

1950

A study of the role of the social worker
in the Boston Floating Hospital as
reflected in twenty-four cases in which
the social worker was active

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE ROLE OF THE SOCIAL WORKER IN THE BOSTON
FLOATING HOSPITAL AS REFLECTED IN TWENTY-FOUR CASES
IN WHICH THE SOCIAL WORKER WAS ACTIVE.

A Thesis

Submitted by

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(B.A. Mount Holyoke College, 1948)

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

1950

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CHAPTER I
INTRODUCTION

The reactions of a child in the hospital away from his family often under traumatic circumstances emphasize in many cases the emotions and reactions the child has regarding his own family. In these circumstances his emotions can come to a climax.

It is of importance, therefore, in the first place, to make the period he has to stay in the hospital as pleasant as possible and in the second place to enable him to use this experience, when returning home, in the most constructive manner. To make that possible, it is necessary to know the child physically, intellectually, and emotionally and to determine what his environment is like and how he is reacting toward it. With these factors in mind it will be necessary to help him to recover from his illness physically as well as emotionally and to aid him in adjusting to his environment as far as that is possible. In order to bring this in effect cooperation is expected from the psychiatrist, the psychologist, the medical doctor, the nurses, and the social worker, if these people with different skills are all connected to a pediatric hospital.

A psychiatric unit was established in the Boston

Floating Hospital, a pediatric hospital, part of the New England Medical Center and affiliated to Tufts Medical School, in 1947. A full-time social worker was employed in 1948.

The purpose of this thesis is to make an attempt to evaluate the role of the social worker in this kind of a setting in which the emotionally or physically ill child has to be helped. The study was thought to be valuable, as a setting, as the one in the Boston Floating Hospital is new in this part of the country and not found often in other parts of the country.

In relation to the main purpose of the thesis the writer was interested in attempting to answer the following questions: In how far can the social worker as part of the team aid in treatment of the child in this setting? To answer this question the reason for referral to social service at the Boston Floating Hospital must be investigated. In how far was the psychiatric recommendation followed? What are the different skills a social worker needs in a psychiatric unit of a pediatric hospital? In how far can the community resources be used by the social worker in order to aid in treatment? What are other practices used by the social worker for further treatment? What are the factors which make the participation of the social worker

in the team successful and which factors prevent success?

Going through the entire file of cases the writer has selected 24 cases from the records of the Boston Floating Hospital psychiatric unit in which the social service was active in the years 1948 and 1949. Several limitations for making an exact evaluation of the work of the social worker in this setting have to be taken into consideration. This unit has only operated with a full-time social worker for about two years and is still in an experimental stage so that the social worker's role is not yet clearly defined. As there is lack of time, hardly any process recording is done and thus the material had to be gotten from the summaries which go into the medical record. The ultimate results in many of the cases cannot be declared as the cases are still being followed. Conclusions will not be definitive nor valid on a statistical basis as they apply only to the cases studied.

The plan of development for this study is the following: In Chapter II the agency setting will be discussed. In Chapter III an attempt is made to review the role of the social worker as found in the literature. In Chapter IV the whole group of cases will be reviewed and will give the case presentations. In Chapter V summary and conclusions will be stated.

CHAPTER II
AGENCY SETTING

The Boston Floating Hospital, part of the New England Medical Center, was a barge in Boston Harbour since 1894, designated for the care of ill babies and children under five years of age. When the barge burned in 1927, the present building was erected in the South End of Boston called the Jackson Memorial Building, but legally still the Boston Floating Hospital, and it became affiliated with Tufts Medical School. Its goal, as stated in its handbook, is "to make available a complete medical and surgical, diagnostic, and therapeutic service for babies and children."¹ The children served range in age from premature babies to fourteen-year-olds. For the fifty-six beds there are six resident physicians of which one is full time and five assistant resident physicians. Sixteen registered nurses and thirty-six student nurses are available. It has pediatric affiliations with nineteen training hospitals throughout the New England area.

In the summer of 1946, a play group was organized in the Boston Floating Hospital by the Director of Nursing

¹ The Boston Floating Hospital A Handbook for Physicians and Children p. 2.

and a skilled nursery school teacher was employed. In the summer of 1947, supported by the Ladies Committee of the Boston Floating Hospital and by funds appropriated by the trustees of the Boston Floating Hospital, the playroom was connected with Dr. Rowland G. Freeman's psychiatric clinic. In September, 1947, these two units were officially amalgamated, being supported by the Charles H. Hood Foundation, and additional grants from the Department of Mental Health of Massachusetts.

Illness in general has emotional implications for the child. In order to prevent these from developing into actual neuroses, it was felt essential that the entire staff become aware of the emotional implications faced by the child. It was also felt essential that the parent be helped in accepting the illness of the child. An extensive educational program was set up for the medical students and the nurses. Several lectures are given to these groups by the psychiatrist, the psychologist, and the social worker. A student nurse assists each week in the playroom, which is on the fourth floor of the hospital, sitting in on staff conferences and taking notes of the children's behavior. One conference per week is held with the medical students to discuss one patient or more referred to the psychiatric unit. All the children present in the hospital are seen by

the psychiatrist on medical rounds.

Three kinds of patients are referred to the psychiatric unit:

- a. Children for whom a physical illness is extraordinarily traumatic emotionally.
- b. Children referred to the Boston Floating Hospital because of physical symptoms for which no organic basis can be found; such children being observed by the psychiatric team since the diagnosis has raised questions of emotional influence.
- c. The children who are referred to the Boston Floating Hospital because of problem behavior such as enuresis or temper tantrums.

The patients may be referred by a resident physician, a staff physician, or may be discovered by members of the staff. The referral to social service may be either by another agency which wants the patient to be followed up or by the medical staff when family or environmental troubles are suspected. When the patient is referred for complete psychiatric evaluation, the following observations are made in order to treat the patient as a whole person:

- a. He is observed in the playroom through a one-way glass window and by the play supervisor.
- b. Study and evaluation are made by the psychiatrist.

- c. Mental testing is done by the psychologist.
- d. The family and environment are studied by the social worker.

The Boston Floating Hospital receives patients from all over New England and from New York State and elsewhere. The ward fee of \$11 per day will be fixed according to the income of the family if necessary and the hospital is thus able to serve all levels of the population.

When going up to the fourth floor, passing by the second and third floor wards, one is immediately impressed by the friendly atmosphere in the hospital. Often one meets little Jimmy or Mary in the hall, dressed up in blue jeans, waiting to take the elevator up to the playroom. The smaller children are all in the large playroom which is filled with the most appealing toys, doll houses, tricycles, finger paints, etc. Here the children can do whatever they feel in the mood for doing. Sometimes the new surroundings are too much for little four or five year olds and one suddenly hears loud crying. Usually the child is calmed down by the psychologist or one of the doctors. And frequently one sees the same child playing quietly for the next days or weeks depending on how long he is to be in the hospital.

Often the parents are found in the little observation

room watching the way the play supervisor handles the children. A lunch program was set up in the winter of 1950 in which the children are served lunch in the playroom when well enough. The parents and staff members can observe them as they eat, this being an important part of their behavior.

An attempt is made by studying and treating the child as a whole person to prevent rather than cure severe neuroses. Team work between the psychiatrist, the psychologist, the play supervisor, and the social worker is of utmost importance. The close cooperation of the medical staff is in most cases required and freely given. Through the lectures given to the medical staff, the medical doctors and nurses have become aware of the psychiatric unit and its importance.

All the patients accepted for complete psychiatric evaluation are patients in the hospital. In some cases they have been seen by the psychiatrist in the Children's Clinic of the Boston Dispensary and are referred by him to the hospital. Only seldom is an outpatient admitted to the psychiatric unit and then only for psychometric testing. When the child is still in the hospital the psychiatric referral is usually for diagnostic purposes. Psychometric tests are done by the clinical psychologist; the psychiatrist

interviews the child, and the parents one or more times; the social worker acquires the social history from the parents, other relatives, the school, and any other sources which can give pertinent data. The play supervisor gives a report of the child's behavior in the playroom. After the data are gathered a staff meeting is held. If it is decided that the child is to come back to the Children's Clinic of the Boston Dispensary, the case is referred to the social worker connected with the Children's Clinic. If, however, the decision is to follow the patient in the Boston Floating Hospital, then it is the responsibility of the social worker here to follow this case.

In some cases the recommendation is placement directly from the hospital. It is the social worker's task to arrange for that usually through the help of other agencies. In cooperation with the parents a decision must be made.

As was mentioned already in Chapter I, the role of the social worker is developing and growing, and her place in this setting has not been clearly defined yet. There is only one social worker in the hospital, who is responsible to the head social worker of the New England Medical Center as well as being part of the psychiatric team. As she is in charge of all cases in the hospital referred to social service, the intensive work which might otherwise be done is therefore often limited.

CHAPTER III

SURVEY OF THE LITERATURE

In order to understand better what social work in the psychiatric unit of a pediatric hospital means, it was thought of importance to investigate other related fields of social work. The work of a social worker in a psychiatric unit in a pediatric hospital is closely related to that of a social worker in a child guidance clinic, yet it also has many aspects of medical social work. Though it is impossible in this paper to cover all facets of these two fields, an attempt will be made to give an account which will supply a background for the case material which will be presented in this study. The field of social work is very young yet and still needs a great deal of expansion and experimentation. Nevertheless in the last thirty years social work with children has developed rapidly and certain definite methods and procedures have been established.

It must be remembered that all fields of social work are aimed at helping the individual adjust better to his family and to the very complicated society in which he is born. All fields of social work are aimed at helping the whole person use his personality to the greatest advantage, physically, socially, emotionally, and intellectually.

The child guidance clinic as an organized clinic was

started at the beginning of the twentieth century. The term child guidance was coined in 1922². Before that time a few attempts had been made at child guidance. In the year 1909, the Chicago Juvenile Psychopathic Institute was founded. The Judge Baker Clinic in Boston followed in 1914, and the Boston Psychopathic Hospital started in about the same time to treat children with behavior problems. Others were the Johns Hopkins Hospital and the Henry Phipps Psychopathic Hospital. Before the child guidance clinic took its own distinctive form, only the symptom was treated. The cure was thought to be complete when the deviation was ended³. The entire philosophy has now changed. The behavior deviation is thought of as an inseparable part of the individual's total functioning. The case can be dealt with most effectively by understanding the interplay of conflicting stresses and by relieving the tensions to which they give rise. In other words, the aim is to modify the controlling patterns of the reaction.

Since the beginning of this century many articles and books have been written about this subject. Leading magazines in the social work and psychiatric field such as *The Family*, *The Newsletter of the American Association of*

2 George Stevenson and Geddes Smith, Child Guidance Clinics, a Quarter Century of Development, N. Y.:1939 p. 19

3 Ibidem p. 61

Psychiatric Social Workers, and The Journal of Psychiatry have published articles touching on some aspects of this subject.

The child guidance clinic is an attempt to marshal the resources of the community in behalf of children who are in distress because of unsatisfied inner needs, or are seriously at odds with their environment; children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior, or inability to cope with social and scholastic expectations⁴.

Child guidance "deals with individuals at a time when they are dependent upon their surroundings when ways of reacting--patterns of behavior are being formed⁵." The child may express this difficulty of adjustment by temper tantrums, enuresis, by being withdrawn, or any other kind of a social behavior.

The tasks, then, of this kind of agency is to study and treat patients, to interest other community agencies, and by treating individual children to reveal to the community needs of groups of children. Also the training of psychiatrists is of importance. And as a last task the child guidance clinic has to do research in order to improve its procedures.

4 Ibidem

5 Lois M. French, Psychiatric Social Work, N. Y. 1945 p. 121

We will very often see that the child's warped relationship with the parent may lead the parent to the child guidance clinic. Treatment of the child is of importance but at the same time treatment of the parent is equally important, if not more so.

As it is impossible to treat either parent or child in a vacuum, it is best to treat both, having the same goal in mind for both, namely, to give security in parenthood and to give the parent complete freedom from fear and anxiety⁶. At the same time the child's feeling of security should be fostered so that warmth and love are found in an adult, who may be at first the therapist. Later this feeling should be transferred to the parents.

Psychiatric social case work with children has concentrated, primarily, upon work with the child's environment. This includes his play, his school, his friends, his interests as well as his family life--the forces representative of the child's externalization of self⁷.

Analysis of the environment will help the psychiatrist uncover the child's inner emotional and mental life. Often the neurotic parent will need supportive therapy. Even though the social worker may see other emotional tension in

6 Ruth Walton, Trends in Treatment Practice, Newsletter Autumn, 1941, p. 221

7 Nolan D. C. Lewis, M.D. and Bernard L. Pacella, M.D. Modern Trends in Child Psychiatry p. 319

the parent's life, case work should be focussed on his relationship with the child. This does not mean that the caseworker should carefully avoid touching the parent's difficulties. Nevertheless when the parent's own difficulties are discussed, this should always be done with the child's well-being in mind.

Here we touch on another much discussed subject, namely, the importance of team work. Dr. Van Ophuyzen discusses this in the pamphlet of the Jewish Board of Guardians⁸. At first it was assumed that the social worker's job was entirely different from that of the psychiatrist. "Suspicion permeated the atmosphere on every occasion in which caseworker and psychiatrist had to collaborate." It was only in the 1930's that some attempt was made to find a way of cooperation. And nowadays close team work is expected. Dr. Van Ophuyzen's first impression of the work of the social worker was to "indicate a special kind of intelligent methodical and devoted effort on the part of the caseworkers to improve the behavior of those children and adolescents who appeared to be in constant conflict with their homes, schools, and neighborhood environments⁹".

⁸ Jewish Board of Guardians, The Case Worker in Psychotherapy p. 10 - 15

⁹ Ibid.

In a child guidance clinic it is thought most desirable to have one psychiatrist who is the director of the agency, one psychologist, and two or three social workers. Adolph Meyer compared this kind of teamwork to a tripod, a little chair supported by three legs. If any of the legs should be taken away, the chair would be unable to stand up. In other words, the teamwork should be "not a compromise between three points of view but a unified interpretation and plan of treatment in which the contribution of each profession should be merged¹⁰".

In general the social worker's task is:

1. To study case situations and by taking the social history and investigating the environment complement the examinations by the psychiatrist.
2. To effect changes in the environment...to this end familiarize herself with all public and private social welfare and educational facilities in the district in which the clinic or hospital operates.
3. To secure the cooperation of other social agencies.
4. To effect changes in or modify attitudes of patients and more particularly their relatives, in order that changes in the environment and the advice of the psychiatrist may be accepted and followed regarding their attitudes and activities as related to the problems in the case situations¹¹.

Yet the social worker works under the guidance of a psychiatrist:

¹⁰ George S. Stevenson and Geddes Smith,
op. cit. p. 108

¹¹ Lois Meredith French Psychiatric Social Work N. Y. Family Service Association, 1945

1. The psychiatrist retains full responsibility for the activity of the psychiatric social worker and yet delegates to her that part of the casework which the psychiatric social worker has evolved as a separate but closely allied field of activity.
2. The psychiatrist and the social worker confer frequently.
3. The psychiatric social worker reviews all the work done on a case in relation to the social needs¹².

A child guidance clinic usually takes on children with normal intelligence, where we find emotional imbalance either in the children or in the parents, educational maladjustment, and destructive influences. Children who have more serious problems, such as mental defectives, epileptics, or children with other neurological organic handicaps in general cannot be taken on by the child guidance clinic. It is often the social worker who is in charge of intake. In general the children are referred by the school, the family physician, or the parents themselves. It is then the task of the social worker to interpret the agency's function to the parent.

The social history which is acquired by the social worker in the first few contacts aids the psychiatrist in diagnosing a case. Also, the environmental factors will be of importance in the recommendations he will make.

¹² Ibid.

Often the case is treated entirely by the social caseworker who acts as agent of the team and therefore depends a great deal on these staff conferences. The case may be closed when the situation seems alleviated and the goals seem to be reached.

The psychiatric social worker in a child guidance clinic thus has the following tasks:

1. To decide which clients may be accepted for treatment within limits.
2. To take the social history.
3. In conjunction with the psychiatric team to aid in diagnosing the case and making a plan of treatment.
4. To manipulate the environment: (a.) by casework with the parents; (b.) by referral to other agencies which might be helpful in the case.
5. To do therapy with the child under guidance of the psychiatrist.
6. To attend regular staff conferences to evaluate the case.

Until now the medical and psychiatric social work profession were thought of as being more or less distinctive groups. The medical social worker's task was to assist the medical doctor and to facilitate hospital treatment and convalescent care. Her task was:

1. To facilitate admission to the hospital or clinic.
2. To bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment.
3. To assist patients in carrying out treatment.
4. To interpret the treatment to family and community and patients.

5. To make social investigations contributing to medical social records¹³.

Yet the medical social worker's task is not far removed from that of the worker in a child guidance clinic when she is working with the families of ill children. She must have an understanding of the dynamics in a case in particular where the child is using illness as a means of getting certain satisfactions.

"Disturbances in parent-child relationships may serve as contributory cause of the development of illness or of continued disability of the child. The child caught in an atmosphere of emotional conflicts sets up various defense mechanisms to handle the anxiety created by the family tensions. An escape into illness may be the child's only way of handling pressures that are too heavy for him to bear¹⁴."

On the other hand when a child with a secure environment is ill, he can weather most storms. Anxiety may be found in the parents who fail to grasp the doctor's explanation of the illness¹⁵. It is the social worker's task to give a more full explanation. The social worker in both cases will have to understand and interpret the diagnosis, the medical

¹³ Harriet M. Bartlett, Emotional Elements in Illness, Responsibilities of the Medical Social Worker, The Family, April, 1940

¹⁴ Frances A. Upham, Dynamic Approach to Illness, A Social Worker's Guide, N. Y., Family Association of America, 1949 p. 54

¹⁵ Ibidem p. 72

care required for the patient, the prognosis, and the resources available for the best care for the special case. The social worker should reduce anxiety the parents might have. At all times it is necessary to encourage participation in planning of the patient or in case of a child of the parents.

Casework in some cases will necessitate aiding the child in giving up the illness when used for neurotic ends. In convalescent planning the social worker should help find the best place for the child when coming out of the hospital. When he needs convalescent care away from his own home, his age must be taken into consideration. When a very young child foster home care is generally better. The separation from the mother will be less acute. When an older child, he can be placed in a larger convalescent home or group placement. The social worker has to plan carefully for the child's schooling when he is convalescing or when he has a chronic illness on a physical and emotional basis. Other factors have to be taken into consideration; these will differ in each individual case. Some of these factors will be financial help, acquiring of braces, or transportation, etc.

The social worker will run into entirely different problems when she has to deal with cases that create social or educational difficulties, such as epilepsy, mental

retardation, or congenital handicaps. Here the parental attitudes may be rejecting or overprotecting, which may be due to feeling of guilt. It is the social worker's task to face the conditions with the parent and interpret it to them. Sometimes the parents do not want to accept the diagnosis and in that case the social worker has the difficult task to see that through with them.

In these cases the social worker will need to know the resources which will provide care for children with the abovementioned defects and also here careful planning is required.

It is Dr. Deutsch's suggestion that we combine these two different functions into the "psychosomatic social worker." "Psychosomatic medicine is the systematized knowledge of how to study bodily functions in which emotional processes are associated and amalgamated with organic processes to form a complex of specific patterns and the treatment thereof¹⁶."

It is interesting to note that certain personalities who cannot cope with actual situations may develop organic illness. "Organic neurosis is the pathological psychosomatic expression of the interrelationship between the organic

¹⁶ Felix Deutsch, Social Service and Psychosomatic Medicine, 1945, p. 9

processes and the emotions¹⁷." The essential emotional factors are desires and forceful wishes which are either rejected or suppressed because of contradiction of reality. Then follows condemnation of these desires plus fears and guilt feelings regarding gratification of desires. At last punishment for the desires and wishes in the form of pain follows. Here the social worker's task is significant in helping the doctor diagnose the case. She should find out the patient's illness as interrelated with the environment, the emotional factors, and the external factors. In order to test the patient's memory the social worker should verify his data concerning the different important occurrences in his life. Another important factor is a description of his attitude and that of the environment, the bodily habits of persons in the environment, and the psychosomatic factors which could be responsible for the illness¹⁸. It is often true that an illness is said to be inherited. Though this may be true in part, yet it might also be possible that there is identification with the ill father or mother. The patient gets a certain amount of gratification from being ill. He gets more attention and is able to regress to the early stages of childhood when somebody took constant care of him

17 Ibidem p. 10

18 Ibidem p. 15

and thus give up the struggle with the reality of the situation. In psychosomatic illness therefore we see that the relationship with the social worker or the medical doctor can bring forth a new identification and may be a factor in the patient's cure.

The child when in the hospital will be given a completely secure environment and gradually be re-educated to independence in so far as his age allows. It is important that the entire staff cooperates toward towards this goal, so that a therapeutic environment is extended for the child.

In the hospital the parents are seldom seen by the social worker first, but by the doctor. If, however, the child is then referred to the clinic, the social worker must deal with parents who, instead of knowing what their child's illness signifies, are doubly anxious and confused. In general the parents will not accept the idea that their child can have anything else but a physical illness. Otherwise, this referral seems to mean to the father or mother that he or she has been an inadequate parent. The social worker's job is to reassure the parents and interpret the illness of the child to them.

In summary we see then that different skills are required of the child guidance worker, the medical social worker, and the "psychosomatic" worker. Yet basically the

skills are the same in either setting. The caseworker should be able to meet the different problems.

(a.) The social worker in child guidance participates actively in the psychiatric team. Her task is divided between intake, history taking, and manipulating of the environment in order to further a cure. Often she does therapy herself under the close supervision of the psychiatrist.

(b.) The medical social worker will aid the medical doctor in data finding and the patient in discussing his illness with him and what it will mean economically and socially. She will assist in hospitalization, convalescent care, and in his returning to society and will interpret to the doctor the problems involved.

(c.) The "psychosomatic" worker will have a combination of these two jobs. History taking will be of the utmost importance. Manipulation of the environment will be essential in many cases and in hospitalization, convalescent care, and returning to society is of great importance.

CHAPTER IV
REVIEW OF THE CASES STUDIED.

Before presenting the cases it is necessary to review the twenty-four cases as a whole. As there are only twenty-four cases the findings will not have a statistical value. Yet, it is of interest to see what the problems were in these cases and what was done about the problems by the social worker as a member of the psychiatric team and as a medical social worker in some of the cases. Reasons for referral, possible causes and the function of the social worker will be discussed in this chapter. The twenty four cases referred for social service can be divided into four main groups.

- a. The group in which the patients with physical ailments were referred for a complete psychiatric evaluation or merely to social service because the parents were over-anxious about their child's illness, or because the child had special difficulty in adjusting to the hospital routine. Six referrals fall into this group. One child, a two year old girl with pyelitis, was referred because of difficulty in adjusting to the hospital routine. Five patients were referred because of over-anxiety

in the parents caused by the illness. Their ages ranged from two to thirteen years. The diagnoses in these cases had a wide range: diabetes, epilepsy, severe atopic eczema, chronic bronchitis, and one boy was in the hospital three times because he was a bleeder.

- b. The group in which the children were referred with symptoms of unknown origin or with a question of a definite diagnosis. Nine cases fall in this group. Every single one of the patients had developed their symptoms because of a maladjustment at home. Five of these patients were referred with a question of a definite diagnosis, such as nephrosis, rheumatic fever, hyper-thyroidism, fracture of the pelvis. Four referrals because of symptoms of unknown origin, such as abdominal pain, failure to gain weight, pallor, and migratory pains. After all medical tests were performed and came out negative the child was referred for a complete psychiatric evaluation. The ages ranged from two to eleven years.
- c. A third group was composed of four patients which were referred to the Boston Floating Hospital because of emotional problems. One child, a ten year old boy was referred because of school failure,

two children because of problem behavior. Of these two patients one was an eleven year old girl who was referred for enuresis, but later was found to have nephrosis. One case was referred to social service because the premature baby was illegitimate. The emotional problem of the mother had to be worked through.

- d. Four patients were referred because of mental deficiency. One patient, a nine year old girl, was referred for rigidity and peculiar habits. After a year of placement it was decided that she was also mentally deficient. The four patients who were referred for mental deficiency were all under five years of age, the youngest being twenty months.

So it is noted that there are four main reasons for referral to the psychiatric service or to the social worker: the children with actual physical illness; the children with symptoms of unknown origin; the children with emotional problems; and the children who are mentally deficient.

When reviewing the cases, usually the family picture was significant in the problem. Most interesting is the fact that eighteen children were "only children." Of these two were living with their mother only; one because of death of

the father and one because of separation of the parents. In four cases the parents were over-anxious and in one the mother was particularly anxious. In four cases where the parents were over-anxious it was brought on by the illness of the child, as one had a diagnosis of epilepsy and another excessive bleeding. In one the illness of the child which was abdominal pain was for a great deal caused by the over-anxiety of the parents. One was a pure behavior problem. The cases where the mother only was over-anxious the child had gastro-intestinal complaints. The other case the child had migratory pains of unknown origin.

In these eight cases, in which the main problem was over-concern of the parents, which either brought on the illness or had a cause in a real illness, the following methods of casework were used: In one case, that of the epileptic child, only a social history was made and an attempt was made to reassure the parents in this one contact. In five cases there was a short-term contact with only three or four interviews in the office or in the home. In all five some improvement was noted. In one case where the father had died and the child had bronchitis, intensive casework was done with the mother with weekly contacts. In one of these eight cases intensive casework was accomplished in letter form because of the distance. Both were successful. One

mother was given help with convalescent care.

Of the twenty-four cases there were two in which the main reason for the problem was sibling rivalry. One was an adopted child, who had pallor and failure to gain as soon as a second child was born. Another expressed his feelings in enuresis. Both cases were helped by the social worker through correspondence, as the distance was too great for personal contacts.

Two cases were school failures, one in all subjects and the other only in reading; the first child came from a large family, who were indifferent towards the boy, attempts to give the mother some insight failed. The second case was a success as the child was referred to a camp where there was a reading teacher and the mother was able to release her feelings.

The problems of two patients were caused by inadequate homes; one patient had a behavior problem, the other developed abdominal pains. The first was helped by referral to a child guidance clinic, the second to the Children's Aid, who in turn referred it to the Society for the Prevention of Cruelty to Children.

In one case tiredness was caused by the situation at home where the parents were incompatible. A camp referral was made here.

There were five cases of mental deficiency, as discussed in referrals. In one a referral to another agency was made; in cooperation with that agency the child was placed in an institution. In this same case casework was done with the family. In three cases casework was done with the mother in order to give her a greater ability to accept the child. In one case a social history only was taken as the parents were well-adjusted and accepted the child.

The group of children ranged in age between newborn babies and thirteen years of age. There were fourteen boys and ten girls in this group. The I.Q.'s ranged from mental deficiency to bright normal.

In order to understand the function of the social worker better the psychiatric recommendations for the twenty-four cases will be discussed briefly here, keeping in mind why the patients were referred and what the actual cause was for their symptoms.

In Group A the six patients with a diagnosis of an actual physical illness was one recommendation of placement in a foster home, one placement in a convalescent home and all six cases should have casework done with the parents.

In two of the cases in Group B camp placement was recommended. One case was to be referred to a child guidance clinic as the problem in the child was too deep and the

Boston Floating Hospital has not the capacity to treat that kind of a case.

One case was referred to the clinical psychologist for psychotherapy, the same patient went to camp on recommendation of the psychiatrist. Again supportive casework was recommended with the family in all cases.

In Group C two of the cases were considered "medical" and thus there was no psychiatric recommendation. One boy with a behavior problem was to be referred to a treatment camp. In the case of the school failure, casework with the parents and interpretation to the school was recommended.

In two of the mental deficiency cases the new "shunt" operation was recommended and in three cases eventual institutionalization of the patient. In all cases reassurance of the parents was necessary.

Thirteen cases will be presented which describe in how far the social worker could follow the recommendations and where limitations were met.

The cases studied were classified according to the work the social worker did, rather than according to medical diagnosis. Though it is an artificial classification, yet, it will give somewhat of a picture of the work of the social worker in this kind of setting. There is one group of patients for which the diagnosis was chosen as classification,

namely, the mentally deficient as this is a group set apart from the rest of the patients. Five patients were found to belong in this classification.

T The rest of the cases were divided according to main groups

- A. The cases in which casework with the parents was done.
- B. The cases in which only a social history was taken or where there was a very short contact.
- C. The cases which were referred to another agency or a camp and where no further casework was done.
- D. The cases which were referred to a convalescent home and where additional casework was done.
- E. The cases of mentally deficient children.

Group A is sub-divided:

- 1. Long-term casework with both or one parent with personal interviews.
- 2. Long term casework by means of correspondence.
- 3. Short-term casework with the mother or both parents.

In this chapter one or two cases in each group will be presented in order to give an adequate picture of the problems the social worker at the Boston Floating Hospital meets and the way in which these problems are solved.

An attempt has been made to give the following in-

formation so far as known for each case presented:

1. Reason for referral of the patient.
2. Social history and family background of the patient.
3. The psychometric testing done.
4. The psychiatrist's recommendation.
5. The role of the social worker in the case.

Group A. Casework with the parents.

1. Long-term casework with both or one parent is shown in four cases of the twenty-four studied which had long-term casework, three of which in cooperation with the psychiatric team and one after referral by the medical doctor for follow-up. Two of the four cases will be presented. In the first the mother was worked with intensively and several community agencies were enlisted in aiding in treatment. In the second case work was done by the social worker only, as it was not a psychiatric case. The third case is similar to the first in so far that the psychiatric team cooperated in treating the patient.

Case I.

Arthur, a seven and a half year old boy, was referred to the Boston Floating Hospital by the Deaconess Hospital in December, 1949, as there was a question of bronchiectasis. The social worker at Deaconess Hospital referred mother to social service, as she thought there was emotional complications. Contact was established immediately. Arthur's father had

died two years previously. Mother and Arthur live in a town near Boston in a slum area in a two-room apartment. Mother is on A.D.C. Arthur, who had according to the mother always been ill since his birth, is a frail, quite attractive, blue-eyed boy who is very hostile. The psychiatrist who saw the boy on the ward was interested in him, and it was decided after discharge to have him back on an ambulatory basis. This was told to the mother. She had had some contact with the Lynn Child Guidance Clinic, but she thought that Arthur's trouble was completely physical. She wrote a letter to the medical doctor that she was thankful for what he had done but that she did not want to make use of the psychiatric service. A conference was organized with the social worker of the Deaconess Hospital, and it was decided that Arthur was to come back on a physical basis, as there was still a question of Rheumatic Fever. The psychiatrist was simply interested in seeing all patients, it was to be told her.

Arthur came back. At this time mother could accept that there might be an emotional problem.

Mother told her life's story to worker which is in short the following: Maternal grandfather left maternal grandmother with six children while she was pregnant with mother. Maternal grandmother lost her eyesight for about a year and had a cancerous skin disease. Mother used to take care of her up to her death. The last four years she suffered with tuberculosis. Mother had hardly any friend and was never in good health. She contracted tuberculosis when she was eleven and had to leave school. She was somewhat better when thirteen and could take small jobs. She had to go into a sanatorium at twenty-one and stayed there for two years.

After she came out of the sanatorium she had several jobs, among others as cashier in a large cafeteria. She had several rich attractive boy friends but she decided to marry father, who was much older and suffered from angina pectoris and cancer. He had

lost all his money in the depression and had two grown sons who had been to college. All she did during her marriage was take care of the sick father. He was on the danger list all the time she was pregnant. He idolized Arthur and together they would be against her--both had very bad temper tantrums.

The mother was seen by the social worker weekly. She was given an opportunity to talk all her problems over. The worker referred her to the Family Agency for financial aid and the worker had several contacts with the A.D.C. worker, who was very understanding and cooperative.

Arthur came into the hospital several times with "high fevers" (according to the mother, but when he came in no fever was found.) He was sent for a month to a convalescent home, partly to give mother a rest, with eventual placement in a foster home in mind. Worker made a visit to the convalescent home. Arthur had no physical symptoms in the convalescent home. Mother refused foster placement and recommendation was to wait until mother would ask for it herself.

A month later mother brought Arthur in for vomiting. She stated at that time that he was "a hateful boy" and described his tantrums. When the symptoms were cured, he went back home and was able to go to school. About two weeks later mother brought him back, stating that he had a 103° temperature.

A good foster home had been found by the social worker of the Family Agency and mother was given the choice of putting him there on a trial basis. The reasons were: (1.) he could identify there with a father figure; (2.) he would have better air; (3.) he would be able to get individual attention in school. Mother went out to see the home but refused, as she could not bear to be separated from him. She would consider a camp placement for him. She is still being seen weekly and realizes that she needs psychiatric help. The minister is also very interested in the mother and

has sought contact with the Boston Floating Hospital. Mother has frequent pains in her chest and had started physical examination with support of the social worker. She thought that she had angina like her husband. At the moment she is unwilling to go through with the examination, as she feels that Arthur's well-being is more important than hers.

Arthur, who is of superior intelligence is not passing in the first grade and the worker has gone to the school several times.

The new recommendation of the psychiatrist is to place him through the Children's Mission to Children on the basis of his medical health. A letter has been sent out to the Children's Mission to Children and the placement will be discussed with the mother. Intensive casework has been done for six months and will be continued for an indefinite time.

Comment. Casework in this case was done in the following manner: Contact was established because of the referral to social service by the social worker of the Deaconess Hospital. Also the psychiatrist who sees most children in the hospital referred him to social service. It was in cooperation with the social service of the Deaconess Hospital that the mother was convinced that she should come back to the Boston Floating Hospital. The mother has been seen every week and casework has been done with her on a supportive basis.

Other agencies cooperating were the convalescent home and the family agency, the first by providing Arthur with a different environment in which he was given the opportunity to develop physically and mentally, the latter by giving

material aid and providing a foster home. The last agency enlisted is the Tuberculosis Association. The mother asked for Arthur's placement in their preventorium, as she remembered her own stay at a sanatorium, she could accept the same for Arthur.

Many staff meetings have been held on this case and the team work has been very good, each member contributing to helping the mother understand that Arthur would be better off away from her for a while. Other community agencies also are cooperating, the school teacher, and superintendent of the school have been interested by the social worker to help Arthur pass to the second grade. The minister has had several discussions with the social worker by telephone; he, too, is interested in helping Arthur as well as his mother.

This case is a good example of community cooperation on the one side and giving supportive casework on the other side, by having the mother talk about her problems to the social worker.

Lacking in this case is the fact that no psychotherapy has been done with Arthur. It still remains to be seen if manipulation of his environment will be adequate. Yet, it seems necessary that something more should be done, as Arthur's personality had been severely damaged by the absence of emotional stability on the part of the mother as

well as of his father.

Through regular contacts with the mother with the social worker and the psychiatrist, she has gained some insight into Arthur's condition. While at first she could only accept that his condition was purely physical, she is beginning to accept that his symptoms might be caused by emotional strains.

Case II.

Joe was referred to the Boston Floating Hospital as a premature baby in the summer of 1949. The case was referred to social service as the mother had several emotional and environmental problems. Mother, 36, looks like an eighteen year old girl. She was married fifteen years ago. Her husband is now in jail for an indefinite time. There is one boy age eleven from this marriage. Mother, who lives with maternal grandfather, maternal aunt, and uncle in a four-room apartment, had an illegitimate child five years ago and A.D.C. was refused her. Finally after much time and taking the father to court she was granted A.D.C. Now Joe was born and again mother was taken off A.D.C. on the basis that she was an unfit mother and given general relief. Mother did as well as she could; all three children are well-cared for and seem well-adjusted. Worker worked for many months to get mother to appeal the refusal. She did not want to and the time limit was past. Again worker wanted mother to apply. When the refusal came back in February, 1950, worker took mother to the A.D.C. office to appeal. The A.D.C. worker said in front of many other people that mother was immoral and that her children would be better off in a foster home. Mother had gone out of the office. When worker came out, she stood crying like a little girl. At this point she could get rid of all her bitterness. She was able to tell worker how hard

it was for her to bring up three children alone and that she knew she had done wrong, but that she had to suffer very much. Yet, she would never give up her children.

At the fair hearing in March, 1950, the mother seemed to have much matured. Not only did this show in her way of dressing, but she was able to answer questions in a poised manner. Two months later answer was received that mother would receive A.D.C., retroactive until January first. A plan was made to refer her to the Family Service. She made a contact easily.

Comment. The social worker had a two-fold interest in getting A.D.C. for the mother. One, it would enable the mother to provide better care for her three children and also it seemed that it was necessary to pull the local board out of their old-fashioned idea of immorality. As the reply of the State Board was favorable, it is possible to say that these goals have been reached. Also the mother has gained a feeling of self-respect. This was accomplished by the social worker's repeated reassurance that the hospital was on her side and that the medical doctor, as well as the nurse and the social worker felt that she was a good mother. Also reassurance was given her that her children did not have to go to foster homes. At the same time the traumatic experience at the A.D.C. office gave her an opportunity to talk to the worker. The contact with the Boston Floating Hospital social worker enabled her to establish a contact at the Family Society.

The work done in this case was mainly supportive. Through this the mother gained some insight into her behavior and was enabled to establish a contact with the Family Society, so that the role of the social worker in this case was to help the mother overcome her shyness and to move on towards wanting more support.

2. The second sub-group of these cases is represented by three cases in which long-term casework was done by means of correspondence with the mother under guidance of the consulting psychiatrist. Two cases were successful; in one of these the social worker worked with the mother on the child's problem, while the psychiatrist worked with her on the marital situation. The third case was only partly successful, as the home situation and the mother's own problem were too difficult.

Case III.

Ronnie, a two year and eight months old boy, was referred in January, 1949, to the Boston Floating Hospital for pallor and failure to gain. He vomited once or twice a day and had anorexia. He was in the Hospital for nine days during which time the social worker had one contact with the father and two with the mother and the family friend, who was the next door neighbour, in order to get a general picture of the boy's problem.

The parents had adopted the boy a year previous to his admittance to the hospital. His history had been one of deprivation; he had been sent from one foster home to the other.

The father, a professional man, not in Massachusetts, was a weak individual, who had been pampered throughout his life. He suffered from diabetes. The mother, a highly intelligent woman, was very nervous. The couple had been unable to have children, the mother told the social worker, because of her infantilism, while the father told the psychiatrist that it was because he was impotent. The mother, who had a severe skin irritation, was hardly able to sit. At a hospital where she had gone she had been treated merely for the symptoms. The psychiatrist at the Boston Floating Hospital attributed this skin condition to the inadequate marital situation.

While the psychiatrist tried to help the parents with their marital situation, the recommendation to the social worker was to do casework with the mother on a supportive basis. Though there was a minor organic symptom, namely, the malfunctioning of the pancreas, this could be discarded as the cause for his behavior. An appeal was made to the mother's intelligence and narcissism in caring for Ronnie.

As the distance was too great for personal interviews with the mother, a correspondence was started by the social worker. About two weeks after discharge in February of Ronnie a letter was sent by the social worker. A few days later an answer was received from the mother in which she reported in detail on Ronnie's behavior. Marked progress was seen. The baby sister, Gaby, was given a different room, and though he was still aggressive toward her, this aggressiveness was less marked. His appetite was better.

About ten days later the social worker wrote a letter again, this time asking if the parents could come in to bring Ronnie for an appointment with the psychiatrist. The reply was that Ronnie had made more progress, and the mother hoped that the appointment did not mean anything bad. Later a letter was received again, saying that it was impossible for them to come. Ronnie was very active now and was into everything. He showed a tinge of protectiveness toward

baby.

A month later the mother wrote again. This time she asked advice as it was impossible for her to cope with the problem of Ronnie's unwillingness to go to the bathroom for anything. The social worker advised the parents to keep a chart of when Ronnie soiled, what exactly precipitated his soiling, so that she could show the chart later to the doctor.

In six weeks nothing was heard from the parents and the social worker wrote to them again, asking if no news meant good news? A week later a letter was received from the mother, stating that Ronnie was doing much better. The neighbours came to the mother now to ask for advice with their children. The social worker praised the mother for having handled Ronnie so beautifully. Also, the marital problem had cleared somewhat. The parents were supposed to come in for another check-up, but the record does not report that they did.

About a year later the case was closed, as everything seemed to have improved. Yet, the way was left open for the parents to come back if they needed to. The letter writing back and forth lasted about five months.

Comment. The psychiatrist's recommendations of supportive therapy of the mother was followed by the social worker by letter, as the distance was too great. The mother responded very well to suggestions from the social worker and was open to praise. The contact established with both parents in the hospital was continued in this letter form.

The problem was mainly due to over-anxiety and rejection on the part of the mother and sibling rivalry, which had a realistic basis on the part of Ronnie. The physio-

logical problem was only a minor one. The mother could release her anxiety by writing to the social worker (a mother-figure). She could understand the sibling rivalry and relieve that somewhat by taking the baby out of the room. Also, it appealed to her intelligence to have success with Ronnie and to her narcissism to have the neighbours ask her advice. Teamwork is illustrated in this case; the social worker, namely, could support the mother in care for the children, while the psychiatrist helped both parents in their marital relationship. If anything was done with Ronnie on a therapeutic level, except for manipulation of the environment, it is unknown to the writer, as it was not in the record.

Case IV.

John, an eleven year old boy, was referred to the Boston Floating Hospital because of abdominal pains. No organic causes were found. These had started two and a half months before entry into the hospital when he hurt himself in the school gym. He went home with nausea and vomiting and abdominal pains, the latter returning every three days. When he has the pain, he would not eat for fear of having more pain. He had a great fear of crowds, such as in church, but he enjoyed skiing and skating. In the hospital he was cooperative for twelve hours after which he expressed a desire to leave.

He was given several psychometric tests--such as the Stanford-Binet, the Wechsler-Bellevue, the Healy, and the H.T.P. Test. The test showed that he had a high average intelligence and the H.T.P. brought forth that he rejected and retreated into illness.

The social history was reported by the mother in office interviews. The family is well off. They live in a duplex house in Maine. The father is a general contractor who has worked day and night for the last five or six years. He is a healthy man who loves hunting and fishing. He does not understand John at all. Yet, he likes to spend some time with John and takes him out on Sundays for breakfast to let mother sleep longer. Mother finished high school and worked as a stenographer for seventeen years before and after her marriage until three years prior to John's birth. Mother had nephritis when John was five after having lost a baby girl. A woman friend who lived next door was always interested in the family and mother was able to tell her her troubles. She could also spend a great deal of time at her house. At three years of age John swore like a trooper. He was quite upset three years ago when a cousin got divorced and John was afraid his parents would do the same thing.

Mother was oversolicitous of John's illness. The mother saw that the abdominal pains coincided with fright and excitement. He was sick two days before school started and had the flu at Christmas.

The psychiatric recommendation was that John was socially and emotionally retarded, as shown in his extreme attachment to the mother, his fear of needles and haircuts. It was of great importance that work be done with the mother to show her first, that John can grow up and, second, that it will be more fun for him to give up his dependence upon her. On leaving the hospital the mother said that, backed up by the hospital, she felt she could be firmer now with John, who, she had said earlier, "she knew he was spoiled."

Since the family lived so far away, it was thought best to continue the contact by mail. There was frequent correspondence between the mother and the social worker from January to June, 1949. It was very surprising that the mother, who had been quite reticent in the interviews, expressed herself very

well by mail. Eventually, though he still complained of stomachaches, mother could get John to go to school. Mother told the teacher and children that there was nothing wrong with John. The social worker responded to that that, "though there was nothing wrong", he could still feel a real pain. Mother saw also that it was better to get an attitude of "help yourself instead of I'll get it for you." He did much better in school and developed a good relationship with the father. After a while the mother wrote that she really needed help herself and asked for advice with her home troubles. Then, until November nothing was heard from mother. After that she wrote that John went to camp and did very well. Mother was very thankful for suggestions given.

Comment. Most interesting in this case is that supportive casework could be done by letter. The mother was really eager to receive suggestions and was very able in describing John's problems, so that a real picture was obtained. The contact was kept as long as the mother wanted it to and a follow-up letter was sent four months after the mother had not written. It is not known if an answer was received.

In this case it is clear that the mother gained some insight into her relationship with her son, because she was able to put her thoughts on paper (in this case the equivalent of talking to the social worker) and she got serious advice and praise in return.

3. The next subgroup is represented by five cases in which there was a short-term contact. Three cases were in so far successful that the symptoms of the patients

disappeared. In two of these cases there was a real problem, one of diabetes, one of an excessive bleeding tendency, which was met by the parents by overprotection of the child. In both cases the social worker succeeded in giving the parents some insight and helping them to enable the child to be more independent. Of the first three cases mentioned, in one the goal was to enable the mother herself to be less dependent upon the maternal grandmother. There was some success. In one case the contact was too short to accomplish anything, and in the third case, which was a patient with eczema, it was a case where supportive work was done with the mother.

Two cases in this group will be presented; one in which there was a real problem which had to be faced by the parents, and one in which the illness was caused by the parent's overprotection.

Case V.

Eugene, an eleven and a half year old boy, was referred because of diabetic acidosis. He had lost weight after having been put on globulin insulin, had pain at his heart, and vomited. It was extremely difficult to rouse him. He was found to be poorly developed and ill-nourished. As there seemed to be emotional factors, he was referred to the psychiatric unit.

He is the eighth of thirteen children, ranging from twenty-three to three years of age. His nineteen year old sister gives him his insulin, because it hurts least when she does it. Father is a foreman in a machine company and he makes \$72.00 a week. Father lets Eugene taste for-

bidden foods, He also eats cookies, in school-- gum and sugar. The last two months he has been seen in bad company. In general, he is unco-operative toward restrictions.

The social worker had an interview with the mother and also with the school superintendent. Manipulation of environment was thought necessary in order to give him legitimate opportunities within the limits of his ability. His abilities were explained to the school principal by the social worker, and it was decided that he could be on the school team if he were qualified enough. As he was interested in art, an art class was advised. The principal was interested, and the parents were greatly concerned.

The case was closed due to the fact that the family lived at too great a distance from the Boston Floating Hospital.

Comment. Most important for the social worker in this case was to "manipulate" the environment. This was done by helping the parents understand what diabetes means to a boy of Eugene's age. Also, the school was drawn into the picture and the school superintendent promised cooperation. Yet, we do not know in how far this was given, as also in this case, contact had to be broken because of the distance.

Case VI.

Joy, a two year old girl, was referred to social service to relieve the tension in the home. Joy was in the hospital for severe atopic eczema for about a month in 1948.

The social worker had two office interviews with the mother when Joy was in the hospital. Mother, twenty-nine, had eczema and bronchitis as a child. The father was asthmatic during the winter. Joy

had eczema when she was six weeks old; this cleared upon elimination of orange juice. At about one year she had eczema again.

The parents had their own home and yard. The maternal grandmother had moved in with the family since the present illness. She felt that the child should be left alone more.

The child resented the restraint imposed by the treatment, and it was particularly important that the parents be less anxious. They seemed to feel guilt for the child's present behavior.

The play supervisor reported that Joy forgot her ailments under stimulation of play. The mother was permitted to watch the child play through the one-way glass window.

In a third interview mother was extremely upset because Joy still scratched, and the social worker was able to give some reassurance and insight.

A few days after Joy's discharge the social worker phoned and the mother said that Joy was better in every way--walked and scratched less. The mother sounded more relaxed than she had been before.

A week later mother was phoned again. This time there was great progress. Joy scratched only when tired and was beginning to play with other children. The mother said that she would stop in the hospital sometime to see the social worker. It is not recorded if she did.

Comment. In this case the social worker relieved immediate anxiety, rather than going deeper into the problem with the mother. The social worker became the supporting mother figure who listened to the mother's anxieties. The mother gained some insight in the third interview, although contact was too short to go deeper into the case. Later, after

discharge, by phoning she still showed interest and thus the mother felt that she had the support of the hospital. The way was left open for mother to come back if she desired.

Group B. Only social history was taken; no follow-up was done with the family.

Two cases are represented in this group. The social history was necessary to establish a psychiatric diagnosis. Both patients lived at a great distance from Boston which made follow-up more difficult. One case will be presented.

Case VII.

Roger, a ten year old boy, was referred as an inpatient in Boston Floating Hospital because of school failure. He had repeated the second grade four times.

Roger was of low normal intelligence (88 Stanford-Binet, Drawing Test - 92; and Bellevue-Wechsler - 99; Porteus Maze 10.5 years). He was very resistant to his tests and did not expect to understand them.

Social history was obtained from the mother in an interview. Roger has four brothers, fourteen, twelve, eleven, and eight years of age, and two sisters, four and one year of age. Father, forty-one, is the ninth oldest of ten brothers. He finished the first year of high school and is the owner of a mink farm. Mother, forty-two, finished the sixth grade, had a difficult youth, as she had to work in a foster home. She always hated the maternal grandfather, a woodchopper and slate-roofer. She had had several operations and had been anemic since. The family live in a ten-room house. Roger shares a room with his eleven year old brother. The paternal grandparents, who have a house in Florida, live with the family during the summer.

Roger, whose siblings are on the honor role, was a good pupil in the first grade but "won't read."

The psychiatric conference stated that Roger was a dull normal boy, who had no drive at all; no physical

skills to compensate for his shortcoming. He is a symbol of the mother's frustrations.

An application was made to a small private school but he could not be accepted at that time. The mother called up frantically, as he seemed to get worse and was into everything. He was sent back to the second grade. A letter was written by the social worker to the teacher to explain the situation.

The mother had little insight into the problem and no attempt seemed to have been made to give her some more insight.

Comment. Not much could be done in this case. One of the reasons was distance. Another reason was the fact that Roger was not accepted in the school to which the social worker had applied. It is not known if the social worker's letter to his old school was of any effect.

The importance of the social history in this case, as in all other cases, was that the social worker in her investigation of the environment aided the psychiatrist in making a diagnosis.

Group C. Cases that were referred to a camp or other agency where no further casework with the parents was attempted. Three of the twenty-four cases fall into this group.

One boy was referred to a treatment camp. Follow-up was done by telephone calls to the mother in order to find out how the boy was doing and also to the social worker of the agency which sponsored the camp.

In one case the symptoms were caused by an inadequate home situation. The mother was inaccessible to casework. There was close cooperation with another agency and finally the Society for the Prevention of Cruelty to Children was called in.

The third case is that of a boy who was disturbed and had a poor home environment. He was referred to a camp and later to a child guidance agency. The two latter cases will be presented.

Case VIII.

Mary, an eleven year old girl, was referred to the Boston Floating Hospital because of abdominal pains of several weeks' duration. Since no physical cause was found and the cause was thought to be functional, she was referred to the psychiatric unit for a complete psychiatric evaluation. Mary was in the hospital for 14 days.

Psychometric tests brought out that she had a low average intelligence (Stanford-Binet - 94, Good-enough Drawing - 75, and Wechsler-Bellevue, Adult

Scale - 83). During the test she was shy and showed little interest. There was a scatter in the test, indicating emotional problems.

The social worker had an interview of three hours with the mother. The social history brought out the following: Mary comes from a family where she finds little security, as the parents are frequently separated and one or more of the children are often placed in foster homes. She has a sister eighteen, who is married but still lives at home; a brother sixteen and a half, has frequently been punished for truancy from high school and for playing cards for money. At one time he was placed in the Children's Village. A younger sister, Ann, was treated in the psychiatric unit for problem behavior in 1947.

From September, 1947 to August, 1949, Mary was placed in a foster home by the Children's Friend Society because her family was evicted from their house. She liked the foster mother very much and showed her love by stealing up to \$20.00 worth of candy from the A. & P. to give to the foster mother. Her own mother insisted on her return home as she was jealous of the foster mother.

The father is a letter carrier and makes \$25.00 per week. The mother works in a restaurant as an assistant to the detective and pays for semi-private care in the hospital because of pride. The Social Service Index showed that since 1939 fifteen agencies have helped the family for financial reasons.

The mother seemed quite intelligent. She reported having the same symptoms when she was eleven or twelve, being often nauseated and suffering from fevers and pains. Now she feels like vomiting when she has intercourse and she has frequent hallucinations that she will kill father or herself. She was referred to the psychiatrist at the Free Hospital for Women and Children but had given up the contact. She wanted a divorce but she said that the father would never give her up. She has had several operations. She goes frequently to New York. It is thought

that she goes to New York, according to the record, to see her boyfriend. According to the social worker of the Children's Friend Society she is a very efficient woman and rules the home with a rod of iron. Mary does all the cooking and is fearful that if her older sister leaves she will have to do all the housework. Mary slept with Ann in one bed until the social worker of the Children's Friend Society insisted that the mother procure another bed.

The recommendation of the consulting psychiatrist was that Mary be placed, as the environment was undesirable, and it seemed impossible to work with the mother--yet the mother refused on the basis that she was a good mother, as she kept Mary well dressed and cared for. Though the symptoms had disappeared, the cause was not solved.

The psychiatric social worker had several contacts with the mother. Her comment was that, "Mary needed warmth and consistent handling." The mother seethes with hostility and patient does not find any security in the home. The mother has absolutely no insight."

There was close cooperation with the social worker of the Children's Friend Society who had known the family for a long time. Intensive therapy with the mother was needed but she was too resistant to accept it. In a follow-up of the Children's Friend Society, it was found that Mary was doing all the housework. It was decided to get the Society for the Prevention of Cruelty to Children to take Mary from the home. About a year after hospitalization Mary was removed by the Society for the Prevention of Cruelty to Children.

The social worker was mostly active in this case in helping the psychiatrist diagnose the case by her report on the environment to him.

Her second task was cooperation with the social worker of the Children's Friend Society, as this worker had

known the family for a long time. The findings of the psychiatrist were also discussed with her. It was the social worker of the Children's Friend Society, who took the responsibility for getting the Society for the Prevention of Cruelty to Children.

This was a case where the physical symptoms were largely due to the environment. It was the social worker who could manipulate the environment with help of the social agencies. She was the link between the psychiatric recommendations and the other agencies.

Case IX.

Alan, a thirteen year old boy was referred to the Boston Floating Hospital with a question of a fracture of the pelvis and humerus by a doctor of the Division of Child Guardianship. He had fallen off a cliff. No fracture was found. As Alan seemed to be an unhappy boy, he was referred to the psychiatric unit.

He was a boy who tested 122 on the Wechsler-Bellevue. He was self-assured and able.

A social history was gathered from the social worker of the Division of Child Guardianship, the probation officer, and the social worker of the Society for the Prevention of Cruelty to Children.

Alan's father and mother were separated. His father drank and always had wanted to be "the man in the house." He had five siblings. His older brother, Albert, fourteen, and he were together most of the time. Alan was sarcastic of his sister, fifteen. He was the leader of a gang in his neighbourhood. He made fun of his teacher. When Alan and Albert ran away from home several months earlier, his

mother had him picked up by the police, and they charged his mother with neglect. These charges were found to be grossly exaggerated. This was repeated periodically until Alan was placed by the Division of Child Guardianship with an understanding foster mother. The consulting psychiatrist diagnosed Alan as not psychotic and he had advised placement and careful supervision.

As it was not possible for Alan to have psychiatric treatment in the Boston Floating Hospital, he was referred to the Judge Baker Clinic by the social worker of the Division of Child Guardianship. He was thought to be a potential psychopath or an unhappy, frustrated boy. As there was a long waiting list, he was to return to the Boston Floating Hospital playroom until the time for his acceptance at Judge Baker Clinic. This was discussed with Alan by the social worker on discharge, he agreed to this plan, but insisted that his brother Albert come with him. He was told that he could call up the clinical psychologist any time he wanted to. He came to the playroom once a week for about nine weeks. Here he adjusted very well. He got his report card and had several poor marks for which he only blamed himself. Albert was thought to be more disturbed than Alan and should be taken up by Judge Baker too.

As Alan worried about school, the school principal was called by the social worker. He said that Alan's marks were below passing, but that there was time enough to make it up and pass.

The mother did not show any interest in the boy and did not seem to make an attempt to improve her living conditions. This would be taken into consideration by the Judge of South Boston, and he might be committed to the Division of Child Guardianship.

Alan was finally accepted at the Judge Baker Clinic six months after admittance to the Boston Floating Hospital. The social worker reported periodically to the social worker at the Boston Floating Hospital. Both Albert and Alan were receiving psychiatric

treatment.

The two boys both went to camp; arrangements were made that Albert's camp time was paid for by the Division of Child Guardianship, and Alan was paid for four weeks by the Boston Floating Hospital and one week by the Judge Baker Clinic.

The Judge Baker social worker reported that Alan had done very well at the camp, was generally liked. The boys had chosen their own "judges", and he was considered to be one of the fairest. He was still seeing the psychiatrist as he had made a deep attachment to him, and it did not seem wise to break it at this moment.

Comment. The question of fracture was only coincidental in this case. The real problem was Alan's maladjustment at home and in school. Through cooperation of four agencies, the Division of Child Guardianship, the Juvenile Court, the Boston Floating Hospital, and the Judge Baker Guidance Center Alan and his brother could be helped toward a better adjustment.

Talking the plan over with Alan gave him a feeling of responsibility.

Because Alan was in the hospital and wanted Albert to come in too, Albert was helped also.

Group D. The cases which were referred to a convalescent home and where additional casework was done.

Three cases represented this group in the cases studied.

One was a patient who was referred to the psychiatric unit for a behavior problem but who turned out to have an advanced kidney condition with a poor prognosis. Convalescent care and casework with parents and with the child was done.

Another case was that of a baby with gastrointestinal problems. The casework with the mother had to be centered around her acceptance of convalescent care for him.

The third case was a somewhat similar problem; namely, an eating problem. Though added to that, the eight month's old girl had a diagnosis of pyelonephritis. It was the social worker's task to have the mother accept convalescent care.

Case X.

Linda, an eleven year old girl, was referred to the Boston Floating Hospital as a behavior problem. She suffered from severe enuresis and wet all times of the day and night. On several occasions she had taken the clothes of her sister and wet on those or on the clean bathtowels of her mother. In the intake examination the stepmother told the doctor that Linda was the third child of her father's first marriage. The mother had died in childbirth. Linda had been brought up by a maternal aunt until she was five years old. The father remarried in the meantime and wanted Linda back home. The aunt refused and court action had cost about \$4,000.00. The aunt

had told Linda that the stepmother was hateful, and she should disobey her and wet in the house to show her disgust. Later on the relationship with the stepmother became much better and Linda told her everything. She still kept on wetting in the house and the mother tried to punish her or promised her that she could go to the movies. Nothing helped. At last she was referred to the hospital by the family doctor.

Linda's mother was referred to social service and Linda was given psychometric examination and was seen by the psychiatrist. In the meantime, it was found that she had a very bad case of nephrosis with a poor prognosis. Linda stayed in the hospital for about five months. She had several operations.

Her social situation was inadequate. She had three stepsisters and brothers. She was especially fond of her one year old brother, whom she used to take care of frequently. The father suffered from stomach ulcers and the mother, who was not very intelligent, had a hard time keeping the family going. Yet she managed quite nicely and her home was always immaculately clean. All the children seemed well-adjusted, including Linda. Linda was a cooperative patient and made many friends among the other children.

The task of the social worker has been to find convalescent care for Linda, which was not easy as the prognosis is so poor. The mother did not want to take her back, claiming that the house was too cold and that she was too sick, and also she seemed to spread a distinct odor which neither the teacher nor the children could take.

Linda gave considerable trouble to the nurses when her dressings had to be changed, yet it was necessary. The worker had some talks with her about that. And also her going out to the convalescent home was discussed with her. She did not like to leave the Boston Floating Hospital, and the worker was able to discuss this with her.

Furthermore, the parents were unable to meet the very large bill. Though it is not the custom that the

social worker concerns herself with money matters, she did help, as that is the treasurer's role. In this case the mother was particularly upset. The worker discussed it calmly with her and was able to find a solution for her to pay a little in small installments.

Linda, though at first unhappy at the Convalescent Home, was later very pleased with the activities and gained two pounds in one week.

After two months she had to leave the Convalescent Home and new arrangements were made for her. Every-time new arrangements were made it was done through the stepmother, and the father became extremely upset about that. The social worker made several attempts to see him, but at first he was at work and later he broke his leg and was unwilling to talk to the social worker.

Linda had to come into the clinic every two weeks and arrangements were made for transportation by the Red Cross.

Comment. The social worker's role here was one of interpreting Linda's illness to the parents and planning care for her when out of the hospital. Also, the financial problems had to be settled. Thus here the social worker's role was a supportive one, rather than on a deep emotional level. Linda was helped to understand that at first she would not like it at Wellesley as it was a new place and it always took some time to like it anywhere. Arrangements had to be made for transportation and other minor services had to be done. The social worker will probably have to stay with Linda and her family a long time to come, as her illness is chronic.

The father has been talked with but was too concerned with his leg to give any response. Preparations are being started with the stepmother and Linda for the time when Linda will come home.

Case XI.

Larry, an 11 months old boy, was referred by the family physician for gastrointestinal allergy May 25, 1949. No organic cause was found. He was found to be a baby of average intelligence with good affective response. He greeted everyone and cried when he wanted to be picked up. He investigated all play material and imitated adults. When he was 9 weeks old, he had virus pneumonia. After that he had frequent colds. He was able to sit at six months and stood at seven months. As he had a deformity of both feet, he was referred to the orthopedic department.

The father was a Carpenter's Mate in the Navy and now does repair work for the maternal grandfather with whom the family lives, paying \$15.00 a week in addition for use of the room. The father, mother, and Larry all had to live in one room. The father finished high school and took some courses at M. I. T. in aeronautics but had to discontinue these, as he was financially unable to continue. He always has a stuffy nose and has several allergies. The mother was a typist before her marriage. The maternal grandparents had been opposed to the marriage. The mother looks older than the father and seems to dominate him. Pregnancy had been difficult with vaginal bleeding of seven months' duration, constant vomiting, and headaches. Labor had been induced three weeks early and the delivery had been with high forceps.

The recommendation was to send Larry to the Wellesley Convalescent Home, to keep regular contact with the family on an organic and dietary basis, and to try to emancipate mother from the maternal grandmother,

and thereby provide an environment in which the child can develop normally.

The social worker saw both parents for the social history. Two days after his discharge the social worker phoned the mother and she thought he was doing very well. About 7 weeks later he was again in the hospital. At this time the summer substitute social worker had this case. Mother came in to take Larry home, as it was very hot. She and father had hired a boat for the summer and it was too expensive to leave him in the hospital. The worker talked this over with the mother and mother appeared to have insight in her feelings. She could express what it meant to be separated from the child. She would leave the child in the hospital and talk it over with her husband. Three days later she came back to tell the social worker that she believed it would be wise to send Larry to the convalescent home.

He was taken to the convalescent home, but it was not known if he could stay longer than a few days, as the polio epidemic was just in full swing. Nothing more is recorded.

Comment. The social worker's task was diagnostic and supportive. She found that the mother was too disturbed to handle the problem. In talking her feelings over with the mother she was able to send Larry to the convalescent home. She gained a certain amount of insight into her relationship with Larry and was thus able to let him go.

Group E. Mental Deficiency. As is explained in Chapter IV this classification was chosen as it represents a special group of patients. A problem is found here which in many cases stirs up emotions of guilt or rejection in the parents. Special skill is required to handle these cases. Skill to help the parent accept the child as it is and to understand his own feelings about the child in case a placement in an institution is found to be advisable. Four cases are represented in this group.

One patient was referred at the age of nine because of spasms of rigidity. It was especially difficult for the parents to accept her retardation.

Another case is that of a two year old girl. The picture was complicated by the problems of the mother herself; some work could be done with her.

A third case was that of a two year old boy. The picture here was also complicated, as the mother was a war bride and was quite homesick and the father was unwilling to accept that his son was retarded. Some supportive work with the mother was done. The father was inaccessible to casework.

The fourth case was a twenty months old boy. The parents would not accept that he was mentally retarded and due to too great a distance only a social history was taken and two follow-up interviews were had. Two cases in this

group will be presented.

Case XII.

Miriam, a nine year old girl, was referred to the Boston Floating Hospital by a private physician because of spasms of rigidity and because she seems easily frightened. She has stiffening of her hands and arms when writing or talking. She is afraid of the dark and of noises and has frequent temper tantrums. She is enuretic at night if she receives fluids after 5:00 p.m. She is a picky eater. Especially significant was that she hugs strangers at first and afterwards suddenly becomes frightened.

Pregnancy with Miriam had been normal. The social history was acquired by home visits and the contacts with the teacher. Child was born by a high forceps' delivery. She sat at ten months, walked between sixteen months and two years and talked at two years. She had pneumonia at seventeen months. At two months she had fecal impaction, the removal of which was manual. Mother thought that that had been very frightening to Miriam. She had great anxiety about her toilet habits. Her father used a strap to punish her, and she had some peculiarities, such as always wanting to wear dresses with pockets. She had to be taken to school. Mother and father both worked in a mill. The family was comfortable. Mother made \$50.00 per week. Father made \$60.00. Mother had finished the 8th grade and had worked ever since, only stopping for about three years when Barbara, sixteen, was born and a short time before and after Miriam's birth. Miriam, who was found to be of dull normal intelligence on the Stanford-Binet, the Good-enough, the Porteus Mazes, the Sequin Form Board, and lived with her family in a six-room, two-story house. Miriam and Barbara sleep in one room; each has a double bed. Family always lived near maternal grandmother. Mother was a nervous person, i.e. she could not eat her lunch when social worker visited at first, and she was particularly anxious.

When Miriam had been on the ward for several weeks, there was excellent improvement in her behavior. She seemed to be much more secure. There were several contacts with the family, including the

sixteen year old sister, Barbara. Some casework was done with this girl, who was self-conscious about her tallness. Since Miriam had improved so much on the ward, it was decided that a placement in a very secure surrounding with normal children would be the best for her. The father and mother, who were at first opposed, later on accepted it. She was referred to the Children's Aid and a good home with an understanding foster mother and some children was found. Close cooperation with the social worker at the Children's Aid was required. This social worker worked with Miriam and the foster home, while the Boston Floating Hospital social worker was the link between her and the parents.

Miriam at first improved a great deal. After a few months she relapsed again and had the same symptoms. Half a year later her intelligence was tested again, and it had gone down from 84 to 73. This case was now considered one of mental deficiency. The Children's Aid felt that she should be institutionalized and the case was closed at the Boston Floating Hospital, as not much could be done and the Children's Aid had taken the responsibility.

Comment. Social worker's role in this case was mainly to find a home for Miriam and have her parents accept the idea that Miriam was below normal intelligence and that her troubles, though probably increased by mother's nervousness, were constitutional. Since she could not adjust in a foster home and was not able to adjust to normal people, it was found necessary to place her in a state school where she probably would be less frustrated as the other children were more or less on her own level.

Here was the task of the social worker to interpret Miriam's behavior to the parents. It was most difficult for

them to accept that Miriam was not "like other children." With help of the worker they could accept placement for her. At request of the parents some casework was also done with Miriam's older sister, who was better adjusted after a while.

Case XIII.

David, age two years, was referred to the Boston Floating Hospital because of mental deficiency. The problem had been noted first at the age of fifteen months, when the parents had a specialist for him.

The mother, twenty-three, had married the Italian father when he was in Holland with the Army three years earlier. Living with the Italian parents-in-law had been very difficult for the mother, who did not know Italian and was not used to the Italian way of life. When she was pregnant with David, she had been very frightened by the maternal grandmother's frankness. She has had two miscarriages since David's birth.

She was seen by the social worker in the hospital first, but did not want to come back, as she was frightened of the psychiatrist. No contact with the father is mentioned in the record. It was decided that the social worker drive her into Boston for her next appointment. Again she became frightened of the psychiatrist, and it was decided that further contacts with the hospital were only to be through home visits from the social worker in order to do supportive casework with the mother. Two visits were made. After that the follow-up visits were referred to the student social worker, who happened to be of the same nationality as the mother. Several letters were sent out to the mother in her native language and a visit was made. No answer was received until the mother wrote that she would be delighted to see the worker, and she made her excuses for not having written earlier. She had been in Holland for two months. The situation had greatly improved as the father had built his own house, and

they did not have to live with the in-laws any longer. At this point she asked to see the psychiatrist. The father was still unable to accept retardation of his son.

The recommendation of the psychiatrist at that time was that eventually he be accepted in a state school. The social worker was able to discuss placement with the mother. At this time the mother discussed her guilt feelings and anxiety about having a mentally deficient son and her hostility toward her parents-in-law. The social worker was accepting these feelings and could be reassuring.

Comment. In this case of mental deficiency the task of the social worker was mainly a supportive one. This case was complicated by the mother's insecurity in a foreign country.

The social worker by making the home visits and reporting back to the psychiatrist was able to avoid the upsetting experience of coming to the hospital for the mother.

The fact that the parents lived later on in their own house had much to do with the change of attitude in the family. There was much less anxiety in the mother, as she did not have to live with her in-laws, whom she felt to be overconcerned about the boy. The fact that the student social worker could write in the mother's native tongue also made her more ready to accept a visit and feel secure with her. This case was first referred in the summer of 1949 and the last visit was made in May, 1950. Acceptance of mother by social worker had made her less frightened of the psychiatrist. Through his recommendation of sending David to a state school

she was able to release her emotions. In the course of the treatment, she had gained some insight into her own feelings.

CHAPTER V

SUMMARY AND CONCLUSIONS

An attempt is made in this study to evaluate the role of the social worker in the Boston Floating Hospital, as reflected in twenty-four cases which were taken from the files. Before this evaluation can be made, it must be remembered that all cases treated are, or have been, inpatients at some time at the hospital. As was stated in the first and third chapters, hospitalization has a specific meaning for the sick child with which the members of the staff have to deal. If the child comes from a secure environment, he and his parents will not be unduly upset by this new experience, but in general will be able to see the hospitalization in its real significance. On the other hand, the experienced staff members will be able to notice by means of the child's behavior if the relationships between the parents and the child have been distorted.

The reasons for referral to the hospital have been discussed, and also the causes for the child's illness. In relation to these factors the role of the social worker as member of the psychiatric team in treatment was noted.

It has been found that nineteen of the twenty-four cases studied were referred to social service because there was a disturbance in the relationship in the family. In

six cases there was over-anxiety on the part of the parents because of the diagnosis of the child's illness. In thirteen cases the child's symptoms were caused by the family background and home environment. The remaining five cases were those of mentally deficient children in which the social worker has to deal with guilt and anxiety feelings in the parents.

It has been noted that very little psychotherapy was done with the children themselves, yet it must be remembered that the psychiatric unit has a playroom program for all inpatients who are well enough to get out of bed and for some patients who are still followed on an ambulatory basis. Besides being observed by a skilled nursery school teacher in this setting they learn to modify their behavior and adapt themselves socially.

A function the social worker has in every case referred to her is that of making a social diagnosis in order to aid the psychiatrist and the physician in gaining a clearer picture of the situation. The social history which is taken by the social worker combined with the physical findings, the mental tests, and the psychiatrist's interview with the child and with the parents will enable them to make their diagnoses and recommend a course of treatment. In general, when a child is in the hospital, the parents are

willing to give information eagerly as they are anxious because of their child's illness. The first interview can be utilized therapeutically by the social worker in order to relieve the parent's anxiety regarding the illness or treatment of the child. As is seen in some of the cases studied the taking of a social history might be the only function of the social worker, as further treatment is not indicated. Or in other cases not possible because of the great distance in which the patient lives from the hospital or because of resistance on the part of the parents.

Therapeutically the social worker has the following functions: referral to community agencies, direct casework with the parents of two kinds, supportive and interpretative; and interpretation to persons in the community working with the patient. In the twenty-four cases studied it has been found that in order to treat a patient often several community agencies have to cooperate. This was best illustrated in the case of Arthur (Case I), where the Family Society, the Public Welfare, the Convalescent Home and the Camp all cooperated towards Arthur's better adjustment. The social worker at the Boston Floating Hospital acts as a central agent in such a case in interpreting the problem to the different agencies on the one hand, and on the other hand she has to discuss with the parents referral to these agencies and what it will

mean to them.

Direct casework with the parents is difficult to separate from the other functions of the social worker, as doing "direct casework" is in most cases interrelated also with history taking and referral. It is difficult to draw a line between supportive casework and interpretative casework, as in most cases these two skills will be interwoven. This is illustrated in the case of John (Case IV) where the social worker, through doing supportive casework, enabled the mother to gain insight into her relationship with John.

A skill used by the social worker in this setting is that of doing casework by letter. Often the patient comes from another state, yet he is still followed by the Boston Floating Hospital. This method has many possibilities, depending on the facility of expressing his idea in writing. This letter by the parent combined with comment from the social worker constitutes together the insight in the relationship needed.

In general the psychiatrist's recommendations are followed. In some cases the parents are resistant towards further treatment. In other cases the distance might be too great, as in the case of Roger (Case VII). Of great importance also is interpretation by the social worker of the case to other people in the community who are working with

the patient, such as school teachers and ministers. These people will often prove to be a great support in the treatment of the patient.

Conclusions. The social worker in the Boston Floating Hospital meets many different problems of illness, of behavior problems of mental deficiency, each of which she has to treat individually. As well as being a medical social worker, she is also part of a psychiatric team. Of great importance is the fact that the social worker enters into the case at the crucial point when the child is ill and when the parents generally are concerned about the child's wellbeing. The cases are varied according to their diagnoses, yet all of them require emotional adjustment of the child towards its environment, and insight of the parents into the personality of the child and their relationship with the child. Often other community agencies have to be brought in in order to accomplish these goals.

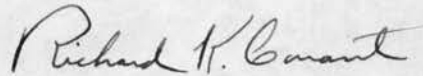
Ideally each patient in the hospital should get a psychiatric evaluation as a routine. That would mean a contact of the social worker with all parents in order to take a social history and discover any problems, emotional or otherwise. That would possibly mean referral of more patients to other agencies and further casework with more

families.

The present setup with a consulting psychiatrist, only in the agency for one and a half day, and only one employed social worker, does not provide such an intensive program. Only the patients who need psychiatric treatment or support from the social worker very obviously are treated that way.

The conditions described in this study appear to indicate that a program which covers every child admitted to the hospital is needed. To do this, the community must somehow be made aware of the importance to everyone of a program in the Boston Floating Hospital, which deals with every child adequately.

Approved



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Dean

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