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A study of patients at a mental health clinic who presented occupational problems

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A STUDY OF PATIENTS AT A MENTAL HEALTH CLINIC WHO PRESENTED OCCUPATIONAL PROBLEMS

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CHAPTER I

INTRODUCTION

It is well known that "vocational problems - unemployment, irregular employment, dissatisfaction at work - bring more clients to the doors of social agencies than any other kind of difficulty."[1] What, then, is happening to patients in general and to patients in Southard Clinic?

This paper presents a descriptive study derived from a complete sample of the closed case records of patients who presented employment problems when seen at intake in the Southard Clinic between June 1, 1954 and January 1, 1955. These patients also met the following additional criteria: (1) I.Q. over 70, (2) Non-psychotic, (3) Not women with small children. Thus, patients considered in this study will have had one year or less of treatment unless they were seen in the clinic previously and their case reopened during the period under study.

Criteria for judging which patients presented employment problems were arbitrarily selected for the purpose of this study. Since the face sheet, filled out by the social worker at the initial intake interview with the patient, includes information regarding his

1/ Emilie T. Strauss, "The Caseworker Deals with Employment Problems", Journal of Social Casework, (November, 1951), 32:388-392.

occupation, place of employment and a statement of the presenting problems, it was decided that this data should be the basis for selecting cases for the study. Thus, for example, the notations "unemployed," "sporadic employment", dissatisfaction at work", or "unable to work" and the like were considered to indicate patients who had employment problems. It is recognised, however, that further data in the body of the record might well reveal employment problems that can not be discovered from studying face sheet information alone. This was not undertaken for the present study and must be considered a limitation.

As previously noted the cases of certain patients who presented employment problems when seen at intake during the six month period being studied were omitted from the final sample when further examination of the body of the record revealed either that the patient's I.Q. was below 70 (mentally deficient), or that the patient was considered psychotic at the time of intake, or in the case of women patients when they had young children. These categories of patients were omitted from the sample because they did not appear to be employable for one or another largely self-evident reason.

Mentally deficient patients may possibly be able to perform certain routine types of jobs. However, their employment appeared to present special problems which are unlike those presented by the patients chosen for the sample.

Patients with overt psychosis were omitted because they can not

properly be regarded as clinic patients since most such patients require hospitalization. Thus, they would be better studied under a project investigating the rehabilitation problems of former hospital patients rather than with a group of clinic patients.

It was finally decided to eliminate mothers of young children from the study largely on an arbitrary basis. The question of employment for these women seemed to present special problems beyond the scope of the present study. For example, the broad cultural bias against mothers of small children working provides a special deterrent to their so-doing. Whereas, there is, on the other hand, an even stronger social pressure on those selected for the sample in favor of their solving their employment difficulties as soon as possible.

The principal goal of this study is to make more explicit the Southard Clinic practices in regard to occupational rehabilitation of patients who present employment problems at intake, during the period under consideration. Some of the questions it is designed to answer are the following:

1. How many patients seen at intake during the six month period being considered and whose cases were closed pri or to this study presented employment problems at the intake interview?
2. What sorts of patients come to the clinic with employment problems?
   a, What were their ages, sex, educational backgrounds,

marital status, and occupational backgrounds?

b. What was the patient's presenting problem and/or his referral problem - if referred by another agency or physician?

3. How long had these patients been unemployed or had employment problems of other types?

4. What sources of support did the patients find while they had employment problems?

5. What was his clinic experience? What personnel did he see? What recommendations were made for treatment? Were these recommendations carried out? If not, why not?

6. Upon what basis was the case closed? Was the patient employed? Was he referred elsewhere? Was he referred

7 directly to a vocational rehabilitation counselor or agency? If not, would such a referral have been useful (in my opinion)?

7. In view of the material obtained in this study, how may vocational rehabilitation of patients who apply for treatment at a mental hygiene clinic be made more effective?

8. What psychiatric diagnoses were made of patients in the sample?

This study has certain further limitations than the ones previously mentioned. Case records, for example, were sometimes rather difficult to find. It was finally decided to collect the

data by examining the complete file of closed records for the period being studied as well as to look through the open file to ascertain whether certain records which should be included in the sample could be located there. The secretarial staff was extremely helpful in suggesting where records might be located. Another limitation was that of time both in compiling the data as well as recording the findings.

CHAPTER II

THE CLINIC SETTING

The Southard Clinic is a state mental health clinic operated by the state on a fee basis. The fee for each patient is determined by a set scale arranged according to income and number of dependents supported by that sum. People whose income is more than $115 - $124 per week and who have fewer than four dependents are not accepted as clinic patients but are referred to private physicians or agencies.

The clinic is a part of the Boston Psychopathic Hospital but has its own separate entrance and address. Its location is convenient to two public transportation lines, thus making it fairly easy for patients to reach from most sections of Boston and its immediate suburbs. Since there are still few clinics of this type available in the state, many patients come from a considerable distance. They must be living in the state in order to be accepted for treatment. The clinic is open five days a week and has emergency staff available on Saturday mornings.

The professional staff is made up of psychiatrists, psychiatric social workers and clinical psychologists. There are a number of trainees in all fields, including fourth year Harvard Medical School students, psychiatric residents, and second year social work students from four different schools of social work. It should be pointed out

that the clinic is closely affiliated with the Psychopathic Hospital and with its other clinics, the Childrens Clinic and the Community Clinic (for former House patients). The chief social worker heads a department made up of workers from all the clinics, the House, and the recently developed Rehabilitation Unit. There are head social workers, under her, in each unit as well. Staff members in each unit, however, work exclusively in that unit, although students frequently see patients in different units.

Treatment in the Southard Clinic consists for the most part of individual psychotherapy* carried out either by psychiatrists or social workers, and psychiatric residents, social work students, and fourth year Harvard Medical School students under staff supervision. There are a few psychiatrists who are carrying groups for psychotherapy, particularly groups focused on specific types of problems such as obesity and homosexuality. Certain patients are treated with electro-shock therapy on an out patient basis, but this is the only other form of therapy offered in the clinic since not chemotherapy is attempted with clinic patients. Many patients are referred for psychological testing. Psychologists occasionally see patients in psychotherapy, as is done in a number of other settings.

* For the purpose of this study L.N. Austin's definition of psychotherapy is used. It is as follows - "Psychotherapy is a goal-limited method of treatment of personality difficulties."1/

1/ L.N. Austin, "Social Casework," American Journal of Orthopsychiatry, (January, 1956), p. 49.

Patients are assigned to one discipline or another for treatment in accordance with suggestions made during their diagnostic work up. The diagnostic process consists of an intake interview with a social worker, followed, in approximately two weeks, by a diagnostic interview with a psychiatrist, or psychiatrist with a group of students from various disciplines. At this second interview, the doctor makes a diagnostic formulation and makes specific recommendations regarding treatment. This is then reviewed by members of the senior staff before final disposition of the case is made.

There are several possible dispositions for any one case. It may be assigned to one of four "pools": social work, staff physician, group therapy or teaching (residents and medical students). Social work student cases are assigned from the general social work pool at the discretion of their supervisors. Since the clinic has more applications than it can process immediately, and since it does not close its intake because the staff feels it is important to try to meet the many requests made for help, there are always people on the waiting list who have been assigned to one or another pool but must wait for treatment until a therapist is available. It should be made clear that each case is evaluated regarding the immediacy of the patient's need for help, therefore, some begin treatment at once. However, sometimes the delay extends to periods of six months or more, or occasionally, a patient comes in who is just what is needed immediately for a teaching case.

Policy for assigning patients to one or another of the pools is based on careful diagnostic evaluation. Generally speaking, patients are assigned to the social work pool when there appears to be a large social or environmental component in their problems. However, social workers are also assigned a few patients for whom the treatment goal is insight development. Psychiatric supervision is considered an absolute essential in such cases. All social workers in the clinic, it should be made clear, have regular psychiatric consultations available to them, in regard to any of their cases that they may wish to discuss. Social workers are often assigned patients who can be helped by the casework methods known as "supportive therapy aimed at the maintenance of strengths in existing adoptive patterns."1/ However, in evaluating any group of records it becomes evident that each of the disciplines is at various times assigned cases that are more usually thought of as social work cases or psychiatric cases. Thus, in evaluating treatment of patients who apply to the clinic with employment problems, the writer is not making any distinction between those who are treated by social workers and those treated by psychiatrists. The writer believes that the well-trained therapist, whatever his basic orientation, will treat a given case according to methods that have been found useful in meeting the particular problem or constellation of problems that the patient presents and in terms of

1/L. N. Austin, "Social Casework," American Journal of Orthopsychiatry, (January, 1956), p. 49.

his own competence. He is not bound to do a particular form of psychotherapy without regard for the patient's needs merely because he is trained as a social worker or as a psychiatrist.

CHAPTER III

REVIEW OF THE LITERATURE

Vocational rehabilitation for the mental patient rather than the physically handicapped patient is a relatively recent concept. Most articles and books on this subject have appeared since World War II. The term rehabilitation is frequently used to convey a variety of different meanings. According to one authority,[1] "Because of the problems involved in and the disagreements about what constitutes the concept of 'rehabilitation', there is today no clearly delimited body of rehabilitation literature per se." Accordingly each writer who uses the term must make clear precisely how he defines it. The National Council on Rehabilitation has chosen a definition that is inclusive but has certain implications with which this writer is not in accord. Their definition states:

> "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefullness of which they are capable."[2]

Restoration implies the patient has at some time functioned in a way superior to the one he is doing at the time rehabilitation attempts

1/ C. Schwartz, Rehabilitation of Mental Hospital Patients, Public Health Monograph No. 17, (1953) U.S. Government Printing Office, Washington, D.C., p. 2.

2/ Ibid. quotation from Whitehouse, F. A., "Vocational Training in a Rehabilitation Center," J. Rehabilitation, 17:3-8. Jan.-Feb. 1951.

are being made. From the point of view of people working with psychiatric patients this implication may well create a false impression for much of the work with such patients is focussed towards the goal of raising their level of functioning to a higher plane than they have ever before been able to attain. Thus, for the purposes of this study of rehabilitation efforts with psychiatric patients, the writer has chosen to use the following definition of rehabilitation by Celia Benney as more appropriately inclusive. She states:

> "For practical purposes, rehabilitation can be thought of as an 'all out', concerted dynamic process that involves the use of professional skills and community resources when and as they are necessary, to help handicapped people achieve the maximum functioning of which they are capable."1/

This definition makes clear that. . ."the philosophy of rehabilitation is closely related to the psychiatric insistence on the whole man."2/ One might say further that the definition's emphasis on using community resources brings out the social worker's special function in rehabilitation.

The bulk of the writing about occupational rehabilitation of psychiatric patients has been devoted to the problems faced by the hospitalized patient, or the one just released from the hospital and on trial visit status. It has been felt that many mental hospital

1/C. Benney, "The Role of the Caseworker in Rehabilitation," Journal of Social Casework, (March, 1955), p. 118.

2/T. Burling, "Vocational Rehabilitation of the Mentally Handicapped," Americal Journal of Orthopsychiatry (1952), p. 202.

patients have been discharged from the hospital without the benefit of adequate planning to help them meet such practical problems of daily community life as finding jobs suited to their particular needs. The former hospital patient faces unusual problems in finding a job for many employers are extremely reluctant to hire people whom they know to have been mental hospital patients. However, it has been found that choice of job and the opportunity to find satisfaction in the job often makes the difference between the former patient's ability to make an adequate adjustment outside the hospital and having to return for further treatment. The efforts of the social worker in the mental hospital and of the vocational rehabilitation counselor, whether he is a member of the hospital staff or of a vocational agency, require close coordination if the hospitalized mental patient is to be helped adequately to find satisfactory job placement when the time comes for his discharge from the hospital.

The Therapeutic Community, by Maxwell Jones describes a special, new type of hospital for non-psychotic psychiatric patients. This experiment will be described at some length since the types of patients chosen for treatment there are ones who would only be provided clinic therapy in the United States.

Jones' volume is an account of the Industrial Neurosis Unit set up in England at the Belmont Hospital in April, 1947 for the treatment of "patients who have longstanding neuroses and character disorders, and have also employment difficulties." 1/ These male and

1/Maxwell Jones, The Therapeutic Community, Basic Books Inc., New York, 1953, p.xvi.

female patients came to the hospital from all parts of England and were from various socio-economic groups, with diverse educational and employment backgrounds. Their clinical diagnoses varied, including for the most part chronic neurotics, character disorders, schizoid personalities, psychopaths, sexual perversions, and organic damage, including epilepsy. Patients diagnosed as psychotic were not accepted. This book, then, tells of a new broad approach to the treatment and occupational rehabilitation of a group of patients, "the hard core of the unemployed," who are usually considered particularly unresponsive to orthodox psychotherapy or group therapy alone. These latter techniques were, of course, used as were chemical and shock therapies where necessary. The major focus, however, was upon the therapy brought about by total community participation and its resultant development of a sense of belonging for many individual patients.

There was a great impetus towards social methods of psychiatric treatment as a result of World War II with its great numbers of patients needing psychiatric treatment, with only limited numbers of trained personnel available. In this volume Jones tells of two earlier experiments with community therapy; one, the Effort Syndrome Unit at Mill Hill Emergency Hospital during the war and the other, the Ex-Prisoner-of-War Unit at the Southern Hospital, Dartford in 1945. Both of these reflected the trend towards communities assuming increasing social responsibilities within recent years, as well as providing the experimental foundation upon which the Industrial

Neurosis Unit was based.

Dr. Jones describes his goals in the Industrial Neurosis Unit as follows:

1. To study a sample of this group (chronic unemployed neurotics) and as far as possible understand its clinical characteristics.
2. To give appropriate psychiatric treatment.
3. To decide on the most suitable job.
4. To arrange resettlement, preferably while the patient is still in the hospital.
5. To test the effect of these procedures by carrying out an adequate follow-up study.1/

The choice of suitable staff was particularly important where each person on the hospital staff and patients alike were viewed as essential components of the whole community. Staff members included psychiatrists, psychiatric social workers, nurses, and Disablement Resettlement Officers (D. R. O.s). These latter appear in many ways to be the equivalent of vocational rehabilitation counselors in this country. Dr. Jones carefully describes the customary roles of each of these professions in the usual hospital, then points out in what ways their role differed when their treatment method was community rather than individual therapy. Here only the social worker's role

1/Maxwell Jones et al, The Therapeutic Community, Basic Books, (First American Edition), New York, 1953.

will be described in detail.

The social worker's role at the Industrial Neurosis Unit was traditional to the extent that she obtained intake social history information from all new patients and that patients were told to refer to her in regard to "problems to do with housing, pensions, rationbooks, etc."[1] Some of her most interesting work were the surprise home visits made to discharged patients as part of the follow-up study. These visits were unannounced and informal in nature inorder that the social worker could "interview the man in the family situation where interpersonal relationships were readily apparent."[2] Thus, "the man was seen in his home situation, coping with the interview himself, and using his family in much the same way as one would suppose he used them in other circumstances. In making qualitative assessments of the patient's adjustment since leaving the hospital, and of the way he handled things, his relationships with his family served as an important guide."[3]

A further new facet of the social worker's role in this study, besides evaluating the usefullness of community therapy for former patients at the Industrial Neurosis Unit, was to make certain interesting speculations about some critical social ills she found in the densely populated urban centers while doing a control study of

1/Maxwell Jones, op. cit., p. 49.
2/Ibid., p. 98.
3/Ibid., p. 98.

disabled persons who had not been treated in the hospital. For example, the social worker found that the disabled people as a group had little faith in anything, that "pills and medicines, with an occasional visit to an out-patient department, no longer held out very much hope."[1] In addition, "nearly all the disabled persons asked for help at the interview."[2] She further states that in the urban areas she studied there is

> "...a real paucity of group life...due to the fact that in many cases there was no real geographical cohesion and no focal point on which the inhabitants could centre their emotions....In addition, there appeared to be no social cohesion from within the group. Problems which arise within a group or small community are nowadays solved outside the group.... These problems are in nearly all cases dealt with by officers who are often not an integral part of the community from which the specific problem has arisen....There has been a decline in the individual awareness of the role required of each group member and their relationships to one another. This has led to the disintegration of the group and thereby the support given by the group to the individual has in part disappeared."[3]

As a result of such social ills, she believes there exist numerous individuals who are socially, emotionally, and occupationally disabled. She concludes then that "It would seem that healthy groups do help to make healthy individuals, and that to ensure within a community, however small, the proper functioning of groupslife is to do much to provide an environment in which people can hope to lead a full life."[4]

Community treatment in the Industrial Neurosis Unit consisted of helping the patient to learn, adapt to, and feel a part of the community

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1/Ibid., p. 105.
2/Ibid., p. 105.
3/Ibid., p. 106.
4/Ibid., p. 106.

culture. It was asserted that "The most important therapeutic factor was the growth of a sustained group culture."[1] Staff and patients were all members of the hospital community wherein this "...sustained group culture which belongs to the Unit over and above any single group of patients..."[2] became established, changed, and became ever more clearly defined in its customs and patterns the longer the therapeutic community operated. The growth of this group culture mean that

> "...a certain set of beliefs and habits were taken over by each patient on entering the unit...which made it possible for each patient to develop an initial identification with the group." "...it seems probable that it is the degree to which this initial identification takes place, irrespective of the severity of the patient's illness, which determines his accessibility to the Unit's influence."[3]

The basic idea of community therapy was one well known to other therapeutic techniques as well, e.g., experiential relearning. In casework this experiential learning is achieved through careful conscious use of the relationship by the therapist. In this case, the learning takes place in the patient's relationships within the total community group. These patients had the experience of feeling, often for the first time, that they belonged to a group. This experience was extremely helpful in increasing their individual self-esteem and confidence. It was felt by the staff that "...one fact seems to emerge that those patients do best who can develop a positive relationship with someone (from any staff specialty or patient) in the hospital

1/Ibid., p. 140.
2/Ibid., p. 140.
3/Ibid., p. 146.

structure."[1] However, since most of the patients admitted to the Unit were not good candidates for individual therapy, and since each doctor had a case load of twenty or thirty patients, and since the patients' average hospital stay was four months, the therapy, other than by way of membership in the community, was largely either group therapy or psychodrama. These psychodramas were an interesting innovation at the Unit. They were formally structured like plays and were written and produced by a patient about his own life experiences and problems.

One of the important innovations in regard to vocational rehabilitation of patients in the Unit consisted of requiring all patients to work, for part of each day, in either the hospital workshops or at some job found for them in the wider community. The hospital workshops were set up with the aim of providing a "normal factory environment."[2] The goal for the patients in these work assignments was to give them occupational roles while still in the hospital. Job assignments were based on vocational and intelligence tests, interest, previous employment experience, and conferences with the D. R. O.s. It was felt that the vocational tests were not as helpful an index of interest and successful adaptation to a job as were the intelligence tests, and the history and interview material. The jobs themselves were distinctly not the sort of work that hospitalized patients have more conventionally done at occupational therapy shops but were rather designed to be realistic training for potential jobs upon leaving the hospital.

1/Ibid., p. 84.
2/Ibid., p. 157.

During the patients' stay at the hospital, each was evaluated in terms of his "employability or capacity for general adjustment."[1] It was found that where assessment of a patient's employability just prior to discharge was accurate, his general adjustment after discharge would be accurately predicted. Employability, then, appeared to be "...without doubt a function of the patient's personality and psychiatric state."[2]

The authors draw the conclusion from their work in the Industrial Neurosis Unit and from the findings of the follow-up study that "...it is possible to change social attitudes in relatively desocialized patients with severe character disorders, provided they are treated together in a therapeutic community."[3] The follow-up study demonstrated that "...six months after leaving the hospital, two thirds of the patients made a fair adjustment or better, and one third were rated poor or very poor adjustments; just over half had worked the full time since leaving the hospital."[4] They suggest that the reason community treatment is effective is that "...adjustment to a group of hospital patients was a transitional stage towards readjustment towards such groups as the family, or employers, or workmates."[5]

The authors make several pertinent suggestions about the general problems of hospital care and rehabilitation of non-psychotic mental

1/Ibid., p. 149.
2/Ibid., p. 150.
3/Ibid., p. 156.
4/Ibid., p. 156.
5/Ibid., p. 95.

patients based on their experience at the Industrial Neurosis Unit. They suggest, for example, that one area worthy of investigation is the total treatment role of a hospital community. They state that

> "All too often established practice bears no relationship to the treatment needs of the patient. In many instances they appear to be an elaborate defense protecting the staff against such needs." "It is not until patients have returned home that they can talk about the very real problems that now face them... one of the major aspects of treatment, the patient's own emotional problems, has been ignored."1/

A further question the authors raise is whether or not community treatment, such as that at the Industrial Neurosis Unit, would be more effective if patients were treated in their own native communities or at home, rather than being gathered from all sections of the country as was done in this study. Dutch experiments keeping the patient within the home environment, e.g., at the Amsterdam Municipal Health Service, are cited.

The Therapeutic Community was found to be a fascinating survey of a forward-looking experiment with the use of total community experience for rehabilitating a group of patients who are usually not reached very effectively by the more orthodox methods of treatment. The authors have discussed all aspects of their community treatment in detail and at the same time suggest new areas for further experiments. Their core philosophy appears to be that many individuals are lost in modern society because, due to the breakdown of family and community institutions, they never have a sense of belonging to any group. This sense of belonging, these authors suggest, is a requisite for a healthy,

1/Ibid., p. 159.

positive self-concept which is necessary to adjustment in all areas of life. Treatment, then, involves providing these individuals with a community with which they are enabled to feel identified.

One might question whether or not the authors might think further about their policies in regard to actual job assignments of patients being treated in the community. For example, they state that their patients come from a variety of educational, occupational, and social backgrounds yet the jobs available are largely in 'factory-like' positions. This is probably fine for many patients but what about the person whose aspiration level or employment goals would not be satisfied in such work? It might well be that the process of group identification could be slowed down or inhibited when the occupational choices are too limited.

One of the most important aspects of this book is that it points the way to a new, broader approach to, and philosophy of, treatment and suggests that we not be bound nor blinded by what have been almost sacred traditions of medical and hospital care. The stress here is on what social workers have considered their particular contribution to understanding patients, i.e., knowing the whole person as he is in all aspects of his life adjustment.

Since this present study is focussed on problems regarding the vocational rehabilitation of the psychiatric clinic patient, let us now turn to look at some of the ways in which the clinic patient's situation differs from that of the hospitalized patient and investigate how these differences affect his treatment and ultimate rehabilitation.

The clinic patient lives in the community and is viewed by others as a member of that community although his adjustment may be so marginal that he is regarded as inadequate or eccentric by his fellow community members. He is, nonetheless, expected to perform the activities associated by the community with his various social roles. Thus, for example, if he is married he is seen by the community in the social role of husband and is expected to support his wife and family, provide them with a home, food, clothing, etc. These expectations, however, place many individuals under severe strain, for they must, in this culture at least, be prepared in the occupational world to compete with their fellows, meet regular time schedules, and adhere to relatively complex social customs in regard to clothing, cleanliness, and behavior. It is the people who are making marginal adjustments in some specific area, or number of areas, of their lives, or those who feel significantly dissatisfied with their achievements, who apply for help at a mental health clinic. In contrast with these typical clinic applicants are those individuals who are predominantly unable to meet in acceptable ways the expectations associated with their social roles. These latter persons are ordinarily relegated by society to special institutions such as prisons or mental hospitals. This study is concerned with those patients who apply to a mental health clinic because they feel, or others convince them, that they need help because they have employment problems.

These unemployed patients are aware, since they are neither psychotic nor mentally deficient, that work - in order to be self or family

supporting - is expected of them by their community. However, for various reasons, they find themselves unemployed or unable to keep what jobs they are able to obtain. From the patient's point of view, the reasons for these difficulties are varied, as we shall see. From the point of view of the professional person who may see such patients in a clinic the causes for the patient's unemployment problems are more uniform. They may be found both in the sort of environmental pressures to which the patient is subjected, as well as in his internal environment, or personality structure. The causes for any patient's unemployment may thus be considered psycho-social in nature.

Work itself present stresses, both in view of difficulties in the work environment, such as poor working conditions of various sorts, as well as in terms of its unconscious meanings to people. According to an unpublished thesis by S. Bean, in which she quotes the various authorities such as Karl Menninger, Felix Deutsch, Ives Hendrick, and Sigmund Freud, work has dynamic significance to the individual.1/ It often serves various emotional needs such as providing a healthy outlet for aggressive tendencies. It is viewed as a function of the ego in that it is an expression of the "instinct to master." Work is also seen as an indicator of maturity for it means giving up the fear of activity and coming to terms with real or imagined shortcomings and relying on one's resources. Since work is a source of economic independence as well as serving as an outlet for libidinal and aggressive

1/S. Bean, Employment Problems of 28 Psychiatric Patients, Unpublished master's thesis, Boston University School of Social Work, 1955.

drives, loss of work may produce various emotional problems. Individuals may feel a marked loss of self-esteem, depression, anxiety, and feelings of rage. At the same time, people may fear work in terms of what it has come to mean to them, such as criticism, competition, self-betrayal, and ego-alien independence. Work may have significance in terms of interpersonal relationships and the meanings these have had to an individual throughout his life. He may, for example, unconsciously re-enact early familial patterns in his work relationships. Thus, if he has had difficulty as a child in accepting his father's authority this may carry over into the work situation in terms of problems in accepting his boss' authority. Work maladjustment may then be seen as symptomatic. Since psychotherapy cannot be administered like a pill, whether or not the patient is cooperative, the patient's motivation for treatment when he applies for admission to a mental health clinic will largely determine the degree of success in treatment. Some patients are poorly motivated at the time they come to the clinic, for they may, for example, have bee persuaded to come by a relative who is distraught because the patient is depending upon him for support. In such cases the therapist may be able to stimulate the patient to feel adequate motivation to work in treatment. The patient's effort, persistence, and desire for help is an absolute requisite for successful clinic treatment.

The patient's alternative to working with the therapist in an effort to ameliorate psycho-social factors interfering with his employment adjustment is for him to give up completely and settle back to be

supported by others in the community, whether relatives or public welfare. Those patients who are not adequately motivated and cannot be helped to feel so must then face this alternative.

In some cases an individual's life circumstances may change in some way that enables him to return to work without professional assistance. However, patients who give in to their dependency needs to the point of being supported exclusively by others present a difficult social problem. Is it less expensive in time, energy, and money for society to accept the burden so imposed by these inadequate people or would the preferable alternative be to find a way of helping them to become self-sufficient? This question is one that remains unanswered at the present time. The federal government and states spend huge sums each year to support people through public welfare of various types. Probably the recipients of disability assistance and general relief would include the largest number of unemployed but potentially employable people, provided adequate rehabilitation facilities were available to them. What is being offered then, in the way of clinic treatment for unemployed members of society? How is the problem of rehabilitation being approached in our clinics?

I. Stevenson and T. M. Fisher describe "Techniques in the Vocational Rehabilitation of Chronically Unemployed Clinic Patients at the "...clinics of the Psychiatric Service at Charity Hospital, New Orleans, conducted by the Louisiana State University School of Medicine."[1/]

1/I. Stevenson & T. M. Fisher, "Vocational Rehabilitation of Unemployed Psychiatric Patients," Am. J. Psy., October, 1954.

Their summary and conclusions are as follows:

> Summary: 1. An approach to the vocational rehabilitation of chronically unemployed psychiatric patients is described, consisting of a collaborative effort between a psychiatrist and a social worker.
>
> 2. Twenty of twenty-five patients returned to work and have remained working steadily for six months or longer. The average number of interviews before a return to work was ten...
>
> 3. Diagnostic category, age, duration of illness, and duration of unemployment did not influence results. Lack of training, excessive dependency, and lack of supportive family relationships were handicaps, but not insuperable obstacles to rehabilitation.
>
> 4. Significant techniques and factors in successful cases were:
>
> (a) Preliminary clarification of the patient's physical condition with appropriate treatment or reassurance and explanations.
> (b) Adequate working through of the primary psychological problems.
> (c) Deliberate focussing of discussions of the topic of employment.
> (d) Generous support and reassurance from the social worker during the period of return to work.
> (e) Increase of economic pressure by planned termination of public assistance.
> (f) Attention to selection of jobs suitable to the patient's psychological needs.
> (g) Continuous therapist-patient relationships.
>
> Conclusion: This study demonstrates the feasibility of vocational rehabilitation in chronically unemployed psychiatric patients. Provided the patient is given adequate support, he may also be exposed to considerable personal and economic pressure designed to increase motivation for return to work. When a patient does return to work there is usually a marked further improvement or complete disappearance of symptoms. This can be attributed to the increased income accompanying employment and the increased self-esteem accompanying economic independence. Only a small amount of time is required to achieve vocational rehabilitation by the method outlined. The final therapeutic results seem to be greater than when the same time is spent upon more traditional psychotherapy not especially focussed on the problem of employment.[1]

This study, then, describes specific methods that the authors feel

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1/ Op. cit., p. 289.

proved effective in rehabilitating one group of chronically unemployed clinic patients. This writer questions how it is possible "...in a small amount of time..." adequately to work through "...the primary psychological problems." However, this question of working through may actually be beside the point for far more important, in terms of these patients' ability to return to work, may well be the fact that they were given "...generous support and reassurance..." which would, in all probability, stimulate their sense of self-esteem and perhaps their sense of belonging. It should be noted that in this study the patients were treated collaboratively by the psychiatrist and social worker, whereas at the Southard Clinic patients are seen individually by either psychiatrist or social worker but not by both.

Another study of rehabilitation efforts with psychiatric clinic patients, in five New York clinics and one clinic in Michigan, is presented by T. Rennie, M. D. and M. Bozeman in their book entitled Vocational Services for Psychiatric Clinic Patients. The authors studied

> "...the extent to which clinic patients presented vocational problems,...the need among these patients for vocational service to help them resolve their vocational problems, and of the ways in which clinics and vocational agencies can work effectively together so that patients with vocational and emotional problems will receive the maximum benefit from the coordination of services."[1]

These clinics differed

> "...in acquaintance with and use of vocational agency resources, but patients who needed and could use direct vocational service

1/T. Rennie & M. Bozeman, Vocational Services for Psychiatric Clinic Patients, Harvard University Press, Cambridge, 1952, p. 1.

> usually received it. This does not mean...that these clinics had achieved the full potential use of vocational services as an adjunct to psychotherapy."[1]

It was found that

> "1. Approximately 80 per cent of the patients brought to their psychiatrist vocational problems which were either coincident with or a result of their over-all emotional problems.
> 2. ...about one-fourth of all the patients in this study, received vocational service in addition to psychotherapy.
> 3. Nearly two-thirds of the patients who presented vocational problems were either helped toward resolution or lessening of their problems with no service other than psychotherapy or were presumed to be unamenable to appreciable help by present facilities for service.
> 4. The proportion of patients who received vocational service varied from clinic to clinic, depending in each on size and intake policies social service function and coverage, and characteristics of the group of patients served.
> 5. Groups of patients who most commonly needed vocational service in addition to psychotherapy were: Patients under 30 years of age..., patients with severe physical handicaps as well as emotional problems; recent immigrants; and patients over 50 years of age. Lack of vocational direction..., unemployment,...were much more likely to indicate the need for vocational service than were poor personal relationships on jobs...
> 6. In spite of the recognized need for vocational service for patients in older age groups, the result of vocational service for these patients was poor.
> 7. ...Best results occurred when clinic personnel and vocational service personnel operated as a team, determining the patient's total need and planning total service by pooling psychiatric and vocational evaluation."[2]

According to this study, then, patients are most effectively helped with their vocational problems when they receive vocational service as well as psychotherapy, particularly when the various professions work closely together. The clinics represented in the above study all included both psychiatrists and social workers in their professional

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1/Ibid., p. 9.
2/T. Rennie & M. Bozeman, op. cit., pp. 78, 79.

staffs. As in the New Orleans study, the two professions worked collaboratively with each patient rather than individually as is done at the Southard Clinic. The authors felt that the social workers "...played a key role in the discovery of vocational problems and in their resolution through attention to and assistance with social aspects of the patients' lives and through referral to vocational agencies."[1]

Thus, as we have seen, employment maladjustment appears to be symptomatic of more general social and emotional problems in the patient. Patients who apply to psychiatric clinics for help with their occupational problems may be treated by a team composed of psychiatrist, social worker, and vocational counselor, or by any combination of these, separately or together. Treatment is based, by whatever therapist, on careful diagnostic evaluation of the individual patient's psychosocial environment. What appears to be important in the ultimate outcome for the patient is whether or not he can be helped, through whatever treatment he gets, to feel more adequate in terms of resolution of inner conflicts and competence in meeting external pressures. Specific vocational help, when the patient is ready for it, appears to be of marked assistance in his vocational rehabilitation.

The following two chapters will present the findings in this study of psychiatric patients who presented vocational problems when they applied for treatment at the Southard Clinic. The next chapter

1/T. Rennie & M. Bozeman, op. cit., p. 19.

will discuss the general characteristics of the selected sample and will describe the patients' contacts with the clinic. The following chapter will present a few representative cases.

CHAPTER IV

DESCRIPTION OF THE GROUP

This chapter describes the group of patients selected for this study and investigates their clinic contacts. During the six month period under study, approximately 380 patients were seen at intake at the Southard Clinic. The patients who were found to meet the criteria described in Chapter I were found to number 31. The sample selected thus consists of 31 patients, 8 of whom are females and 23 males. The male patients ranged in age from 17 to 61, the females from 19 to 45, as may be seen in Table 1. As may be seen, the

Table 1. Age and Sex Distribution of Patients with Employment Problems

Sex	Age Groupings					Totals
	19-22	23-30	31-40	41-50	over 50	
Males	5	7	4	4	3	23
Females	6	1	0	1	0	8
Totals	11	8	4	5	3	31

largest group of patients with employment problems was found to be among those under 31, the number of males was much the larger, and

the males were more evenly distributed within the age group than were the females.

Religious affiliations in the sample were varied, although more than half of the group and the largest number of patients of any one religion were Catholics. This may, perhaps, reflect Boston's unusually large Irish-Catholic population due to mass migrations here from Ireland during the past 75 years. More detailed information about religious affiliations may be obtained from Table 2.

Table 2. Religious Affiliations of Patients with Employment Problems

Religious Affiliation	Number of Patients
Catholic	16
Protestant	9
Jewish	5
Greek Orthodox	1
Total	31

The educational level of the patients in the sample was relatively high. The majority of the group had completed high school and several attended college, business, or commercial schools. No patient in the sample had less than a seventh grade education. Since the group generally had attained a fairly adequate education, which would presumably enable them to enter a great variety of jobs, one might reasonably infer that their employment problems were not correlated

with the amount of education they had acquired. However, several records mention that the patients presented disciplinary problems in school. This type of school problem may well reflect personality difficulties which may later interfere with employment adjustment. Table 3 presents more detailed information regarding the educational backgrounds of the patients in the sample.

Table 3. Educational Background of Patients with Employment Problems

Education Attained	Number of Patients
Less than 8th grade	1
8th grade	1
Less than 12th grade	9
12th grade	8
Attended business or trade school	4
College, incompleted	4
College, completed	2
Unknown	2
Total	31

With one exception patients who attended college or trade or business schools had completed high school also. The one exception was a female patient who attended secretarial school (listed under business or trade) after completing the tenth grade.

Male patients were quite evenly divided between those who were married and those who were single. Only one man was separated from

his wife. Since no married women with young children were included in the sample, the women's group is made up largely of unmarried females. See Table 4.

Table 4. Marital Status of Patients with Employment Problems

	Marital Status					
	Single	Married	Widowed	Divorced	Separated	Total
Men	11	11	0	0	1	23
Women	6	0	0	1	1	8
Total	17	11	0	1	2	31

The patients' occupational background was quite varied. In general patients did not appear to have been at any time as successful vocationally as might have been expected in view of the level of their educational attainment. Although it is somewhat difficult to classify individual jobs, the patients in the sample may generally be considered to fall into the employment categories shown in Table 5. None of the patients in the sample was employed at the time of application to the clinic for treatment, at least not on what was self-perceived to be on a satisfactory basis. Largely, they had been unemployed, or had had only sporadic employment, for varying lengths of time and for diverse reasons. Correlation of the lengths of time these patients had employment problems with their psychiatric diagnoses, re their inability

to work, revealed which types of patients had the most long-standing

Table 5. Occupational Background of Patients with Employment Problems

Classification of Occupation	No. of Patients
Skilled and semi-skilled	12
White collar	10
Service and unskilled	5
Professional	4
Total	31

employment problems. The diagnoses listed in Table 6 are those assigned by the clinic psychiatrists at the diagnostic interview or, where this information was lacking, by the referring agency or physician. The patients' own reasons for applying for clinic help usually included mention of their employment problems. On the other hand, a few patients applied at the suggestion of another agency or private physician, usually because of depression, anxiety, emotional problems, or somatic symptoms for which no physical cause could be found. As may be seen in Table 6, patients who had been employed for two or more years all had some sort of somatic problems. These somatic problems gave the patients what they felt was a legitimate reason for not working and were clung to persistently even when the emotional basis for the complaint was pointed out time and time again. This type of reaction poses very difficult problems to the therapist.

The patient's motivation is usually much more strongly directed towards remaining passive than towards attempting to become independent and

Table 6. Types of Employment Problems and Diagnoses in Terms of Patients' Work Problems

Types of Employment Problems	Number of Patients		Diagnoses in Terms of Patients' Work Problems
Employed part-time	3		Anxiety reaction & depression Passive-hysteric, Somatization
Employed sporadically	13	(2)	Response to trauma, e.g., death
		(11)	Inadequate personality, schizoid, passive-aggressive
Unemployed 1 year or less	10	(4)	Response to trauma, e.g., loss, death, brain tumor, court charge
		(1)	Work conditions posed special problems, e.g., noise, night work
		(5)	Inadequate personality
Unemployed 2 years	3	(1)	Back injury & inadequate personality
		(2)	Somatization
Unemployed 3 years	1		Somatization
Unemployed 4 years	1		Somatization
Total.....	31		

self-sufficient. One social worker noted in the record of one of these somatizing patients that she felt it was important for the clinic to evaluate carefully whether or not it was more economical of professional time and state funds to help the patient apply for disability assistance than it would be to undertake psychotherapy with such a poorly motivated

patient.

The 23 patients who had been employed sporadically or had been unemployed for less than a year composed the largest group in the sample. The diagnoses for 16 of these patients suggested very borderline adjustment; the inadequate personalities, schizoids, and passive-aggressives. Six patients' employment problems appeared to result from their difficulty in responding to traumatic events in their lives. One patient was diagnosed as having an inadequate personality but his employment problems may have been, in part at least, due to special difficulties in his working conditions.

Three patients had part-time jobs at the same time they applied to the clinic. These jobs were, however, regarded as inadequate in terms of the patients' needs to support themselves and their families. The diagnoses in this group were similar to those who had been sporadically employed or employed less than a year.

Since a great deal of the social pressure on these patients was to return to work in order to support themselves and/or their families, let us now see what their sources of support were while they were unemployed. Who carries the financial burden imposed by non-self-supporting members of society? Table 7 indicated how the patients in the sample were being supported.

Since the largest number of the patients in the sample were being supported by their relatives, helped by them, or likely to need their help at any moment, it becomes clear why many of the patients are likely to be poorly motivated for treatment. A patient who is pushed

to the clinic by a relative is not as likely to make an effort in psychotherapy as is the one who comes solely of his own volition.

Table 7. Sources of Support of Patients with Employment Problems

Sources of Support	No. of Patients
Relatives	11
Self; at least for the time being when seen at intake	4
Self and relatives	3
Public Welfare Disability Assistance (2) D. A. supplemented by Aid to Dependent Children (1)	3
Savings	3
Unemployment Compensation (1) and Insurance (1)	2
Unknown (no indication in the record)	5
Total	31

It is important then in evaluating the patient's emotional involvement in applying to the clinic to note how it is that he comes to the clinic; who referred him. The sources of referrals for the sample are described in Table 8.

It should be noted that only one patient referred himself to the clinic. It is difficult to estimate how many of the others asked to be

referred ow how many relatives sought the referral. It is probable that a number of the referrals from other agencies came about primarily

Table 8. Sources of Referrals to the Southard Clinic of Patients with Employment Problems

Sources of Referrals	No. of Patients
Other Agency	14
N. E. Home for Little Wanderers (1)	
Family Service Society (2)	
V. A. Facilities (4)	
City, State, & Private Hospitals and Clinics (5)	
Rehab. Clinic & D. P. W. (1)	
Division of Vocational Rehab. (1)	
Local Doctor or private physician	8
Friend	6
Psychologist (4)	
Osteopath (1)	
Physician (1)	
Relative	2
Self	1
Total	31

because of relatives shopping around for help with a non-supporting family member, or because the staff at the other agency became discouraged and decided that perhaps psychotherapy might help where the treatment they offered had not been adequate. This latter type of referral is very common when there are psychosomatic problems. The patient is given extensive medical study and treatment before it is decided that the problem has emotional sources. Many patients will, for example, apply to the clinic saying they have numerous aches and pains but that

the doctor told them it was 'just nerves'. Such patients often have no idea what psychotherapy is and will discontinue treatment when they find they are not going to be given some wonder drug they have read about in popular magazines. One patient in the sample applied for treatment because he had read an article in The Reader's Digest about the benefits of hypnosis. When the diagnostician pointed out that this would not be offered him at the Southard Clinic he decided not to return.

Many patients have, of course, had some previous treatment for varying lengths of time either specifically in relation to their employment problems or in relation to their more general emotional problems. Table 9 indicates where patients have had treatment prior to coming to the Southard Clinic. In a number of cases it was, naturally, the agency or physician who provided the previous treatment who referred the patient to the clinic, feeling the patient would benefit more from the type of treatment offered there than from what was available at the referring agency. A few patients had been known for some time to a variety of agencies. One, for example, had been taken by her mother from one agency to another, hoping each would offer an easy remedy for her emotional problems. She had been known to the New England Home for Little Wanderers in 1940, to the Ladies Helping Hand for Jewish Children in 1941, and at other times was known to the Douglas Thom Clinic, Children's Hospital Neurological Ward, Peter Bent Brigham Hospital social service, and Beth Israel Hospital Psychiatric Clinic. This is a rather extreme example, but is cited to indicate that some of these patients have applied to most of the agencies in the area

seeking help for emotional problems. When they become adult and are expected to take over an occupational role, they turn to a new clinic for help. A review of the records of previous agency contact often gives a discouragingly clear and complete picture of these patients' search for help.

Table 9. Previous Treatment Agencies of Patients with Employment Problems

Treatment Agency	No. of Patients
None	11
Hospitals and Clinics	9
Private Physicians	5
Children's Study Homes	2
Sweetser (1)	
N. E. Home for L. W. (1)	
Family Service Society	2
Vocational Agencies	2
Total	31

What, then, happens to people with employment problems when they apply to a new clinic or, for those who have not had previous treatment, to a clinic for the first time? Let us now investigate the length and type of clinic contact experienced by these patients, which of the professional staff they saw, the length of their treatment, what had taken place at the time their cases were closed in the clinic files, and the reason why the case was closed. Table 10 describes

the type and duration of the contacts the patients had at the clinic.

Table 10. Length and Type of Clinic Contacts Made by patients with Employment Problems

Length and Type of Contact	No. of Patients Male	Female
Intake Only	4	4
Intake and Diagnostic	8	4
Psychological Testing	6	1
Treatment Interviews	6	0
1 Interview (2)		
3 Interviews (1)		
9 Interviews (1)		
13 Interviews (1)		
17 Interviews & EST (1)		
Totals	Inappropriate*	

*Some duplication makes totals inappropriate.

It should be noted that patients are only referred for psychological testing after being seen for both intake and diagnostic interviews, and then only when there is some further question that needs answering, such as the patient's basic intellectual endowment or degree of pathology.

It now becomes clear that only a small proportion of this group of patients with employment problems actually received clinic treatment beyond the diagnostic stage. It should be remembered that "treatment begins in the first moment of contact" with the patient, as Gordon Hamilton points out."[1] Few were sufficiently motivated to maintain

1/G. Hamilton, Theory and Practice of Social Casework, Columbia University Press, (Second Edition, Revised), New York, 1951, p. 29.

their contacts with the clinic beyond the first two interviews; the intake interview with a social worker and the diagnostic interview with a psychiatrist. Of course, not all of the group were recommended for treatment at the clinic, for a number were either felt to be unsuitable candidates for psychotherapy and/or referred to other agencies. Those patients who did come for treatment only remained for a relatively short time. Table 11 indicates the recommendations that were made in regard to further help for these patients after the diagnostic interview and shows why the cases were closed in the Southard Clinic files.

It may be seen that a total of five men and two women were referred elsewhere rather than being offered treatment at the Southard Clinic. Eleven patients either were considered unavilable for treatment, did not keep their diagnostic appointments, or were felt to require reconsideration, in regards their treatability, at a later date. At any rate, this group was not offered treatment in the clinic at this time.

A total of 13 patients was offered treatment at the Southard Clinic, within the scope of this study. It should be noted that this is less than half of the original applicants, indicating to this writer the difficulties faced by professional people attempting to rehabilitate unemployed psychiatric patients. To be sure, those who were referred to other agencies were being offered treatment. For two in this latter category the treatment offered was directly focussed on their employment, rather than their more general psychiatric, problems.

Table 11. Recommendations for and Reasons for Closing Cases of Patients with Employment Problems

Recommendations	No. of Patients Male	Female	Reason for Closing
Referral Elsewhere:			
Vocational Guidance	1	0	Referral elsewhere
Dept. of Voc. Rehab	0	1	"
Boston City Hospital	1	0	"
V. A. Mental Hygiene Clinic	1	0	"
Alcoholic Clinic	1	0	"
Dept. of Public Welfare for Disability Assistance	1	0	"
Private Physician	0	1	"
None (patient did not keep diag. app't.)	3	3	Self-reject
Patient not ready for treatment	2	1	Not ready for rx.
Re-evaluate Rx. possibilities later	2	0	Pt. moved No response
Treatment:			
Staff physician	5	1	Brain tumor Employed Resistance Inadequate motivation
Social Service	2	1	Private Rx. No response
Harvard Medical School student	1	0	Pt. left Rx. when transferred to female resident.
Residents	1	0	Rx. elsewhere
Waiting list (type unspecified)	2	0	Pt. moved No response
Totals	23	8	

Nonetheless, the total number of patients in the sample who were offered treatment of one sort or another was only 20 out of 31. Further, none was able to remain in treatment for more than a few interviews as we have noted in Table 10. Rehabilitation of patients who apply to an outpatient psychiatric clinic, then, presents very difficult problems. The next chapter will discuss a few of these cases in more detail in order that the reader may have a clearer impression of the lives and problems of some of these patients.

CHAPTER V

PRESENTATION OF SELECTED CASES

This chapter will present a few representative case studies in order that the reader may have a clearer picture of the sort of people who apply for help at a mental health clinic in connection with their employment problems.

D. C., a 26 year old, single, white, Unitarian male was the only person in the sample who referred himself to the clinic. He had been born in Maine and lived there for some years before the family moved to Massachusetts. He had a sister two years older than himself and another two years younger. His father was employed as a superintendent of schools and tended to be somewhat alcoholic. When the patient was about 12, his father committed suicide by taking an overdose of phenobarbitol. After the father's death, the mother went to work as a cashier in a railroad station. The patient left high school when he was 12th grade age, never obtaining his high school diploma, although he has taken a number of evening courses since then. These latter courses were in the social sciences and physics.

When the patient was 19 he applied for psychiatric help at the Massachusetts General Hospital Psychiatric Clinic. He described his problems at that time as: having "lost interest in things," lacking satisfactory relations with people, shyness, severe stuttering, and

occasional asthma. He was treated both at the clinic and, for one month, on the psychiatric ward. It was felt that he had superior intelligence and, indeed, his I. Q. was determined to be 122. He was given an electro-encephalogram which proved to be normal and thus was apparently free from neurological problems. He was given the diagnosis of "character neurosis, mixed with psychoneurosis." Unfortunately, after several months of treatment, the patient's therapist terminated treatment, "prematurely," according to the patient. Patient learned shortly thereafter that his therapist at the hospital had committed suicide. This only served to re-enforce his feeling that treatment had been terminated too abruptly.

For two years prior to his application to the Southard Clinic the patient was employed as a commercial artist for a label company. However, he had managed to work only sporadically during this period because when anything went wrong at work he became extremely upset, depressed, and stayed away from his job. Fortunately, since his employers thought highly of his performance, he was not fired. At the same time they made it clear to him that they disapproved of his absences. The patient always returned to work eventually because he "knew there was work that badly needed doing."

He applied to the Southard Clinic for help because he felt his emotional troubles were getting in his way at work. He described "feelings of depression, futility, withdrawal, and sensitivity to criticism." He said he lived at home with his mother and younger sister and that he had "only one friend." This friend was a young man

with whom the patient went out and had a few drinks every night. The patient described his friend as an intelligent and friendly person who tended to be rather shy. He and his friend shared "a wide range of interests," but the patient felt somewhat superior because he had had more formal education than his friend. The patient's other interest was his National Guard Unit whose weekly meetings he regularly attended.

This patient was sent an appointment for a diagnostic interview shortly after his intake interview with the social worker. He did not keep the appointment. Instead he wrote a letter explaining why he was not coming back to the clinic. According to the letter, he had lost his job because of his repeated absences and, rather than obtain new employment while undergoing treatment at the clinic, had decided to become a non-commissioned officer in the National Guard. At the same time he was going to enlist in the regular army as a career. He hoped in this way "to avoid the internal conflicts of civilian life" and to "channel my energies" into a "satisfying" field.

Since he came apparently entirely of his own volition, this patient is one who might have appeared unusually well motivated for psychotherapy when he was seen initially at the clinic. This proved not to be true and one can only hope that an army career fulfills enough of his dependency needs, enables him to express outwards in a socially accepted way his apparent hitherto inward-directed hostilities, and reduces whatever anxieties were produced through his living at home with his widowed mother. And, indeed, it does seem possible that he will achieve, in the army, a more satisfactory adjustment than he

had so far been able to in his civilian life. He may thus have found a way of meeting his needs and solving his problems through changing his environment rather than through psychotherapy.

W. K., a 17 year old, white, single, Catholic boy, was referred to the Southard Clinic both by the Family Service Society and his probation officer. He lived at home with his parents and two younger sisters, one 16 years old and the other 6 months. His older brother, 19, was away in the Air Force. The patient had left school in the first year of high school, when 15, and worked sporadically since then. He never liked school and often played "hookey." When he was in the sixth grade the school nurse commented that she had "never seen such an unhappy boy."

At the time this patient was referred to the clinic he had been placed on probation for stealing two cars, one of which he had crashed. However, when he came to the clinic accompanied by his mother, his complaint was that he was "worried" about his health. "The boys call me 'Bones' because I'm so tall and thin." He also expressed worry about being "crazy." His mother informed the social worker that the boy was depressed and did not get along with people outside the family, particularly with boys his own age. She said he "hates girls" and has never had any dates. Three times he "accidentally" set his bed on fire, causing the whole family deep concern. The mother talked at some length of his relationship with his father, a 43 year old, alcoholic, unemployed, truck drive. She felt she had not protected the children adequately from their father's displays of temper. The father "picks

on W., calls him a 'jerk', and swears at him." She felt the patient had a peculiar attitude toward the advent of his baby sister. He had told his mother that she "should be ashamed of having a baby at 40."

There seemed to be only one positive factor in the boy's history. He worked at one time as a messenger for the Western Union Company and did such good work that they recommended him to another company for a job as messenger. However, the patient quit this job in a short time because he "felt that people were laughing at me because of my size." This feeling that "people didn't like me" and that he had "nothing, no work, no school, no social life - solitary only" vividly described his strong sense of inadequacy and self-doubt.

He came to the clinic twice. He came once for the intake interview and then, later, for his diagnostic appointment. According to the referring letter, he was "a very peculiar boy who doesn't make friends, and doesn't get along with anyone at home." The psychiatrist who saw him at the clinic gave him the diagnosis "schizoid personality" and added that he presented "a typical picture of an emotionally deprived, rejected, seriously traumatized individual." The psychiatrist also questioned his basic endowment. Whether or not this latter observation was based so much on the boy's true native intelligence as on ineptness resulting from early and severe psychopathology was never determined.

The diagnostician's recommendation is particularly interesting in this case in terms of helping this sort of patient with his problems, the final goal being rehabilitation. He suggested psychotherapy with the comment that, "This patient needs a warm, reassuring, encouraging,

accepting, loving relationship with a fellow human being." He further suggested a "male therapiest in view of the difficulties with his father." Long-term therapy was recommended as necessary to help the patient feel worthwhile. His final comment was that the alternative, "particularly in response to strain, might well be psychosis."

The patient was sent an appointment to take psychological tests before starting therapy. However, his mother cancelled the appointment, saying that the boy had just returned to work and did not want to take time off to come to the clinic. She said he had asked whether or not he might be given a Saturday appointment. None was available. It seems probable that the family felt a great deal of financial pressure due to the father's unemployment and were only too glad to have the patient contribute to the family support. The fact that he needed psychotherapy presumably seemed of secondary importance to them. It may also be speculated that the family was fearful of the very idea that

This case demonstrates two apparently crucial factors in the rehabilitation of unemployed psychiatric clinic patients. First, it makes painfully clear the patients' feeling of utter unworth and loneliness. Second, as the psychiatrist points out so eloquently, the patients need to feel loved, to feel that they are accepted and belong somewhere. This patient's pathetic statement that he is "solitary" tells us his need in his own words. How, then, can the psychiatric clinic help such a person? Perhaps psychotherapy alone is not enough. It may well be that a patient os this sort needs the type of group experience Maxwell Jones has described as so helpful in his

Therapeutic Community.

Now let us turn to a somewhat different sort of patient, one whose unemployment appears to be more a reaction to a recent emotional trauma which proved to be more than a somewhat inadequate personality could tolerate. Many of the people who become psychiatric clinic patients manage their lives fairly well, have at least a borderline adjustment, until some unusual stress upsets their rather precarious balance. For some of the people in the sample leaving school and being expected to take a job produced more stress than they could tolerate. For others in the sample the stress came at a different time, e.g., when their first child was born. The case of D. H. illustrates one of these latter people. She found herself unable to make an adequate adjustment, at the age of 40, subsequent to her divorce.

D. H. was referred to the clinic by her local doctor and her daughter, because of "her inability to adjust to her environment and her trouble keeping employment." She was a 45 year old, white, divorced, Protestant at the time she came to the clinic for her intake appointment. She was unemployed and living with her eldest daughter, as, surprisingly enough, did her former husband. Since the divorce in 1950 she had been employed only sporadically and had been fired from each job for a variety of reasons. She had done factory work but was laid off because she was "too slow, unable to keep up with the younger ones." She was also told that she was too slow on another job where she was a waitress. Here she was fired too. Her own feeling, however, was that she was not slow but that the real reasons were her "age and looks."

The social worker commented that the patient "thinks she's ugly due to her protruding teeth and her age, although she is actually fairly nice looking." She had made numerous efforts to obtain other employment through newspaper advertisements and the U. S. Employment Service but none of these efforts had proved successful.

The patient's social situation was painfully barren. Her parents were both dead. Her father died in 1935, her mother in 1948 after seven years illness with arthritis. Her only brother, several years older, lived far away. Her own family was broken up by the divorce and the unpleasant feelings associated with it. One married daughter lived some distance away. She told the social worker that she feels "no one wants me - children, husband, employers." Nonetheless, she denied that she needed help other than in finding a job. The social worker explained what the clinic could offer her and suggested she come for the diagnostic appointment. The patient refused the diagnostic appointment, repeating that all she wanted help with was her employment problem. The social worker than sent a letter to the patient's daughter, with whom she had talked previously in regard to patient's initial clinic application, explaining that the clinic did not see how they could be of help since they were a psychiatric clinic and the patient was only concerned about getting a job, had no interest in treatment, and was unable to say what was troubling her. The social worker added that it did seem the patient might need help and suggested that the daughter telephone to discuss the situation. However, no more was heard, either from the patient or from her daughter.

These case histories, brief as they are due to the brevity of the clinic's contact with the patients, suggest some of the sorts of problems these patients present; the emotional problems underlying the occupational problems, the latter often symptomatic of the former. What impressed the writer most in reading over the 31 case histories was the terrible loneliness of these people, because of life circumstances, rejection by key figures, etc. It becomes apparent that few are able to be helped by individual psychotherapy, at least if the findings of this small sample can be generalized to a wider group. The next chapter will summarize the findings of this study and discuss the writer's conclusions as to how these people may more often be helped and rehabilitated.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study has sought to examine and describe what happens when psychiatric patients with occupational problems apply for help at a mental health clinic, the Southard Clinic. As was pointed out in Chapter III, various agencies have dealt with this type of problem in different ways. Several other mental health clinics offer their patients collaborative treatment in which social worker and psychiatrist both see the patient. In these instances the psychiatrist offers psychotherapy while the social worker offers the patient emotional support and referral to vocational agencies. Maxwell Jones treats the same type of patient with marked success in his therapeutic community within a hospital setting rather than in a clinic. The Southard Clinic offers these patients individual psychotherapy with a therapist trained in psychiatric casework or therapy, either individual or group, with a psychiatrist or other doctor with psychiatric training.

The following research questions were answered:

1. How many patients seen at intake during the six month period being considered and whose cases were closed prior to the study presented employment problems at the intake interview?

There were 31 patients in the sample.

2. What sorts of patients came to the Clinic with employment problems? The patients in the sample are discussed in detail in Chapter IV. They ranged in age from 17 to 61, were more often single than married, were fairly well educated, frequently had at some time been employed at semi-skilled, skilled, or white collar jobs, and, in a majority of cases, were of the Catholic religion. Their diagnoses usually made mention of dependency, inadequacy, passive-aggressive, or schizoid features. The presenting problems usually made reference either to employment problems or to depression, anxiety, or somatic problems.
3. How long had these patients been unemployed or had employment problems of other types? Patients in the sample had been unemployed or had other employment problems for as short a time as a month or two and for as long as four years prior to the time they applied to the Southard Clinic.
4. What sources of support did the patients find while they had employment problems? Patients were preponderantly supported by their relatives, although several were contributing to their own support through sporadic work, savings, or insurance. Surprisingly few were receiving welfare aid.
5. What was the patient's clinic experience? What personnel

did he see? What recommendations were made for treatment? Were these carried out? If not, why not? Patients in the sample generally had fairly brief contacts with the Clinic, the majority coming only for an intake interview with a social worker and a diagnostic appointment with a psychiatrist. Eleven patients were not offered treatment because they had not kept other appointments or were considered unavailable for therapy. Seven were referred elsewhere, and thirteen patients were offered treatment at the Clinic. Six of these latter were to be treated by staff physicians, three by social service, one by residents, one by a fourth year medical student, and two were put on the waiting list without specification regarding therapist. Those who were recommended for treatment frequently did not respond when they were notified a therapist was available for them. Some of these patients had moved away, others had started treatment with a private physician, and one had found a job and refused treatment so as not to lose time from his new job. Those who did keep appointments came for varying lengths of time, four months being the maximum. It appeared that these patients were not sufficiently motivated to remain in treatment very long.*

*Although this was true of the patients in the sample, the writer knows personally of a number of other patients who meet all the sample criteria except the date of intake and who have been in treatment with both social workers and psychiatrists for several years. The writer has herself been seeing for seven months two patients with employment problems.

6. Upon what basis was the case closed? Was the patient employed? Was he referred elsewhere? Was he referred directly to a vocational agency? If not, would such referral have been useful? Cases were frequently closed, as noted above, due to lack of patient response. Only one patient was employed, insofar as could be determined, and he, very probably, only on a temporary basis. As noted above, seven patients were referred to other agencies, either back to the original referring agency or to a new one. Two patients were referred to vocational agencies, one indirectly during the diagnostic interview, the other through her mother's conversation over the telephone with a social worker who urged her to encourage patient to follow through with the contact she had already made with a vocational agency. It is difficult to evaluate whether or not others might have been helped by such referrals. The writer tends to feel that it is more important for these patients first to be helped to feel they are more adequate human beings before they are ready for specific vocational services. In some cases, where the idea of psychotherapy is threatening to a patient, he might be helped to accept his need for it through the guidance of a perceptive vocational counselor.

7. In view of the material obtained in this study, how may the vocational rehabilitation of patients who apply for

treatment at a mental health clinic be made more effective? This question is very difficult to answer. It appears, however, that the type of patient who applies to a mental health clinic with occupational problems is more fundamentally asking for help with his sense of inadequacy and feeling he does not belong anywhere. The family histories of these patients describe marked emotional deprivation throughout the childhood years. The patients frequently have had school difficulties prior to their employment problems, although they have managed to stay in school for a surprisingly long time, often through high school. Since the patients seemed to find it extremely difficult to accept treatment at the Southard Clinic, one wonders whether or not treatment such as was described in other U. S. clinics may offer more. Similarly one may consider the advantages of setting up hospitals for these patients similar to the Jones therapeutic community. Another somewhat similar method of treating these patients might be to include them in a day care program such as is being used in Canada as well as for former hospital patients at the Boston Psychopathic Hospital. Such programs provide the patients with meaningful daily programs planned especially around their needs and abilities as well as providing them with the experience of becoming assimilated in a group. It was the writer's impression that the

greater margin of success with patients with occupational problems in other institutions was perhaps due to the fact that the patients' underlying needs for a sense of belonging were more fully gratified. Further comparative studies of types of treatment methods with these patients might help to answer this question of more effective rehabilitation efforts.

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SOUTHEND CLINIC

APPLICATION DATA

Name:

Address:

Tel. No.

Age:
Sex:
Correspondent (if not the patient)

Date of Application
Method of Application
Referred by:

Person calling:

Problem:

Signed: Clinic Secretary

Date and Place of Birth:

Years in the U.S.

Religion:

Race:

Education:

Status:
M S D W Sep.

Occupation:

Place of Employment:

Personnel of House:

Military Service (for pt. and/ or spouse - specify)

Dates
From To
From

Types of Discharge:

Branch of Service

Locus of Combat:

Fee:

Net Income

Unusual Deductions

Number of Dependents

Fee

Reason if no fee settled:

Worker's signature _____

Date of Intake: _____

FAMILY HISTORY

NAME	BIRTHPLACE & AGE	COLOR & RELIGION	DATE OF MARRIAGE (and divorce)	OCCUPATION	REMARKS: if deceased, date, of what; if separated, when, etc.
FATHER:					
MOTHER:					
Step or Foster Father:					

Sibling: (Name, age, marital status, relationship - own, half, step - living or deceased)

Spouse: Name, age, occupation, color, religion, marriage date; if more than one, same information plus divorce date.

Children: (Own, step or foster - list separately; list all pregnancies)