1955

Cases treated solely by the social worker in a psychiatric clinic

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

CASES TREATED SOLELY BY THE SOCIAL WORKER IN A PSYCHIATRIC CLINIC

A thesis

Submitted by

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CHAPTER I

INTRODUCTION

I. General Purpose

The general purpose of this study is to investigate and to describe current casework practice at the Psychosomatic Clinic of the Massachusetts Memorial Hospitals. In the last few years there have been a number of student social work theses that dealt with various aspects of the casework process in this clinic[1] and it is the writer's intention to follow up their endeavors by a study of another aspect which has not yet been undertaken: the study of cases carried solely by the social worker.

In recent years there have been a number of new trends developed in the practice of casework in psychiatric settings and a great deal has been written about the role of the psychiatric social worker within the framework of the clinic team.

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1 Dorothy E. Cadieux, "Casework with Patients Treated Concurrently by Social Worker and Psychiatrist", Smith College School of Social Work, 1953.

Katharine Mary Freeman, "A Study of Casework Focus and Treatment of Ten Women at the Psychosomatic Clinic of the Massachusetts Memorial Hospitals", Boston University School of Social Work, 1953.

Robert James Hiltner, "The Role of the Social Worker Treating a Patient Cooperatively with a Psychiatrist in a Psychiatric Clinic", Boston University School of Social Work, 1953.

Before proceeding to describe the role of the psychiatric social worker at the Psychosomatic Clinic of the Massachusetts Memorial Hospitals, the writer thought it would be helpful to outline in a general way some of the current theories and practices in the field in order to provide a meaningful background and framework for this study.

II. The Role of the Social Worker in a Psychiatric Clinic

The Group for the Advancement of Psychiatry addressed themselves to this subject in an attempt to describe how the social worker functions as a member of a psychiatric clinic team.[2]

> In modern psychiatry the patient no longer appears as a fragment of psychopathology, but as a human being in a structured social situation, a part of an organic social group who is involved at all times in a complicated system of interpersonal relationships, and whose inner tensions and conflicts are inseparably bound to his social matrix. In recognition of these interrelationships, the provision of effective psychiatric service in clinics has become a collaborative activity of the several professional disciplines, particularly psychiatry, clinical psychology and psychiatric social work, functioning together in the interests of the patient and the persons important to him.[3]

Because of the distinctive training of the social worker which involves the understanding of psychological

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2 Committee on Psychiatric Social Work, Group for the Advancement of Psychiatry, Psychiatric Social Work in the Psychiatric Clinic, No. 16, p. 1.

3 Ibid., p. 1.

processes within the individual as well as an interest in, and understanding of, his interpersonal relationships, and knowledge about the community in which he lives, the social worker is often the member of the team chosen to represent the clinic to the community.[4] This function involves interpreting the clinic's services to the potential patient, helping the patient determine whether the clinic's services are appropriate to his problem or whether another social agency could best meet his needs. In a broader sense, the interpretive function of the social worker may extend to his participation in mental health education programs in the community.

As a part of the intake process which is so often the responsibility of the social worker in a psychiatric clinic, he must present to other team members an accurate description of the patient and his problem at the intake conference, and for this he must have dynamic understanding of personality, social factors, community resources, and the clinic's role in the community.[5]

In the process involving study and exploration of the patient's problem the social worker has traditionally been

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4 Ibid., p. 2.

5 Ibid., p. 3.

the member of the clinic team who is responsible for taking a social history, and for working with the patient's relatives around preparing them for the patient's treatment, as well as at times functioning as a coordinator of the various diagnostic processes necessary, and providing a sense of continuity for the patient involved in them.[6]

The treatment role of the social worker is not so easily delineated. Clinics vary considerably in the treatment role they assign to the social worker. In most child guidance clinics, for example, it is the psychiatrist who treats the child, and the social worker who treats the parents or operates in the environment as the treatment of the child calls for changes. In other psychiatric settings the patient is treated by the psychiatrist, regardless of the diagnosis and the treatment plan, and the worker obtains the social history, works in the environment to try to change it for the patient's benefit. In some cases this might mean involving relatives in casework treatment as part of the total treatment plans of the patient.

There has been some experimentation in recent years in extending the role of the social worker in the psychiatric clinic to include the direct treatment of the patient by

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6 Ibid., p. 3.

the worker. This has evoked much discussion among professional people in psychiatry and social work about the caseworker as therapist.

Benjamin Lyndon in a discussion of this recent trend in the field of psychiatric social work delineates four main levels of treatment:[7] environmental modification, supportive treatment, experiential treatment, and insight therapy. The social worker has traditionally been seen as qualified to use any of the first three of these. The newer trend extends to the worker the possibility of using all four levels, depending on the worker's own personal competence and the needs and abilities of the patient. In clinics or hospitals where this view is held, the worker may in fact be doing psychotherapy under the guidance of a psychiatrist.

Lyndon points up the fact that this has definite implications for the clinic team, because it cuts across professional lines. The needs of the patient and the personal qualifications of the team member determine who is to treat the patient. There is not the dichotomy of the psychiatrist treating the patient and everyone else supporting the therapy.[8]

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7 Benjamin J. Lyndon, "Psychiatric Social Work in Evolution", Journal of Psychiatric Social Work, 19:54-61, Autumn, 1949.

8 Ibid., p. 59.

Within the main stream of what is considered generally as appropriate methods of casework treatment (the first three levels mentioned by Lyndon but not including insight therapy), there is still the question of how to make optimum use of these casework methods in the treatment of patients.

Rose Goldman, in a discussion of what the criteria of selection should be for casework treatment as the treatment of choice in a given case,[9] felt that it depended on the goals of the treatment planned in each case. For instance, when the goal is to strengthen a patient's weakened ego, by improving its capacity to deal with reality, then she felt that the casework method is optimum. On the other hand, where the goal is to break down defenses and explore unconscious conflicts, then a form of psychotherapy is indicated.

She felt that whenever the predominant focus of treatment is on improved reality functioning then casework is the best form of treatment. This may be due to the fact that the patient is so preoccupied with his reality problems that he cannot benefit by another form of treatment initially, or because his reality needs are an acutely pressing factor. Also in those cases where opening up the inner problems is

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9 Rose Goldman, "The Psychiatric Social Worker's Treatment Role", Journal of Psychiatric Social Work, 20:65-68, December, 1950.

contraindicated and the goal is helping to build or rebuild the defenses of the patient with impaired ego strengths then casework can be of benefit to the patient.

She adds a further point which is that in situations where there is a period of tapering off of direct therapy, it may be important to provide or encourage enriching life experiences, both by material and psychological means, through which the patient can consolidate or assimilate his therapeutic gains. This can be a very important function of the caseworker.

Along these same lines, Grete Bibring feels that in general the aim of casework is not to eliminate the internal causes underlying the patient's personality difficulty, but to help him find the satisfactory form of social adjustment, on the basis of psychological understanding and often through direct help with the actual problem. She feels that casework treatment that utilizes both environmental and personal treatment methods has in it the potentialities for effective reorientation of the patient.[10]

It can be seen from this brief description of some of the current theories and practices regarding the role of the psychiatric social worker in the psychiatric clinic that

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10 Grete Bibring, "Psychiatry and Social Work", Journal of Social Casework, 28:203-211, June, 1947.

there is no definite or easily defined role assigned to the social worker, and that the function of the worker varies depending on the clinic and its orientation and structure. The use of the social worker in the direct treatment of the patient is very definitely still in the exploratory stages of development.

III. The Clinic Setting

In the Psychosomatic Clinic of the Massachusetts Memorial Hospitals, the role of the psychiatric social worker is mainly adjunctive, and complements to a large degree the therapeutic endeavors of the psychiatrist who is responsible for the overall treatment plan of the patient.

The Psychosomatic Clinic is one of a number of clinics within the total Out-Patient Department of the hospital, and at the time of writing included the Seizure Clinic as well as the Adult Psychosomatic Clinic in its scope. The Clinic as a whole is staffed by senior psychiatrists, resident psychiatrists, a full-time psychologist, and two full-time social workers. The seizure section of the Clinic treats patients with epilepsy and the psychosomatic section treats patients suffering from psychoneurotic and psychosomatic symptoms, and those having physical illnesses with concomitant emotional disturbance. Psychotics, drug addicts, and alcoholics are not generally accepted for treatment.

The Clinic is under the joint auspices of the Massachusetts Memorial Hospitals and the Boston University School of Medicine as one service in the medical school's Department of Psychiatry and Neurology. It thus serves also as a training center for psychiatric residents and fourth year medical students. In addition, the Clinic provides training experience for social work students and students in psychology.

Patient referrals are accepted from both inside and outside the hospital. Those referred from other departments within the hospital are assigned and seen directly by a psychiatric resident for evaluation. Those referred from outside the hospital--usually from a social agency, another hospital or by a private doctor--are asked for a letter of referral to the head of the Social Service Department within the Clinic. When a patient is referred by a friend or relative, or is self-referred, he is seen first by the head social worker. If, on the basis of the referring letter or the preliminary interview, the case seems appropriate for the Clinic, an evaluation interview or series of interviews is scheduled with a psychiatric resident. Then, before final acceptance of the patient for treatment, there is an intake conference with the Director of the Clinic, at which are present the Director and the psychiatric residents, the psychologist, and the head social worker, and final disposition of the case is decided. This referral and intake

procedure will be noted as having both similarities and dissimilarities with procedures in other clinics with regard to the function of the social worker in the intake process.[11]

Social Service within the Clinic is a part of the hospital's Social Service Department, and accepts cases for treatment from the psychosomatic section and the seizure section of the Clinic. Of the two full-time social workers at the Clinic, one functions as the head of the Social Service Department, and the other is primarily casework supervisor of social work students, of which at the time of writing there were six. A large proportion of actual casework done at the Clinic, therefore, is done by the students.

Not all the patients treated in the psychosomatic section of the Clinic are referred to the Social Service Department. Patients or relatives of a patient are referred to Social Service by the doctor in consultation with the head social worker, when there are problems in a patient's current environment, either material or personal, which affect his response to therapy, or when a patient is in need of a supportive relationship during or following therapy.[12] Referrals may be made at the time a patient's case is discussed at the intake conference or at any appropriate time

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11 supra, p. 2.

12 Katharine Mary Freeman, op. cit., p. 5.

during the course of therapy.

Cases are referred to Social Service from the seizure section of the Clinic when it is felt by the doctor and the head social worker that either the patient or a member of his family, or both, could be helped by casework treatment.

Psychiatry and social work function in close proximity at the Clinic. Many cases are carried concurrently for at least a part of the total Clinic contact, by the psychiatrist and the social worker, and there is close collaboration between them in the sharing of information and in the planning of treatment goals. Each discipline accepts basic responsibility for its own procedures, but at the Clinic the overall diagnosis and treatment planning for the patients is primarily a medical responsibility.

IV. Specific Purpose, Scope, Limitations and Value of the Study

A number of cases carried in the Social Service Department of the Clinic fall into the category of being seen in treatment by the social worker alone, and the purpose of this paper is to describe in detail what this type of service consists of, examining the total procedure of casework with these patients, and within specific areas of social adjustment, what kind of help is given.

From a detailed description of the casework contact

of social workers carrying these cases alone, it is hoped that the department will be in a better position to evaluate and improve their services to these patients. The value of this study, however, is limited, as it is applicable to and descriptive of only the Social Service cases within this particular clinic. Further limitations include that of the writer's own inexperience and the fact that case material available for this study is primarily the work of social work students, and varies greatly in comprehensiveness and usability for the purposes of this study. In addition to these general limitations, it should be made clear that it is not the writer's intention to evaluate the results of casework treatment per se. This is unrealistic in the light of the writer's own inexperience and the fact that some of the patients studied will have also had treatment by a psychiatrist, and it would be difficult to assign specific results to each discipline.

This study will attempt to answer the following four questions:

(1) What kinds of referrals are made to Social Service in those cases where the worker carries the case alone?

(2) What are the problem areas of social adjustment for which casework help is given?

(3) What social adjustment is achieved, in terms of these problem areas, at the termination of the casework treatment?

(4) How does the worker help the patient to achieve a better social adjustment?

In order to secure case material, a survey was made of all closed Social Service records of adult patients, to select those carried for any length of time by the social worker alone. These cases amounted to forty-two altogether, and were broken down into two sub-categories: those patients referred from the psychosomatic section of the Clinic, having had (or at the time of referral, still in the process of having) psychotherapy, constituted one group of study cases. The second group was made up of those patients referred from the seizure section of the Clinic, having had no psychotherapy. There were sixteen cases from the psychosomatic section and twenty-six from the seizure section of the Clinic.

V. Method of Study

When the study group was selected, the cases were read and evaluated according to a schedule and a quantitative descriptive analysis was made of the patient group as a whole in order to answer the first three questions posed in this study. The fourth question, "How does the worker help the patient to achieve a better social adjustment?" will be answered through a detailed study of six cases selected to illustrate the casework done with one patient in each problem area of social adjustment for which casework help was given.

The selection of cases to be used in the second part of the study was limited by the fact that some cases illustrated less clearly than others the area of social adjustment handled by the worker, and how the worker helped in this area.

CHAPTER II

QUANTITATIVE ANALYSIS OF FORTY-TWO CASES TREATED SOLELY BY THE SOCIAL WORKER

I. Introduction

This chapter will attempt, through a quantitative examination of the total cases to be studied, to answer the first three questions posed by the writer: (1) What kinds of referrals are made to Social Service in those cases where the worker carries the case alone? (2) What are the problem areas of social adjustment for which casework help is given? (3) What social adjustment is achieved, in terms of these problem areas, at the termination of the casework treatment?

The data for this chapter was collected using the schedule found in the Appendix. The group of cases studied was selected by examining all the closed Social Service records to determine those having had Social Service contact at some time without concurrent psychotherapy. It was found that those appropriate for this study amounted to forty-two cases altogether which were closed from January 1949 through November 1954. Eliminated were those cases that were seen prior to 1949, because of insufficient recording, and those cases where part of the contact had for some reason not been recorded. All others were included in the study group.

II. Description of the Group

In examination of these cases it was found that sixteen out of the total of forty-two cases were referred from the psychosomatic section of the Clinic, and twenty-six from the seizure section. Of those patients referred from the psychosomatic section, all had had some psychotherapy, although the length of time in psychotherapy ranged from one month to over three years. None of those patients referred from the seizure section of the Clinic had entered into psychotherapy, but all of them were being seen periodically for check-ups and medication by psychiatrists on the staff.

The patient's ages ranged from fifteen to sixty-six, but more than two-thirds of the total group were between twenty and twenty-nine years old. Ninety-three per cent of the patients were under forty. Of the total group, eleven were men and thirty-one were women. Sixteen out of the twenty-six patients referred from the seizure section were women and all of the patients referred from the psychosomatic section were women. Table I shows a more thorough breakdown of the study group's source of referral according to age and sex.[1]

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1 For this table and for all the following tables, "psm" is used to denote the referral of patients from the psychosomatic section of the Clinic, and "sx" is used to denote the referral of patients from the seizure section.

TABLE I

AGE DISTRIBUTION BY SEX OF A GROUP OF PATIENTS REFERRED FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTION OF THE CLINIC

Age	Male		Female		Total	
	psm	sx	psm	sx	psm	sx
15-19		1	1	4	1	5
20-29		8	12	7	12	15
30-39		2	2	3	2	5
40-49						
50-59			1		1	
60 +				1		1
Total	0	11	16	15	16	26

Forty patients out of the total group of forty-two were white, and the remaining two were Negro. Twenty-two of the total group were Catholic, sixteen were Protestant, and two were Jewish. Twenty-six were born in Massachusetts, fourteen in other states, and two were of foreign birth. These statistics seem to reflect the racial and religious preponderance of the population in the surrounding community.

More than half of the total group of patients had had some high school education or had completed high school. Ten patients had had some elementary school education or had

finished the eighth grade, and three had had some college or had finished college. In seven cases the educational level reached was unknown.

Seven patients at the time of referral to Social Service were engaged in, or had been working last in unskilled or semi-skilled jobs, one was a skilled laborer, four were employed in white collar jobs, one was a librarian, five were in service occupations (i.e., waitresses, domestics, hospital attendants, etc.), eleven were housewives, one was a student, and eleven were unemployed--their previous occupations, if any, were not known. Scattergram I shows educational level as correlated with occupation for the group as a whole.

It is interesting to note that the patients referred from the seizure section constitute those patients who were unemployed, with previous jobs, if any, unknown, and that these patients as a group had less education than those in the psychosomatic group. The fact that the employed seizure patients for the most part were those in service or semi-skilled occupations might indicate that these occupations, where fewer questions are asked about the worker's background, are those that are most available to the epileptic patient. However, these occupations are the very ones in which employment is most uncertain.

The majority (twenty-seven) of the total patients studied were single, nine were married, three were separated,

and three were divorced (Table II). Twenty-one out of the twenty-six patients from the seizure section were single, while only six out of sixteen patients from the psychosomatic section were single. This disparity possibly could be related to the disabling effect of epilepsy on the patient, or social prejudice about the illness.

SCATTERGRAM I

EDUCATIONAL LEVEL AS CORRELATED WITH OCCUPATION IN A GROUP OF PATIENTS REFERRED FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTION OF THE CLINIC*

Occupation	EDUCATION: Finished some Grades	Finished Eighth Grade	Finished some High School	Finished High School	Finished some College	Finished College	Educational Level Unknown	Total
Unemployed	xx	xxx		xx xxx			x	11
Unskilled or Semi-skilled	xx	x	o xx	x				7
Service Occupations		x	xx	x				5
Housewife			oo	oo	o		ooo ooo	11
Skilled			x					1
Student			o x					2
White collar		x	x	x		o		4
Professional					o			1
Total	4	6	14	10	2	1	7	42

* "o" refers to patients from the psychosomatic section, and "x" refers to patients from the seizure section of the Clinic.

TABLE II

MARITAL STATUS ACCORDING TO SEX OF A GROUP OF PATIENTS REFERRED FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTIONS OF THE CLINIC

Marital Status	Male		Female		Total	
	psm	sx	psm	sx	psm	sx
Single	9		6	12	6	21
Married	1		8		8	1
Separated	1			2		3
Divorced			2	1	2	1
Total	0	11	16	15	16	26

Twenty-one out of the twenty-seven single patients in the total group were living with either one or both parents. The great majority of the seizure patients were single, and of these, nineteen out of the twenty-one were living with one or both parents, which again might suggest a relationship between the special handicap involved in this kind of illness and a desire of the patient or his family to live with those who could care for him in need.

Four patients out of the total group studied were living with other relatives, and two were living alone. Of the patients either separated or divorced, some were living with either one or both parents, and the rest were living alone or with their children.

III. Psychiatric Diagnosis and Length of Treatment

The sixteen patients in the study group referred from the psychosomatic section of the Clinic varied widely in the problems they presented. The differential diagnoses (see Table III) included depression, anxiety state, hysteria, character disorder, enuresis, and ulcerative colitis, with a variety of somatic symptoms often accompanying them. These included vomiting, headaches, palpitations, pains in various parts of the body, irritability, sleeplessness, tics, and others. All of the patients in the study group referred from the seizure section of the Clinic had epilepsy.

All patients referred from the psychosomatic clinic had had psychotherapy. Four of these patients had less than six months in therapy altogether, five had between six months and one year, two had up to a year and one half, three had between one and one half years and two years, one had between two and two and one half years, and one had more than three years in therapy.

The length of time in which these patients were seen concurrently by a psychiatrist and a social worker ranged from one month to a year and a half. Six patients were seen concurrently for less than three months, six were seen between three and six months in concurrent treatment, and the remaining four were seen by a psychiatrist and a social worker together for more than six months.

The patient in therapy has interviews with the doctor anywhere between once to three times per week generally, while casework interviews are not generally more frequent than one interview per week.

TABLE III

DIFFERENTIAL DIAGNOSIS OF A GROUP OF PATIENTS REFERRED FROM THE PSYCHOSOMATIC SECTION OF THE CLINIC

Diagnosis	Number of Cases	
Depression	3	
with somatic symptoms	6	
Total	9	
Anxiety state	1	
with depression and character disorder	1	
with somatic symptoms	1	
Total	3	
Hysteria		
with depression and character disorder	1	
with somatic symptoms	1	
Total	2	
Enuresis	1	
Total	1	
Ulcerative colitis	1	
Total	1	
Total		16

IV. Reasons for Referral to Social Service

The inclusion of the social worker in the total treatment plan for the patient in psychotherapy was due to a variety of reasons. Frequently the social worker is called in on the case to provide a supportive female figure either to lessen the intensity of the transference to the psychiatrist, or to provide the patient with an additional parental figure. On the other hand, sometimes social workers are called in to help with an environmental problem that is blocking the progress of the patient in therapy, or for both these reasons. In some of the cases where the worker is called in for the above reasons, there may have been no predetermined plan whereby the social worker will continue with the patient after the termination of therapy. However, in the cases included in this study the worker did continue with the patient after therapy was discontinued.

Further reasons for the inclusion of the social worker in the treatment plan for the patient concern the termination of therapy more specifically. When a patient has worked through to some satisfactory solution the intrapsychic problems which were the focus of the therapy, he may well need further help on a less intense level, frequently in terms of the environmental situation, including relationships with

family members.[2] In such cases a social worker will enter the case at or near the termination of therapy and will continue with the patient after the close of psychiatric treatment. In this kind of referral an important consideration is the nearness and availability of psychiatric service, in the event that a crisis occurs, or the patient again feels the need for the psychiatrist's help. When it is thought that the patient no longer needs to be seen in a psychiatric setting, the worker will either transfer the patient to another community agency for further casework help, or will close the case.

On the other hand, a patient may not be responding well to therapy and treatment may be discontinued for the present time. If it is thought that the patient might be able to use casework with more gain, he may be transferred to Social Service, with the idea that at some future time he might resume treatment with the psychiatrist.

In all of the forty-two cases included in this study--those from the seizure section, and also all of those having been in therapy in the psychosomatic section of the Clinic--environmental problems were explicitly stated as the reason for referral to Social Service, although in some cases "a relationship with a female (or male) figure" was also stated

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2 It can be seen that this important function of the social worker at the Clinic reflects what Ruth Goldman felt to be one of the ways to make optimum use of the social worker's skills in a psychiatric clinic. See page 7.

as a reason. The patient, however, is always given the situational problem as the reason for his coming to see the social worker. This enables both the patient and the worker to focus with a minimum of difficulty on the more tangible problems, and helps to clarify the role of the social worker for the patient. There may, however, be other problems that emerge during the casework contact, and the focus at the time of referral may shift to meet other needs of the patient. The problem areas for which casework help was given will be discussed in more detail later on in this chapter.[3]

As was mentioned, the reasons for referral to Social Service always included a situational problem area, and often more than one--as well as, in some cases, the explicit request for a supportive figure.

It might be wise to make clear at this point that although an environmental problem is given as the reason for a patient being referred to Social Service, casework treatment in any problem area is through the medium of the therapeutic worker-client relationship, and that effective casework treatment depends on the worker's thorough understanding of the individual's personality and social functioning.

As reasons for referral in the forty-two cases in the study group, the writer found that there were six problem

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3 See pages 29-30.

areas mentioned. To clarify what kinds of help might be given in each area, each will be discussed separately.

1. Vocational or employment planning often involves helping the patient in making a decision about his vocation as well as helping to support a decision already made. Help in this area may also include making the actual arrangements, such as making an appropriate referral, or writing letters, etc. Often the worker will help the patient explore his own interests and encourage him in realizing his interests in a vocation through specialized vocational training, or will help him with personal problems centered around his job.

2. Social outlets or contacts might involve helping an isolated patient to form more meaningful relationships with others, or helping a patient gain satisfactions in clubs, volunteer work, hobbies, jobs, etc., which might improve the patient's self-esteem, enrich his social life, or redirect his energy from less healthy preoccupation to more appropriate activity. The development of a strong positive worker-client relationship is especially important in casework in this area as a way of providing a new and more constructive and meaningful relationship in which the patient can both work through some of his difficulties and experience a positive relationship which hopefully may strengthen his capacity for improved social contacts.

3. Household planning might include the placement of children, the arranging for housekeeping services, helping in the management of the household, and problems around moving.

4. School planning might mean helping a patient to make a decision with regard to his future academic schooling, or might more simply mean helping him make certain arrangements with regard to schooling. Also included in this category would be helping a patient with a personal problem centered around school.

5. Financial planning would involve help with budgeting, or arranging for public assistance, or the giving of financial or material aid.

6. Family relationships might include problems between the patient and his or her parents, spouse or child. The worker is often able to help in this less tangible area by stress on the conscious use of himself as a parental figure to the patient, and the constructive relationship between them can help in mitigating some of the neurotic needs of the patient which he may act out on those in his family. Often the relationship with the worker will itself reduce pressures and tensions which the patient feels in his own family. It will become clearer in a later part of this study in which actual case material will be presented, how the worker can help the patient with problems in this area through casework.

In many of the cases studied there was more than one reason for referral stated, and it can be seen in Table IV that there were sixty-seven reasons given in all.

TABLE IV

MULTIPLE REASONS FOR REFERRAL TO SOCIAL SERVICE OF A GROUP OF CASES FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTION OF THE CLINIC

Reasons for referral	Number of Cases*		
	psm	sx	Total
1. Vocational planning	6	21	27
2. Social outlets or contacts	7	6	13
3. Household planning	7	1	8
4. School planning		5	5
5. Financial planning	4		4
6. Family relationships	2	1	3
7. Supportive male or female figure	6	1	7
Total	32	35	67

* "Number of Cases" indicates the number of cases in which the problem area appeared as a specific reason for referral.

It is interesting to note that in twenty-one out of the twenty-six cases referred from the seizure section of the Clinic, help with vocational planning is indicated as one of the reasons for referral, as compared with only six out of the sixteen cases from the psychosomatic section. Again, this high correlation with the seizure group might point to particular difficulties the epileptic patient has

in finding suitable employment. For the group as a whole, the largest number of cases included vocational planning in the referral, while the next largest number listed help with social outlets as the reason. In those cases where more than one reason was given for referral it was found that the most frequent combination of reasons were social outlets or contacts and vocational or employment planning.

V. Focus of Casework Treatment

It was found that there were some differences between the problems each patient was referred for, and the problems that were included in the focus of the casework treatment. The most conspicuous difference, as can be seen by Table V, is that only three out of a total of forty-two cases included help with family relationships as a reason for referral to Social Service, while actually family relationship problems were one of the main foci of casework in eighteen out of the total of forty-two cases. This would seem to indicate that relationship difficulties underlying the specific referral problem emerged during the casework contact.

In general, comparing the number of reasons for referral to Social Service, and the number of problems handled in the actual work with these patients, an increase of twelve was found in the total number of problem areas mentioned, which does indicate that other problems emerged during the

casework contact for which the worker gave his assistance.

In the three cases referred for help with school planning, upon exploration by the worker it was found that the main difficulty was really in another problem area of social adjustment and therefore the focus of casework treatment changed to meet the patient's needs.

TABLE V

PROBLEM AREAS IN WHICH CASEWORK HELP WAS GIVEN IN THE SAME GROUP OF CASES

Problem areas	Number of Cases		
	psm	sx	Total
1. Vocational planning	6	24	30
2. Social outlets or contacts	5	10	15
3. Household planning	7		7
4. School planning			
5. Financial planning	6		6
6. Family relationships	12	6	18
7. Adjustment to illness		3	3
Total	36	43	79

One of the problem areas which was not found in any of the cases as a reason for referral was the patient's adjustment to his illness, which was found to be one of the specific areas included in the casework treatment of three patient's with epilepsy.

VI. Length of Social Service Contact

The length of Social Service contact for the patients ranged from less than six months to between three and four years. As Table VI indicates, a little less than half of the total number of patients were seen for less than six months. This group, however, includes most of the patients in the seizure group, while none of those patients referred from the psychosomatic clinic are included in this group.

TABLE VI

LENGTH OF SOCIAL SERVICE CONTACT OF A GROUP OF PATIENTS FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTION OF THE CLINIC

Length of casework contact	Number of Cases		
	psm	sx	Total
From 1 to 6 months		17	17
From 6 months to 1 year	2	5	7
From 1 year to 1½ years	5	2	7
From 1½ years to 2 years		1	1
From 2 years to 2½ years	6	1	7
From 2½ years to 3 years	1		1
From 3 years to 4 years	2		2
Total	16	26	42

The majority of the psychosomatic group were in casework treatment for one year through two and one-half years. The median for the psychosomatic group was from two to two and one-half years, for the seizure group from one to six months.

In relation to these findings the writer thought it would be worthwhile to correlate the length of social service contact with the evaluation by the worker of the patient's social adjustment at the termination of the casework contact, but before going into this, the reasons for the closing of the cases will be discussed.

VII. Termination of Social Service Contact

The writer found after examination of the total group of cases, that the reasons for the closing of the cases could be broken down into nine categories, and each of these will be explained.

First of all, as was noted earlier in the introduction to the study,[4] in the large majority of the cases handled by Social Service, the caseworkers are students who are placed in the clinic for usually about a nine month period of time by the schools of social work. This means that cases are frequently transferred, necessitating a readjustment for the

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4 supra, page 10.

patient. This is not always accomplished easily and it was found that one of the reasons for closing in the cases studied was that the patient either did not return at all after the student worker left, or failed to maintain the contact with the next worker.

Another category is simply that the patient failed to keep his appointments with the worker and terminated contact. In such cases it is not always known why this occurred and the writer has not attempted to find out.

A third category is referral to another agency, frequently to a family agency. In the cases of patients referred to this kind of agency, it was thought that the patient no longer needed to be seen in a psychiatric clinic, yet could benefit by further casework help. Of the cases studied there was one instance where referral to another agency did not mean referral to a family agency. In this case the patient was referred to an adoption agency for the placement of her illegitimate baby.

The fourth category, "solution reached; termination by mutual agreement", indicates that further casework help was not felt to be necessary by either the worker or the patient, and that the patient had reached a satisfactory solution to the problems they had been working on together.

The fifth category, "the patient felt no further need", indicates that the patient did not wish to continue

with the casework treatment plan, and felt there was no further need to do so. This is to be distinguished from the fourth category where there was mutual agreement about terminating contact.

The sixth category, "patient returned to therapy", indicates that at some time during the casework contact the patient again needed psychiatric help and re-entered therapy.

Category seven and category eight, "patient moved away" and "patient died" are self explanatory.

The ninth category, "poor prognosis; case closed when student left clinic", indicates that such cases were not terminated, although it was felt that the patient could not benefit very much from casework, until a natural break in the relationship occurred--i.e., when the student left the clinic.

Table VII shows the number of cases in each of these categories of the total cases studied--again in terms of the source of referral, as there is some difference between the two sub-groups.

It can be seen in Table VII that the majority of the psychosomatic cases were closed because of referral to another agency, while the majority of the seizure cases were closed because the patient did not return--either because the worker left or otherwise. This would seem to indicate some difference in the two groups regarding their response to

casework treatment. It might also mean some difference between the two groups in terms of the relative outcome of the cases upon closing, and it is this which will next be discussed.

TABLE VII

REASONS FOR TERMINATING CASEWORK CONTACT IN A GROUP OF CASES REFERRED FROM THE PSYCHOSOMATIC AND THE SEIZURE SECTION OF THE CLINIC

Reasons for closing	Number of Cases psm	sx	Total
1. Worker left; patient did not continue		7	7
2. Patient did not return	2	9	11
3. Patient referred to other agency	9	1	10
4. Solution reached; termination by agreement	1	2	3
5. Patient felt no further need	1	5	6
6. Patient returned to therapy	1		1
7. Patient moved away	1	1	2
8. Patient died	1		1
9. Poor prognosis; case closed when worker left		1	1
Total	16	26	42

VIII. Evaluation at Termination of Social Service Contact

In only a very crude way, in terms of this study, can change or results be measured. The writer has attempted to indicate in general terms the evaluation of the patient by the worker at the close of the case. This information was often stated explicitly in the recorded closing summary. Where this was not the case, the writer has used her own judgment in evaluating the information given in the closing summary to determine to which category the evaluation most nearly corresponds.

The first category is "specific referral problem met". This refers to such reasons for referral as help in finding a job, or arranging a school placement, or help in solving a financial or household problem. It cannot be applied to less tangible problems such as family relationship problems or the need for social outlets or contacts. To crudely evaluate adjustments in these areas, three further categories were set up, namely "no appreciable change", "some improvement", and "much improvement". It will be noticed in Table VIII that there is a higher proportion of cases showing improvement in the psychosomatic group than there is in the seizure group, and that half of the seizure group showed no appreciable change. (This also implies that in some of these cases the specific referral problem was not met either.)

TABLE VIII

EVALUATION AT CLOSING OF A GROUP OF CASES ACCORDING TO SOURCE OF REFERRAL

Evaluation	Number of Cases psm	sx	Total
Specific referral problem met	2	7	9
No appreciable change	4	13	17
Some improvement	6	3	9
Much improvement	4	3	7
Total	16	26	42

The writer was interested in seeing if there might not be a correlation between the outcome, as indicated in Table VIII, and length of Social Service contact, as indicated in Table VI.[5]

Table IX indicates there is at least one general correlation. This is most significant in terms of the epileptic patients, as it will be remembered that only these patients are included in those having only up to six months in casework treatment.[6] It can be seen that ten patients

5 supra, page 31.

6 supra, page 31.

out of the seventeen that were seen for only this length of time showed no appreciable change. In general those patients who were in treatment for more than a year showed more improvement than those who were seen only up to one year.

TABLE IX

LENGTH OF SOCIAL SERVICE CONTACT ACCORDING TO SOCIAL ADJUSTMENT ACHIEVED AT TERMINATION OF CONTACT

Length of Contact	Specific Need Met	No Change	Some Improvement	Much Improvement	Total
1 - 6 months	5	10	2		17
6 months - 1 yr	2	3	1	1	7
1 - 1½ years	2	1	1	3	7
1½ - 2 years				1	1
2 - 2½ years		3	3	1	7
2½ - 3 years			1		1
3 - 4 years			1	1	2
Total	9	17	9	7	42

CHAPTER III

PRESENTATION OF SIX CASES ILLUSTRATING THE CASEWORK DONE IN EACH SITUATIONAL PROBLEM AREA

I. Introduction

In the last chapter it was found that there were six problem areas of social adjustment for which casework help was given. This chapter will attempt to answer the fourth question posed in the study: "How does the worker help the patient to achieve a better social adjustment?" Through a detailed description of six cases, selected to illustrate the casework done with one patient in each of these six problem areas, it is hoped that what is involved in the treatment will become clear.

These six cases were selected out of the total group of forty-two cases because they seemed to illustrate more clearly than others what the casework focus was, and how the worker helped the patient in his attempt to handle his problems.

II. Vocational Planning: The Case of Mr. John Bryant

Mr. B., a twenty-two year old single man, had been followed in seizure section for two years. He had petit mal attacks but at the time of referral for vocational planning, his seizures were under control.

He lived with parents and brother, two years younger. In the initial interview, he discussed previous work experiences and graduation from high school two years ago. During school he worked part-time in a factory as errand boy to earn spending and clothing money. He did not want to continue, but was discharged anyway as a returning veteran was given job. Since graduation, he had many odd jobs. He had vocational testing at the Y.M.C.A. They felt he should have some technical training in radio work, as he was primarily interested in that. The worker explored this interest. He went to one training school six months a year before, but did not like it. He preferred the T-- School. He did want further training in radio work, and the worker agreed to talk with Mr. X at the State Department of Vocational Rehabilitation. Mr. X suggested that the Clinic send a letter and he would interview Mr. B. The worker arranged the appointment and saw Mr. B. after his appointment there. There was a possibility of obtaining a scholarship to the T-- School, and he was very enthusiastic. He talked a great deal of his interest in science, radio and television, and used many complicated technical words, seemingly in an attempt to impress the worker. The worker explored his interest, learned he read much, and often hurt his eyes. He shared a room with his brother, and the light was poor. His mother disapproved of his having his own lamp. This led him to talk of his mother, who was very critical of him and he seemed quite bitter. His and brother's interests were very different, and they did not get along very well. When asked about other friends he mentioned the "Y" and his liking for card games and pool especially.

He was hesitant to speak of his epilepsy, but wondered if the school would admit him even though his seizures were practially gone. He decided the school should know; planned to work this out himself.

He had to wait a couple of weeks before hearing the final decision about admittance to the school. He hoped to start in December, and wanted a part-time job as well. The worker helped him in exploring his feelings about having to wait for so long, and was interested in his plan for working. Before the next appointment with the worker he was accepted by the school, obtained the scholarship, and the course would last till August. The worker called the State Employment Agency for him but they had nothing to offer. She congratulated Mr. B. when he came in, on his acceptance and the scholarship and asked to hear about it. His family was somewhat

cynical about the news; father thought it was just a "fool's luck" to get the scholarship, and Mr. B. felt rather dubious about it himself. The worker clarified what a scholarship involved and he seemed a bit relieved to learn it was not wholly "gratis". About the job, the worker suggested he go to the State agency and register anyway.

When he started school, he seemed to like it. He had some anxiety about it, and with encouragement could talk more easily about it. At first he went into a long technical description of his schooling, which seemed to be a defense against insecurity. The worker said it was difficult for anyone to go back to school after a long absence, especially hard for him missing the first weeks of classes. With this reassurance he began to talk about his difficulties with mathematics and his insecurity about it.

He was more secure in the training as the weeks went by. He had not found a job, but was not very upset about it, and showed little enthusiasm about going to various employment agencies, etc. He would tell the worker the good marks he had received, and seemed pleased at her compliments.

After this he did not come in for a couple of months, for an appointment, but was seen briefly once when he came for his seizure medicine. He was busy with school and liked it, and saw no need to come in again for the time being. He came later for an appointment in response to a letter of interest sent him by the worker, and continued to be pleased with school. He liked the other students, but had no special friends among them, preferring his friends at the "Y". His family continued in their indifference to his progress at school, but he did not go into either of these subjects with the worker, and felt no further contact was necessary as things were going well. He did come in again in May to say good-bye as the worker was leaving then, and spoke at some lengths of the good marks he obtained, and his hope to go into television work eventually.

During the contact with the first worker, the focus was on his training experience; he did not respond to her attempt to explore his family situation or his social life, although he did respond positively and happily to all marks of recognition, reassurance and compliments regarding his training. Although he cared less about

having a part-time job, he would face the problem of a job when he left the school in August and might need help with this. She recommended a male worker as he seemed to have difficulty establishing relationships with men.

He was seen sporadically during the summer, did have difficulty finding a job, and accepted a transfer to a male worker in the fall. He had not gotten a job, resented his father's attitude that he should get out and do any kind of work, not necessarily that for which he was trained. The worker agreed it would be good if he could get a job in radio, but because of lacking experience, the worker asked about jobs in a related field. He thought about wiring victrolas but there were no jobs open.

The worker again tried to explore his social life but he denied any problem in this area, and responded in the same way to discussions around his family, although it was obvious his relationship with father and brother were not positive, and he seemed very dependent on mother.

In contacts the worker had with Mr. X and also with the "Y" it was clear that Mr. B. was not being very realistic or agressive in searching for a job. The worker tried to encourage him in this, and help him to see his situation more realistically. The worker focussed also on his past jobs, pointing up and complimenting him on the positives of his work experience. Finally in January Mr. B. announced that he had found a job in an electronic tube factory through the State Employment service, and did like the work. The worker helped in eliciting his initial anxieties about starting the new job, and was reassuring and accepting of them, pointing out that his willingness to learn on the job was what was important.

When he was settled in the job he felt no further need to see the worker, and was very happy with his job. There was no further contact and the case was closed.

It can be seen in this case that the specific reason for referral to Social Service was around vocational planning and that this remained the focus of the casework contact. In this area the worker first explored Mr. B.'s previous job

experiences and learned of his unsteady and sporadic job history, and that he had some difficulty with authority figures. The worker learned a little about Mr. B.'s family relationships but he was resistive to exploration in this area. As he indicated his interest in vocational training the worker encouraged and supported him in following through with this plan both by helping to make the actual arrangements and by showing active interest in how Mr. B. was adjusting to training school, constantly supporting his strengths.

When the next student worker was assigned to the case, he was a male worker which was thought might help him in his relationships with men, by providing a constructive relationship experience for him to build on. Again the worker functioned in a supportive way and accepted the focus and the limitations of the treatment which Mr. B. desired. There was no active attempt to involve Mr. B. in treatment around his family or social situation as it was evident that Mr. B. was too threatened by this. Instead the worker helped by accepting his feelings of inadequacy and pointing out positives in his past experiences which helped him to meet present difficulties. By not mirroring the attitudes of people in authority in Mr. B.'s life--too great expectations, criticism, and devaluation--the worker tried to help Mr. B. to see himself somewhat more realistically and to adjust to and

accept himself in the position first as a student, and then as a trainee in his job.

In this case environmental manipulation and psychological support constituted the main casework techniques, towards the goal of improvement in social functioning, and increased ability to handle reality problems.

III. Social Outlets: The Case of Miss Louise Jones

Although this case is presented to show casework activity in the problem area of social outlets, it will become apparent that the focus of treatment might be more aptly described as preparation for social activities, as the patient was quite isolated and very insecure in her relationships with others.

> Louise Jones, an obese, twenty-one years old girl, was referred to Social Service in October for help with vocational planning and social outlets. She had been in therapy for seven months because of depression, amenorrhea, and overweight. She had attended a teachers' college, but left in the second year because of poor work. She was very upset and went to live with grandmother and two aunts in Vermont for the rest of the winter. When she returned home she started therapy at the Clinic.
>
> At the time of referral to Social Service, she was to begin a job as librarian. She lived with her parents and seventeen-year-old brother. Father was a plant superintendent and the family was quite comfortable financially and had certain intellectual standards. Mother was described as being "sugary" and insincere. Brother, according to Louise, was favored by father especially. He was not outstanding intellectually but was athletically, and there was intense rivalry between them.

Grandmother, in Vermont, was described as very domineering. One of the aunts was also domineering; had urged Louise to go out and get a job which she resented. The other aunt was a social worker of whom Louise was very fond. She had at one time wanted to be a social worker, but then did not think she could do that kind of work. She was interested in nursing, but Mother had insisted on teaching, so Louise had gone to the teachers' college. She had very few friends, was quite isolated. Her depression and amenorrhea had disappeared in therapy, and it was felt she could use casework in social areas. Her therapist was leaving the clinic, and therapy was discontinued about one month after casework began.

At the beginning of contact, Louise appeared to relate easily, talked freely about her job as librarian which was to begin, soon. It was felt however that underneath she was quite anxious about the new job, and how she would get along with the head librarian. Miss M had been in the library since 1918, and "liked things a certain way". She used an old fashioned filing system instead of the Dewey decimal system. Louise tried to "explain away" her doubts about how she would get along with the old lady, and how to fulfill her expectations. Louise seemed quite anxious about the job and was trying to handle this by rationalizing Miss M's exact demands.

In the forthcoming interviews, there was much discussion about the new job, the main difficulty being the relationship with Miss M. Louise had difficulty expressing her negative feelings about her; would only admit she was "difficult to get along with". Each time she showed her hostility, no matter how remotely, she would immediately deny these feelings saying she really liked Miss M, and there was a great deal to learn from her. Although she stressed external things that made it difficult to get along with Miss M, the worker felt she was more concerned about her habit of devaluating anyone's suggestion, her inconsistency in mood swings, and the fact that Miss M felt hurt if anyone showed the slightest degree of hostility towards her. On the few occasions when Louise showed some irritation, Miss M bent over backwards for the rest of the day doing favors for her, thus increasing her guilt and keeping her from further show of annoyance. Louise associated to her grandmother here, stressing her conviction that one should show respect and loyalty towards elders. The worker encouraged her to express feelings about Miss M and her grandmother, but for the most part she could only talk about the facts of their beha-

vior, and blocked on the expression of feeling.

In the fourth interview Louise talked for the first time about her social life. She belonged to a young people's group at church, and was dissatisfied with the way things were going. She talked about Jean, who recently had joined the group, with the expressed purpose of gaining the attention of John. Louise greatly disapproved of Jean's agressiveness, and her methods of gaining attention. As Louise continued to talk about the group, it became evident that Jean was very popular and that Louise was not included in the boy-girl relationships, although she did not mention this. Louise was jealous of Jean, and the reason she was dissatisfied with the boy-girl emphasis in the group was her own exclusion from it. Her isolation was quite evident.

Later on, Louise went to a group party, and her role became more clear. She was the one to whom the other members went to talk over their problems, and related to the other members in this way, rather than in full participation in their activities. As the relationship grew stronger with the worker, Louise could express some resentment about being used in this way, and eventually began to involve herself more actively in the group. In the spring she began to form a relationship with another girl and they began to share their mutual problems and interests.

It was still difficult for her to express her feelings about Miss M to the worker, but with consistent support and encouragement she began to do so more readily. She even began to mention a few things to Miss M directly that irritated her, but each time would be overwhelmed with guilt. However, with much of the interviews centering around this area, Louise began to be able to use them to drain off tensions she felt with Miss M until she came finally to handle Miss M as she was, and to focus more, with the worker's guidance, on the more satisfying sides to the job, which helped to put the problem in more perspective. As initial hostility began to come out, Louise's own feelings of inadequacy and fear about not doing a good job emerged as the deeper problem. Mistakes she had made on the job, that she had never mentioned before, were talked over with the worker. Louise related these feelings to other experiences in the past with her mother, where she was afraid and needed her mother's guidance, and did not feel confident enough to do things on her own.

When the worker left in May, she was referred to a family agency. She initially thought she should be able to handle her own problems at this point, and needed the permissiveness and support of the worker to allow herself to accept the further help that she really wanted.

At the time of the worker's leaving Louise was finding more satisfactions at work, had made some satisfying friendships, felt more secure about her budding independence, and had lost thirty pounds. It was felt she could use further help well, towards gradually becoming more independent and broadening her social contacts.

Throughout the casework contact the focus remained that of the problems in her job and her progress in social areas. There was very little mention of her relationship with her mother, which diagnostically was very important in Louise's difficulty. Her mother had also been seeing a social worker at the Clinic at this time, but it was difficult to involve her in the casework relationship. Mother was quite dominating with Louise, and there seemed to be quite a hostile-dependent relationship between them. As part of the goals in casework treatment with Louise was to help her to become more independent from her mother, and to be able to form other relationships and find satisfactions in her job, it is interesting that there was not a great deal of emphasis on the relationship with mother directly. One way whereby Louise's relationships with elders was brought out and helped to be worked through was in her relationship with the head librarian, Miss M, which seemed to have many

of the elements in the primary relationship between Louise and her mother.

Throughout, there was much in her feelings about Miss M that were similar to her feelings about her mother, but the worker did not encourage her to talk more about her mother beyond what Louise brought up spontaneously, and instead handled these feelings more in relation to Miss M and other authority figures towards whom the expression of the hostile side of her ambivalent feelings were less threatening.

The casework aim of growing independence and ability to form satisfying relationships with others, was furthered by the relationship with the worker, who functioned as a supportive mother person to Louise, providing a reeducative experience for her, one in which she could discuss her problems and lessen the tensions she felt at home, at the job and in her social group.

With regard to the group, Louise gained some clarification about her role in the group and gradually was able to participate more fully, and form more mutual friendships. she still was very immature and it was felt she could benefit by continued casework treatment. She therefore was referred to a family agency as there was no further need for her to be seen in a psychiatric setting. Her symptoms had not reappeared and she seemed much happier.

IV. Household Planning: The Case of Mrs. Angelo

Mrs. A, a twenty-three year old divorced woman with two children, Tony, four, and Marie, two, was referred to the psychosomatic clinic because she was acutely disturbed, anxious and depressed. She had for nine months prior to referral to Social Service, been in therapy. The worker was called in to make plans for the placement of the children during Mrs. A's acute stage of illness.

Mrs. A had a history of much deprivation and insecurity. Her parents were divorced when she was very young. Shortly after, mother remarried and Mrs. A had a very poor relationship with step-father and step-sister. She had a good high school record, but found it unstimulating and lost interest in studying. There was much difficulty at home with many episodes of running away. Once she remained away for about eight months. She was returned by the police, and mother took her to court on the charge of "stubborn child". She was sent to a mental hospital for evaluation, then to an institution for delinquent girls. When she was discharged at eighteen, she married in haste to get off probation. Her husband enlisted, and she joined his family in Utah where she supported herself and gave his allotment check to his mother. She was unhappy there and left for another city where she met and lived with a sailor. Then she returned East and became pregnant by another man. She refused his offer to join him and lived with still another man who deserted her, by whom she bore another child. Following this she lived with her two children on A.D.C., estranged from her family.

In the first casework interview, she was quite depressed. She was anxious about placement for her children, and outlined another plan; she knew a girl willing to come in to care for them. She didn't want help with the housework, just someone to handle the children. Nothing was wrong with the children, the trouble was with her. She tried not to yell at them but she couldn't help it. The worker conveyed his acceptance, replying it was hard being sick and trying to care for the children at the same time. Both psychiatrist and worker felt that immediate placement of the children was too threatening to Mrs. A at that time, and the worker contacted A.D.C. and made arrangements to carry out the plan that Mrs. A. had outlined. As she was so upset, these arrangements were put through immediately so she would have someone with her, until a more permanent arrangement could be made.

During the next month, things went more smoothly. The worker arranged with a family agency to have a housekeeper come each day to care for the children. Mrs. A liked the housekeeper very much, yet was envious of the way she handled the children. During this time the worker focussed on things at home week by week, eleciting expression of her feelings about the housekeeper's taking over in her home, supporting the positive things Mrs. A herself had been able to do regarding housework and the happy moments she had with her children. Mrs. A gradually told of her relationship with Tony's father and the deprivations she had endured when the children were younger and before she had gone on A.D.C. The worker again showed support and acceptance, pointing up positives in her relationship with them again.

There was a crisis at the Clinic at the end of the first month of concurrent treatment, when Mrs. A was panicked by fear of harming the children, and threatened to commit suidide. Immediate commitment to a hospital was planned if she might really harm her children or herself. The worker visited at her home, but found her calmer, and against either the children being taken for a while, or hospitalization for herself. The housekeeper agreed to stay with her and hospital care and placement were postponed.

The following week, however, the children were placed in a foster home, and the worker kept frequent contact with the children's worker. Mrs. A accepted this plan for the time being, planned to move to her mother's. She was only going to allow the children to be away for a month as she thought she could care for them again then.

The worker left the clinic soon after the placement was arranged. During this contact, the worker focussed on the current reality situation; her household management, her role as mother, her children and her relationship with the housekeeper. Although the negative side of her ambivalence about her children was accepted, it was not explored as it would have been too anxiety provoking, and would not have helped Mrs. A in maintaining her tenuous adjustment.

During the summer, Mrs. A continued with a second worker. At first she talked about how she liked living at mother's. She felt she wanted a job to repay mother for all she had done. She was concerned about her financial situation also. Her A.D.C. budget was cut and she felt

she had to take the children back again because she could not get along on the amount of aid she was alotted without them. Other than in these terms she referred only briefly to the children, and seemed quite ambivalent about visiting them. Later on, she did visit them, with her mother and her boyfriend Doug (about whom she had spoken only briefly) but she hid from them so that she could see them but they could not see her. This was how she managed her fear that she would break down in front of them if she visited.

Discussion about her financial situation led to more talk about working. The initiative came from her, since it was felt wise to talk about employment only slowly and gradually. With some satisfaction she discussed previous work experience, yet indicated her ambivalence--thinking she was not up to working at the present time. The worker did not encourage her towards taking a job in the near future but chiefly talked with her about past job satisfactions. Clearly, she needed help with budgeting on the limited amount she received in aid, but she did not seem to be able to tackle this problem in itself, and it was after her visit to the children. She became depressed and anxious again, sometimes agressive and hostile towards the worker and psychiatrist, and demanded that her children be returned. It was felt best to help Mrs. A to allow the children to remain away at least over the summer, but because of her impulsiveness the child welfare agency was prepared for a sudden decision to withdraw the children.

Mrs. A needed help paying her furniture bill, but had difficulty bringing herself to ask the worker's help. Later on, part payment was arranged and she seemed pleased about it. The furniture meant a great deal to her--somehow having it stored in the cellar of mother's house signified that she still had something of her own, even if she no longer had her children or her own home.

While the worker was away on vacation she demanded that the children be returned to her, and she went to bring them home. She did not keep any further appointments with the worker or psychiatrist, although she was contacted many times.

Three months later, she called to ask Social Service to arrange an examination at the gynecological clinic for her. She was also upset about the children and an appointment was given to talk over these matters, which she accpeted. During the lapse of contact, she had married her

boyfriend, they were living with his mother and she talked quite positively about her marriage. The trouble she had indicated on the phone concerned a visit by an S.P.C.C. worker, which she resented. Another appointment was given but she did not come in.

A year later she desired Clinic help; she feared she was going to be ill again. She kept only a few appointments with a therapist however. There was difficulty living with her mother-in-law and Tony was unhappy. She asked about treatment for him also. The grandmother much preferred Marie to Tony and made Tony's life miserable. Mrs. A saw the worker regularly for about a month and a half and was finally able to move into an apartment of their own which worked out much better. She was still concerned about Tony, and the worker talked with her about referral to a family agency for help for Tony and herself, which she accepted. A detailed letter was sent to the worker there and it was made clear that if her symptoms or behavior became more serious they feel free to refer her back for further treatment.

It can be seen in this case how a social worker was called in to help with environmental problems that were blocking her further progress in therapy. In this situation Social Service was to arrange for placement of her two children during Mrs. A's acute period of illness. This specific reason was given to Mrs. A as the reason for her contact with the social worker. Mrs. A was acutely disturbed during the initial period with the worker and it was necessary for the worker to take over to some extent in an authoritative way. Along with the environmental manipulation, which involved the worker's contacting, interpreting, and arranging with other workers in other agencies around housekeeping service and placement for the children, the worker also

functioned in a supportive way with Mrs. A--helping her to adjust to the new housekeeping plan and supporting her in her relationship to the housekeeper. There was no attempt on the worker's part to explore deeper levels of Mrs. A's difficulty which were thought to be the proper focus for the psychiatrist.

During the period when Mrs. A's children were in the foster home, handling Mrs. A's extreme ambivalence and guilt feelings about it was a major part of the worker's responsibility. The worker tried constantly to support her in being able to carry through with the placement plan, but this was very difficult due to her intense feelings about it. During the summer the worker also focussed on her current reality household problems, involving her financial situation and her living arrangements when she moved to her mother's home from her old apartment. It was necessary for the worker in a situation like this to be very aware of the meanings of separation to Mrs. A, as well as what significance there was in her move to her mother's. This came out more clearly around discussion about her furniture.

As Mrs. A brought up various current reality problems, such as finances, or medical needs, or moving problems, or the possibility of working, it was the worker's function to recognize and to evaluate what these things meant to her,

and thus how to be of the most help to her. For instance, with the possibility of her working, the worker did not encourage her to work right then but used the discussions chiefly to support her feelings of adequacy. With regard to her financial problem, although it was evident that she needed help with budgeting, it was not thought she was able at that time to come to grips with this problem, and furthermore, that it was only one aspect of her general anxiety around her children. It was necessary for the worker to explore and evaluate what problems the worker could help the patient with and in what way.

The use that Mrs. A made of Social Service later on when she returned to the Clinic was interesting. She asked something tangible of the worker in terms of making arrangements for an appointment at another clinic, but this appointment she did not keep. Nor did she return for a second appointment with the worker. She was unable to use further casework help at that time around the problems in her new marriage and she showed her ambivalence about returning to the Clinic. She came impulsively around something specific but was unable to sustain contact.

She came the next year around her concern around her son, and her own fear that she would be ill again. This time she did accept help on a casework basis around her current problems and was able to accept the referral to another agency.

The main casework techniques were environmental manipulation, which involved a thorough knowledge of community resources and the particular needs of the patient, and psychological support which was directed towards helping the patient cope with reality and maintain her tenuous adjustment.

V. Financial Planning: The Case of Mrs. Mainsted

Mrs. M was referred by a psychiatrist in the psychosomatic section for help with financial planning with regard to the patient's mother. The psychiatrist was discontinuing treatment the next month and wanted her to have a supportive relationship with a femal figure.

Mrs. M developed symptoms of an hysterical nature about five months prior to coming into treatment. She had floating sensations, and was fearful her heart would stop. She was so fearful that she couldn't leave her home or engage in any activities. At this time her brother, who had been living with her mother, got married leaving the mother alone. She became upset and came to Mrs. M to "cry on her shoulder". Mrs. M had mixed feelings; she was angry about her mother's complaining, but felt she should take mother to live with her. Mr. M did not care for this plan and there was much quarreling between them.

In therapy Mrs. M at first would only talk about quarreling with her husband, but later had talked more about mother who did finally move out of the M's house to a place of her own. Since mother's moving, Mrs. M's symptoms had abated. However, mother had no source of income, and depended on her children for support.

Mrs. M lived with husband and two young children in a small apartment. Husband worked as a bus boy with little salary, and it was difficult making her own ends meet, much less provide anything towards the support of her mother. She wanted to go to work, but thought her youngest child too young to go to nursery school.

In the initial interview in November, she talked about her children and she and husband seemed extremely fond

of them. In talking about mother, she mentioned that the psychiatrist told her that much of her difficulty was connected with her feelings about mother, but she said she couldn't help it. She felt close to mother, and mother felt freer to confide her troubles in her than in the other five siblings. Mother often visited the M's and had meals there but even this was a burden.

As one reason for referral to Social Service was in terms of trying to help with mother's financial problems, the worker explored mother's situation to learn of any possible sources of financial help, but found there were none but public welfare and the possibility of Soldier's Relief. The worker gave the address of the public welfare office so that mother could make application for aid. Mrs. M thought mother would be willing to try this, and Mrs. M felt she could not help any further and that something had to be done.

Home visits were made by the worker throughout the winter as Mrs. M could not come to the Clinic with no one to care for the children. Throughout this time the worker focussed on Mrs. M's financial difficulties and those of her mother. Mother went to the welfare department. They had sent her to Soldier's Relief, who required the veteran son to sign a paper in the presence of the agent, but the son, a truck driver, couldn't afford to take time off from work to do this, but would try to do it later on. Mrs. M and her sister were bringing mother food but it was very trying for them all. Mother became ill, but Mrs. M felt there was nothing organically wrong; this was mother's way of protesting against her son's attitude. In January mother was locked out of her apartment owing three months' rent, and Mrs. M's sister took her in. Mother still complained of not feeling well, yet would not consent to see a doctor, and insisted that none of her children were doing anything for her. Mr. M became increasingly irritated and would lash out at his wife. Mother did go back to the public welfare office to apply for aid as she could not get her son to sign the necessary papers, but public welfare had not yet aided. Mrs. M thought it might have something to do with her sister's welfare record; for some reason she had been abruptly taken off aid but Mrs. M did not know why. The worker agreed to call them.

The worker supported Mrs. M in her attempts to separate herself from such involvement with mother, but her own household was thrown off balance by the difficulty with

mother. This got to the point where Mrs. M was thinking of divorce. She allowed that marital difficulty could be because mother was such a problem but she could not take it any longer. The worker did not go into this at great length as Mrs. M was to have a follow up visit with her therapist and as it turned out, this interview helped to put her marital crisis in more perspective and Mrs. M did not feel she would file for divorce at the present time. Mrs. M was able to express some of her resentment about mother, yet felt very guilty about her hostility. The worker tried to relieve some of her guilt by pointing up all she had been doing to try to help mother.

In January, the worker met mother. She was condescending towards daughter, making subtle but cutting remarks about Mrs. M in her presence. She explained that her aid had not come because she had not yet turned in an affidavit about her residence. When mother finally did complete the necessary steps, Mrs. M was more relaxed, thinking that her mother's situation would resolve itself. As mother's problem seemed about to be solved, she could not understand why she still had difficulty getting along with her husband. The worker clarified that she was probably exhausted in her efforts with mother, and it was difficult setting her own life in focus once more.

The welfare did not come through, however, and the worker called them. It was true they had difficulty with Mrs. M's sister, and were reluctant to give aid to mother; the children should be made to support her. If they could not do this, they should at least say in court why this was not feasible. If welfare was forced to aid, they would recommend institutional care for mother.

During the spring there were a number of crises in the M family. Mother had a stroke and was in the hospital for two weeks. When she returned, Mrs. M's siter suddenly moved away, leaving mother to fend for herself, and Mrs. M took her in again. Tension with her husband mounted, and her symptoms reappeared. She then had an interview with her therapist, and accepted temporarily the idea that mother rather than husband was the cause of her illness. She was more determined to see less of mother and to try to work through her difficulties with husband. However, with mother coming to live with her this was not easy to do, and the interviews during this period were used largely to drain off some of the tension and resentment she felt. The worker tried to broach the idea of an institution for mother, but she was very ambivalent.

The worker tried to relieve guilt feelings by accepting what a hard decidion this was to make, however mother was really responsible for her own predicament, and it was not Mrs. M's fault.

The student worker left in May. A great part of the next worker's contact was focussed on trying to obtain financial assistance for mother. Mrs. M was still very resistive to mother's being institutionalized, so the alternative plan of mother living alone was worked on. Finally, through the worker's efforts, mother was granted aid, and this eased some of the strain. By the end of the summer things were much better. Mrs. M felt she was able to manage well withomt having to see her therapist in times of crisis. Her husband had a higher paying job, and there were no complaints of marital friction. Mother was still living with them, but she was still hoping mother would find a room. Mrs. M's son was going to nursery school, her daughter started school, and Mrs. M wanted to obtain part-time work herself. Referral to a family agency was brought up for the purpose of continued help around her children, and was accepted.

It was very important for the worker in this case to be fully aware of the deep conflicting feelings involved in Mrs. M's relationship with her mother. The worker functioned in a supportive good-mother role for the most part and did not stir up these deep feelings or attempt to interpret these to the patient. The focus was primarily on the financial situation of the mother, although concerns around the children and Mrs. M's husband also played a part. The worker frequently attempted to reassure Mrs. M about her feelings of guilt towards her mother, but did not explore her hostility to the extent that it would become overwhelming to her. Instead the worker focussed on the positive things she had done for her mother, which did seem to help

her.

The social worker carried the main responsibility for the case after referral was made to Social Service, although the patient did see the psychiatrist at times of particular crisis. At the time of closing, Mrs. M seemed much more capable of handling her household difficulties, and did not any longer feel the need of casework in a psychiatric setting. She was glad to accept the referral to a family agency, however. By this time the main source of tension and strain was cleared up as her mother had finally been able to obtain financial aid.

It can be seen in the activity of the workers on this case that it involved a great deal of inter-agency contact to provide for the needs of the patient, as well as the use of psychological support (mainly reassurance, acceptance, and support of ego strengths), and some clarification for the purpose of helping Mrs. M disentangle her marital difficulties from her problems in her relationship with her mother.

VI. Family Relationships: The Case of Miss Carol Welch

Although this patient was referred to Social Service for help with broadening her social contacts, through giving her the opportunity of having a supportive relationship with a mother-person, the patient was not ready for

help in the social area, and the casework focus was centered around the patient's family relationships.

> Carol, a twenty-two year old girl, was referred to Social Service in October by the psychiatrist for help with social outlets. The therapist was planning to leave in two months and felt she needed a supportive relationship with a woman.
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> She had ulcerative colitis, was hospitalized the year before, and subsequently began therapy at the Clinic. Carol was the third oldest of ten children. At six she had rheumatic heart disease, was in a convalescent home for a year. She repeated a grade because of this. As a child she was a tomboy and played with her brothers, but a fourteen mother died and she gave up school and her tomboy activities to become the homemaker for the family as her older sister left home then. Since then she had been at home all the time and was quite isolated. Her only relationships were with various neighbor women but these relationships were not close ones. In therapy she briefly mentioned mother, saying she was a good mother and they were very close. Father was hard working and conscientious, and she felt close to him. Eleanor, the eldest sibling, was divorced with one child. Carol liked her but thought she was self-centered. Ronny, her older brother, in the Army, drank heavily and had been A.W.O.L. several times. Carol had a good relationship with him in the past and was worried about his recent behavior. Anne, two years younger than Carol, was irresponsible, used to gamble her earnings, was separated from her husband, was pregnant. In therapy Carol had expressed most resentment towards Anne. Tom, three years younger than Carol, was in the Navy, and she seemed quite fond of him. Louis was at home and worked infrequently. She had little to say about the younger children but seemed to get along well with them.
>
> She was very reticent and in therapy would say almost nothing, giving only monosyllabic responses. Gradually she was able to talk a little more, primarily about her family. The early part of the treatment was mainly to establish a relationship with her. The psychiatrist worked with her about referral to Social Service for several weeks, as she was most reluctant to see a worker. She thought the worker would try to take the children from her. The basis for referral was given to her in

terms of enabling her to have someone to talk things over with when the therapist left, and she finally agreed.

Carol was a stocky red haired girl, very neatly though plainly dressed. Initially she spoke rather freely of her reluctance to see the worker, telling of her previous contact with a worker as a child, who placed her in a home when she was ill. It was difficult to establish a comfortable relationship with her and it took a number of months for her to relate with some ease and comfort. Until then, she was unable to introduce subjects, was only able to answer questions.

Throughout the year of contact she was extremely concerned about her family and would use the interviews to discuss such things. She could not understand why Ronny was A.W.O.L. so often as he had chosen to re-enlist. She was also concerned about Louis, and asked if the worker could help him get a job. The address of the state employment agency was given and it was suggested that Louis call them. Carol seemed very pleased to have the information, but in a later interview told that he had not followed up on this and was troublesome at home, being very bossy, insisting that they all cater to him. The worker supported her resistance to his incessant demands. She said she used to do things for the younger children but now they were getting older she encouraged them to do things on their own. She visited Eleanor often and enjoyed it. Later on, Carol spoke of visiting Anne, who had not visited them for some time. Father was worried, suggested Carol go see her. She talked quite a bit about Anne, recalled how Anne and father used to argue about her husband before she was married and that she did not tell her family until months after the marriage. As children, Carol would frequently quarrel with Anne, who always wanted her own way. Anne was father's favorite and everyone was well aware of it. As Carol talked more about Anne, she brought out much of her feelings of resentment and rivalry with her for father's attention.

When the therapist left, the worker tried to help her bring out her feelings about this, but she could not do this easily. Only later, she sometimes compared talking to therapist and worker, recalling how hard it had been to talk to either of them at first. During the rest of the winter, spring, and summer Carol gradually became more relaxed with the worker, seemed gay and cheer-

ful. The worker emphasized the positives in her relationships with siblings and father, functioning as a kind older mother person in talking over her family concerns. As the relationship and transference deepened she began to talk a little bit about her mother, always in positive terms.

In the spring, Anne had a baby, quieted down, was not so irritable. Carol scarcely mentioned baby, remarked only on Anne's improved disposition. There was still difficulty at home; Ronny was home from the Army, neither he nor Louis were working. Ronny got a job soon, which improved relations in the family somewhat, but the brothers did not get along well, and Carol was frequently caught between the brothers, or them and father.

In May the children baked her a Mother's Day cake, pleasing her greatly, and Ronny gave her candy. The worker began to broach the subject of camp plans for the children, but after Carol discussed this at home she reported they preferred to be at home with her. She would prefer this too; she would miss them if they went away.

Carol continued in casework through November. She was in good spirits and related much more freely with the worker. In November, however, Carol got infectious hepatitis, was hospitalized, contracted severe liver damage, and died. A letter was sent to father offering assistance if it were needed.

The worker's role in this case was to be a supportive mother figure to the patient, who had lost her own mother when she was in her early teens, and had since then taken on adult family responsibilities in caring for her large family. Although the referral was not only so that Carol could be provided with a mother figure, but was also to help her with overcoming her isolation and encouraging social activities, the worker attempted to explore the social area. However, the patient was not ready for this, and it took a

long time for the worker to build up a positive relationship of trust with Carol. She was extremely isolated and her family duties absorbed her time. Therefore the worker focussed on her family relationships and Carol used the worker to confide in about these things. Even when the relationship had developed between Carol and the worker she was still seldom able to express directly her own feeling. She seemed to feel quite secure in her position at home especially with her father and the younger children, and seemed to have an unusually strong ties to them.

It is possible, that had Carol lived, she might have eventually through long casework treatment of this supportive nature, come to lead a more healthy life of her own, and have become less tied to her family.

In this case it can be seen that although one of the reasons for referral was around social contacts, the patient's needs dictated the focus of the casework treatment which was in the area exclusively of her family relationships.

VII. Adjustment to Illness: The Case of Miss Mary Bloom

In this case the problem area of the patient's adjustment to illness did not emerge until quite a while after beginning treatment, but it can be seen that it was extremely important both in making a meaningful diagnosis and planning the treatment.

Mary Bloom was referred by a psychiatrist soon after the intake conference on her, for help with social outlets. She was a nineteen year old girl who had epilepsy since childhood. She lived with parents, had an older sister on whom she was dependent prior to sister's marriage three years before. Mary complained she could not make friends, was very isolated. She had graduated from high school the summer before, had worked in a factory for only a few months, wanted to work again as she had nothing to do.

She was agressive and demanding with the student worker who saw her from February to May. She would demand direct answers to questions concerned with boys and how one should act with them. Casework focussed however, on vocational plans, as a job might help in assisting her in forming social relationships, and on her previous positive relationships with girls, as it was felt that she was not at all ready for heterosexual relationships. Mary's discussions around boys seemed to be a way of resisting help. The persisting questioning was compulsive, a primitive expression of hostility.

During the summer she saw another worker, and talked a great deal about how difficult it was to know what to say when she was with other people. She did not know how to mix with girls and it was through girls that she hoped to meet boys. She would become very concerned and upset when anticipating going out on a date. She wanted to date, yet was fearful about boys' reaction to her. This fear she said was because she wished to hide the fact that she was so isolated, and wanted to give an impression of many friends and social engagements. In talking of a lack of friends she recalled the years spent at home never going out. She left school after the fourth grade after her seizures began and had no friends during this time and return to school was hard for her. She remembered having friends when she was about six, but this was only because they played games then, when they outgrew this they were not interested in her. In much of her discussion about her attempts to make friends particularly among girls, the worker supported her, showing much interest in the few girls she knew. It seemed there was little real relationship in the associations with either girls or boys; she seemed preoccupied with the impression she made, and the idea that she would not be liked.

She talked about her sister some; compared herself disparagingly with her. Sister was popular, was engaged at

nineteen, married at twenty. It came out that Mary's parents were concerned about her dating for fear she would have a seizure and be at the mercy of the boy. Mary resented that they treated her sister so differently and had let her go where she wished.

The worker arranged for vocational testing; the results were discouraging, in effect indicating she was not employable. She was of dull normal intelligence although there were some contraindications of mental deficiency as she had two brain operations when she was fifteen.

In the fall Mary was transferred to another worker and seemed eager to get a job, actually went out to find one and obtained a job in a store as a sales clerk. She enjoyed this very much. It did not come out until later that Mary had some seizures while sorking which were probably the reason for her being fired in January. After this she complained constantly she did not know why she was fired or why they would not take her back, demanded that the worker tell her why. When her demands were not met she became angry, refused to leave the interview, The store finally told her not to come back until March when they would let her know if they had another opening for her. She had gone daily insisting they either give her a job or tell her why they would not hire her. In March when she was finally given a definite "no", other material began to come out in her interviews. She was angry about the job situation, finally told about the seizures she had at work. The worker asked if there was some difficulty at home also; she said things had always been difficult at home for her, but she had not felt she could tell the worker before this. She had thought if she told, the worker would take her parents' side and say she should not do this or that. She then began to talk with great vehemence about her parent's strictness. It was hard to hold her to specific situations because her feelings were so strong, so hostile.

Much feeling about her seizures came out; she was very resentful she was treated any differently than anyone else. She wanted her parents to come to a social worker so they could be told how strict they were, and to leave her alone. If they did not change their attitude she would leave home. The worker pointed to the unrealistic aspects of this plan, yet accepted her angry feelings towards her parents.

After this Mary spoke more frequently about her feelings about her seizures. At one point this came up around

the possibility of her going to camp for the summer. At first she did not want to tell anyone at camp about her seizures, as she did not think she would have a good time if anyone knew. The worker universalized her feelings, mentioning the sensitivity of other people with seizures, and Mary was astonished to know there was anyone else who had them. She had always thought she was the only one. Much time was spent in discussing Mary's concern about people knowing of her seizures for fear they would ostracize her as they had done when she was in school. Another fear finally came out which was that she did not think she would ever get married because of her seizures.

By this time a very positive but dependent relationship had been established with the worker, and the worker's leaving in May was very difficult for her. She could not express her anger directly but said she would miss her and could not expect the worker to stay just on account of her.

The next worker had difficulty in establishing a relationship with her. She tried to focus on her relationships with sister and other girls, but Mary reverted to her earlier behavior and demanded answers about boys and how she should act. There was little she would say about her seizures. The worker left on vacation in August. When she returned she tried to reach Mary who had not responded to letters sent for appointments with either the worker or the seizure section. Her family was very vague when the worker telephoned them, and said that Mary was out of town for an indefinite period. The Clinic had no further contact with her and the case was closed.

Mary was referred to Social Service for help around her social isolation. She was seen by the first student worker only from February until May when the worker left. This contact was marked by her incessant questioning of the worker, insisting that the worker tell her what to do and what not to do with boys and girls. The worker refrained from falling into this trap which would have cemented for Mary the identification of the worker with her parents, to-

wards whom she felt very ambivalent. The hostility she felt towards her own parents was not directly expressed by her in this contact. It was not until the second student worker began to work with Mary that she began to form a warm and dependent relationship with her, and could give up her compulsive questioning to some extent and begin to express her own feelings. At some periods Mary did become hostile towards the worker but gradually this was worked through and related back to her parents. It was only after Mary was fired from her job that a great deal of material came out about Mary's feelings about her seizures. She had very intense feelings about this, and some fantasies which distorted her concepts of herself and made her feelterribly inadequate. She could not express any of this until a firm relationship had been established. The worker tried to help Mary to abreact some of these painful experiences around her seizures, but she could not remember specific instances very well, and the talk was more general, revealing her intense feelings about both these areas--her seizures and her family. It was unfortunate that the student worker left at the point where Mary had managed finally to establish a trusting relationship with her, as she could not relate very well to the next worker and the student worker's leaving was very difficult for her.

She was helped by the worker in terms of her social relationships by the re-educative experience with the worker in treatment, and by the worker's focussing on the positives in her current and past relationships with girls. However, a deeper source of her feelings of inadequacy and ineptness in social relationhips--her feelings about her seizures--began to emerge only towards the end of her Clinic contact, and much work in this area was necessary in order for Mary to feel really comfortable with other people.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The role of the social worker in psychiatric clinics varies widely according to the organization and philosophy of the particular clinic. In most clinics the social worker does the intake, and social study of the patient, as well as work in the environment to make changes beneficial to the patient in treatment with the psychiatrist. In other clinics role of the social worker reflects a newer trend in the psychiatric field, that of adding a treatment function to the more traditional responsibilities of the social worker. Currently, there is a great deal of controversy about this, and the question of how to make the optimum use of the particular skills of the social worker, in a psychiatric setting, is still far from being answered in any definitive way.

It was the writer's intention to describe the social worker's function at the Psychosomatic Clinic of the Massachusetts Memorial Hospitals. Particular emphasis in this study was on the casework treatment of patients carried by the social worker alone, as this aspect of the social worker's treatment role in the Clinic had not yet been investigated.

Four questions formed the focus of the study: (1) What kinds of referrals are made to Social Service in those

cases where the worker carries the case alone? (2) What are the problem areas of social adjustment for which casework help is given? (3) What social adjustment is achieved in terms of these problem areas at the termination of the casework treatment? (4) How does the worker help the patient to achieve a better social adjustment?

Forty-two cases were selected on the basis of having been carried at some period of time solely by the social worker, and these cases constituted the data for this study. Sixteen cases were referred to Social Service from the psychosomatic section of the Clinic, and twenty-six from the seizure section. All the patients in the psychosomatic group had had psychotherapy; the length of time in treatment ranged from one month to over three years. None of the seizure group had had therapy, although they were all being seen periodically by a psychiatrist on the staff for check-ups and medication. A wide range of personality disturbances were included in the differential diagnosis of the psychosomatic group, and all of the seizure patients had epilepsy. More than two-thirds of the total group were between twenty and twenty-nine years old, and almost all of the patients studied were under forty. Eleven of the total group were men, and thirty-one were women.

The patients were referred to Social Service for a

number of reasons, and in all cases an environmental problem was given as a reason, although in some there was also a specific request for a supportive relationship. In some cases the social worker was called in during the patient's therapy to help with an environmental problem which was blocking the progress of therapy, while in other cases therapy was near termination and casework was needed to help the patient in certain problem areas of his social life, after the therapy was discontinued. Six problem areas were mentioned as reasons for referral: vocational or employment planning, social outlets or contacts, household planning, school planning, financial planning, and family relationships. The majority of patients were referred for vocational planning.

With regard to the second question in the study, "What are the areas of social adjustment for which casework help was given?", it was found that there were some differences between the problems for which each patient was referred, and the problems that were included in the focus of casework treatment. The most conspicuous difference was that only three out of a total of forty-two cases included help in the area of family relationship problems as a reason for referral, while actually family relationship problems were one of the main foci of treatment in eighteen cases. This seemed to indicate that relationship difficulties underlying the specific referral problem emerged during the casework contact and were made a

main focal area of treament. It was also found that help with academic school planning (among the reason for referral in three cases) did not appear to be a main focus of casework treatment in these or any other cases in the group. An additional problem area that was not included in the reasons for referral was the patient's adjustment to his illness, which became one of the specific areas of casework treatment in the cases of three patients with epilepsy.

In general, comparing the number of reasons for referral and the number of problems handled in the casework treatment, an increase of twelve was found in the total number of problem areas mentioned, which does indicate that other problems emerged during the casework contact for which help was given.

To answer the third question, "What social adjustment is achieved in terms of these problem areas, at the termination of the casework treatment?", the writer categorized the study group into four divisions: (1) those cases in which the specific referral problem was met (nine); (2) those cases in which there was no appreciable change in social adjustment at the time of termination (seventeen); (3) those cases showing some improvement (nine); (4) those cases showing much improvement (seven).

There was a correlation between the evaluation at the time of closing the case, and the length of casework contact.

A majority of those patients in casework treatment for one to six months showed no appreciable change at the time of closing the case. In general those patients who were in treatment for more than a year showed more improvement than those who were seen only up to one year.

The writer selected six cases to show the casework done in each of the six problem areas on which casework treatment focussed in order to answer, by way of illustration, the fourth question, "How does the worker help the patient to achieve a better social adjustment?".

In each case the supportive relationship the worker established with the patient was the main therapeutic tool towards the goal of improved social functioning and greater ego capacity. In one case supportive techniques were coupled with some clarification of the patient's symptoms and marital difficulties and her strong ties to her mother. In most of the cases, however, psychological support was in conjunction with manipulation by the worker of the patient's environment to meet the particular needs of the patient.

In the case illustrations it can also be seen how the worker used different techniques at different stages of the treatment depending on the particular patient's abilities and psychological needs. Also evident was the difficulties in and the importance of the relationship between the patient and the worker, and the necessity that the worker be aware

of the kind of transference being established, in order to control it and to use it constructively in the treatment process. The interpretation of underlying dynamics of the patient's personality disturbances were not seen as a suitable realm for casework, but the worker's awareness of these deeper implications was necessary in planning and carrying out casework goals.[1]

Casework practice at the Clinic, then, can be seen to be characterized by a focus on current environmental problem areas, in which environmental manipulation for the patient's benefit is often actively undertaken by the worker, as well as the use of supportive ego-strengthening techniques in the therapeutic relationship with the patient. This can be seen to be in distinction to, yet complementing, the therapeutic endeavors of the psychiatrist who also employs and manipulates the relationship to attain his therapeutic goals, but focusses on and deals more directly with the intrapsychic problems of the patient towards resolving unconscious conflicts.

A number of facts emerged that were not immediately relevant to the four main questions posed in the study, but

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1 This corresponds to what Rose Goldman felt to be the proper area of casework; the emphasis on ego strengths rather than on exploration and solution of unconscious conflicts. See supra, page 6.

which did throw some light on certain aspects of casework with patients carried solely by the social worker, and might prove worthwhile for further study.

Among these are the many instances of considerable difference between these patients referred from the psychosomatic section of the Clinic, and those from the seizure section. These differences were apparent in the description of each group, the reasons for referral, and the response to casework treatment.

It was found, for instance, that all the eleven men in the study group were seizure patients. There was a difference in the level of education reached by each group--the epileptic patients as a group had less education than the patients in the psychosomatic group, and the epileptic patients were those who were unemployed. There was a difference too with regard to marital status--twenty-one out of the twenty-six seizure patients were single in comparison with six of the sixteen psychosomatic patients. Most of the single seizure patients lived with their parents.

With regard to the reasons for referral, the large majority of the seizure patients were referred for vocational planning, and it was this group that constituted those in casework treatment for less than six months. The majority of the psychosomatic cases were closed because of referral to another agency, but the majority of the seizure cases

were closed because the patient broke contact. In evaluating the social adjustment achieved at the end of the casework contact it was found that one half of the seizure patients showed no appreciable change, in comparison to only one-fourth of the psychosomatic patients.

In the main body of the study the writer indicated some possible explanations for these important differences, but feels that a thorough investigation of why the seizure patients responded so poorly to casework, in particular, is warranted, on the basis of their comprising a sizable proportion of the patients in the Clinic referred to Social Service.

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APPENDIX A

SCHEDULE

CASE NO: REFERRED FROM:

NAME: AGE AT REF: MALE: FEMALE:

RACE: RELIGION: BIRTHPLACE: EDUCATION:

OCCUPATION:

MARITAL STATUS:

SPOUSE: AGE: OCCUPATION:

CHILDREN: AGES:

PARENTS: AGE: RACE: RELIGION: BIRTHPLACE: OCCUPATION:
Mo:
Fa:

PT LIVING WITH:

PSYCHIATRIC DIAGNOSIS:

LENGTH OF PSYCHIATRIC TREATMENT:
Date of beginning treatment:
Date of termination:

SOCIAL SERVICE CONTACT:
Reasons for referral:

Date of referral:
Date of closing:

Problems for which treated by Social Service:

Reason for closing:

Social Adjustment evaluation by worker at termination of casework contact: