started primarily as a means of distributing relief in an organized way to needy citizens in the community. Its original name was the Associated Charities and it was founded in the year 1879. The name of Family Welfare Society assumed in 1921 was indicative of the interest of the agency in the area of family life. This interest persists today as a major emphasis of the Society, although the administration of relief has in recent years been taken over by the Department of Public Welfare. In 1950, close to forty-five hundred persons and families were served by this Red Feather Service which covered two main areas, namely, case work service and the promotion of Family Life Education. Following the recommendations of the Greater Boston Family Society Pamphlet, Perhaps Someone Can Help.
Community Survey of 1948, Family Society of Greater Boston and Boston Provident Association joined in September, 1953, to form a new agency, the Family Service Association of Greater Boston.

For thirty years the Department for Older People operated as a specialized department of Family Society. It was named in its earlier period the Bureau for Aged Women, although men closely related to clients were also given aid. Later it changed its name to Field's Memorial, in memory of one of the Society's founders. In 1951 it was re-named for its function, Department for Older People.

The first function of the department was counselling of older persons, and this service was extended to include counselling to younger persons whose major concern is the problem centered upon an older person or persons within the family group. Because of its early pioneering in this special field, this department was much in demand in its second main function of education. It served as a clearing station for information concerning resources and problems affecting the senior citizen, a service more widely in demand as public interest grew. Director, Associate Director and case workers of the Staff of the Department for Older People responded to this growing interest by writing for the press and professional social work journals and took active part in meetings and conferences whose aim was to promote the well-being of older people and fill the gaps in community facilities. Staff members belonged to the United Community Services' standing committee on the aging and the Director was a member of the first National Conference on Aging held in Washington in 1950.
Because of its consciousness of the special need of older people to form new and substitute relationships and to develop fresh interests, the Department has been called upon for advice in the formation of Old Age Groups in the community and was initially responsible for the formation of two now thriving groups. The Never Too Late group is composed of mentally alert older persons who meet at the centrally located Public Library. The Senior Associates, the second, is now run by a competent group of men and women over sixty, whose wide range of interests has done much to enrich the quality of life experience of the membership.
Case Work and Case Work Modifications in Method to Meet Needs of the Older Client

A detailed study of the case work methods used in this specialized department was made by Elizabeth Anger in 1952. In analyzing the total agency case load, she found that with 55 per cent supportive techniques were used, in 23 per cent environmental techniques were mainly evident, and in 21 per cent clarification was the method. While admitting that this numerical analysis was oversimplified, Mrs. Anger allocated each case on the basis of the method which was primarily used or which was most significant in the conduct of the case.

"Case work and psychotherapy can be successful with older people," she concludes from her study. "Each older client is an individual with capacity to grow and change in much the same way as he was able in former years, but often with greater odds against him." In discussing the treatment plans given consideration in her study, Mrs. Anger noted that emotional maladjustment was the third largest category of problems, an observation which is pertinent to the present study of an emotional problem.

Direct treatment through the interview is used in the supportive method, which aims to revive the positive ego-strengths within the individual. It capitalizes upon the healthy aspects of the personality and (although it is diagnostically based) little insight is expected on the

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2Ibid., p. 19.
3Ibid., p. 22.
part of the client. Acceptance and recognition is here the keynote. The role consciously assumed by the worker may be the 'good parent' or the ego-support of the 'good daughter' role through which the worker gives recognition and respect for the past achievement of the individual client on the basis of which he may be helped to accept a less strenuous life or an honorable and well-earned retirement. Or he may be fortified to meet the pressures to which he is currently exposed.

Gordon Hamilton devotes a large portion of her chapter on Treatment to the consideration of the therapeutic goal of reducing the pressure of environment. Environmental treatment may be partially corrective of an emotional problem as it may involve manipulation to reduce strain. This reduction in strain may be brought about by actually moving a person, by lessening competition, by providing new stimuli and outlets, or by changing the attitude of persons peripherally involved. This is particularly appropriate in describing environmental case work with older people.

Coleman suggests that "the individual's life situation may need to be changed so that it will not negate the positive gains of therapy." In recognition of this need the Department for Older People worker offers environmental aid and in many cases helps to establish a relationship with a group as the case work relationship is gradually tapered off.

Clarification or counselling. In the method thus designated, the client is given, through the medium of the interview, an opportunity to

7 Gordon Hamilton, Theory and Practice of Social Case Work, Chapter 9.

strains placed upon him in the past?

The entire past history needs to be known...the developmental approach has to be made...in order to discover characteristic patterns

'explore' his situation and to explore and express the feelings which relate to his situation and its accompanying problems. This allows the client to see in better perspective the factors operating in his life. Thus he may be helped to clarify and distinguish what is real and what is fantasy. In this way he may be helped to identify the unrealistic load of past emotion he has carried forward to intensify the difficulty of the present. Corrective ideas begin to follow this attainment of emotional veracity, or insight. In addition, the client, by expressing his feeling, has been helped to tolerate it. Some time may be taken in assimilating this material before the client assumes a new attitude or reorientation which gives him the motivation necessary to make realistic choices and if necessary, changes, in his life.

In describing case work treatment for the older client, Mrs. Amy Powell, Director of Department for Older People, has said that it becomes essential to regard each older person as an individual to "attempt to lift him out of the category." This process the worker initiates by exploration which involves assessing the measure of the present difficulty in the individual, and the weight of impact and suddenness of onset of the present stress. It attempts to assess his unmet need, whether it is real or subjective. It asks, in effect, what kind of a person was this particular and unique individual? How was he able to meet the strains placed upon him in the past?

The entire past history needs to be known...the developmental approach has to be made...in order to discover characteristic patterns

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of adjusting reactions which will predetermine his reactions in old age.\textsuperscript{10}

Ruth Cavan states this idea in a somewhat different way:

Personality in old age rests upon and grows out of his earlier personality...there is a continuity of personality from birth to death...this continuity in attitude implies a certain predictability in the person's manner of adjusting...Lowry has stated that if a child grows up gracefully through adolescence he will probably grow old gracefully.\textsuperscript{11}

In this same chapter Hartwell is quoted by Cavan:

It is important to know about the individual's integration in active life, if the adjustment and mental health have been good there is a greater probability that the old person will have a quiet senility. Old age is often blamed for things that are due to lifetime personality factors.

All this takes place in the diagnostic procedure of case work, upon which treatment is based.

Treatment involves helping the client clarify and assess his unmet needs and choose for himself the avenues open to him by which these needs may be met, environmental and emotional. In achieving readjustment out of a period of unadjustment it may be necessary for him to recognize that human life is such that certain losses cannot be made good in the present reality.

Wishes and drives cannot be completely transposed. Loneliness cannot be completely satisfied by social recognition. The desire for usefulness cannot be completely filled by recreation, especially of the passive type. All that can be hoped for is compensation for lack of satisfaction.\textsuperscript{12}

Acceptance may be made easier by the development of an attitude which views life as a whole.

\textsuperscript{10}Otto Pollak, Social Adjustment in Old Age, p. 55.
\textsuperscript{11}Ruth Cavan et al., Personal Adjustment in Old Age, p. 75.
\textsuperscript{12}Ibid., p. 78.
Those who have made a successful adjustment, are those able to see it philosophically in perspective embracing their own life and the whole of life. They view old age not as a period of decline and frustration, but of self-integration and of fulfillment in the sense of a task brought to a close.... They feel happiness in the recollection of past achievement and are well adjusted and content.\(^\text{13}\)

\(^\text{13}\) Otto Pollak, *op. cit.*, p. 63.
Modifications in Case Work Methods used by the Department for Older People

Modification in case work method, as it applies to older persons, is made in cases where the case work function must be mainly protective, as in the case of very sick persons or those who are mentally impaired. Even the physically handicapped can however exercise some choice in the direction of their lives and are encouraged in self-direction. The mentally impaired can also be given help in clarifying their ideas with the principle of self-direction still operating as far as possible. But where the health and safety of the individual are threatened, the worker must sometimes intervene on behalf of her client, as would be the accepted case work policy in the case of a child who needed protection.

The extent and degree of worker activity may go beyond that of case work as it is generally practiced. Clients are harder to reach and slower in response. With the emotionally handicapped, the worker may go three-fourths of the way to make the client feel accepted and understood. Because many are withdrawn and inertia has set in, the client is a 'slow starter' and the worker may have to become more active in her effort to reach him. Even in making environmental changes, the worker may have to accompany the client in his first steps, although he may be well able physically to undertake these alone.

After rapport has been established in this way, the worker's role may have to be consciously more warm and friendly than would normally be thought helpful because the worker may have to fill the role of relationships which have been outlived.
Helping a client plan for his future is often a part of the worker's role with the younger client. In working with the older group, the worker develops by contrast a different philosophical attitude which Mrs. Anger has described as "an awareness of the value of life. It is not the length of life that is important as it is the ability to live fully a moment or a day."

\[^1\text{Anger, op. cit., p. 21.}\]
CHAPTER III
THE WITHDRAWAL SYMPTOM

Withdrawal has been defined as "the exclusion of external stimuli." It is further described as a defense mechanism of old age.

The most common explanation of this phenomenon found in the literature is that the subject is acting in response to fear. In the older person a further factor influencing motivation is also the need to conserve energy and strength. As a means of conservation it is a symptom of all natural life in approaching its end. Leon J. Saul supports this idea: "Withdrawal from life is a biological reaction, like hibernation in animals," he writes, "it is related to schizophrenia."

David McLelland suggests a slightly different approach to the problem. He defines withdrawal as a method widely adopted as a means of dealing with anxiety.

The simplest reaction to a pain producing situation appears to be to escape from it altogether. The mechanisms of escape have been variously named, for example, inhibition, going out of the field, repression. The primary aim of escape seems to be to reduce the instigation to act...At one level the subject may in effect say, "I give up, or I quit," indicating that he refuses to struggle, which is a way of reducing tension.

In all these mechanisms the person is trying to reduce anxiety by substituting a less severe type of tension, by altering the situation in some way, or by changing the interpretation of the facts which would normally be given...if all these attempts fail, one might expect a regression to the simple withdrawal method of dealing with anxiety.17

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15Jack Wineberg, Growing in the Older Years, p. 61.
16Leon J. Saul, Emotional Maturity, p. 35.
17David McLelland, Personality, p. 508.
Flight from instinctual danger is met by the defense mechanisms of regression, reaction formation, projection withdrawal and isolation. Psychosis would indicate a depth of regression to early infantile stages, early indications of which are seen in flight of ideas, extreme changes of mood and depression.

Freud describes a preservative function of the withdrawal mechanism as it may be observed in the complete withdrawal of the normal individual in sleep. He stresses the recuperative power of this condition and describes it as a blissful state of absolute narcissism in which "the primal state of interuterine isolation is induced."

In further describing the self-preservative or flight function served by the withdrawal mechanism Freud notes the presence of the coexistent condition of inertia. "Where there is a threat of danger to life" (and this is a universal condition of old age), he finds objective anxiety in the face of danger. "We perceive fear and we take to flight." But he goes on to explain that this condition of anxiety interferes with action, which alone would be expedient and serve the purpose of self-preservation.

Coleman quotes Karen Horney regarding the self-perpetuation of the withdrawal symptom in the client. "His adjustive reactions intensify the very problems he is trying to solve."

In view of the significance of anxiety, we may now ask: What are

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18 Ibid.
19 Sigmund Freud, Introduction to Psychoanalysis, p. 424.
some of the common sources of anxiety to which older persons are exposed?

Freud, in treating the problem of anxiety, examines first that primal anxiety which may derive from separation from the mother. The basic fear is of loss of love, and this is what the ego apprehends as danger and to which it responds with a signal of anxiety. The superego, Freud suggests, imposes a new form of social anxiety, which is fear of separation and exclusion from others. The final transformation of this fear is death, he concludes.

Whitehorn describes a condition closely approximating withdrawal which he ascribes to anxiety over loss of affection. This he names the "Don't Mind Trend," a seriously disabling condition in which the subject says in effect, "Nobody cares for me, well I don't mind, I don't care for anybody also." Whitehorn warns that with greater success in 'not caring,' the person who responds in this way to pressure of anxiety may make a schizophrenic adjustment to life.

In addition to anxiety over loss of the loved person there is the further basic anxiety over not having needs met. The need for food and shelter is a very real source of anxiety for some of the clients who approach the Department for Older People for aid. But requirements for attention and being valued are just as important as the need for vitamins, according to Saul. Whitehorn describes this as the emotional need for satisfaction which may be met in a wholesome manner by the affection and respect of others. He further states that anxiety or depression, or

21Sigmund Freud, op. cit., p. 404.
both, may follow if this primary satisfaction is not met. Moreover, if
this state is either so excessive or so prolonged as to prevent inte-
grated effort, the situation seriously endangers mental health.

Freud refers to the helplessness of the ego in the face of exces-
sive tension due to ungratified needs. He relates this helplessness to
the anxiety of infancy and further notices the effort of the ego to fix
this kind of anxiety by means of symptom formation.

Although Pollak draws the distinction between the social withdrawal
which is an adjustive reaction to actually being unwanted and, on the
other hand, the social withdrawal which is based upon unrealistic factors
arising out of the subject's feelings of inferiority and rejection,
"Social withdrawal," he says, "indicates maladjustment and is one of the
traits found in neurotics regardless of age." "It is associated with
depression, self pity, hypochondria, regressive tendencies (autoerot-
cism, etc.)."

Pollak quotes Gordon W. Allport, who includes social withdrawal in
his list of maladjustive traits which are commonly found in older people.
This listing is included here as it compares with the descriptive listing
of traits found in cases under study (see Workchart A, Appendix, p. 57).

1. Feeling of inadequacy.
2. Feeling of rejection, being unwanted.
4. Hypochondria, including overvaluing genuine physical symptoms.
5. Anxiety, worry.
7. Boredom, restlessness.
8. Apathy, passivity.

23Otto Pollak, Social Adjustment in Old Age, p. 63.
24Ibid.
10. Guilt feelings.
11. Narrowing of interests.
13. Rigidity, difficulty in adjusting to new conditions.
15. Loss of social inhibitions (vulgarity, untidiness, uncleanliness, overtalkativeness).
16. Regressive tendencies (voyeurism, autoeroticism).

Ruth Cavan, in a similar listing, adds suspicion and hoarding, and compares these characteristics with symptoms found in cases of senile dementia.

In commenting on the above list, Pollak stresses the fact that these traits are found in neurotics with regard to age. In *Social Adjustment in Old Age*, he follows up by asking: This being so, why are older people more neurotic than others? One answer which immediately suggests itself is that sudden and overwhelming traumatic experiences do commonly beset older people, who at the onset of old age may be forced into new, strange and frightening situations, which will place a strain upon the equilibrium they have acquired in the course of life experience. At this time of life, a person may be deprived at one blow of the basic props of his lifetime. He may suffer the loss of his spouse by death, and may thus be deprived of his home at a time when he is also facing retirement, a threat not only to his income and sustenance but also to his status in the community. In addition, his stamina may be depleted by the onset of illness and physical handicap resultant upon the degenerative processes of aging.

Loss of home may involve an uprooting of the older person from his

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25 Ruth Cavan et al., *Personal Adjustment in Old Age*, p. 6.
own familiar community, which further intensifies his sense of loss and severs his connections with resources where he might have built up substitute relationships.

Familiar surroundings enable the very old to operate successfully, because the responses needed have become automatic. Loss of familiar surroundings results in frustration and irritation and confusion. This irritation may be directed against himself or the new people in his new habitat. Or if his old habit patterns do not seem to fit, he may break down so much as to be unable to do anything for himself.26

"If the stress demands were to increase markedly, it is probable that most neurotics would eventually become psychotic...think of a continuum from neurosis to psychosis."27

Why are older people more neurotic? The Director of the Department for Older People supplied the answer--"Because they have more reason to be."

"Lieben und arbeiten"--to love and to work--Freud described as basic human needs. In losing both, an older person is subjected to the stress of deep deprivation.

At any age, a person may be expected to regress in times of illness. Under stress, people of any age become more narcissistic, and in anxiety they are apt to become extremely so. At any age, the first reaction to grief is withdrawal; as health and courage return, the symptom gradually subsides.

Pollak makes further additions to the reasons why an older group can be expected to be more neurotic. These people have fewer chances in the future to fulfill or regain the satisfactions of which they have been

26Ibid., p. 80.
27Coleman, op. cit., p. 221.
thwarted by circumstance. Their capacity is less, partly through decline in motor function and vitality, and partly because of the decline in importance in the social role which has been enforced by current attitudes toward the older group in the community. Neither is there an opportunity for retraining or making the best use of capacities remaining to older people.

This author assesses the problem of assistance to the older person as being a matter of first measuring the degree of frustration which he is experiencing and then evaluating the resources which he can muster within himself to further the process of change and adjustment.

The human being has needs which he strives to satisfy, and from this view all studies of human behavior are studies of adjustment or of failure to achieve it. Common every day experience, as well as scientific observations, indicate that growing old is essentially a process of biological, psychological and social change. All components of human behavior seem to undergo modification as the individual grows old. Any one of these changes associated with aging implies potential frustration and special problems of adjustment concerned with the re-establishment of equilibrium between needs and satisfactions which has been disturbed.28

The well adjusted person, he adds, "is able to satisfy his wants quickly and adequately as they arise," whereas the poorly adjusted individual remains "in a condition of unadjustment or maladjustment." The degree of adjustment will depend upon how well the individual's basic needs are being satisfied. Various attempts have been made to summarize the basic needs of the individual.

Pollak reduces his essential needs to five categories. Side by side with these needs he indicates the manifestations which may be expected if

28 Pollak, op. cit., p. 32.
those basic needs are not met. In order to discover a person's adjustment, he suggests, list his complaints and check with an inventory of this kind.

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<th>THE NEED</th>
<th>LACK OF SATISFACTION LEADS TO:</th>
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<td>I Physical health</td>
<td>Discomfort, pain, annoyance.</td>
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<tr>
<td>II Affection, love (to give and to get)</td>
<td>Loneliness, rejection, self-pity, hatred, jealousy.</td>
</tr>
<tr>
<td>III Recognition</td>
<td>Inferiority, worthlessness.</td>
</tr>
<tr>
<td>IV Expression of interests</td>
<td>Boredom, restlessness, apathy.</td>
</tr>
<tr>
<td>V Emotional security (intimate contacts)</td>
<td>Anxiety, worry</td>
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All these needs may be met within the family, this author suggests.

Dr. Mary Thorpe summarizes her analysis of basic needs as follows:

Whether a person is sixty or six he needs: (1) acceptance, at home, at work or at play; (2) affection—the security of knowing that someone cares; (3) adventure—a stimulating experience, something to look forward to; (4) achievement—to say, "I did it," and have it recognized.29

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29 Ibid., p. 35.
30 Dr. Mary Thorpe, Contribution of Education to the Care of the Aging, p. 3.
CHAPTER IV

BACKGROUND OF CASES; SOCIAL AND EMOTIONAL WITHDRAWAL SYMPTOMS; CASE WORK SERVICE.

The fifteen cases in this study were active with the Department for Older People of the Boston Family Society within the five-year period July 1948 to July 1953. The following material is derived from facts recorded in the agency record of each case summarized on the basis of a Schedule (see Appendix, p. 54). Ten women and five men were included in the study. Table I indicates identifying data at the time of application to the agency.

Ages ranged from sixty to eighty years, the average age being seventy years. Four persons were in the sixty to sixty-five age group; six were in the sixty-six to seventy age group; and four were between the ages of seventy-one and seventy-five. Only one person was over seventy-five.

A significant proportion, namely, twelve out of the fifteen persons, were living alone. Of the remaining three, two were married and living with their wives; the third, a widow, lived with her only daughter.

Seven individuals were self-referrals; eight were referred by others. The referring agencies were: Division of Old Age Assistance, two cases; American Red Cross, two cases; Family Agency, one case; eye clinic, one case. Two persons were referred by close relatives.

Background; Family relationships; Degree of actual isolation; Work history.

Information about the early life of these clients was not in every case available in the record. But in the seven cases in which specific mention was made only one client remembered a happy childhood, while six described particularly unhappy childhood experiences which they felt had
TABLE I
BACKGROUND

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<td></td>
<td>with self others alone close relative</td>
<td>good poor</td>
<td>good fair</td>
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</table>

**Education:**
good = high school plus occupational training
poor = little or no formal education in public school
grades--no formal training

**Work History:**
good = steady earnings; financial security in middle years
fair = intermittent employment, periods of financial insecurity (not including indigence)
characterized that period of their lives.

More is known of middle life experience, since in the case of elderly persons the middle years are more easily subject to recall. Four had remained single, eleven had married. At the time of intake two had living marriage partners, six were widows, and three widowers. Of the clients who had married only one expressed satisfaction in the marriage relationship, while nine expressed the belief that their marriages had proved unsatisfactory.

Seven of these clients were known to have children living and also grandchildren. Of these only three clients were in close touch with their relatives at the time of intake; the remainder appeared to have lost touch with their relatives, mainly by reason of geographical location in the case of younger relatives, or through death or separation from those closer in age.

Of the three persons who were living with relatives at the time of referral, it is recorded that they had experienced recent transfer from familiar surroundings and friends.

The group as a whole, therefore, presents a picture where isolation is a reality factor. In only three cases do we find resources within the family group to assist these older individuals in times of stress.

Education and training; Work history.

In assessing the assets of the group as a whole in terms of education and training, Table I gives some indication of findings. The group were evenly divided in that seven persons had good education, consisting of High School graduation plus some form of occupational training, and
seven had very little formal education even in terms of public school grades. In one case this information is unrecorded.

Work history was classified in Table I as being good where the client had a history of steady earnings and self-support, with comfortable living conditions in middle years. Ten persons could thus be classified as having good work history. Five were classified as having had a fair work history, in that they had experienced in middle years some periods of economic difficulty and uncertain and intermittent employment. There was no case in which work history could be considered poor: no case in which the client had been a public charge in middle life.

An unusual feature of the group was the fact that of the ten women included, only one had considered her main occupation to be that of housewife in middle years; the others had either been the bread winners of their families (three cases) or had been accustomed to supporting themselves by their own earnings.

Only five persons had both good education and good work history, all five being among those later classified as Group I (see Table VI).

Apparent pre-disposing factors: a) Crisis or unusual stress immediately prior to intake.

Results of Question 11 of the Schedule showed that the impact of retirement was a significant factor affecting ten of the total group. In seven of these the retirement came about suddenly at a time when the client was unprepared for the change.

Impact of grief following the loss of a close friend or relative was a factor in three cases.

Sense of loss due to change of location from old familiar surroun-
ings and friends of their own age group was observed in five cases.

Apparent precipitating factors: b) Anxiety about health and environmental situation at time of intake.

According to Question 22 of the Schedule, twelve persons showed marked anxiety about their health or fear of terminal illness, and eight were concerned about financial support. Six had difficulty in securing adequate living arrangements and six were worried over their unsuccessful search for employment.

How did the Symptom of Withdrawal Manifest Itself?

Evidence of withdrawal was sought on the basis of two main areas of enquiry, namely, the extent of physical withdrawal and the intensity of emotional symptoms. Findings relating to A) physical withdrawal are tabulated in Table II; findings relating to B) emotional areas are contained in Table III.

A) Physical withdrawal.

Physical withdrawal was examined under four divisions, corresponding to Questions 12 to 15 of the Schedule. Social withdrawal from contacts with groups and group activities, clubs or organizations, was noted in ten cases. In three this habit of non-participation had been a long-standing characteristic, but with the remainder it was a recently acquired behaviour pattern.

It has been noted above that a distinctive characteristic of the group as a whole was the reality of isolation from close friends and family contacts. Question 13 indicated that six persons were known to have drawn away from close relationships, close relatives and close
### TABLE II

**TYPES OF PHYSICAL WITHDRAWAL**

<table>
<thead>
<tr>
<th></th>
<th>New pattern behaviour</th>
<th>Old-established behaviour</th>
<th>Total no. cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group I</td>
<td>Group II</td>
<td>Group I</td>
</tr>
<tr>
<td>I Withdrawal from groups</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>II Withdrawal from family and close friends</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>III Withdrawal from activity</td>
<td>10</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>IV Withdrawal into claustrum, within four walls of own room</td>
<td>6</td>
<td>4</td>
<td>0</td>
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</tbody>
</table>

**Group I:** clients in whom symptom of physical withdrawal subsided at close of case or time of termination of study

**Group II:** clients in whom symptom of physical withdrawal remained substantially unchanged

### TABLE III

**TYPES OF EMOTIONAL WITHDRAWAL**

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Regressive symptoms</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>II Depressive symptoms</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>III Illness (no organic basis)</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>IV Mental confusion</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>V Paranoid trends: extreme projection</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

**Definition of terms:** see text

**Group I:** clients in whom symptom of emotional withdrawal subsided at close of case or time of termination of study

**Group II:** clients in whom symptom of emotional withdrawal remained substantially unchanged
friends, and that in five out of the six the symptom was not new.

In terms of activities, exercise of skills, interests and hobbies, and forms of physical exertion such as walking, it was found that twelve of these persons had retreated markedly from their usual patterns of living.

A severe form of physical withdrawal was noted in nine cases where the client had retreated into the claustrophobia created by the four walls of his own room, from which he hesitated to emerge even to satisfy the needs of hunger.

Regarding the severity of physical withdrawal symptoms it was noted that all four types of physical withdrawal were present in three cases. In one of these the situation had become habitual over a number of years.

B) Emotional withdrawal.

Evidence of emotional withdrawal was gathered from Questions 16 to 19 of the Schedule under five headings: 1) regressive symptoms; 2) depressive symptoms; 3) feelings of illness and symptom formation, in the absence of serious organic disease; 4) mental confusion; and 5) feelings of suspicion and persecution (see Table III).

Regressive symptoms were defined in this study as regression in the direction of more primitive or infantile modes of behaviour. These forms of behaviour included extreme dependency, orally demanding behaviour, such as is exhibited in constant and insatiable requests of other people. Excessive need for oral gratification in terms of food and drink, excessive smoking and other forms of auto-erotic self-indulgence were also included in this category. Also included were character changes in a retrograde
sense, restlessness, malaise, discontent, quarrelsomeness. Ten out of the fifteen persons were affected.

Depressive symptoms were noted in twelve out of the fifteen. Signs of depression included self-devaluation, feelings of uselessness, prolonged grief reaction, and anorexia.

Escape into illness, expressed feelings of illness, and physical symptom formation in the absence of organic disease were recorded in ten cases.

Mental confusion in some form was observed in twelve cases. This category was taken to include disorientation of thought processes and the development of fantasy and bizarre ideas.

In three cases unjustified feelings of suspicion and persecution were noted.

Emotional withdrawal symptoms varied in intensity. Emotional withdrawal symptoms were markedly severe in six cases which exhibited traits occurring in all five categories.

Attitude to problems at intake.

Question 26 of the Schedule enquires into the attitude of the clients to their problems at intake. Fourteen out of the fifteen expressed to the worker their complete lack of hope and in the same number of cases the worker recorded an attitude of immobilizing inertia towards the solution of those problems.

This description of the attitude of the group as a whole may be modified, however, by the information regarding source of referral, which indicates that seven persons were in a position to recognize their need
for outside help and were in possession of sufficient energy and self-
direction to apply in person to the correct agency.

Areas of Case Work Service.

Table IV indicates the areas of case work service directed towards
the solution of problems indicated above. In helping the client obtain
better food, shelter and medical aid the goal of case work was to relieve
fear, anxiety and tensions which as stress factors could be expected to
have a bearing upon withdrawal symptoms.

In offering opportunities for group experience, activity and recrea-
tion, workers attempted to compensate in some measure for losses which
the client had suffered in terms of companionship and useful activity.

Table IV indicates that in three cases the client was unable to
accept the help which was offered. In three cases he could accept help
only in terms of the concrete items of environmental aid.

Methods of Case Work.

Table V indicates the methods used, definitions being as described
in Chapter II. In all cases a supportive relationship was offered.

In only six cases was direct help with emotional problems given, by
means of the method of clarification in which the worker's goal is that
the client will achieve a degree of insight into the nature of his prob-
lems and thereby learn to seek his own solution.

In eleven cases some degree of modification of usual case work prac-
tice was found to be necessary. In six cases the protective function of
the agency was called for. In nine cases the form of modification was
either in the greater degree of activity on the part of the worker, the
greater degree of friendship offered, or in the maintenance of informal
<table>
<thead>
<tr>
<th>Case no.</th>
<th>Health</th>
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<th>Living Arrangements</th>
<th>Groups Recreation</th>
<th>No. of areas of help</th>
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Group I = x (see Table VI): clients in whom withdrawal symptoms subsided

Group II = (x) (see Table VI): clients in whom withdrawal symptoms remained unchanged

R = rejection of help offered in this area
### TABLE V
CASE WORK TECHNIQUES

<table>
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<tr>
<th>Case no.</th>
<th>Environmental</th>
<th>Ego-support</th>
<th>Clarification</th>
<th>Protective</th>
<th>Modification</th>
<th>Other forms</th>
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**Other forms, modification of usual case work practice:**

1. Degree of self-help expected
2. Degree of friendship offered in case work relationship
3. Continuance of informal contact after formal closing of case
contact through brief interviews and attendance at group meetings—a contact maintained over an extended period after the time of formal closing of the case.

Status of cases at time of closing.

Table VI summarizes the findings of Questions 28 and 33 of the Schedule. In nine cases the withdrawal symptom had subsided at the time of closing of the case. These nine showed also marked improvement in other areas where maladjustment was evident at the time of intake. They were also, according to Question 31 of the Schedule, self-directing at the time of closing. Three were employed and eight were participating in group activities of some kind.

In six cases the symptom remained substantially unchanged. Improvement in environmental situation was noted in three of these, two having received help in changing their living quarters and one having accepted advice relating to financial matters.

Average length of case work contact from date of referral to time of termination of the study was twenty months. The shortest duration of contact was five months and the longest three years and five months.

The question arises as to whether the improvement of the client in terms of the withdrawal symptom could be maintained after closing of the case. Information is available in regard to this question in six cases where the client continued to be known to the agency informally or formally until the time of closing of this study. In every such case, improvement was maintained.
<table>
<thead>
<tr>
<th>Case no.</th>
<th>Duration of contact</th>
<th>Withdrawal symptom:</th>
<th>Improvement in unsided environment</th>
<th>Self-directing</th>
<th>Not self-directing</th>
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</table>
CHAPTER V

CASE STUDIES

The following abstracts are presented as specimens of the evidence used in this study, upon which evidence the Schedule findings are based.

Cases Two, Four and Thirteen are representative of the nine cases (Group I) in which the symptoms of withdrawal were observed to subside at the close of the case or at the time of termination of this study.

In Group II are classified the six cases in which little movement was shown and in whom the withdrawal symptoms remained substantially unchanged. Cases Three and Fifteen are presented.

In the interpretation which follows each abstract particular attention has been given to the case work methods used. Case Four, for example, illustrates case work with an older person similar in procedure to that which is commonly used in dealing with the younger client. The other cases illustrate the modifications in case work practice which were made to meet the needs of the older client exhibiting severe withdrawal symptoms. The worker is shown helping the client to overcome this problem and the immobilizing inertia which was his attitude at the time of intake. We observe in detail the steps by which members of Group I overcame their difficulties, emotional and environmental, became self-directing, and moved towards healthful participation in the life of the community. In Group II resistance to offers of case work help may be observed.
ABSTRACT I

Case Number Four - Mrs. D. - Group I

Mrs. D., a widow of sixty years, was referred by eye clinic, 11/2/49. Doctors at the clinic had been unable to find anything wrong with her eyes, although she complained of clouded vision and severe headaches.

She had left her home community to join her only daughter in the city two years previously, and was dependent entirely upon her daughter for financial support. Mrs. D. realized, however, that if she could earn her own living her daughter would be free to travel abroad for the importing firm in which she was employed.

For four weeks Mrs. D. discussed with worker her feelings for and against leaving her daughter. In weekly interviews at agency office, Mrs. D. revealed her ambivalence. Intellectually she was aware that her daughter should be allowed to live her own life, but emotionally the client was tied to her daughter by the closest bonds. This daughter had evidently taken the place of Mrs. D.'s husband in her affections, and Mrs. D. devoted her life to her daughter's interests. Mr. D. had been a selfish and demanding figure from whom Mrs. D. had never been able to break away, in spite of his infidelities, until the time of his death, which had occurred ten years previously. Her personality was friendly and helpful and she had made many friends and acquaintances in her church and home town. Missing these contacts since coming to the city, Mrs. D. was all the more dependent on her daughter's company.

In dreams described to worker she felt trapped in situations from which there was no escape. She was never able to express hostility towards her husband, but she did appear greatly relieved by the opportunity to discuss and clarify her present situation. She was able to emerge by degrees from a state of frozen inactivity and indecision, and began to make realistic plans for employment. Her sight improved.

Worker now assisted Mrs. D. with advertising and supplied information about employment agencies. After this Mrs. D. was able to apply, unassisted, for housekeeping positions with elderly couples in whose employment she could secure room and board for herself, as well as a modest income. She reported her headaches improved and her dreams less troublesome.

Mrs. D. secured a suitable position. Her daughter was thus able to travel abroad, obtaining promotion from her firm. This daughter expressed satisfaction that she could now leave her mother without undue anxiety, knowing that agency and worker would stand by in case of emergency.
As Mrs. D. was now self-directing and independent, the case was closed, 4/51, one year and five months after the first interview. Mrs. D. rejoined her church in a new locality and made new friends near her work.

**Interpretation**

Mrs. D. was an intelligent person who related well to worker. In the interview she relived with considerable emotion (abreaction) the events of the past and the conflicts of the present. As she talked, her view of life took on better perspective and the present impasse was clarified by her own insight into what was happening. With mental enlightenment, her difficulty of physical vision righted itself, proving to be of psycho-somatic origin.

Symptoms of withdrawal and inertia disappeared in proportion as she was able to translate her decisions into action. In middle life she had been a competent housekeeper and was able to utilize this skill. In making new friends she was able to escape from her over-dependence upon her daughter.

Treatment here was mainly clarification, with some environmental help with employment information. But the client was mainly self-directing after the early interviews and little environmental help was needed. Case work followed a similar course to that which would usually be offered in the case of a younger individual and no modifications were necessary.

**ABSTRACT II**

**Case Number Two - Mrs. B. - Group I**

Mrs. B., a widow of sixty-eight years, applied to the agency 8/24/51. She had seen publicity relating to Department for Older People, she was anxious about her health and did not know where to go.
She was attractive in appearance, looked younger than her years, and was physically active. Yet she had been paralyzed to act up to this time, owing to a growing fear of cancer. Her symptoms were backache, leg pain, and headaches. Chiefly because of the headaches, she had given up her employment and now, after two years, had exhausted her savings.

Application for O.A.A. was suggested as a means of securing financial and medical aid. Worker had to accompany her in this initial step, which she was quite unable to take alone. Worker was again obliged to accompany her both for medical examination and for eye examination which followed. A condition of glaucoma was revealed, and medication prescribed for control of this condition.

A minor operation relieved symptoms and proved the client’s fears regarding malignancy to have been unfounded. With the removal of this fear and control of the glaucoma the headaches subsided.

As case work contact continued, client told worker about her early life as the youngest of a large family, where she had felt unwanted and inefficient. Her self-esteem was so low that worker found it difficult to help her. Marriage had been merely an escape from an unhappy home situation and had ended in divorce. At this time Mrs. B. had moved to Southern City where she found considerable satisfaction and a number of friends and acquaintances through conducting a successful hairdressing business. This work became her major interest for the next twenty years of her life. The loss of this business two years previous to application to the agency had been the greatest blow of her life.

Following hospitalization, Mrs. B. remained depressed and suffered marked changes of mood. She lost any sense of self-direction and neglected her health to the point where worker had to call in the doctor on her behalf. Mrs. B. seemed unable to think. Worker maintained a close contact and helped discuss plans for the future. During convalescence worker introduced handicraft activity, including new skills such as rug-hooking, for which agency supplied instruction and materials. Patient became less anxious when engaged in activity.

Six months later an employment opportunity presented itself, suited, in worker’s opinion, to the capacity and temperament of Mrs. B. Mrs. B. lacked the courage to apply, but worker accompanied her to the place of interview and encouraged her to try the position for a week. Mrs. B. proved able to do the work and satisfy her employer. The people she met in the course of her work reminded her of her former customers.

After two weeks Mrs. B. was able to discard O.A.A. and became independent. She continued to enjoy her work up to the time of termination of this study.
She continued to see worker on her days off, worker remaining her only confidante. The case remained open, contact having been main­
tained one year and eleven months. Case work plan includes contin­
uation of a less intensive but supportive contact.

Interpretation

The immediate plan at intake was to secure financial and medical aid. This process was rendered the more difficult by the intense anxiety and withdrawal of the client which inhibited action. Worker had to assume both a protective and a supportive role. Patient's emotional health did not improve with return of physical health, and regressive and depressive symptoms returned. Worker now sought the further goal of restoring a sense of achievement and purpose to her client.

Study of client's early life had revealed that she had achieved the greatest sense of satisfaction in her work. Therein she had found also a sense of belonging and usefulness to the customers who became her friends. The worker assumed a parental role in supporting the client, especially at the time when employment opportunity occurred. Modification here was in the protective role assumed by worker, and in the more active role she played. It was further shown in a more intimate and friendly relation­ship than is customarily offered, and also in the degree of permanence in the relationship. At the same time, effort was being made to build up friendships which would partially compensate for earlier friendships which had been lost.

ABSTRACT III
Case Number Thirteen - Mrs. M. - Group I

On 4/6/49, Mrs. M., a widow of seventy-three years, applied to the agency on her own behalf, at the suggestion of a friend. She was
distraught and did not know what to do, since the elderly employer in whose home she had worked, without wages, for the past two years had just died. Her only brothers had both died the previous year, and she was alone in the city. Her married daughters lived with their families on farms outside the city.

She had lost heart, she said, and did not feel able to work any more. She felt tired and discouraged, and during the first weeks of agency contact frequently expressed the idea that she "could not carry through." Her "morale was low," she would say, but "people just can't lie down and die when they want to." She was not feeling well but had not seen the doctor for some time.

As Mrs. M. had no financial resources, worker helped her accept the prospect of well-earned retirement. She had indeed worked hard all her adult life as breadwinner for her family and had supported herself by her own earnings after her two daughters had grown up and married. Although the client was at first reluctant to do so, from lifelong habits of independence, worker helped her see that O.A.A. was a dignified program to which all citizens contributed in their working life and to which they were entitled. Worker then assisted Mrs. M. in making her application for O.A.A., and accompanied her to the doctor for an examination, neither of which procedures the client was able to accomplish alone, although physically well able to do so. The medical examination revealed that there were no symptoms of illness, thus dispelling incipient fears of cancer which the client afterwards admitted, and which had been part of the reason why she feared to seek medical advice.

The doctor's examination gave evidence of malnutrition. Mrs. M. explained this by saying that when she crept back into her little room she found it hard to emerge for any reason, even to get food for herself.

Mrs. M. said she did not want to go out and mingle with people, but worker encouraged her to come to the office for regular interviews. She was encouraged to talk about herself, her past life and her present difficulties. This small task was at first difficult and Mrs. M. would sometimes have difficulty in locating the office, although she had been there before.

It was not easy for this client to verbalize, and it was particularly difficult for her to express the resentment she felt over the lack of reward following a lifetime of hard work and over her rejection by her two daughters, who never invited her on a visit unless someone was ill in their home and they needed grandmother for a nurse. Once she had been able to express this feeling in words, she seemed relieved and able to face the reality of this situation instead of running away from the problem and making excuses for her daughters.
After several interviews, Mrs. M. spoke of her early life, disclosing a childhood of severe emotional deprivation when she had been left behind by her parents in boarding school while they conducted their business abroad. The only motherly person of these days had been the matron of her school. Even in marriage her dependency needs were not met, as her husband had deserted her soon after her second daughter was born. Her dependency needs had been met only vicariously through a life of service devoted to others. She had never been able to make demands on her own behalf, and accordingly had been imposed upon by those around her, including her employers and her own children. This source of vicarious satisfaction being lost to her through the onset of weakness and the present crisis, she felt useless, unwanted, lost and lacking in any spark of determination or interest.

Worker gave recognition to Mrs. M. on the basis of her past achievement and the devoted service she had given to others. Thus a new sense of self-esteem was promoted within the client. Worker encouraged her to give some consideration to her own interests, her own comfort and appearance. She helped Mrs. M. to find a more cheerful room and encouraged her to improve her personal style and appearance. This change Mrs. M. was able to carry through.

In order to compensate partially for the companionship and the sense of usefulness and achievement the client had formerly secured through her work, Mrs. M. was introduced during the following year to groups of congenial people in church and library. She was also encouraged to revive her handicraft skills.

When the client's interest flagged, worker would encourage her to persist in her participation on the basis of her usefulness to others, which had been a lifetime motivating force with this individual. Thus she gradually built up a sense of usefulness and 'belonging' and slowly built up friendships with other members of these groups.

Although the client gained insight into her own compulsive need to put the interests of others before her own, she found this trait difficult to correct and needed a good deal of support from worker, especially in making choices where a conflict of interests was involved.

After one year of case work interviews on a regular basis, worker was able to taper off the relationship and then closed the case. In the closing evaluation, worker estimated that the client had made considerable gains in insight, but that her lifetime habit of self-negation had made it difficult for her to put into practice what she believed. Her views of other people were now more realistically based. She could refuse unreasonable demands placed upon her by her children and could even accept small services from them.
The case was closed 8/50, fourteen months after opening, but informal contact were maintained through contacts with the groups to which she belonged. Improvement was maintained up to the time of termination of this study.

Interpretation

This case illustrates physical and emotional withdrawal symptoms and illustrates anxiety due to environmental factors. Methods of case work were supportive. Diagnosis revealed narcissistic and dependency needs which worker helped client to meet through better attention to her own comfort and appearance. Environmental aid was given to relieve anxiety by directing the client towards financial resources, medical aid, housing and recreation. A major service was also rendered in the area of clarification. Modification in method is seen in the warm and personalized relationship maintained over a long period, and the greater initiative and activity on the part of the worker herself at a time when the client was overcome by inertia.

ABSTRACT IV

Case Number Three - Mr. C. - Group II

Mr. C. had read in the papers that new resources were available for the use of older people through the Department for Older People. His first contact with the agency was an angry letter, which he wrote 3/51 complaining of the monotonous idleness in which he and people of his age were obliged to live out their days. He requested tools for handwork.

Worker visited his home, since he declared himself unable to reach the office. The client told worker that his only relative was a sister who lived outside the state and that now his only companion, his dog, had just died, leaving him lonelier than ever. He explained that he had a "tired heart," yet he had had no medical diagnosis for years. His financial support was Old Age Assistance. He never went out, he explained, so that it would be necessary for worker to arrange to come to him. Home visits were arranged on a regular basis with the hope that Mr. C. would later be able to reach the office. It was noticed that Mr. C. was able to travel to the stores near his
home for food without any apparent difficulty.

Worker offered medical service which would relieve him of his worry about his tired heart, but he refused this and continued to do so throughout the contact. His own case, self-diagnosed, he described as being like that of the T.B. patient who has to take great care in order to live long. "We must make an effort not to want to die," he said.

Tools and material were provided and Mr. C. started on several projects. He liked to make corn cob pipes and he liked to tie flies for fishing equipment. He took up these activities with considerable skill and interest and made some attractive and saleable models as first samples.

In interviews he reviewed his past life, his high school education, and his work in a newspaper office, where he described himself as a successful and dashing reporter. He drifted into travelling salesmanship, where his greatest business success had been. After the war he had some difficulty in securing employment. He suffered pneumonia and a 'tired heart' on one of his temporary jobs, and then applied for Old Age Assistance. He had been married for a short time, but his wife had died.

He liked to boast of his prowess in manly sports as a younger man, but his appearance and interest in his belongings indicated a feminine trait.

After the completion of his first samples, Mr. C. demanded a good deal of praise from worker and resented any suggestion or criticism she might offer with a view to making his products more marketable. He insisted that each article must be entirely his own invention, so that he might receive the whole credit for its production. Worker showed his samples in local stores and was able to elicit a limited number of orders. Mr. C. was always dissatisfied with the price he received, and was never able to follow up his initial effort by industry over any continued period of time. At the slightest criticism he was ready to give up. Lists of business contacts were supplied to him, but he made no move to follow up any of the leads supplied, although he was physically well able to reach those in his own locality. He had the ability to write letters and handle business contacts, but he made no effort to contact by mail the sporting goods outlets where he might have found a ready sale for his fishing flies.

Any small amounts he made by the sale of his first samples he used to buy himself food. But each time he appeared to be within reach of establishing a regular supplement to his income he reduced his effort as though afraid he might earn enough to be self-supporting. Although he verbalized his wish to be independent, his actions tended in the opposite direction.
Worker encouraged him to renew friendship with his sister, who had offered him transportation to her home for the vacation, but he could not make the effort to renew this family contact, easily within his reach in terms of his physical strength.

Case work contacts had continued for about a year. Mr. C. now became increasingly less active. He became increasingly critical of worker and appeared to project his own failures upon her. Worker, in closing the case, felt that little more could be accomplished, but she supplied him with a little dog to take the place of the one which he had lost. Duration of contact was one year and ten months.

**Interpretation**

Worker's diagnosis stressed the element of conflict, the client's urge to conserve his life, to be taken care of--his deep dependency was in conflict with his wish to be active, productive and masculine. Case work methods were mainly environmental and supportive, with some effort in the direction of self-knowledge. It seemed important to avoid giving client insight into his own basic insecurity, so that worker supported his defenses--his concept of his own skill and importance. His work history, even in middle years, had been only fair so that his present effort was not supported by lifetime habits of industry.

**ABSTRACT V**

Case Number Fifteen - Mr. O. - Group II

5/26/50, Mr. O. was referred by the family agency which had helped him at the time of his wife's terminal illness. At age sixty he was so broken by the strain of his wife's lingering illness and death that he told worker he felt as if he wanted to die himself.

He wondered if he were not "going crazy," he felt entirely lost. He had suffered a leg injury and retired from work. He felt himself to be a hopeless cripple and request help with planning his own funeral. He was looking for a rest home in which to end his days. He could take no action on his own behalf. He expressed fear that people would not like him; he had doubts about his religious faith.

Worker helped him to work through his grief by reliving his experience. She helped him to find a room and accompanied him to
the Old Age Home in which he had thought he would like to be institutionalized. The sight of this Home and its elderly decrepit inmates led him to change his plans.

One year after his wife's death he was still refusing to take medical care. He felt that he was going to have the pain "just as his wife did in her last lingering illness." There were days, he said, "when he just didn't feel like leaving his room--a room with four walls--but just had to in order to eat." He felt that he had nothing to live for, nothing to keep him occupied, his life was empty. Yet when worker reminded him of the interest he had shown in the group to which she had accompanied him some weeks previously, he withdrew abruptly from his suggested activity.

In early life Mr. O's affectional needs had not been met. As a boy he had run away from his home. His wife seemed to have met this need in her lifetime by mothering and nourishment and friendly fun. She was evidently supportive of him emotionally, but also found she had to go to work to supplement the family income. They had one daughter, but his wife had carried the responsibilities for the parent role in the household. Worker clarified that always in life it had been the responsibility he did not like. He accepted this as being true of himself and made an effort to pull himself up. He felt he did not need to limp as much when the "young pretty lady" who was his worker expected him to take action, but he was never quite able to achieve the goals he set himself. He expressed an interest in the volunteer work which worker suggested as a relief from his feeling of uselessness and boredom, but he was never able to start doing it.

When he was suddenly taken ill, worker asked his married daughter to take him into her home for a while, thinking that a sense of family support would promote his wish to get well. The daughter confirmed worker's interpretation of her father's need, but said that it was understandable "in terms of his life-long pattern." She added that he "never would go out in the evening, never went out of his way to make friends or ask people over. He was always fussing." This was especially true when his wife was ill (and his needs were not met). His daughter commented on the disillusionment of her mother when she had found that her husband's ambitions were only a 'facade'. She was a kindly person and was good to her father while he was ill.

Worker now concentrated her efforts in helping Mr. O. to find a room where he could be taken care of by a motherly landlady. Having done so, she tried once more, on the basis of his wish to be manly and well, to have him see a doctor. She succeeded in doing so, but her client refused to take advantage of the treatment offered, which would have considerably aided his lame condition. "I am just a stubborn old man," he said of himself, "who simply will not be helped."

The case was closed 12/52, after two years and seven months of
agency contact, the status of the withdrawal symptom being unchanged at the close of contact.

Interpretation

Case work was supportive, help being given with depressive symptoms during a prolonged period of grief reaction. Worker attempted to support client in his expressed wish to be independent and to regain his manly strength and health. When the client proved unable to take steps to fulfill his expressed wishes, the worker limited her treatment goals to finding a motherly home for him, where he could participate still to some extent in the life around him. Mr. O. rejected her offers of help in seeking his chosen claustrum, his old men's home. Diagnostically, worker attributed the long mourning period to a sense of guilt over the client's own inadequacy and failure to support his wife in her lifetime.

Worker assumed considerably more initiative and continued her interest over an extended period, but the withdrawal symptom persisted and the situation remained substantially unchanged at the close of the case.

Other cases vary from the illustrations above in respect of education and work history, as shown in Table I, Chapter IV.

Extent and severity of the withdrawal symptom also varied. The severity of the symptom could be partially gauged by the number of cases where the protective function of the agency came into operation, as summarized in Table V.

Case work methods were similar in most cases, with the modifications illustrated. An exception is noted in Case Number Five, where the case was handled by a volunteer in a relationship more closely allied to a friendship of the "Big Sister" type, direct and vigorous in its approach.
CHAPTER VI
SUMMARY AND CONCLUSIONS

The purpose of this thesis was to study fifteen cases known to the Department for Older People, Boston Family Society, active within the five-year period July 1948 to July 1953, in which the symptom of withdrawal was a major problem.

The four main questions asked were: How did the withdrawal manifest itself? What other problems were evident? What were the areas and type of social work activity? What was the status of withdrawal symptoms at the close of contact or at termination of this study?

The group was, for the most part, composed of persons between the ages of sixty and seventy-five, precipitated by the crisis of retirement into a transition period for which they were not prepared, and which they faced with anxiety and immobilizing inertia. In two-thirds of these cases, work history had been good in middle years and work a major source of satisfaction in the individual's life. The sense of loss on retirement was therefore correspondingly great.

The majority of the cases studied were isolated persons with few close relatives and friends to help them in this period of maladjustment.

The symptom of withdrawal was noted in varying degrees of intensity in all cases studied. Manifestations were noted in the area of social and physical withdrawal and also in emotional traits. In terms of social and physical withdrawal all had withdrawn from customary activities and interests, the majority had withdrawn from customary group contacts, and the more severe cases had shut themselves off from intimate relatives and friends. In all but three cases there was a decided tendency for
the individual to withdraw into the claustrum created by the four walls of his own room. In terms of emotional manifestations, withdrawal traits included, in two-thirds of the cases, regressive symptoms, marked evidence of depression, some form of mental confusion, and feelings of illness without organic basis.

Over a period averaging twenty months, the agency worker attempted to help each individual to explore his situation and to try to do something about it. "The actual facing of his problems...is required in any effective therapy."

When a situation is thoroughly understood and when there is something we can do about it, it ceases to be so fearful. Knowledge dissipates enshrouding fear, which commonly renders us helpless, much as radar enables us to see through the obscurity of fog, darkness and storm."32

Sources of anxiety discovered in these clients were the realistic basic needs of food, shelter and clothing, and also anxieties concerning health and fear of terminal illness. When the client, with the help of the worker, sought medical advice, the medical diagnosis either established the basis for a treatment plan or, as happened in most cases, proved the fear to have been unfounded. As Table IV shows, however, there were four cases in Group II where the client could not bring himself to accept help in this area. Rather than face his problem he continued to cling to his withdrawal symptom as a self-prescribed mode of conservation, involving him in no outlay of fresh effort.

Environmental and supportive techniques were employed in every case.

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Environmental help was offered in matters of housing, financial difficulty, employment, recreational and group activities.

Clarification was a method used effectively with four of the nine persons in Group I, these persons gaining considerable insight into their problems both environmental and emotional.

Case work procedures were used flexibly to meet the need created by the withdrawn condition, which rendered the client harder to reach. Modification of method was evidenced where protective measures had to be taken. A further evidence of flexibility of procedure to meet the condition of inertia was the greater activity on the part of the worker. The relationship also had an element of warmth and friendliness beyond what is usual in casework practice. The contact was also maintained over a longer period, either on the formal basis of keeping the case open and active longer, or on the basis of an informal contact maintained after closing, either through informal brief interviews or through contacts with old age group activities.

Movement was shown in nine out of the fifteen cases (Group I). In these nine the symptom of withdrawal was observed to have subsided in both emotional and physical manifestations at the time of closing of the case or at time of termination of this study. They had also accepted help in other areas of maladjustment which had been evident at intake. They were rehabilitated in the sense that they had become self-directing and participating members of the community. Three were gainfully employed, five were achieving satisfaction from a life of retirement. A source of major satisfaction to the majority of Group I was also the fact that they belonged to a group of friends of their own age. In the emo-
tional area, the withdrawal symptoms which had characterized this period of unadjustment, namely, dependency, despair, feelings of illness, daydreaming and delusion, were replaced by renewed hope and effort and a feeling of well-being and usefulness appropriate to a well-adjusted old age.

As case work help was accepted by the client in many areas of maladjustment, it would appear that case work had a major role to play in fostering this change in the lives of the nine persons in Group I of this study.

In six cases (Group II), very little movement was noted, the symptom of withdrawal remaining substantially unchanged. Some assistance was given to three individuals in this group in respect of environmental difficulty.

All fifteen cases continued to live within the community at the close of the case or at the time of termination of this study.

These findings are suggestive of further questions for study. How many older persons in the community are in a similar position to these fifteen, at a period of crisis without family and friends to help? How many can be reached by case work service? What proportion of the older population exhibits in severe degree the withdrawal symptom? How many of these can be expected to achieve readjustment without help from outside themselves? How many may be expected to drift into custodial institutions by reason of exacerbation of these and similar symptoms of senility? What resources of the community at large can be mobilized to offset this downgrade course and facilitate rehabilitation? "An effective program would
be aimed at keeping elderly persons a healthy unit within the community, out of mental hospitals." These questions are, however, beyond the scope of this thesis.

Approved:

Richard K. Conant
Dean

APPENDIX

SCHEDULE

1. Case no.:____  
2. Date opened:_____

3. Name________________  4. Age___  5a. Marital status____________

5b. Living alone____  Living with close friend or relative____

6. Referred by:  Self____  Others____  7. Reason for referral:________

Background of Client

8. Education; occupational training_______________________________

9. Work history________________________________________________

10. Family history, marriage, children______________________________

11. Events immediately prior to referral:

<table>
<thead>
<tr>
<th>Event</th>
<th>Physical withdrawal symptoms at intake:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of close friend</td>
<td>Recent pattern behaviour</td>
</tr>
<tr>
<td>Change of location</td>
<td>Old-established pattern behaviour</td>
</tr>
<tr>
<td>Retirement or relative</td>
<td></td>
</tr>
<tr>
<td>Other crisis</td>
<td></td>
</tr>
</tbody>
</table>

Withdrawal Symptoms at Intake

12. Social withdrawal from group contacts

13. Social withdrawal from family and close friends

14. Withdrawal from activity

15. Withdrawal into claustrum
Emotional withdrawal symptoms; escape mechanisms:

16. Regressive symptoms in the direction of more primitive infantile modes of behaviour
   (Workchart A items 1, 10, 11, 12, 19)

17. Depressive symptoms: extreme and prolonged dejection and discouragement over affectional or environmental loss
   (Workchart A 7, 15, 16, 17, 18)

18. Feelings of illness: physical symptom formation in the absence of serious organic disease
   (Workchart A 5)

19. Mental confusion
   (Workchart A 8, 9)

20. Feelings of suspicion and persecution
   (Workchart A 4)

21. Strongly marked guilt feelings
   (Workchart A 20)

Environmental and Health Problems at Intake

22. Anxiety re health

23. Anxiety re employment

24. Anxiety re financial support

25. Anxiety re living arrangements

Attitude of Client to Problems at Intake

26. Self-directing action Inertia

Areas of Case Work Activity

27. Emotional Health Employment Financial support Living arrangements Recreation, group contacts
SCHEDULE  
(continued)  

<table>
<thead>
<tr>
<th>Case Work Methods</th>
<th>Protective or other modifications</th>
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</thead>
<tbody>
<tr>
<td>28. Environmental</td>
<td>Supportive Clarification</td>
</tr>
</tbody>
</table>

Status at Closing or Time of Termination of Study

29. Withdrawal symptoms at closing:

- Clearly subsided
- Substantially unchanged

30. Problems of unadjustment due to environmental factors at closing:

- Improved
- Not improved

31. Attitude of client at closing:

- Self-directing
- Not self-directing

32. Date closed

33. Duration of case work contact

34. Reason for closing

35. Continuation of informal contact after closing

36. Special Features of this Case:
APPENDIX

WORKCHART A

Description of traits and characteristics observed which occurred with greatest frequency in the records. (See Appendix, p.59, for interpretation of abbreviations.)

<table>
<thead>
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<th>Case no.</th>
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<th>13</th>
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<th>Total</th>
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<tbody>
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<td>x</td>
<td>x</td>
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<td>x</td>
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<td>x</td>
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<td>x</td>
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<td>x</td>
<td>x</td>
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</tr>
<tr>
<td>3. Fear</td>
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APPENDIX

DEFINITION OF TERMS USED IN WORKCHART A

1. Extreme withdrawal: tendency to withdraw into a claustrophobic shell, to exclude external stimuli; withdrawal from object relationship of any kind.

2. Inertia: immobility, inhibiting indecision, inability to plan, skills and talents fallen into disuse.

3. Fear: generalized feeling of fear, anxiety, apprehension, doubt and panic, or more particularized anxiety as to health, etc.

4. Paranoid trends: unjustified and exaggerated fear and suspicion re assault and theft, feeling that others are plotting against one, etc.

5. Physical symptoms: with no medically proven basis, fatigue and illness—overvaluing of existing minor symptoms. Tendency to regress into minor illness in face of discouragement. Temporary impairment of speech, sight and hearing in absence of organic disease.


7. Devaluation of self: loss of self-esteem or prestige; feeling of being unwanted, worthless, unloved and rejected.

8. Mental impairment: mentally dull, disoriented in thought processes.

9. Fantasy, bizarre ideas: escape into fantasy, bizarre ideas, association with strange sects, turning to fortune tellers, mediums, etc. Wild projection of own troubles onto outside causes.

10. Orally demanding: constant insatiable requests of other people.

11. Excessive oral gratification: regression to the oral level of satisfaction—oral gratification in terms of food and drink and smoking in excess—auto-erotic self-indulgence.

12. Character changes: in a retrograde sense—restlessness, malaise, discontent, sense of frustration and confinement, quarrelsomeness, tenseness and pressure.

13. Lonely: used only where the client expressed his own recognition of the problem.

14. Lost sense of belonging: loss of sense of belonging to a family group or familiar community—accentuated by absence from early homeland or home town.

DEFINITION OF TERMS USED IN WORKCHART A
(continued)

16. **Prolonged grief reaction**: prolongation of the period of mourning for close friend or relative over an extended period so that it affects client's life and habits.

17. **Depression**: and self-annihilatory ideas.

18. **Anorexia**: not eating, unable to go out to buy food, no wish to eat (in each case where this category is used the observation was borne out by medical evidence of malnutrition).

19. **Ambivalence re dependency**: exaggerated independence or dependency or vacillation between the two ideas—usually indicating deep-seated wish and need to be dependent.

20. **Sense of guilt**: feeling that present discomfort is the result of past sin for which the subject is now being punished.
BIBLIOGRAPHY


