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# A study of intake as related to the services offered in the psychiatric clinic at the Boston Dispensary, January 1, 1952 - April 30, 1952.

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

# A STUDY OF INTAKE
# AS RELATED TO THE SERVICES OFFERED IN
# THE PSYCHIATRIC CLINIC AT THE BOSTON DISPENSARY
# JANUARY 1, 1952 - APRIL 30, 1952

A Thesis

Submitted By

Estelle Frances Ruskin

(B.S., Simmons College, 1951)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Science

1953

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# CHAPTER I

## INTRODUCTION

The growing awareness of the need for psychiatric services both within the hospital setting and in the community gives rise to a steadily increasing number of referrals for diagnostic and treatment services. The demand for psychiatric help far exceeds the number of psychiatrists, psychologists, and psychiatric social workers available to provide the specialized type of care that emotionally disturbed patients require. A discriminating use of existing services becomes imperative.

### PURPOSE OF THE STUDY

The purpose of this thesis is to make a study of intake in the Psychiatric Clinic at the Boston Dispensary in order to clarify the following questions:

1. How do the structure and function of the Boston Dispensary and the Psychiatric Clinic affect intake practice?

2. What are the sources of referral to this clinic and how do they affect the role of the intake worker in this setting?

3. What are the different problems presented by the patient during the intake interview?

4. What problems are treated by the clinic and what problems are referred elsewhere?

5. What is the intake worker's contribution to the evalu-

ation of the patient's problem?

6. What is the intake worker's activity in the disposition of patients?

SCOPE OF THE STUDY

This study was made in the Psychiatric Clinic at the Boston Dispensary. It is based on eighty-one cases seen by the intake worker during the four month period between January 1, 1952 and April 30, 1952. Since this study is limited to those cases seen for an intake interview, other cases referred during this period but not interviewed are not included.

SOURCES OF DATA

Intake histories and medical and social service records of the eighty-one cases were used. Data on the Boston Dispensary and the Psychiatric Clinic was obtained from reports and consultations with the psychiatric social worker, the Chief of the Psychiatric Clinic, and the Chief of Social Service. Material on the principles of intake was obtained from books, periodicals, reports, and other unpublished material. Consultation with the research consultant for the Massachusetts Department of Mental Health and the unpublished manuscript, The Massachusetts Survey of Community Psychiatric Resources-1952, were used to help the writer understand current thinking about the problem.

METHOD OF PROCEDURE

Literature on intake was reviewed in order to familiar-

ize the writer with the scope of the problem under study.

A study of the clinic intake book and the intake worker's notebooks provided the cases studied. This list was charted with the following data included: date of referral, source of referral, Boston Dispensary record number, name and address of the patient, date of intake interview, the interviewer, and the final disposition of the case.

A study of the intake histories and medical and social service records of each patient who met the qualifications of the study was made, and data were secured according to the schedule* drawn up for this purpose. These data were then coded and tabulated so that the writer could readily evaluate the material collected. This material was then charted and served as a reference in setting up the tables discussed in Chapter IV.

LIMITATIONS

Some of the histories and records give insufficient material on which a complete study could have been made. This is due to the pressure of work caused by the large number of patients seen in a short period of time. Due to the availability of workers from other clinics, many procedures and contacts are not recorded. Conferences with the Chief of the

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* For Schedule, see Appendix.

Psychiatric Clinic and other staff members are usually omitted. Therefore, some of the writer's observations were based on her own estimate rather than on precise recording of social service action.

In many cases the scope of intake is not defined so that the end of intake and the beginning of continued casework service are not clearly distinguishable at some points. This is accounted for by the presence of only one social worker in the Psychiatric Clinic, and she takes over casework treatment.

The short period of four months is not a sufficient length of time on which to make valid conclusions.

This study has been based on the handling of referrals and the disposition of cases by one worker and psychiatrists whose decisions are affected by subjective observations.

PLAN OF THE THESIS

The study will be preceded by a brief description of the present structure and function of the Boston Dispensary and the Psychiatric Clinic. This discussion will also include a description of the professional staff during the period studied. The writer will focus this material on the implications for intake in the Psychiatric Clinic.

A review of the literature on the general principles of intake will include the implications of the process in an out-patient psychiatric clinic. This will be followed by the presentation and discussion of the statistics derived from the eighty-one cases studied.

A more intensive analysis of selected case material will be presented for the purpose of further clarifying the questions under study. This will be followed by a final summary and conclusions based on the findings.

## CHAPTER II

## THE BOSTON DISPENSARY AND THE PSYCHIATRIC CLINIC

Much has been written on the history of the Boston Dispensary and the Department of Nerve and Mental Diseases, of which the Psychiatric Clinic is the larger part,[1] but only a brief statement on the organization and purposes of both during the period studied will be given here. It is also the purpose of this chapter to describe the role of the Psychiatric Clinic in the Boston Dispensary and the composition of the clinic staff in order to point out how they affect the practice of the intake worker.

The Boston Dispensary is a Community Fund Agency which derives its income from capital funds (less than one third); from the State; from patients' fees (one third of operating expenses); and from Red Feather funds (one third). The fee for morning clinic visits is set at two dollars and twenty-five cents and for the evening clinic at two dollars and fifty cents, with adjustment made according to need. "No patient is rejected because he cannot pay, and fourteen per

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1 Lorraine Winifred Luce, The Role of the Psychiatric Social Worker in the Psychiatric Clinic at the Boston Dispensary as Seen Through a Study of Fifty-Four Cases, Unpublished thesis on file in library of Boston University School of Social Work, Chapters II and III.

cent of all visits are free."[2]

The Boston Dispensary is a unit of the New England Medical Center. The Center consists of four units - the Boston Dispensary, the New England Center Hospital, the Boston Floating Hospital, and Tufts College Medical and Dental Schools. The broad purposes of the Center are to provide diagnostic, medical, surgical, and psychiatric services to patients; to provide a hospital extension service to affiliated hospitals throughout New England; to offer a medical education program; and to provide facilities for medical research.[3] Thus the Center attempts to meet the needs of patients in an age of complex medical practice.

Founded in 1796, the Boston Dispensary now operates clinics for low income groups and for working people through the Evening Clinic Service. Although originally organized for the poor, it now serves these people, "normally self-supporting, to whom sickness brings financial catastrophe."[4] The high cost of private psychiatric care makes clinic care the resource for many in this self-supporting group. The Dispensary "services are also of help to the family doctor for consultation or therapy, or for providing X ray, laboratory, or other diagnostic procedures for his private pa-

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2 Pamphlet, The Boston Dispensary, 1951.

3 New England Medical Center. Directory of Present Services and Their Locations, 1952, p. 1.

4 Op. cit. The Boston Dispensary, 1951.

tients."[5] It receives referrals from other units within the New England Medical Center and from agencies within the community. The clinics are also used to provide educational services to students from Tufts College Medical and Dental Schools and schools of social work. These aims help formulate the basic role of the Psychiatric Clinic as it makes its unique contribution in serving patient, student, and physician.

The Department of Nerve and Mental Diseases handles neurological and psychiatric problems in separate clinics under a single administration. The Psychiatric Clinic meets on Tuesday and Friday mornings and Monday evening; the Neurological Clinic meets on Thursday morning. Dr. Paul Myerson is the physician in charge. The social worker is the Clinic Executive for both clinics. It is the procedure for this worker to take the initial social history of the patient with a psychiatric problem.

Dr. Myerson, in a statement to this writer, has said that

> the purpose of the Psychiatric Clinic at this time of study is to serve the Boston Dispensary as an aid in evaluation and diagnosis and to make a disposition of psychiatric problems as experienced by the patients treated in other Boston Dispensary clinics. Insofar as facilities permit, this is done for the community as individuals are referred from physicians and outside agencies. When conditions permit, patients are treated for their psychiatric problems along the lines of modern dynamic psychology. The therapeutic orientation is increasingly psychoanalytic. Teaching services are pro-

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5 Ibid.

vided to third year medical students who discuss cases with a member of the staff. Two fourth year students do treatment under supervision for a month. An additional service is provided to the Medical Clinic by making available a staff member for case consultation during the Medical Clinic session.

The following criteria for acceptane for treatment were outlined by Dr. Myerson: the need for help, a personality structure which can be helped, the willingness with which the patient accepts help, physicians' interest in special cases, and patients who offer particular teaching value. The clinic does not handle organic disorders, acute alcoholism, or borderline psychotic or psychotic disorders. The intake worker must keep these considerations in mind when helping a patient with his decision whether or not to use psychiatric help.

During the period of study the staff of the Psychiatric Clinic consisted of two consultants in psychiatry, a physician in charge, twelve physicians offering psychiatric service, two psychologists, one of whom is devoted primarily to therapy, and a psychiatric social worker. Eight fourth year medical students also offered treatment. Thus the disciplines of psychiatry, psychology, and psychiatric casework are used for diagnostic and treatment purposes. Except for the social worker, the staff is part-time.

The Psychiatric Clinic is operated according to the same procedures which govern other Dispensary clinics. A patient may be treated first in this clinic on a personal or agency referral, or he may he may be directed to it from other clinics.

The Psychiatric Clinic also uses the complete medical outpatient services available in the Dispensary for the physical care of its patients, or to complete medical findings in making a psychiatric evaluation.

The complexity of the setting necessitates that the intake worker maintain a practical knowledge of the policy and procedures of the entire Dispensary. Time spent as the Clinic Executive for both the Neurological and Psychiatric Clinic and as the caseworker for both clinics imposes limitations on the time available for intake responsibilities. The size of the clinic staff involves the interchange of information with many physicians during the brief clinic session.

Intake in this clinic begins with an application for help either by the patient or by referral from another clinic, physician, or agency. An appointment is then arranged for a history to be taken by the social worker. This history, together with any pertinent medical record data and information received from other agencies, is reviewed with the Chief of the clinic. At this time a decision is made as to whether or not the patient should be seen for further evaluation by a psychiatrist or should be referred to another clinic or agency. If further evaluation is indicated, disposition is deferred until the patient is interviewed by a psychiatrist. Psychometric tests may be given in order to complete the diagnostic evaluation. After evaluation by the psychiatrist, which may include one or more interviews, final disposition is made.

This decision may be to keep the patient for psychotherapy or to refer him to another clinic or agency. The social worker helps the patient carry out referral from the clinic if this has been recommended. In view of the fact that the clinic meets only two days a week and one evening and that the social worker is the only full time staff member, decisions to refer patients for hospital committment may be made by the worker in conjunction with the Chief of the Medical Clinic. If during the history-taking interview it is learned that a patient is known to another agency, the worker may decide to refer this patient back to this resource in order to avoid a duplication of service. Final disposition, therefore, may occur at three points, by the worker during the intake interview, by the Chief of the Clinic after case review, or by the psychiatrist who sees the patient for evaluation. The intake process is considered to have been completed when the final disposition has been carried out.

# CHAPTER III

## GENERAL PRINCIPLES OF INTAKE

Although intake procedure varies according to the structure and function of each setting and the particular problem presented by the patient, basic principles of intake do exist. The following material will discuss: the purpose of the intake interview for both the patient and the therapist; work with the patient's family towards the facilitation of diagnosis or treatment; the intake worker as the liaison between the clinic and outside agencies; casework skills required at intake; and the therapeutic value of the intake interview.

Many persons who come to a clinic for psychiatric help come either "with little awareness of their problems of the incentive to deal with them (and/or) little preparation for what psychiatry can offer them."[1] The social worker, therefore, must help the patient express his problem, "interpret the clinic's services and procedures to the potential patient,"[2] help him decide whether to use the clinic further,

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1 Sol W. Ginsberg, M.D., Medical Director, The Functioning of Psychiatric Clinics in New York City, New York City Committee on Mental Hygiene of the State Charities Aid Association, State Charities Aid Association, New York.

2 Group for the Advancement of Psychiatry, Report #16, September, 1950, p. 2.

to utilize a more appropriate resource or to deal with his problem in some other way,"[3] reassure him of the interest and the desire of the clinic staff to help him, and make appointments for him. The social history obtained from the patient prepares the doctor with a picture of the development of the patient and his problem and frees the psychiatrist to go into feelings so that less treatment time is spent on history taking and therapy can begin immediately.

The intake worker may also see the members of the patient's family towards the facilitation of diagnosis or treatment by explaining the clinic's services and procedures. In the initial contacts the worker tries to modify those attitudes which may interfere with treatment and thus "lay the groundwork for the (therapeutic) relationship."[4] Material secured from relatives often produces a clearer understanding of the patient's problem for interpretation to the team. If a referral to another agency or to a hospital for admission is indicated, the intake worker helps the family understand and accept this recommendation.

Interpretation of the material obtained during the interview with the patient and/or members of his family to the team is a basic part of the intake process. "An accurate

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3 Ibid. p. 2.

4 Kurt Freudenthal, "The Contribution of the Social Work Intake Process to the Psychiatric Treatment Situation," Journal of Psychiatric Casework, 20:22:25, September, 1950, p. 25.

dynamic description of the patient and his problem,"[5] an account of the precipitating factors in the illness, and an evaluation of the patient's motivation for treatment should be conveyed to the team member or members responsible for the ultimate disposition of the case. In this way the social worker aids the psychiatrist in his diagnostic understanding of the patient and his problem and tentative formulation of treatment goals. If the team member should question the effectiveness of treatment for the patient in that particular clinic, the intake worker participates in the discussion of a more appropriate referral.

In the Boston Dispensary Psychiatric Clinic, if a patient is accepted for a more thorough diagnostic work-up or for treatment, the psychiatrist to whom the patient has been assigned may ask the intake worker to repeat the material discussed during the intake conference with the Chief of the clinic. This is usually true where facilities and the pressure of time limit or prevent the recording of intake conferences.

The intake worker acts as the liaison between the clinic and outside agencies when the patient is referred either to or from the clinic. It is the worker's responsibility to interpret the clinic's services not only to the referring

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5 Group for the Advancement of Psychiatry, Report #16, September 1950, p. 2.

agent but to other agencies, clinics, or professional organizations in the community. In an out-patient clinic this interpretation is made to other workers or physicians in other clinics within the setting. "A vagueness among referring social workers (or physicians) about the functioning of the clinic (results in) consequent vagueness on the part of the patient."[6] The intake worker is also in the position to educate referring agents in the importance of sending some information about the patient and the problem to be treated as well as explaining to the patient where he is being sent. The same principle applies to the intake worker when a referral is made to another clinic or agency. The worker must help the patient see in what ways the other clinic or agency can help him. She must also interpret the patient's problem and the reason for the referral to the other physician or worker.

It is not the purpose of this section to discuss casework skills in general, but to focus on those principles which have particular application to the intake interview. The emotionally disturbed patient usually comes to a psychiatric clinic with much anxiety and resistance. As Gordon Hamilton points out, "Resistance is born of insecurity, the unkown or terms to be met."[7] The worker must reduce the

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6 Ginsberg, Op. Cit.

7 Gordon Hamilton, Theory and Practice of Social Casework, Columbia University Press, New York, 1951, p. 170.

threat of psychiatric treatment and handle the patient's anxiety about himself and the potential treatment situation. Rachmore and Kenworthy state that "the purpose of the interview (should be) shared with the patient."[8] In this way he knows that the information will be used to help the doctor help him. These authors also suggest that

> the worker should focus on the presenting problem... History should be limited. ... Too much freedom in talking may lead to a negative preparation for seeing the psychiatrist. ... The loss of focus may result in increasing and regenerating anxiety.[9]

The interview should be structured so that the patient does not become involved in an uncontrolled expression of feelings. Whereas form questions poorly timed may be too threatening to the patient, "responsive questions"[10] help the patient express his problem and the developmental facts related to his problem without making an already anxious person more anxious. The worker should make a mental note of feeling tones as the facts are described. When indicated the worker should be free to give reassurance and support as she explores developmental background.

In an out-patient clinic where many somatic as well as emotional complaints are presented, "the worker should make

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8 R. J. Rachmore and M. E. Kenworthy, "The Psychiatric Social Worker Functioning at Intake in a Community Clinic for Adults", American Journal of Psychiatry, 105:196, September, 1948, p. 197.

9 Ibid. p. 197.

10 Hamilton, Op. Cit., p. 162.

the distinction between the physical and mental nature of the illness."[11] His willingness or resistance to accept the emotional factor in his illness is often a diagnostic clue to his treatability. In addition,

> in out-patient psychiatric treatment, the patient should be allowed to take the lead to treatment objectives. This is particularly true where the service does not attempt major personality change, but seeks to give assistance within limited areas which will help individuals in their adjustment to community pressures and personal problems.[12]

It is, therefore, essential that the worker enlist the patient's willingness to accept help so that the making of the appointment becomes a joint responsibility. This joint responsibility is often achieved by encouraging the patient to ask questions about psychiatric help.

There is therapeutic value in the intake interview for the patient whether he goes on to see a psychiatrist, is referred elsewhere, or rejects help. Amster has written that

> the illicitation of history material with therapeutic emphasis, together with the focussing on the dynamic factors which seemed to underlie the expressed need, has seemed to help each of these clients come to terms, to some extent, with his impasse and to grow constructively beyond it.[13]

Because the patient is helped to see and face his problem

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11 Rachmore and Kenworthy, Op. Cit., p. 199.

12 Ibid., p. 201.

13 Fanny Amster, "Some Therapeutic Implications of Short-Term Therapy," American Journal of Psychiatric Social Work, Vol. XXII No. 1., October, 1952, p. 19.

more clearly and his motivation to seek help is supported, the patient is able to move beyond the thwarting effects of depression, anxiety, or hysteria and begins a readjustive process. Similarly, the person who is referred elsewhere has been helped to face his problem and find the appropriate resource to help himself out of a distressing situation. The person who rejects help at least has begun to look at his problem more realistically with the aid of the worker and has been assured of the continued interest of the clinic in helping him when he is ready for help.

# CHAPTER IV

## STATISTICS OF EIGHTY-ONE CASES STUDIED

The purpose of this chapter is to present and discuss statistical tables derived from the eighty-one cases seen by the intake worker during the period of study. These tables will give a picture of the age, sex, and marital status of the patients, the sources of referral to the clinic, the types of problems and symptoms described at intake, the disposition of the cases, and the number of contacts made by the worker.

### AGE AND SEX DISTRIBUTION

TABLE I

AGE AND SEX FREQUENCY

| Age Groups | Male | Female | Total | Per cent of Total Group |
|---|---|---|---|---|
| 5 yrs.- 9 yrs. | 1 | | 1 | 1.5 |
| 10 yrs.-14 yrs. | 2 | 2 | 4 | 4.9 |
| 15 yrs.-19 yrs. | 1 | 2 | 3 | 3.7 |
| 20 yrs.-24 yrs. | 3 | 11 | 14 | 17.3 |
| 25 yrs.-29 yrs. | 8 | 12 | 20 | 24.7 |
| 30 yrs.-34 yrs. | 3 | 8 | 11 | 13.5 |
| 35 yrs.-39 yrs. | 2 | 7 | 9 | 11.1 |
| 40 yrs.-44 yrs. | 1 | 4 | 5 | 6.2 |
| 45 yrs.-49 yrs. | 1 | 3 | 4 | 4.9 |
| 50 yrs.-54 yrs. | 2 | 3 | 5 | 6.2 |
| 55 yrs.-59 yrs. | | 1 | 1 | 1.5 |
| 60 yrs.-64 yrs. | 1 | | 1 | 1.5 |
| 65 yrs.-69 yrs. | | | | 0.0 |
| 70 yrs.-74 yrs. | 1 | | | 1.5 |
| Not indicated | 2 | | | 2.4 |
| Totals | 28 | 53 | 81 | 100.9 |

There is a wide variation in the ages of these patients when they were referred to the Psychiatric Clinic.

Of the total of eighty-one patients the youngest was in the five to nine group. The fact that one of the psychiatrists prefers to do child therapy accounts for the presence of this young patient in a group comprised predominantly of adults. The oldest patient was in the seventy to seventy-four age group.

The largest concentration was in the twenty to thirty-nine groups, with the total number of patients within this span being fifty-four. This is 66 per cent or two thirds of all the patients seen.

More women than men were included in this selection. Twenty-eight (35 per cent) are men as compared to fifty-three (65 per cent) women.

MARITAL STATUS

TABLE II

MARITAL STATUS

| Age Groups | Married | Single | Divorced | Separated | Widowed |
|---|---|---|---|---|---|
| 15 yrs.-19 yrs. | | 3 | | | |
| 20 yrs.-24 yrs. | 6 | 8 | | | |
| 25 yrs.-29 yrs. | 13 | 7 | | | |
| 30 yrs.-34 yrs. | 4 | 3 | 1 | 2 | 1 |
| 35 yrs.-39 yrs. | 5 | 1 | 2 | 1 | |
| 40 yrs.-44 yrs. | 3 | 1 | 1 | | |
| 45 yrs.-49 yrs. | 4 | | | | |
| 50 yrs.-54 yrs. | 3 | 1 | 1 | | |
| 55 yrs.-59 yrs. | 1 | | | | |
| 60 yrs.-64 yrs. | 1 | | | | |
| 65 yrs.-69 yrs. | | | | | |
| 70 yrs.-74 yrs. | | | | | 1 |
| Not indicated | 2 | | | | |
| Totals | 42 | 24 | 5 | 3 | 2 |

The largest number of patients are married, with the total being forty-two (55 per cent). The single patients comprise the next to the largest group, with the total being twenty-four (32 per cent). Five patients (6 per cent) are divorced; three patients (4 per cent) are separated; two patients (3 per cent) are widowed. Percentages are based on the seventy-six patients in the fifteen to seventy-four age groups.

In the twenty to thirty-nine age groups, twenty-eight are married, three divorced, and three separated as compared to nineteen who are single.

SOURCE OF REFERRAL

TABLE III

SOURCE OF REFERRAL TO PSYCHIATRIC CLINIC

| Source | Number of Patients |
|---|---|
| Boston Dispensary Clinics | |
| Medical | 31 |
| Admitting | 8 |
| Children's Medical | 2 |
| Neurological | 2 |
| GYN | 2 |
| CAP | 1 |
| Skin | 1 |
| Psychiatric | 1 |
| Sub total | 48 |
| Personal | |
| Self | 12 |
| Physician | 9 |
| Sub total | 21 |
| Agency | |
| Other Hospitals | 5 |
| Public Welfare | 1 |
| V.A. | 1 |
| Sub total | 7 |
| Other NEMC Units | |
| Pratt | 1 |
| Boston Floating Hospital | 1 |
| Sub total | 2 |
| School | 1 |
| Employer | 2 |
| Total | 81 |

The Psychiatric Clinic serves patients primarily from other Boston Dispensary Clinics. Forty-eight (59 per cent) of the total number of referrals make up this group. Special attention is directed to the large number of Medical Clinic referrals which total thirty-one (64 per cent) of the forty-eight clinic referrals. This may partially be accounted for by the fact that the Psychiatric Clinic is part of the total diagnostic service offered to Dispensary patients, particularly when medical findings are negative and a question of emotional etiology exists. The patient referred by the Psychiatric Clinic is the mother of the youngest patient. She was referred by the child's therapist, seen by the social worker, and referred to one of the psychiatrists for intensive therapy.

COMPLAINTS AT INTAKE

The problems and symptoms described by the patient during the intake interview have been classified under the categories of Emotional, Somatic, Social, and Other. Patients usually present more than one symptom in varied combinations. There is an interrelationship between the complaints under the separate categories since the emotional factor is common to all. The complaints listed in the table on the following page have been described as close to the patient's original statements as possible.

TABLE IV

DISTRIBUTION OF PROBLEMS AT INTAKE

| Problem or Complaint | Number of Complaints | Problem or Complaint | Number of Complaints |
|---|---|---|---|
| Emotional | | Skin problem | 1 |
| Depressed | 15 | Weight loss | 1 |
| Nervous | 12 | Constipation | 1 |
| Panic and phobia | 8 | Blackouts | 1 |
| Inadequacy and inferiority | 7 | Eneuresis | 1 |
| Fear of insanity | 6 | Urinary frequency | 1 |
| Hostile feelings | 5 | Dizziness | 1 |
| Nightmares | 4 | Fainting | 1 |
| Restless | 4 | Gas | 1 |
| Fearful in general | 3 | Inflamed eyes | 1 |
| Crying | 3 | "High blood pressure" | 1 |
| Delusions | 2 | Ulcer | 1 |
| Irritability | 2 | Bitterness in mouth | 1 |
| Confused | 2 | | |
| Suicidal ideas | 2 | Sub total | 70 |
| Fear of dying | 1 | Social | |
| Instability | 1 | Employment | 12 |
| Fear of brain tumor | 1 | Other people and friends | 7 |
| | | Withdrawn and shy | 4 |
| Sub total | 78 | Marital difficulties | 3 |
| Somatic | | Mother-child relationships | 3 |
| Headaches | 17 | School difficulties | 2 |
| Physical tension | 5 | Behavior | 2 |
| Sleeplessness | 4 | Stealing | 1 |
| Fatigue | 4 | Crowded living quarters | 1 |
| Body pains | 3 | Financial | 1 |
| Stomach pains | 3 | | |
| Vomiting | 3 | Sub total | 36 |
| Nausea | 3 | Other | |
| Back pains | 2 | Sexual problems | 9 |
| Tics | 2 | Intellectual retardation | 1 |
| Palpitations | 2 | | |
| Perspiration | 2 | Sub total | 10 |
| Pains in chest | 2 | | |
| Numbness | 2 | Total complaints | 194 |
| Trembling | 1 | | |
| Pains in limbs | 1 | | |
| Breathing | 1 | | |

The total number of complaints was 194, with an average of three complaints per person and a total of fifty-nine different kinds of complaints.

It is interesting to note that somatic complaints (36 per cent) were described almost as frequently as emotional complaints (40 per cent). The relatively large number of somatic complaints is partially accounted for by the large number of Medical Clinic and other clinic referrals noted in Table III.

Sexual problems referred to in this table vary from perversions to problems of frigidity or impotence.

DISPOSITION OF CASES

The disposition of cases has been divided into two main groups: A) disposition after the history taking interview and B) disposition after an evaluation by a psychiatrist.

The intake process is considered to have been completed for those patients in Group A who have been referred to another resource or retained for casework services by the clinic worker. The intake process has not been completed for those patients who have been retained by the clinic for evaluation or who have been put on the waiting list. These cases remain pending in intake until an evaluation has been made and a final disposition has been decided.

The intake process is considered to have been completed for all patients in Group B after the worker has finished helping patients carry out the psychiatrists' recommendations.

TABLE V

DISPOSITION OF CASES AFTER HISTORY TAKING INTERVIEW

| Disposition | Number |
|---|---|
| I Retained for Psychiatric Clinic services | |
| A Evaluation | 47 |
| B Psychotherapy | |
| C Casework | 2 |
| D Waiting list | 6 |
| Sub total | 55 |
| II Referral to another B.D. clinic | |
| A Vocational | 3 |
| B Class in Applied Psychology | 4 |
| C Medical Clinic | 1 |
| D GYN | 2 |
| Sub total | 10 |
| III Referral to outside agencies | |
| A Health | 3 |
| B Social | |
| C Other | 1 |
| Sub total | 4 |
| IV Discharged due to rejection by patient of appointment for evaluation by psychiatrist | 12 |
| Total | 81 |

Of the eighty-one cases presented in Table V, final disposition could be made for twenty-eight without being seen by a psychiatrist for evaluation. Fifty-three cases remained pending in intake. Forty-seven of these cases were given appointments for evaluation and six were placed on the waiting list. The worker's skill in evaluating whether the patient needed to be seen by a psychiatrist and

her knowledge of other services within the setting or the community led to a more economical use of clinic services in the fourteen cases referred under Groups II and III and in the two cases retained for casework services by the worker. These skills are particularly necessary since the staff is part-time, except for the worker.

Twelve patients were discharged bedause they decided not to use psychiatric help.

TABLE VI

DISPOSITION OF CASES AFTER INTERVIEW WITH PSYCHIATRIST FOR EVALUATION

| Disposition | Number |
|---|---|
| I Retained for Psychiatric Clinic services | |
| A Evaluation | 25 |
| B Psychotherapy | 3 |
| C Casework | 1 |
| D Waiting list | |
| Sub total | 29 |
| II Referral to another B.D. clinic | |
| A Vocational | 2 |
| B Class in Applied Psychology | |
| C Medical Clinic | 4 |
| Sub total | 6 |
| III Referral to outside agencies | |
| A Health | 5 |
| B Social | 3 |
| C Other | 1 |
| Sub total | 9 |
| IV Discharged due to withdrawal by patient before evaluation was completed | 3 |
| Total | 47 |

One case remained pending in intake after evaluation by a psychiatrist. Assignment for therapy did not occur at this time because it was felt that the patient would be more responsive to treatment in six months.

TABLE VII

FINAL DISPOSITION OF EIGHTY-ONE CASES

| Disposition | | Number |
|---|---|---|
| I Retained for Psychiatric Clinic services | | |
| Psychotherapy | | 25 |
| Casework | | 5 |
| Waiting list | | 7 |
| | Sub total | 37 |
| II Referral to other B.D. clinics | | |
| Vocational | | 5 |
| Class in Applied Psychology | | 4 |
| Medical Clinic | | 5 |
| GYN | | 2 |
| | Sub total | 16 |
| III Referral to outside agencies | | |
| Health | | 8 |
| Social | | 3 |
| Other | | 2 |
| | Sub total | 13 |
| IV Discharged | | 15 |
| | Total | 81 |

Of the eighty-one cases referred for psychiatric help thirty cases were retained for treatment services offered by the clinic. An additional seven were retained on the waiting list. Twenty-nine cases were referred elsewhere for help.

Fifteen were discharged because of their own decision not to use psychiatric help. These figures point out that intake leads to a discriminating and time-saving use of the clinic's services.

Although the worker's activity in helping patients carry out referrals from the clinic is considered a part of the intake process, the material studied does not give adequate date with which to present a table describing the nature of the follow-up.

ACTIVITY OF INTAKE WORKER

TABLE VIII

NUMBER OF CONTACTS MADE BY INTAKE WORKER

| Group Involved in Contact | Number |
|---|---|
| Agencies or physicians in community | 15 |
| Patients | 90 |
| Staff psychiatrists | 58 |
| Members of patients' families | 18 |
| Workers or physicians within setting | 31 |
| Total number of contacts | 212 |

TABLE VIII a

NUMBER OF CONTACTS REQUIRED BY PATIENTS

| Number of Contacts | Number of Patients |
|---|---|
| Seven contacts | 2 |
| Six contacts | 2 |
| Five contacts | 2 |
| Four contacts | 4 |
| Three contacts | 30 |
| Two contacts | 29 |
| One contact | 12 |
| Total | 81 |

These contacts include intensive interviews, telephone or postal communications, consultations, and conferences.

The number of contacts made by the intake worker in handling each case from the time of referral to the final disposition of the case totals 212, with an average of about three contacts per patient. Intra-agency working procedures and the immediate availability of workers and physicians impose limitations upon securing an accurate picture of the steps taken in handling referrals to and from the clinic. It is felt that a larger number of contacts would have been procured were such material available.

In conclusion, it is noted that intake is not a unilateral relationship between patient and worker. In this

clinic intake involves casework with the patient and his family, the interpretation of the worker's impressions to team members, and the interpretation of clinic findings to other workers or physicians and to agencies or physicians in the community.

# CHAPTER V

## CASE PRESENTATIONS

The twelve cases presented in this chapter depict the problems most commonly seen at intake and demostrate the role of the worker and the clinic in handling the patient and his problem. The case presentations contain fictitious names and are arranged according to the disposition of the case. Except for the first case presented, disposition refers to the final disposition. The first case was selected because it illustrates the type of problem which requires an evaluation rather than the type of disposition made.

### GROUP I A. RETAINED FOR PSYCHIATRIC EVALUATION

Mr. James Berito, a forty year old Italian, Catholic laborer, was referred to the Psychiatric Clinic by the Admitting Physician.

The pt and his wife have been married for sixteen years. The wife appeared to be the more adequate of the two and has worked for the family support at different times during the marriage when the pt was unable to hold a job. The pt was a peddler at one time and has worked in factories. Five months prior to intake, after a period of unemployment, he went to work as a belt cutter in a factory where he had worked before and where there were rats. Although he had not been afraid of rats before, his present difficulties came on after he started this job. The wife, from whom the history was taken, explained that the pt had been "acting funny" for five or six weeks. He had developed a fear of rats; he could think of nothing but rats and washed himself constantly. The pt was unable to work, and the wife was supporting the family at the time of intake.

There were six living children, three of whom were retarded. The oldest, Joan, aged fourteen, was blind and

mentally deficient. A son James, aged ten, was in the third grade. A son Robert, aged seven, was mentally deficient. A daughter Maria, aged six, was very much retarded. She could not walk and was incontinent. A daughter Jeanette, aged four, was normal as was a son Joseph, aged three. The presence of the three retarded children in the home, particularly Robert and Maria, were disturbing to the pt.

The worker spoke briefly to the pt but took the history from the wife who seemed to be the more adequate of the two. Because of the apparent need for an immediate evaluation, an appointment was given for the following day.

After the pt was seen by the psychiatrist, the psychiatrist spoke to the worker and explained the diagnosis and recommendations. The diagnosis was Depression, neurotic but bordering on a psychotic depression, for which a referral to another hospital for a course in electric shock treatment was recommended. The worker interpreted these recommendations to the pt's wife.

Two days later the worker visited the home of the pt to find that these recommendations had not been carried out. An appointment for a reevaluation by the Chief of the clinic was made. At this time it was felt that the pt might benefit by getting away from the home for a week or two. The intake worker was to try to arrange for this. In the meantime the worker was also to work on the family situation in order to try to get the retarded children institutionalized in order to relieve the environmental stresses on the pt.

Subsequent activity was a contact with a social agency to raise the money for a week of convalescent care, a contact with the Chief of Social Service at the Dispensary to raise money for a second week, a contact with a convalescent home to make arrangements for admission, a visit to the pt's home to explain the progress of this plan to the pt and his wife, and a later contact withtthe wife who described him as becoming increasingly more agitated. In view of this and the fact that the convalescent home refused to accept him, the worker encouraged the pt to carry out the recommendation of electric shock treatments and helped arrange for this by clearing the referral to another hospital.

This patient was referred by the Admitting Physician for diagnosis and treatment. He presented phobic and de-

pressed symptoms.

Although the social history is usually more meaningfully taken from the patient, in this case the worker saw that the patient was too disturbed to discuss his problem and background. At the same time the worker was able to begin a relationship with the wife to prepare the way for future interpretation, planning, and support in carrying out plans.

Before the patient was seen for an evaluation, the worker conferred with the psychiatrist to give her diagnostic impressions of the patient and his problem and interpret the significance of the strained environmental situation for this patient.

The psychiatrist and worker collaborated in interpreting to the wife the nature of the patient's disorder and the subsequent recommendations. Since this clinic is not designed to treat border-line psychotic or psychotic patients, a referral to an outside health agency was necessary. It is seen that continued conferences between the worker and the doctor were necessary to assure the successful disposition of this case. The worker was in the position to maintain the clinic's contact with this family to stimulate the patient to seek treatment.

Environmental manipulation was the appropriate function for the social worker rather than the psychiatrist. Contacts with outside agencies, support, and interpretation to the wife were the techniques used in handling this problem.

The intake process extended beyond the intake interview and involved many inter-staff, outside agency, and family contacts. The process is considered to have been completed when the referral to the outside health agency was accomplished. Subsequent service to the patient and his family by the worker was part of the worker's role as the clinic caseworker rather than as the intake worker.

B. RETAINED FOR PSYCHOTHERAPY

Mary Smith, a thirty-three year old Catholic, unmarried girl, was referred for psychiatric help by Dr. H. of the Class in Applied Psychology, known as the CAP or Thought Control Group. Although Miss S. had initiated the present contact with the CAP, Dr. H. felt that the pt needed individual attention in the Psychiatric Clinic. The pt complained of not being able to sleep well and having disturbing dreams of a sexual nature.

Miss S. was an old Boston Dispensary patient. She had been seen briefly in the Surgical Clinic in 1932. She has been growing progressively deaf since age ten following scarlet fever. Her next contact with the Dispensary was between 1942 and 1945 when she was known to the Nerve Clinic (Psychiatric Clinic) and Thought Control Group. At that time she had difficulties in sleeping and was depressed. During that time Social Service helped the pt make arrangements to go to a rest home for two weeks. At that time she seemed to be reacting to her deafness, the death of her mother in 1940, a broken engagement, and employment difficulties created by her deafness. The Dispensary lost contact with her from 1945 until 1952 when she again asked for help.

The pt is the next to the youngest of seven children, four brothers and two sisters. Her father remarried after her mother died. At the time of intake she was living alone in an apartment in the attic of a house where a married brother lived. She intimated that the family relationships were not good.

During the intake interview she appeared quite tense and described her difficulties as not being able to sleep well and having dreams of a sexual nature. She

had not worked for a year and expressed considerable concern over her hearing loss. She noted that when she was relaxed she could hear much better than at other times.

Since it had been so long since the pt had been to the Dispensary, the worker explained the advisability of having a complete physical check-up in addition to being seen by the psychiatrist. The worker arranged for both. After the psychiatric evaluation, the psychiatrist explained that he planned to do intensive psychotherapy with the pt in conjunction with casework help with her social problems. The worker handled a referral to the vocational counselor.

This was presented because it shows how a case is referred from a clinic which treats emotional problems on a group basis to a clinic which offers individual treatment. The presenting problems of insomnia and disturbing sexual dreams and the feelings of depression raise the question of deep, intrapsychic conflicts which are appropriately treated in intensive individual therapy. This case also illustrated the use of casework concurrent with therapy.

During the intake interview the worker helped the patient express her difficulties, point up the relationship between her feelings and ability to hear, and interpret how the psychiatrist might help her rather than the group. The worker's awareness of a previous Dispensary contact and the availability of social data freed the patient of the additional burden of reiterating social history which might have unnecessarily heightened her anxiety. Familiarity with agency procedure led the worker to encourage a medical examination. This is a routine procedure to rule out or point out

physical factors which may have contributed to the patient's sleeping difficulties.

By the time that the patient was ready to see the psychiatrist, the worker had made available to him a picture of the patient's past problems, current difficulties, and Medical Clinic findings. The therapist was able to involve this patient in treatment during the first interview without spending too much time securing factual data.

The worker appropriately explained how the vocational counselor could help her and interpreted to the counselor the meaning of the patient's handicap to her at that time and the need to explore vocational opportunities which would not add to her current despair.

It is also seen that the intake worker in this clinic also continues as the social caseworker, when indicated, in order to continue the social and medical steering for the patient in working out realistic environmental problems. The relationship started during the intake interview makes this part of the total helping process easier for the patient to accept.

C. RETAINED FOR CASEWORK SERVICES

Mary Dennis, a fifty-year old Catholic, divorced woman was referred from the Skin Clinic because she appeared to be depressed while waiting to be seen in the clinic.

The pt described many crushing life experiences during the intake interview; the loss of her mother at age one; the death of the housekeeper who raised her at the age of fifteen; keeping house for her father and herself

between the ages of fifteen and seventeen but finally breaking up home and boarding out because of her father's excessive drinking; marriage at age seventeen to an irresponsible man who left the family twelve years prior to intake and who had apparently obtained a divorce out west and remarried; the loss of two sons at the ages of twenty and twenty-one within seven months of each other during the war in 1944; and more recently the death of her father three months prior to intake. The father had made his home with the pt after her husband left, but a year ago he had been committed to a State hospital where he died.

The pt described her present difficulties as follows: her eyes got inflamed when nervous; funny feelings in her head; depression; the fear of going out of her mind since Christmas; and concern about menopause. She was living with her remaining son, aged twenty-three, and expressed guilt about her dependence on him.

The pt seemed to be responsive to the worker during the history taking interview. She seemed to gain relief from being able to ventilate some of her feelings of grief and her fears about going out of her mind. Since she was Catholic, the worker encouraged her to renew contact with a parish priest from whom the pt said she had gained strength in the past. The worker explored the possibilities of socialization for the pt with her. The worker also encouraged future casework contact.

The pt showed marked improvement during subsequent visits and felt much improved "spiritually and physically." She was making a sincere effort to keep busy and seemed genuinely cheerful. If the pt did not maintain this progress, the worker planned to make an appointment for an evaluation by a psychiatrist.

This case illustrates the worker's role in evaluating the type of service needed by a patient. Intra-agency co-operation in offering comprehensive care to patients is also seen by the fact that the patient was referred for psychiatric help while under medical care in the Skin Clinic. In the worker's opinion this patient could be helped by casework services--support, reassurance, and guidance--and did not re-

quire a psychiatric evaluation. It is considered that the intake process ended when the worker, after the intake interview, decided to keep this patient for casework services rather than to make an appointment for an evaluation for possible treatment by a psychiatrist. Casework service was the final disposition.

The intake worker not only secures facts; she handles feelings as well in order to strengthen the patient's ego. The worker quickly recognized this patient's positive response to the worker's interest and reasurance. Her skillful exploration for social data, while at the same time helping the patient ventilate her feelings of grief related to past trauma, helped the patient face and work through her current difficulties.

Like many patients who come to the Psychiatric Clinic, this patient felt that to be nervous is to be going out of one's mind. The opportunity to ventilate this fear, while support, reassurance and clarification were given, helped to free this patient of this anxiety.

The improvement seen in Mrs. D. during her second visit with the worker shows the therapeutic possibilities which can be utilized during a history taking interview.

D. RETAINED FOR PSYCHIATRIC CLINIC WAITING LIST

Elizabeth Foss, a thirty-five year old Irish, married woman, was referred from the Medical Clinic. She had symptoms of numbness and a dead feeling in her arms and legs for three years duration. No physical basis for

these symptoms could be found.

She is one of sixteen children and the third youngest of eleven living children. Her mother, aged seventy, had a heart condition and high blood pressure. Her father had died of cancer two weeks prior to intake. The pt was still working through her grief related to his death.

Mrs. F. had been married for eleven years and had three children attending grammar school. She revealed that her husband was inclined to be critical of her handling of the children. He thought that she spoiled them. Another irritation in the home was the mother-in-law who owned their house and occupied the first floor flat. She frequently interfered with the care of the children, but the pt tried to overlook this. However, she did admit to the worker that this did bother her. Her husband, aged thirty-eight, was described as a "nice fellow". Except for arguments about the children, they got along fine. Although she alluded to the fact that sex was a problem, she said that her husband was "understanding".

As the interview progressed, other difficulties appeared. She mentioned the avoidance of crowds, fear of elevators, loss of weight, and the sexual problems.

At the time of intake there were no openings for an immediate appointment. This was explained to the pt who felt that there was no urgency in her situation. The worker explained to the pt that she would notify her as soon as an appointment was available; however, she encouraged her to contact the worker should she become anxious while waiting.

The worker felt that this pt was intelligent, showed many strengths, had some understanding of the relationship between her feelings about her husband and family and her symptoms, and could benefit from help.

This patient did not come to the Dispensary expressly for psychiatric help but was referred from another clinic. It was, therefore, the worker's function to interpret to the patient the reason for the referral and the reason for securing social data for the psychiatrist. This interpretation

was necessary especially since the patient had already described her problem, symptoms, and social situation to the physician in the Medical Clinic.

The worker saw that the patient's children, husband, sexual relationship, and mother-in-law were sensitive areas; however, the worker did not dwell on them. By observing the patient's affect as she related these facts, the worker was able to formulate an impression of some of the basic sources of concern.

It is seen that when sufficient rapport had been established, the patient expressed more difficulties disturbing her

This patient was referred at a time when there were no openings. By explaining this reality and observing the patient's reaction, the worker learned how urgent the patient felt her problem to be. This is often a clue affecting the immediate disposition of a case. By having it pointed out that she would be notified and could phone the worker at any time, the patient did not feel rejected, was assured of the continued interest of the clinic, and no longer felt that she had to struggle with her anxieties by herself.

## GROUP II REFERRAL TO OTHER BOSTON DISPENSARY CLINICS

### A. REFERRAL TO VOCATIONAL COUNSELOR

Stephen DuFont, a thirty-two year old unmarried, Catholic male, was referred to the Psychiatric Clinic by a private physician because he had become increasingly more nervous.

Social history is limited. His mother was sixty-five

and working. There was a married sister, aged twenty-seven, who lived next door to the pt and with whom he got along well.

The pt had always been self-conscious. He had not been working for two months and was doing nothing at the time of intake. Previously, he had been employed irregularly as a dishwasher. He had no friends and thought that people were looking at him. He also heard voices.

The worker explained that he would see a doctor, and an appointment was made. The psychiatrist diagnosed him as a border-line psychotic, in good contact, with occasional exacerbations. This physician reassured the pt and his sister about his condition and discussed with the intake worker his recommendation that the pt be referred to the vocational counselor for a job with few people around.

The worker explained Mr. D's problem to the vocational counselor and arranged for an interview with the pt.

This case shows when a general practitioner in the community refers a patient for the specialized evaluation which is the appropriate function of the psychiatrist. This patient presents a problem of social and work adjustment with the fear of people affecting both areas. The psychiatrist, therefore, was alerted to evaluate the patient's illness with special attention to how his condition would affect employment possibilities.

The doctor discussed his findings and recommendations with the worker who, as the liaison between this clinic and other clinics, prepared the patient for the referral and interpreted to the vocational counselor the nature of the illness as it imposed limitations on Mr. D's employment prospects.

## B. REFERRAL TO CLASS IN APPLIED PSYCHOLOGY

Florence Sedar, a forty year old Jewish, married woman, was referred to the Psychiatric Clinic from the Medical Clinic.

She described her problem as headaches, practically all her life, which come every five or six months and last only a half a day. She also said that she was an emotional person.

Her father, aged sixty, was also described as an emotional person. Her mother, aged fifty-nine, had diabetes, as did her father. The pt felt that she had been spoiled as a child and used to have temper tantrums to get her own way. Two sisters are married, with children. The family relationships appeared to be good. Her husband, aged forty-two, was in good health, was a good provider, and there appeared to be a good relationship between the pt and her husband. A twelve year old son was in the seventh grade and in good health.

The pt's health has always been good except for a difficult delivery followed by a hysterectomy a year later. Menstruation began at age fourteen. Headaches predated menstruation.

Later in the interview the pt described her headaches in greater detail, "a feeling of pressure between the eyes which goes to the back of her head and down through her neck." She also complained of phlegm, chest pains, occasionally, and fingers going dead.

Since the worker felt that this patient might benefit more from the Class in Applied Psychology than from individual psychotherapy, she explained the purpose of the group and handled the referral to Dr. H..

This patient's somatic complaint was not complicated by interpersonal or situational difficulties. Due to the long-standing nature of her neurotic pattern and the relative freedom from disrupting areas of conflict, the worker did not feel that this patient would respond to individual therapy. The worker, however, did feel that this patient would respond to the support, inspiration, and instruction in the relation-

ship between the mind and the body to be gained in the CAP group experience. Towards completing the intake process, the worker interpreted the nature of the group and the way it might help her and discussed the referral with Dr. H..

C. REFERRAL TO MEDICAL CLINIC

Michael Mc Shea, a twenty-five year old Canadian born, Catholic, married male, was referred to the Psychiatric Clinic by the Admitting Physician because of anxiety and vomiting.

Mr. M. was the youngest of nine children. His father died a year ago at the age of seventy-eight. His mother was said to be in good health except for anemia and nervousness "like himself". Two of his brothers and a sister, all married, lived in Boston. The family was described as a close unit. He has been married for four years. His wife, aged twenty-five, had had a hysterectomy two years before, but the pt expressed no feeling about the fact that she could not have children.

He had attended school until the eighth grade when he quit to work on a farm. He moved to Boston six years ago. For five months prior to intake, he had been doing odd jobs at a company in this city. He liked his employment but had been suspended until his medical problem, vomiting, had been evaluated.

The pt had been drafted last November but was discharged after a month because of stomach symptoms. This inability "to keep anything down" was the presenting problem at intake (three weeks after the Army had discharged him). Vomiting occurred when he has to hurry.

Mr. M. impressed the worker as a "slow-thinking, slow-moving individual who (did) not appear to be a good candidate for psychotherapy. He had difficulty expressing feeling and described everything and everybody as alright."

Since this pt was anxious about himself and a return to work depended on a medical statement, an immediate appointment for an evaluation was given. The problem was explained to the psychiatrist who, after seeing the pt, said that the pt's symptoms were related to the anxiety of being under the pressure of military train-

ing. He advised an immediate return to work. He also recommended a referral to the Medical Clinic to help the pt plan his diet to alleviate the symptoms and for further treatment, if necessary.

This patient neither saw nor intimated any emotional problem except his somatic difficulty, vomiting. While securing the social history, the worker used her diagnostic skills to see that this patient was a poor candidate for psychotherapy due to his intellectual and personality limitations. However, the worker did recognize the need for an evaluation in order to obtain a physician's approval for his return to work. When the worker anticipates only the need for an evaluation rather than psychotherapy, she may waive the usual waiting period.

The psychiatrist corroborated the worker's impressions and recommended continued medical rather than psychiatric supervision of his condition.

Indications for a Medical Clinic referral in the other cases studied were the presence of somatic complaints in patients who the psychiatrist did not feel were candidates for psychotherapy but whose symptoms could be alleviated by medication. In such instances, the worker explained to the Medical Clinic worker or physician the psychiatric findings and the reasons for not giving psychiatric treatment. This interchange is necessary so that the patients referred to the Medical Clinic will not be returned to the Psychiatric Clinic unless a sudden change in either the physical or emotional

problems arises. Psychiatric consultation is available to the Medical Clinic physician. This interchange leads to more appropriate referrals in the future.

D. REFERRAL TO GYN CLINIC

Genevieve Jones, a seventeen year old Catholic, unmarried girl, was referred to the Psychiatric Clinic by the Admitting Physician for a personality study by the social worker (intake worker).

The pt complained of headaches of about three years duration and blurry vision lasting for about fifteen minutes. Three weeks prior to intake she had an episode of vomiting and nausea. She appeared to be calm and easy going. She and her father did not get along, and the headaches seemed to follow these arguments. The pt also worried about having a brain tumor.

Both her parents were forty-two and in good health. She was resentful of her father's drinking. She did not think that he liked her. The mother had a good relationship with the pt. There were four siblings.

She dated occasionally and had one boy friend who was then attending college so that she did not see him as frequently as she used to. She did not like school work and had recently transferred from a public to a parochial school.

She had had the normal childhood diseases. Menses started at age fourteen and are accompanied by headaches, occasional cramps, and moods.

A Medical Clinic examination three days after the intake interview suggested a seven month pregnancy. Upon learning this information, the intake worker transferred the pt to the GYN Clinic worker for further care and social management.

This patient presented somatic complaints, problems in school adjustment, and difficulties with her father. A complete evaluation of her problem involved both a medical examination and a diagnostic interview with the Psychiatric

Clinic worker. Since the patient was found to be pregnant, a referral to the GYN Clinic worker was made. It is the GYN Clinic's function to handle problems related to prenatal or urogenital care.

The need for a medical examination concurrent with a psychiatric evaluation before final disposition can take place is most strikingly seen in this case. The presence of the adolescent emotional problems might lead to either therapy or casework. When somatic complaints accompany emotional problems, intake should include both medical and psychiatric evaluations as did occur in this case.

GROUP III REFERRALS TO OUTSIDE AGENCIES

A. REFERRAL TO A HOSPITAL (HEALTH AGENCY)

Sylvia Render, a thirty-four year old Jewish widow and mother of a fifteen year old daughter, was referred to the Psychiatric Clinic from the Medical Clinic because of severe symptoms of depression.

The pt was depressed and vague in giving details of her past history. She referred to having been known to the Boston Dispensary Nerve Clinic (Psychiatric Clinic) and to the Boston Psychopathic Hospital in the distant past. She saw her discouraged state of mind related to a poor relationship with her daughter who had recently been in trouble and placed in a home for children by the Youth Service Board.

She had been a widow for fourteen years but had separated from her husband three months after her marriage. She had a mother whom she saw only occasionally; this relationship was not good. She also had a married brother but did not have much contact with him.

Because the pt seemed in need of a psychiatric evaluation as soon as possible, an immediate appointment was given. Since the pt was so disturbed and vague, the worker cleared with the Social Service Index and learned

of contacts with two other hospitals and two social agencies. Telephone calls were made to the hospitals for medical data. It was learned that the pt had been on the waiting list at the Boston Psychopathic Hospital a year ago but had since been taken off the list.

After learning of this background from the worker and evaluating the pt, the clinic psychiatrist recommended hospitalization. The worker contacted the Boston Psychopathic Hospital and arranged for the pt's admission. During a second visit to the clinic, commitment papers were made out by the psychiatrist, and the worker accompanied the pt to the hospital.

This patient suffered from severe depression and received immediate diagnostic service in the clinic. The severity of her illness required hospitalization for treatment services that this out-patient clinic does not provide. This procedure was found in cases presenting similar disorders.

The worker recognized the patient's inability to provide detail and did not press for data. Instead, she made use of the community resources known to her. In the absence of relatives, the worker accompanied the patient to the hospital as this patient needed the support of an interested person.

This case illustrated the need for skill in evaluating the patient's ability to return home to wait for a clinic appointment. In such cases the suicidal risk is always present. In the absence of a full time staff of psychiatrists, this worker was called upon to use her discrimination as to whether immediate hospitalization was necessary or whether this patient could wait two days to be seen by the psychia-

trist during the regular clinic session.

As Table V pointed out, the worker referred three patients to other hospitals or clinics equipped to treat psychotic disturbances. One of these cases required immediate commitment for which another physician in the setting, other than a psychiatrist, was asked to fill out the commitment papers.

B. REFERRAL TO A SOCIAL AGENCY

Claire Jones, a twenty-four year old Catholic, married girl, was a self-referral for psychiatric help.

The pt is the youngest of five children. She described her own family unit as a very close one. Her husband, aged twenty-four, was a steady worker, and the pt had known him for many years prior to their marriage. Her parents did not approve of him because of his poor family background. His parents were said to have been alcoholics and no good so that he and his siblings were brought up as State wards. Mrs. J. had two children, a son aged three and a daughter aged six weeks.

She described her difficulties as follows: she argued alot with her sixteen year old sister-in-law who lives with the family; her husband took sides with his sister which caused her to develop headaches and do "foolish things such as cutting her wrists superficially seven months ago, take any pills that happened to be around the house and on two occasions indulge heavily in alcohol despite the fact that she does not believe in alcohol and never drinks." It was the worker's impression that the pt showed considerable insight into her problems by stating that she may have been doing these things to get attention. The pt felt that her drinking was mainly to spite her husband who felt ashamed of his parents.

The worker's impressions were as follows: "This pt has a difficult problem at twenty-four of being the mother to her sister-in-law who has always been a behavior problem. This is a home situation with which she definitely needs help. Faimily Society may be of

help to her in handling her sister-in-law; however, a psychiatric evaluation is indicated in view of her headaches and acting out which might have serious consequences."

The worker discussed her impressions with the psychiatrist who, after seeing the pt, recommended a referral to a family agency because of the realsistic situational problems. The worker interpreted to the pt the way in which Family Society could help her and contacted the Family Society worker and explained the situation and the psychiatric findings. An appointment was made for the pt. When the worker learned that the pt did not keep this appointment, she made several attempts to help the pt carry out the referral.

The intake interview pointed to several situational factors which affected this patient's behavior. Although the clinic does not handle this type of problem, the somatic complaint and the acting out behavior warranted an evaluation. This was necessary before the final disposition could be made. As in the other cases discussed in this chapter, the intake worker's impressions are seen as a major factor in the ultimate disposition of the case.

On the basis of the intake interview and the evaluation, the worker gave the Family Society worker an interpretation of the patient's problem. It is seen in this case that the intake process did not end until the worker had made several attempts to work through the patient's resistance to accepting the referral from the clinic.

### C. REFERRAL TO A MARITAL COUNSELING SERVICE

Ethel Claire, a twenty-two year old married girl, was a self-referral who asked to see a particular psychiatrist whom she had heard about from a friend. Her complaint was prolonged moods.

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The pt is the only child of a father, aged seventy-two, and a mother, aged fifty-six. Her parents were living in another state. Her father was in a hospital due to Parkinson's disease. The pt had been married for two and a half months. Her husband, aged twenty-five, had been married before and had two children by that marriage.

Mrs. C. was concerned about her moods which she felt threatened her marital happiness and upset her sleeping. The moods last two to three weeks and cause her to do stupid things. They do not affect her at work, only at home. She had gone to Family Society but could not remember anything said to her during the interviews.

At the time of intake, she was one and a half months pregnant. Both she and her husband were ambivalent about this. Her husband wanted her to abort, but she did not and was scared.

The worker discussed the case with the doctor that the pt had requested to see. He felt that the pt and her husband would benefit from the X Marital Counseling Service. The worker contacted the pt and urged her to carry out the doctor's suggestion.

This patient came expressly for psychiatric help. Her problem was adjustment in a young marriage. The patient had sought help before as have many other who either come themselves or are referred for psychiatric help. In this case it is seen that the worker explored the patient's feelings about her previous contact with a social agency to see what the former helping experience meant to her in order to evaluate her current readiness to make use of a therapeutic situation.

It was not necessary for this patient to be seen by the psychiatrist because the material secured during the intake interview was sufficient to help the psychiatrist evaluate what kind of service this patient needed in working through

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her problem of marital adjustment. Thus the worker, as the liaison between the patient and the psychiatrist, conveyed his suggestion to the patient. Through interpretation, the worker helped the patient relate her problem to the special service offered by the marriage counseling service.

The intake worker's service in cases when the disposition is handled without the patient seeing the psychiatrist is a valuable saving of the clinic's and the patient's time.

GROUP IV DISCHARGED DUE TO THE PATIENT'S REJECTION OF PSYCHIATRIC HELP

> Leonard Anderson, a twenty-five year old unmarried male, was referred to the Psychiatric Clinic by the V.A. because of anxiety and long-standing nervousness.
>
> A good relationship between the pt and his step-father and his mother was described. There were two brothers, a step-brother, aged sixteen, and a brother, aged twenty-two, who lived out of the home and has been a behavior problem to the family, and a married sister, aged twenty-six.
>
> Mr. A. left school at the end of the second year of high school and joined the Navy in which he served for three years. His health has always been good. Although his past history included several types of employment, he has aquired a skill and was happily employed. Although not married, he was engaged and planned to be married in a few months.
>
> He described his problem as being nervous and getting an empty feeling which leaves him weak and shaky and usually hits him when he is relaxed. This problem was of about eight years duration. There appeared to be no other problems of sexual, family, or other social adjustments.
>
> The worker interpreted how the psychiatrist might help him, but the pt decided to visit his local physician for a check-up and then return if he wanted psychiatric help. The availability of the clinic was offered to him whenever he felt that he wanted help for his "nerv-

ousness". When no further word was received from the patient, he was discharged.

This patient presented symptoms of eight years duration which did not qualify him for V.A. services; however, he would have been considered for treatment in this clinic had he desired to follow through with psychiatric help. This patient was not ready to face his problem and apparently found psychiatric help too threatening. Instead, he chose to take recourse to a physician still attempting to find a physical basis for his symptoms.

Despite his refusal to accept help, through interpretation, the worker helped him understand how a psychiatrist might help him. Though limited, a relationship was established with the clinic so that the patient knows where to go in the future should circumstances lead him to accept help for his emotional difficulties.

In this case the intake interview is seen as the first step in sifting out patients who want to and can be treated by the clinic. No attempt to follow up this case was made when the patient failed to contact the clinic. The worker felt that to do so in certain cases creates too much anxiety in the patient. This patient was discharged until further word is received from him.

To summarize briefly, it is seen that in addition to taking social data during the intake interview, the worker explained the type of service offered in the clinic and made

appointments when indicated. During the intake interview the worker at first had to decide whether the patient had come to the appropriate resource. She then evaluated how urgent the problem was in order to decide whether an immediate appointment for an evaluation was necessary or whether the patient could wait any time from a day or a few weeks until being seen by a psychiatrist. If the worker felt that a patient could wait, she reassured him that she would contact him and encouraged him to contact her if he should become anxious while waiting. If the worker felt that a patient might require intensive psychotherapy after an evaluation, she deferred the appointment for the evaluation until an opening for psychotherapy was available. Before the intake process was completed, the worker helped each patient carry out the psychiatrist's recommendations. Follow-up after referral from the clinic was not found to be a routine procedure but occurred when the worker felt that follow-up would not create further anxiety in the patient.

# CHAPTER VI

## SUMMARY AND CONCLUSIONS

In view of the increasing number of referrals to the Psychiatric Clinic at the Boston Dispensary, it has become important to clarify, at this time, the different problems, social, emotional, and medical, presented by patients upon applying for psychiatric help. The writer also attempted to study what problems are treated in the clinic and what problems are referred elsewhere. It was also the purpose of this thesis to clarify the role of the intake worker in integrating patient, clinic, hospital, and community. This problem was studied through eighty-one cases seen by the intake worker during the four month period between January 1, 1952 and April 30, 1952.

Intake is directly affected by the structure and function of the Boston Dispensary. The Dispensary is a unit of the more complex organization, the New England Medical Center. As such, it receives referrals from the New England Center Hospital and the Boston Floating Hospital. The Dispensary serves as a teaching unit for medical, dental, and social service students. Its primary function is to provide diagnostic and treatment services to patients. The Psychiatric Clinic, therefore, operates in a complex setting.

Its purposes are to provide diagnostic and treatment services to patients and educational services to medical and social service students. It is not designed to treat organic disorders, border-line or psychotic patients, acute alcoholics, or deep-seated neuroses.

The psychiatric social worker is the only full time staff member. Other team members are only present during clinic sessions. In addition to intake responsibility for all new and old patients referred to the Psychiatric Clinic, she has administrative and casework responsibilities for both the Neurological and Psychiatric Clinics. Although these varied functions make less time available for intake responsibilities, they lead to an harmonious and time-saving integration of the patient with the clinic services.

This worker, in handling referrals and their disposition, is the liaison between the clinic and the referring agent, maintains intra- and inter-agency understanding of the function of the clinic, and helps the patient make use of the other services offered within the setting, either as a part of the psychiatric evaluation of the patient or as an adjunct to psychiatric treatment. In the absence of a permanent staff of psychiatrists her diagnostic skills are required in the evaluation of the immediate disposition of the case when she either encourages the patient to accept psychiatric help or to use other resources within the setting or the community.

The intake process is considered to have been completed

when the patient has either been accepted for treatment by the clinic, referred to another service in the Dispensary or to another agency in the community, or discharged due to the patient's rejection of psychiatric help. Final disposition may be decided at three different points: by the worker during the intake interview, by the Chief of the Psychiatric Clinic after the case is reviewed with the social worker, or by the psychiatrist who sees the patient for evaluation. The intake process, however, is not completed until referral from the clinic has been carried out.

Basic principles of intake do exist and provide a clearer understanding of the role of the intake worker in the Psychiatric Clinic. The value of the intake interview was seen for both the patient in preparing him for psychiatric help and the psychiatrist in providing him with the patient's social history. The intake worker may see the patient's family in order to gain a clearer understanding of the patient's problem in order to facilitate treatment or to assure the successful disposition of the case. The worker interprets her findings to the clinic team either as an aid in deciding on the final disposition of the case or in preparing the therapist with a preliminary picture of the patient and his problem. Intake, from the point of referral to the handling of the final disposition, is a dynamic process. As such, it requires definite casework skills.

In the four month period studied, eighty-one cases were

found to meet the requirements of the study. There was a wide variation in the ages of these patients, the youngest being in the five to nine age group and the oldest in the seventy to seventy-four age agroup. The heaviest concentration, fifty-four or two thirds of the total group, fell between the ages of twenty and thirty-nine. This clinic, therefore, is primarily and adult psychiatric clinic. More women than men were seen. Sixty-five per cent women were seen as compared to thirty-five per cent men. Forty-two patients were married; twenty-four were single; five were divorced; three were separated; and two were widowed. Almost two thirds of the patients in the fifteen to seventy-four age groups were or had been married.

Forty-eight referrals came from Boston Dispensary clinics. Of these, the Medical Clinic sent the largest number, thirty-one. There were twenty-one personal referrals, nine of which were from physicians. Seven came from other social agencies. Two referrals came from industrial health offices and one from the school department. It is seen, therefore, that the Psychiatric Clinic receives referrals from within the hospital setting, from physicians in the community, from other agencies or private organizations, and from a population becoming increasingly aware of the need for psychiatric help.

Patients described a large variety of problems and symptoms to the intake worker and in varied combinations.

The total number of complaints was 194, with an average of about three complaints per person. There were as many as fifty-nine different kinds of complaints. It is necessary, therefore, for the intake worker in this clinic to possess a diagnostic knowledge of the implications of each in order to evaluate what kind of disposition is appropriate. Although the emotional factor is considered to be a large component in all complaints, the presence of seventy somatic complaints and thirty-six social problems in which the emotional factor is often not clearly seen, requires skill in helping the patient see how a psychiatrist who works with feelings can help him.

Final disposition was made for twenty-eight cases after the intake interview with the social worker. The worker gave forty-seven patients appointments for an evaluation by a psychiatrist and placed six patients on the waiting list. The worker's diagnostic skill in evaluating whether the patient should be referred elsewhere before seeing a psychiatrist, whether the patient should be discharged, or whether the patient should be seen by a psychiatrist was essential to this time-saving and discriminating use of the clinic time devoted to diagnosis.

Of the forty-seven patients seen by a psychiatrist for evaluation, six patients were referred to other Boston Dispensary clinics and nine were referred to outside agencies. Since the worker was responsible for handling these referrals,

it was seen that the responsibilities of the intake worker do not end until patients referred for an evaluation have been seen and a decision for disposition reached.

It was found that thirty of the eighty-one cases referred for psychiatric help were retained for treatment services offered by the clinic. The total intake process, therefore, led to a discriminating use of the treatment services available in the clinic.

In the final disposition of the eighty-one cases, the worker's knowledge of the function of the clinic and other Dispensary or outside services was not only instrumental but essential in helping the patient find the most appropriate resource to help him with his problem.

It was found that intake is more than a single contact with the patient during the intake interview. As far as the records revealed, 212 contacts were made by the intake worker in handling the eighty-one cases. The worker spent the greatest amount of time with patients, the number being ninety. Fifty-eight contacts were with staff psychiatrists; thirty-one with other workers or physicians within the Dispensary; eighteen with members of the patients' families; and fifteen with other agencies or physicians or workers in the community. The role of the intake worker, therefore, is not a unilateral relationship between patient and worker. In this clinic it involves casework with the patient and his family, the interpretation of the worker's impressions to the team members, and

the interpretation of clinic findings to other agencies, workers, and physicians.

The cases studied fell into the following four groups as determined by the disposition of each case: Group I, those retained for Psychiatric Clinic services; Group II, those referred to other Boston Dispensary clinics; Group III, those referred to outside agencies; and Group IV, those discharged due to the patient's rejection of psychiatric help. The twelve cases presented in Chapter V were selected as representative of the types of problems seen at intake and of the role of the intake worker in handling each case.

The cases studied in Group I show how the worker used her discrimination in helping the patients make further use of the Psychiatric Clinic as opposed to another resource. The worker provided the patients and a member of one of the patient's families with an understanding of how the psychiatrist might help the patients. This was done during the intake interview. The worker was aware of the availability of appointments for service and judged which patient required immediate attention and which could be put on the waiting list. The worker discussed her psycho-social findings with the staff psychiatrists when the patients were to be seen for an evaluation of for psychotherapy. A therapeutic approach in the intake interview laid the foundation for continued casework services when intake had been completed. The worker continued casework services with the family of one of the patients, with

one patient as an adjunct to psychotherapy, and with the third patient for direct casework treatment.

The cases studied in Group II show that the intake worker interpreted clinic findings to other workers or physicians within the setting in order to help them understand the relationship between the emotional factors and the medical or social problems for which patients were to be treated in other Dispensary clinics. The presence of the group therapy class demanded a diagnostic understanding of which patients could best benefit from group help rather than individual help. This was necessary when the worker, during the intake, interview, referred a patient directly to the Class in Applied Psychology without the use of an evaluation by a psychiatrist.

The cases studied in Group III show that the referrals to outside agencies involved the interpretation of the type of help to be received by the patient and of the clinic's findings and impressions of the problem. The cases were referred to outside health agencies when border-line or psychotic disorders existed. When commitment was necessary and in the absence of relatives, the worker accompanied the patient to the hospital in order to provide emotional support. In the presence of predominantly realistic, environmental problems, the patients were referred to a family or another agency. The intake worker cleared with the outside agency before a patient was referred.

It is felt that there was value for both the clinic and the patients in Group IV who were discharged due to their rejection of psychiatric help. The patient learned of a resource to which he might turn when he was emotionally ready to accept help. Clinic time was saved. The intake interview and the interview for evaluation by the psychiatrist were the first steps in sifting out patients who wanted help.

Although this clinic does not treat severely disturbed neurotics or psychotics, acute alcoholics, or organic disorders, it provides a valuable diagnostic service to the Dispensary and the community. In all cases, the intake worker in the intake interview provided the clinic with valuable data for either immediate or future use in treating patients. The worker's impressions were an intrinsic factor in the ultimate disposition of cases. This worker, as the only full time staff member, offered each patient seen a permanent relationship with the clinic as he used the clinic for treatment or in the event of future need for help. The total intake process was a valuable and necessary step which led to a discriminating use of the psychiatric services available in the clinic.

Approved:

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# APPENDIX

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SCHEDULE

IDENTIFYING INFORMATION

Name: Marital status:

Age: B.D. #:

Sex: S.S. #:

REFERRAL TO PSYCHIATRIC CLINIC

When?

By whom referred?

INTAKE INTERVIEW

When?

By whom?

Presenting problem or problems as seen by patient:

Home situation:

Work situation:

Worker's impressions and recommendations:

DISPOSITION OF CASE

When did disposition take place?

Retained by Psychiatric Clinic?

Referred to another clinic in hospital?

Referred to outside agency?

Discharged?

ACTIVITY OF INTAKE WORKER

With patient? With patient's relatives?

With team members? With other agency members?

With referring agent? With source referred to?