

1955

A study of self-referred veterans to the
mental hygiene clinic of the Providence
Veterans Administration Regional Office
January 1, 1954 to December 31, 1954

<https://hdl.handle.net/2144/6616>

"Downloaded from OpenBU. Boston University's institutional repository."

Thesis
Paliotti,
1955

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF SELF-REFERRED VETERANS TO THE MENTAL
HYGIENE CLINIC OF THE PROVIDENCE VETERANS
ADMINISTRATION REGIONAL OFFICE,
JANUARY 1, 1954 TO DECEMBER 31, 1954

A Thesis

Submitted by

John Henry Paliotti

(B.S., University of Rhode Island, 1948)

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

1955

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK
LIBRARY

TABLE OF CONTENTS

CHAPTER	PAGE
I	1
Introduction	1
Purpose	2
Scope and Method of Study	2
Limitations	3
II	4
The Veterans Administration and the Mental Hygiene Clinic.	4
III	11
The Returning Serviceman	11
IV	19
Analysis of Data	19
V	35
A Study of Three Case Illustrations	35
VI	42
Conclusions	42
BIBLIOGRAPHY	44
APPENDIX	45

LIST OF TABLES

TABLE	PAGE
I Age and Marital Status	19
II School Grade Attained	21
III Branch of Service	22
IV Length of Service	23
V Length of Service and Disability Rating	24
VI Disability Rating and Combat and Overseas Duty	25
VII Employment Status at Referrals	26
VIII Length of Treatment during Previous Referral	27
IX Status at Termination of Treatment	28
X Time Elapsed between Previous Closing and 1954 Self-Referral	29
XI Length of Treatment as of December 31, 1954	30
XII Regularity of Appointments during Self-Referral	31
XIII Complaint at Previous Referral and Self-Referral	32
XIV Diagnosis at Referrals	33

CHAPTER I

INTRODUCTION

It is generally accepted that the treatment in a mental hygiene clinic is geared toward helping an individual function adequately with his family and within the community in an effort to prevent hospitalization. As the methods of therapy employed in a mental hygiene clinic, psychotherapy and casework, are yet to be clearly defined, research and learning are continuous and contribute greatly to both a better understanding of the patient and interpretation of mental hygiene to the community.

Many veterans treated in a mental hygiene clinic have been known previously to the clinic in that they had been referred by other sources. These veterans sometimes return for further treatment due to situational changes and other motivating factors.

The writer feels, therefore, that a study of the veteran returning for therapy on a self-referral basis may be helpful in understanding some of the factors involved in the self-referral.

Purpose

The primary purpose of this study is to explore certain characteristics of the self-referred veteran and to determine in what areas there are similarities and differences which may be related to the fact that they are self-referred, and to later treatment developments in the case. It is hoped that this study will show whether or not there are implications in this type of referral that would have some meaning for the clinic in dealing with a second referral which is a self-referral.

Scope and Method of Study

This study will include sixteen veterans who referred themselves during the calendar year 1954 to the Mental Hygiene Clinic of the Providence Veterans Administration Regional Office. All of the veterans included in this study have had at least one previous contact with the clinic through another referral source. For some this may have been a second self-referral.

A random sample of every third self-referred veteran was selected from the 1954 intake register. This gave a total of sixteen sample cases out of a total of forty-eight self-referrals for the calendar year 1954. Both active and closed cases were included. A schedule was employed and data

were obtained from the case records. Following the tabulation of the data, case situations were selected to illustrate the certain aspects of the self-referred veteran.

Clinic case records and essential folders served as the primary sources of data for this study. The essential folder is a complete record of the veteran's service activity from the date of induction to the present time. The writer discussed the case situations with therapists when case recording was inadequate. Published and unpublished literature pertinent to the topic was reviewed.

Limitations

Limitations exist in any study where social case records are used. The summarized method of recording, although appropriate and workable in the agency function, was sometimes not adequate for the purpose of this research. The limited sample used does not permit a comparison with other studies. Although some of the men had more than one referral previous to the 1954 self-referral, only the 1954 self-referral and the previous closing were included in this study.

This study is not intended to examine the case work process as such, but rather certain areas of activity. Conclusions were limited to the cases studied and are not applicable in any general sense to other groups of self-referred veterans.

CHAPTER II

THE VETERANS ADMINISTRATION AND THE
MENTAL HYGIENE CLINIC

The vast and unique organization known as the Veterans Administration is an agency which had its origin with the integration of three agencies within the United States Government handling the affairs of veterans. In July, 1930, by decree of the President, the Bureau of Pensions, the National Home for the Disabled Volunteer Soldiers, and the Veterans Bureau became one agency. Since that time the Veterans Administration has grown in purpose and scope and has encompassed many services to veterans. A new philosophy of services to veterans has been developed since World War II which has resulted in a rapid expansion of governmental benefits and services now available to veterans. The current focus is on assisting the veteran to readjust to the community and to obtain and maintain a status comparable to one he might have enjoyed had his private civilian life not been interrupted for military duty.

The Veterans Administration is headed by an Administrator who is directly responsible to the President. It is the responsibility of the Administrator to set up programs which have been duly enacted by the Congress of the United States. The Central Office of the Veterans Administration is situated

in Washington, D. C. It has as its duties the establishment of general policies for the administration of the many programs offered to the veteran.¹

The Department of Medicine and Surgery within the Veterans Administration was established on January 3, 1946. The Medical Director of this division is directly responsible to the Administrator of the Veterans Administration. It is the function of this division to provide the best medical care and treatment possible. Currently out-patient treatment is available only to veterans with a service-connected disability.²

The development of the Mental Hygiene Clinic is a necessary outgrowth of World War II. Many of the veterans experiencing neuropsychiatric illnesses were in dire need of psychiatric help. Today the mental hygiene clinic is recognized as an essential and integral function of the Department of Medicine and Surgery. Its purpose, function and operation are set forth in the Veterans Administration Circular 169, July 15, 1946.

1. Jack H. Stipe, "Veterans Benefits and Services", Social Work Yearbook, 1949, pp.521-527.

2. A service connected disability is one which is judged to have been caused or aggravated by military service and has been adjudicated by a board of Veterans Administration examiners.

Mental Hygiene Clinics....will be established in regional offices when the Deputy Administrator having jurisdiction determines that such clinics are necessary and can be properly staffed within the approved personnel ceiling..

Purposes and Responsibility...The need for treatment of the large number of veterans discharged from service with mental and nervous illness is evident.. Experience in civilian practice before the war indicates that the majority of these cases can be treated effectively in a clinic without hospitalization. The Mental Hygiene Clinic will render this treatment on an out-patient status and will be responsible for conducting the the entire out-patient treatment program in the selected regional offices.. This program will serve to alleviate a minor neuro-psychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization..

Function of the Mental Hygiene Clinic... treat the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization.. The veteran may present himself or be referred by another component of the Veterans Administration, a public or private agency, or an organization in the community.5

In relation to the services made available to the veteran with a service-connected disability Dr. Walter E. Barton states that....

some 30,000 veterans receive psychiatric and neurologic treatment either directly in Veteran Administration Mental Hygiene Clinics, or on a fee basis, or from contract clinics. Approximately twenty per cent of the patients receiving out-patient treatment have psychotic diagnoses and would have required hospital care.. The clinic program has effected appreciable savings of hospital beds, as well as economic and social advantages for the individual veteran participants.

The Veterans Administration operates four types of clinics:

- (1) A regional branch clinic offering psychiatric service to fifty-one areas.
- (2) A hospital clinic which operates as the out-patient department of a veterans hospital.
- (3) A traveling clinic.
- (4) A contract clinic (units associated with regional offices directed by qualified private psychiatrists).⁴

In relation to the purposes of mental hygiene Thomas A.. C. Rennie states:

Mental Hygiene has two closely related purposes. Its first aim is to prevent disease through a public health movement. The second aim is clinical and experimental, through teaching people how to accept themselves as they are, to recognize reality rather than live in a world of fantasy and wishful thinking, and to get the utmost out of themselves and the world around them.⁵

The Providence Mental Hygiene Clinic

The Mental Hygiene Clinic, Veterans Administration, Providence, Rhode Island, began functioning on October 14, 1946. Serving the State of Rhode Island, and southeastern Massachusetts including Cape Cod and the islands of Martha's Vineyard and Nantucket, its purpose, as previously outlined, is to treat on an out-patient basis, veterans who are disturbed by nervous and emotional illnesses. The staff is made

3. Mental Hygiene Clinic of the Veterans Administration, Veterans Administration Circular 169, July 1946.

4. Walter E. Barton, M. D., The Veterans Administration Mental Hygiene Clinic, American Journal of Psychiatry, The American Psychiatric Association, Baltimore, Md., Vol. III, #7, January, 1955, p.539.

up of two full time psychiatrists, one clinical psychologist, one case work supervisor, and two psychiatric social workers. In addition to the regular staff there are two students majoring in psychiatric social work fulfilling second year field work placements, and one clinical psychologist trainee. The clinic is situated approximately one mile and one half from the center of the city of Providence. Medical services for veterans are located on the first floor of the same building.

Most patients treated at the Mental Hygiene Clinic are referred by the Out-Patient Examining Section where an evaluation is made by a neuro-psychiatrist. Referrals are also made by Veterans Administration hospitals, agencies, private physicians, relatives, and self-referrals.

The intake process in the Providence Veterans Administration Mental Hygiene Clinic differs from that utilized in most clinics in that the patient is first seen by the psychiatrist, usually the Chief Psychiatrist, rather than a social worker. He may then be referred to a social worker for case work or other services.

An intake conference, attended by the clinic staff and conducted by the Chief Psychiatrist, is held on a weekly basis. At that time the new cases that have been admitted to the Clinic for that month are briefly discussed, specifically

5. Thomas A. C. Rennie, Mental Hygiene, Social Work Yearbook, 1949, p. 318.

for the following:

1. The presenting complaint, reason for referral, and source of referral.
2. The physician's impression of the basic reason for patient's requesting therapy.
3. The diagnostic impression.
4. The role that the psychologist might play in the evaluation of this patient.
5. The prognosis.
6. The goal of treatment.
7. The role that Social Service might play in conjunction with the physician.⁶

Some of the veterans are tested psychologically by the clinical psychologist. Final responsibility for diagnosis and treatment planning rests with the Chief Psychiatrist.

The Mental Hygiene Clinic is presently open two evenings each week for those veterans who are unable to come in during the daytime because of employment or other reasons.

The patient is seen for approximately one hour on an average of once a week. Treatment in this clinic setting is dynamically oriented and the team concept is utilized.

All activity in the clinic is geared to the patient's illness. The overall responsibility for the patient remains with the psychiatrist who may suggest that the skills and techniques of the psychiatric social worker be employed. Frequently the psychiatrist will have all continuous contact with the patient. If certain social problems are presented, the case worker, the casework supervisor and the psychiatrist will decide upon the services that the social worker will offer. Quite often this service will be to provide continuous service to other persons who

6. Melvyn Johnson, M.D., Intake Conference Agenda, Mental Hygiene Clinic, Veterans Administration Regional Office, Providence, Rhode Island

are involved in the patient's illness. In working these associated problems, the function of the caseworker may be to explain the operation and function of the clinic, handle their attitudes toward treatment, and to help them through the difficult periods that are a by-product of the patient's treatment. In addition, the family members are offered the opportunity for discussion of the meaning of change in the patient and even change within themselves.

The psychiatric caseworker carries the responsibility under the supervision of the casework supervisor and consults with the psychiatrist as this is indicated by the nature of the situation and the treatment plan. In addition, the caseworker has contacts with other community resources and utilizes them as they facilitate the treatment of the patient. In the clinic setting, some patients are able to benefit from the supportive techniques of the psychiatric social worker. These techniques aim toward bringing about re-orientation to the immediate reality situation. This supportive work often results in the patient's becoming more accessible to psychiatric treatment through direct help with the social problem. While the psychiatrist treats the illness of the patient, the psychiatric social worker helps the patient utilize the strengths he has at the particular time as effectively as possible in his social situations. The worker deals primarily with the reality situation and interpersonal relationships and uses social work insight and skills to bring about a better adjustment. In general, the aim of the caseworker is not to eliminate the patient's character disturbance but to help him to find a satisfactory form of social adjustment.⁷

7. Unpublished description of Mental Hygiene Clinic, Veterans Administration Regional Office, Providence, Rhode Island..

CHAPTER III

THE RETURNING SERVICEMAN

The veteran is a man who entered the service either by enlistment or enforced selective service. Some came from immigrant families, others from parents who traced their heritage back to the early settlers of America. They had vast differences in personalities and temperaments. Some had successfully emancipated themselves from their parents, others were still dependent. Some left girl friends behind, others left wives and children. Some welcomed the change as an escape, while others bitterly resented it. However, with the exception of the career soldier, they had one thing in common: none of them knew about war, its methods or consequences.

When the serviceman embarked on his military career he took with him a healthy body and psychological equipment. For some the psychological equipment included potentials for psychological difficulties. It may be safely assumed that the serviceman was in good physical condition or he would never have passed the rigid screening process at the point of induction. Although the psychological equipment he brought with him was less conspicuous than his body functioning, it was an equally important part of his total equipment and played a vital role in helping him adjust to the varied experiences of military life.

The serviceman reacted with varying amounts of physical and psychological disability to the physical and emotional stress of combat. The unending strain eventually produced distress signals which affected any part of the mind or body. Enthusiasm and eagerness gave way to a great weariness of battle. Transient fears turned into permanent feelings of apprehension. Anxiety that may have been related for a time only to a reaction limited to the most dangerous moments over the target, had a tendency to spread until it was continuous or was stimulated by only trivial sounds. Good muscular coordination was replaced by uncontrollable tremors, jerky manipulation and tension.

Constant tension lead further to a restlessness which was never satisfied by activity and was intolerant of repose. Sleep dwindled and may have given way altogether to insomnia accompanied by fitful nightmares. Appetite was noticeably reduced and gastric difficulties may have appeared. With the lack of control over the mental and physical reactions came a grouchiness and irritability that interfered with good relations among men. Some became depressed and seclusive, and stayed away from their friends to avoid dissension, or because they felt ashamed. Thinking and behaviour may have become seriously altered. Forgetfulness, preoccupation, or constant brooding over loss of friends and combat experiences

destroyed purposeful activity. The behaviour of the serviceman may have become not only asocial, but inappropriate and bizarre.¹

It required considerable time for any man going into the armed forces to make the many changes required, and some could not make them. How hard it was for a man to become a cog in the military machine depended on many things. If he learned very early to rely on himself and developed a knack of adjusting to all sorts of people, he was able to make the shift without too much trouble.²

Forty-five per cent³ of all medical discharges from the armed forces during World War II were for some psychiatric reason. Many of the servicemen had been subtly predisposed toward instability of some kind years before they entered the armed forces, but others with basically sturdy personalities had instability thrust upon them by the strains of combat under which the healthiest constitution could break down.

Many men experienced some degree of anxiety or some psychosomatic response to combat stress, which nevertheless at no time became severe enough to incapacitate them for full duty.

1. Roy R. Grinker, M.D., and John P. Spiegel, M.D., Men Under Stress, p. 54.

2. Luther E. Woodward, Jobs And The Man, p. 4.

3. George K. Pratt, M.D., Soldier to Civilian, p. 15.

The most frequent symptoms with which servicemen entered hospitals were: restlessness, irritability and aggressive behaviour, fatigue on arising and lethargy, difficulty in falling asleep, subjective anxiety, easy fatigue, startle reaction, feeling of tension, depression, personality changes and memory disturbances, tremor and evidences of sympathetic overactivity, difficulty in concentrating and mental confusion, increased alcoholism, preoccupation with combat experiences, decreased appetites, night mares and battle dreams, psychosomatic symptoms, irrational fears (phobias), and suspiciousness. All of these things add up to fear and anxiety which are the most disrupting emotions known to man.⁴

Among those who first develop symptoms after return home are many with mild and temporary reactions of insecurity to their repatriation and redomestication, and countless numbers with anxieties in anticipation of future difficulties at reassigned duties. Most of these mildly ill patients do well with group inspirational therapy, techniques of indoctrination and a sound convalescent program.⁵

Psychiatric treatment and psychotherapy have been used to treat the veteran both while in the service and in the community as a civilian.

4. Roy R. Grinker, M.D., and John P. Spiegel, M.D., op. cit., p. 210.

5. Ibid., p. p. 370.

Psychiatric treatment and psychotherapy are often confused and erroneously used interchangeably. Psychiatric treatment involves the entire medical approach to the patient suffering from a mental or emotional disorder and includes such procedures as psychotherapy, narcosynthesis, rest, sedation, activity, hydrotherapy, occupational therapy, shock treatment and continuous narcosis. When somatic disturbances are severe or have already crystallized into morphological changes, adequate medical treatment is necessary to complement the psychiatric treatment, the total constituting a psychosomatic therapeutic approach.⁶

Psychotherapy is based on a patient-therapist relationship. It is focused on an understanding of the psychodynamic structure of the total personality. The goal of psychotherapy is to relieve the patient of distressing neurotic symptoms or discordant personality characteristics which interfere with his satisfactory adaptation to a world of people and events.⁷

Many veterans recover quite spontaneously through psychotherapy in which the individual is permitted to abreact his severe anxieties and hostilities, learning from experience how to recover his confidence and how to re-establish his faith in human relations. There are still others who will fail to be greatly improved after psychiatric help. Examination of those men who fail to readapt to life in our demo-

6. Roy R. Grinker, M.D., and John P. Spiegel, M.D., op. cit., p. 368.

7. Kenneth Mark Colby, M.D., A Primer for Psychotherapists, p. 3.

cratic social structure shows, with considerably consistency, that they were predisposed in a characteristic way to the irreversible change which overtook them under the stress of combat or service duty.⁸ This was true even if a veteran was not faced with combat.

If the returning veteran was in the service for any length of time he faced the problem of once again functioning on his own -- unsupported by the group of which he had become a part.. He faced the problem of adjusting to the folks back home.. What should he do about a job? Should he return to his former job or try another? If he was discharged from the service because of some medical or psychiatric difficulty, how could he explain this? What would he do about his hasty war-time marriage? How would he react to the realization that his former girl friend was now married and had a family?

These were but a fraction of the real problems facing all returning servicemen.. Upon returning home the serviceman usually found a changed neighborhood in that some of the old crowd was still in the service, others had moved to different towns.. He realized that things in the home town weren't what he had expected them to be -- and so he reverted to a practice common to many people under similar circumstances: i.e.,

⁸. Roy R. Grinker, M.D., and John P. Spiegel, M.D., op. cit., p.258

he projected his feelings of irritability onto others. Many veterans returned bitter, bewildered and disillusioned over the realities of homecoming. Nothing turned out as they had expected and they found that the difficulties of adjustment on going into military life were no more painful than those experienced coming out. The adjustment difficulties on returning home also affected his family and friends. He recognized some of his behaviour was difficult, but was likely to understand why he felt and acted as he did and he was miserable and sometimes ashamed and guilty.

Relief at leaving the army was mixed with an illogical resentment at having to do so, and happiness at being home again was mingled with sadness over leaving the boys in his company. What about the future? What new groups did he identify himself within an effort to obtain continuing support? He learned he had forgotten how to discipline himself and was plagued by uncertainty.

The rebuilding of a war neurotic, sent home for treatment, must begin by convincing him that he is not a coward or failure, but a battle casualty just as truly as the man who lost a leg. He must also be persuaded that an important job waits for him, either in non-combat duty or in civil life. He has lost interest in things and requires proof of the usefulness of his earth existence.⁹

9. Dixon Wecter, When Johnny Comes Marching Home, p.27.

The veteran does not want to be ignored; he wants to be understood and helped. He is usually responsive to those who understand his problems and know how to help him, as he is cold to insincere or thoughtless approaches. The understanding which means help should be given in the bosom of his family, the first line of civilian therapy. It must, however, be supplemented by public attitudes which avoid the twin evils of oversolicitousness and indifference, while providing adequate medical care and social economic outlets for activity.¹⁰

¹⁰. Roy R. Grinker, M.D., and John P. Spiegel, M.D.,
op. cit., pp. 459-460.

CHAPTER IV
ANALYSIS OF DATA

This chapter contains a presentation of the data obtained from the sixteen case records which constitute the basis of this study. These data are set forth in tables to give a general description of the self-referred veterans as a group. Certain corresponding factors regarding referral, illness and treatment for each of the two referrals will be presented - the current self-referral and the preceding referral in order to see whether and in what areas changes took place.

A distribution of cases according to age and marital status is seen in Table I..

TABLE I
AGE AND MARITAL STATUS

Age	Married	Single
23-28	1	0
29-34	8	1
35-40	5	1
Total	14*	2

* One veteran previously widowed
* One veteran previously divorced

The ages ranged from twenty-three to forty with the highest concentration in the twenty-nine to thirty-four group where there is a total of nine veterans. The next largest concentration is centered around the ages of thirty-five to forty. The average age is 32.6 and it is seen that the early adult years of this group were spent in the service. There is not a sufficient age variation to be of any significance. The age distribution compares similarly to the clinic population in general. Every veteran was a white male.

A majority of the veterans were already married at the time of this self-referral, whereas two of the veterans married while they were in treatment. Included in the married category are one previously widowed and one previously divorced veteran. It is interesting that none are currently divorced or separated, and this may have been a stabilizing factor in their lives. The fact that the majority are married may have some significance. It may be that the wife encourages and supports her husband in coming to the clinic for treatment, or the veteran may be conscious of his marital and familial obligations.

A distribution of cases according to school grade attained is seen in Table II.

TABLE II
SCHOOL GRADE ATTAINED

Grade Completed	No.
7th grade	1
8th "	2
9th "	2
10th "	5
11th "	3
High school graduation	1
1 year of college	0
2 years of college	2*
Total	16

* One veteran entered a law school but withdrew after one year. Law school attendance followed discharge from service.

Only three veterans had a high school education or better. This suggests that they did not have the education or skills which would make for extensive job opportunities or sufficient advancement in rank while in the service.

A distribution of cases according to the branch of service is seen in Table III.

TABLE III
BRANCH OF SERVICE

Branch of Service	No.
Army	11*
Navy	4
Marines	0
Coast Guard	1
Total	16

* One veteran had received a bad conduct discharge from the Navy and later enlisted in the Army..

The fact that the majority of the veterans were in the Army is of no special significance when one considers that the size of the Army is much greater than that of the Navy and other service branches..

A distribution of cases according to length of service is seen in Table IV.

TABLE IV
LENGTH OF SERVICE

Months	No.
6-13	3
14-21	3
22-29	3
30-37	3
38-45	4
Total	16

The range is from six to forty-five months of duty. The average length of service duty was 26.6 months. Most of the veterans had a long period of service which suggests an ability to withstand service for a long period of time.

Table V shows a distribution of cases according to length of service and the percentage of disability rating.

TABLE V.
LENGTH OF SERVICE AND DISABILITY RATING

Length of Service (Months)	Percent of Disability		
	10-30	40-60	70-100
6-13	3		
14-21	1		2
22-29	2		1
30-37	1	2	
38-45	3		1
Total	10	2	4

The majority of the veterans have a low disability rating, and the distribution is such that it suggests there is no relationship between the length of service and the disability rating..

A distribution of cases according to per cent of disability rating, combat and overseas duty is seen in Table VI.

TABLE VI
 DISABILITY RATING AND COMBAT AND OVERSEAS DUTY

Per Cent of Disability	Combat	No Combat	Overseas	Not Overseas
10-30	5	5	8	2
40-60	2	0	3	
70-100	2	2	3	
Total	9	7	14	2

Nine of the veterans were in combat as compared to seven who saw no combat, so that there is no relationship between the percentage of disability rating and combat duty. Fourteen of the veterans, regardless of combat duty, went overseas. Sixty-four per cent of the veterans who went overseas saw combat duty.

A distribution of cases according to employment status at both referrals is seen in Table VII.

TABLE VII
EMPLOYMENT STATUS AT REFERRALS

Status	Previous Referral	Self-Referral	Both Referrals
Employed	11	9	9
Unemployed	5	7	5
Totals	16	16	14

Eleven veterans were employed and five were unemployed during the previous referral period. At the self-referral nine veterans were employed as compared to seven who were unemployed. Two veterans were employed at the pre previous referral, but were unemployed at the time of the self-referral. An examination of the case records showed that the employed veterans were having difficulties at their places of employment and were in need of continued support from the therapeutic relationship in order to function adequately in their employment. Familial responsibilities may have been an incentive for this group to seek help with their problems.

A distribution of cases according to length of treatment during the previous referral is seen in Table VIII.

TABLE VIII
LENGTH OF TREATMENT DURING PREVIOUS REFERRAL

Months	No..
0-6	7
7-13	2
14-20	4
21-27	3
Total	16

Forty-three per cent of the veterans were in treatment from less than one month to six months. The next highest concentration was in the fourteen to twenty months treatment period where there were four veterans, so that it appears that long-term treatment was predominant. All of the veterans were referred to the Mental Hygiene Clinic from the Out Patient Department in the General Medical Section.

The reasons for termination of treatment are shown in Table IX.

TABLE IX
STATUS AT TERMINATION OF TREATMENT

Reason	Previous Referral	Self-Referral
Hospitalized	6	6
Withdrew from treatment	8	0
Closed (not amenable to treatment)	1	3
Goal attained	1	0
Totals	16	9*

* As of December 30, 1954, 7 cases remained active.

Six veterans terminated treatment because of hospitalization at both the previous and self-referral. Eight veterans withdrew from treatment during the previous referral, and none withdrew at the self-referral.

One veteran was found to be not presently amenable to psychotherapy at the time of the previous referral. During the previous referral the goal had been attained for one veteran, and it was felt that nothing further could be done for him at the time. The number of veterans hospitalized at the previous referral is identical to those hospitalized at the self-referral. Fewer veterans withdrew from treatment at the self-referral as compared to the previous referral.

As of December 31, 1954, seven cases were active in the self-referral category. The case records did not indicate at any time that cases in this group had been terminated because the goal had been attained. On the basis of the high number of hospitalizations, some of them voluntary, this appears to be a fairly sick group of veterans who recognized and accepted their illness.

A distribution of cases according to the time elapsed between the previous closing and the 1954 self-referral is seen in Table X.

TABLE X
TIME ELAPSED BETWEEN PREVIOUS CLOSING
AND 1954 SELF-REFERRAL

Months	No.
0- 6	4
7-13	0
14-20	1
21-27	4
28-34	3
35-41	2
42-48	0
49-55	1
56-62	1
Total	16

An even distribution is seen with an elapsed time of less than one month to twenty-seven months for nine of the veterans, and from twenty-eight to sixty-two months for the remaining seven. Seventy-five per cent of the veterans did not return for treatment from over a year to five years. The average length of time between the most recent closing and the 1954 self-referral was 23.7 months. As seen in Table IX, six of the veterans had been hospitalized at the termination of previous treatment and, upon discharge from the hospital and prior to the self-referral, became employed or remained at home, as is seen in Table VII.

A distribution of cases according to length of treatment as of December 31, 1954 is seen in Table XI.

TABLE XI
LENGTH OF TREATMENT
AS OF DECEMBER 31, 1954

Months	No.
0-2	3
3-5	8
6-8	2
9-11	3
Total	16

The majority of the veterans were in treatment from three to five months at the time of the self-referral. The length of treatment ranged from less than one month to eleven months. The average length of treatment was 4.7 months..

Fourteen of the veterans were in treatment with a psychiatrist while the other two were each seen by a clinical psychologist and a case work supervisor. The veterans were seen previously by the same therapist and, in view of this fact, a question is raised as to whether this means that the self-referral returning for treatment is a more severely disturbed veteran as the self-referred veterans in this study were not seen by a social worker..

A distribution of cases according to the regularity of appointments during the self-referral is seen in Table XII.

TABLE XII
REGULARITY OF APPOINTMENTS
DURING SELF-REFERRAL

Regularity	No..
Regular	10
Irregular	6
Total	16

Ten of the veterans showed regularity in keeping their appointments with the therapist whereas six were irregular. By regular it is meant that seventy-five per cent of the appointments were kept. Irregular indicates less than seventy-five per cent of the appointments were kept.

A distribution of cases according to the classification of complaints at the previous and self-referral is seen in Table XIII.

TABLE XIII
COMPLAINT AT PREVIOUS REFERRAL AND SELF-REFERRAL

Complaint Classification	Previous Referral	Self-Referral
Anxiety	11	11
Phobic	3	1
Somatic	2	1
Depression	0	1
Family relationships	1	2
Gastric distress	2	0
Persecution	1	0

The majority of the veterans had complaints of anxiety at both the previous and self-referral. Many of the veterans expressed complaints identical or similar to those given previously. This is particularly true in the area of anxiety.

A distribution of cases according to the diagnosis at the previous and self-referral is seen in Table XIV.

TABLE XIV
DIAGNOSIS AT REFERRALS

Diagnosis	Previous Referral	Self-Referral
Anxiety state	4	7
Conversion reaction	5	4
Schizophrenic reaction	6	5
Reactive depression	1	0
Totals	16	16

Seven of the veterans were given a diagnosis of anxiety state at the self-referral. The next largest group were those veterans with a schizophrenic reaction. The complaints are of a serious nature, particularly anxiety states, for it is perhaps the most important of all the symptoms in the sphere of emotion for psychopathology. Anxiety is important as a symptom because theoretically it occurs as a warning signal that

repressions are about to break down and unconscious conflicts are threatening to become conscious ones.

CHAPTER V

THREE CASE ILLUSTRATIONS

The writer has selected three cases to demonstrate certain of the factors in this study which were significant to the group. Since the case records were particularly sketchy with regard to the Veteran's experience between the time of the last closing and self-referral currently under study, it has not been possible to fill in the information regarding school, employment, relationships, etc. during this period. However, whenever possible, changes in the actual situation will be brought up as the veteran brought them to the treatment situation.

Case I

This thirty-nine year old, married, Coast Guard veteran with a service-connected disability that has been classified as schizophrenia, ten per cent, was first seen in 1948. As the Out-Patient Department of the Veterans Administration had not yet been fully developed, he went to B Hospital, a private hospital for mentally disturbed patients. At that time he had good insight into his illness and said there was nothing organically wrong with him.

The veteran was first referred to the Mental Hygiene Clinic on 8-2-51 when facilities at the B Hospital were closed. His complaints then included an inability to concentrate.

The onset of the present illness was during the summer of 1942 when the veteran was on sea duty with the Coast Guard. At that time he began to show ideas of reference and developed auditory hallucinosis. He was then admitted to a marine hospital.

The veteran was a high school graduate and married at the age of twenty-three. He was the father of three children. He was attached to his mother and had much difficulty following her death. He had various fears and apprehensions as a child. He was seclusive and very intelligent and at one time won a national essay contest. His heterosexual adjustment was considered inadequate, and it was noted that there were many feminine traits about the patient. He entered the Coast Guard in November of 1941 and appeared to make an adequate adjustment. However, it was felt that being isolated on a ship for fifteen months with a group of men was too much for him to handle, and he began to show evidence of underlying schizophrenic illness. The diagnostic impression at the 1951 referral was "schizophrenia, catatonic type, in remission, manifestations being of a hysteroid-schizoid nature."

The patient was seen on a bi-monthly basis by the chief psychiatrist through October 11, 1951. During the course of treatment he said he was in contact with reality and was more in control of his fantasies. Treatment was discontinued when the psychiatrist felt that the patient had had a reasonable trial of intensive psychotherapy previously, and it would be fostering his dependency needs by continuing to see him in that he was using the psychiatrist more as a confidant than as a physician. The patient was informed of this and appeared to be agreeable to the decision of his therapist.

The veteran contacted the therapist on March 11, 1954. He ruminated concerning his preoccupation with mental illness, psychosis, and losing his grip. He felt that he was under pressure at work and perhaps this was the reason for his feelings of insecurity. He said there was no marital incompatibility. He was quite content with his wife and children and did not feel that his problems originated there. He accepted reassurance quite readily and it was felt that he should be seen on a few occasions until his equilibrium was re-established.

In this case, which was active with the clinic as of December 31, 1954, we see familial responsibilities as a motivating factor in the veteran's referring himself. Although the veteran complained of preoccupation with mental illness and losing his grip, it was later determined that he was fear-

ful of losing his wife and children because of his illness.

The veteran had been unable to utilize psychotherapy during the previous treatment period and consequently had to return. He is gaining insight into his condition during the present treatment.

We see a young, fairly intelligent high school graduate who is steadily employed and is in need of support.

During the previous treatment, the transference was in the form of using the therapist as a friend-confidant. However, he was later able to utilize the therapist relationship constructively thus pointing to a positive transference.

As treatment continued he was able to reassure himself of his worthiness and began to take an interest in community affairs. His attendance at the clinic is regular and he is now very active in a tennis group at the YMCA and in a bowling league. He has singled out youth organizations in that he himself has two sons. He describes his home in glowing terms; feels that his wife understands him. In that he now has developed keener insight into his problem, he is being seen on a less frequent basis and will continue to be seen on that level.

Case II

This thirty-five year old, married veteran was the third of seven children. He left high school during his first year at the age of eighteen years. His parents are living and well.

Little was known concerning his birth, growth, and early development.. He worked at various mills until his entry into the service at the age of twenty-one.. He was always happy, related well to people, and was able to perform a good day's work..

The veteran entered service on April 14, 1942 and was discharged on November 9, 1945 after thirty-six months of overseas experience with the artillery. While under combat he became extremely upset and was unable to perform his duties. After several brief hospitalizations he was returned to the line.. His post-service adjustment was considered to be inadequate..

He was first seen in the Mental Hygiene Clinic in May of 1948 as a referral following his pension examination. He complained of nausea, anorexia, insomnia, tenseness and irritability.. He did not continue in treatment but was referred again in March of 1949.. He discontinued treatment in February 1950 but returned in May 1952 complaining again of restlessness, heartburn and headaches. He was seen at intervals of one to two weeks until the case was closed on December 12, 1953.. He was very regular in keeping appointments at the clinic and his condition on closing at the previous referral was moderately improved..

On May 12, 1954 the veteran referred himself without an appointment expressing a desire to continue in treatment.. His complaints at the time were: tension, irritability, restlessness, and inability to cope with everyday affairs..

The veteran was seen in the clinic on a weekly basis and reported feelings of well-being and support from his contact with the clinic. Attendance was regular during the second self-referral.

While in treatment, the veteran held on to two jobs and, although he disliked one of his jobs, which did not hold much security, he was able to make an adequate employment adjustment.

This case was selected to show a veteran who was able to hold on to distasteful employment while receiving support in the clinic..

Again we see a cooperative, fairly intelligent, dependent-type of veteran who found a support in coming to the

clinic. He held on to his job despite a recent reduction in force and supplements this income with part-time employment. He was regular in keeping his clinic appointments.

The patient's attitude toward his own abilities seems fairly positive and seems to suggest that he may have reached a stage in his relationship where he is identifying himself with the therapist. He is making an adequate heterosexual adjustment.

This veteran received psychological testing and in terms of the Rorschach test, his ego showed signs of strength in spite of also showing a slightly below normal respect for reality. The test showed he was able to meet environmental stresses in a more mature manner.

We see a veteran with familial responsibilities making a strong effort to provide well for his family by working at a second job and seeking the help by which he can best cope with everyday problems at home and at work.

Case III

This veteran with a ten per cent disability rating for an anxiety state was first known to the Mental Hygiene Clinic in January 1950 when he was referred by the Medical Out-Patient Department. His chief complaints were those of a constant feeling of nausea, especially at night upon arriving home from work, cramps in his stomach which were extremely painful, excessive headaches and feelings of irritability, tenseness and general unrest. The veteran said that although he had been bothered some by the above conditions since discharge from service in 1945, it was not until three weeks before his referral that it became almost unbearable.

The veteran was the youngest of fourteen children, nine of whom were living. The father was living and the mother had died when the patient was eight years of age. The patient blamed himself for her death for she developed a heart condition following his birth..

He completed two years of high school and left because of economic conditions at home. He lost time from school and repeated the fifth grade because of stomach aches. He married "the girl next door" in 1947. They had one child and the veteran claimed he was not happy in his married life..

The veteran was drafted in September of 1943 and was discharged during December of 1945. His rating was private and he served in an infantry outfit.. He saw combat and was taken prisoner by the Germans.. The veteran remained in prison for eleven months.. He gave a vivid description of his imprisonment..

The veteran made a good employment adjustment prior to being drafted.. He was employed in a box factory and in a torpedo station.. Since his discharge he had several job changes.. He was first employed under on the job training doing auto repair work, but gave this up because he did not receive any pay increases..

During the first referral the veteran was very regular in his appointments and continued in treatment until he was discharged "improved" during April of 1952..

During January of 1954, he returned to the clinic as a self-referral with somatic complaints.. He was somewhat depressed.. He appeared to be quiet and shy and had some difficulty in expressing himself during the initial phase of the interview, but relaxed and became more comfortable and seemingly gained some relief from talking..

The veteran at one time said his greatest problem was fear of death.. This has subsided. He claimed that he had been better able to take care of his problem. He realized he felt tense much of the time and was easily irritated. He gave vent to many positive views and in his way of living plainly demonstrated that his discrimination between right and wrong always favored the wrong where his survival was at stake..

Although his personality has not undergone much change he has acquired a better understanding of the emotional aspects of his somatic complaints. He seems to have acquired

some intellectual and emotional insight, appreciating that he has had a "nasty personality."

In the above case the veteran had an awareness of his problem and was able to function more adequately with simple support from the clinic. Like other veterans in this study, he had gastro-intestinal complaints. Although he admitted he was not happily married, he showed some recognition of moral and familial responsibilities.

The veteran was very regular in his attendance at the clinic and requested continuing treatment. However, there has been no change in his symptomatology. He has continued to work and with much effort. Simple supportive therapy seems to enable this veteran to maintain a fair level of adjustment.

CHAPTER VI
SUMMARY AND CONCLUSIONS

In this study the writer has attempted to explore some of the characteristics of the self-referred veteran and to determine in what areas there are similarities and differences which may be related to later developments of the case. The writer studied sixteen veterans who referred themselves to the Mental Hygiene Clinic during the calendar year 1954. All of the veterans studied were white males, and had had a previous contact with the clinic as referrals.

This was a group of veterans ranging in age from twenty-three to forty, most of them married, with limited education. They had a long period of service, over half having seen combat duty, and fourteen having been overseas. The majority of them served in the Army.

Their complaints at the preceding referral revolved primarily around irritability, nervousness and tenseness, and the complaints which brought them back were similar. Their problems were also focused on their employment and marital situations.

Treatment was of short duration for half of the group during the previous referral, and for more than half of the group during the self-referral. The majority of the veterans were regular in keeping their appointments with the therapists.

Six veterans were hospitalized voluntarily during each of the referrals which substantiates this as a fairly sick group who recognized and accepted their illness.

Seventy-five per cent did not return for treatment from over one year to five years since the previous closing. More than half of the identical veterans were employed during both treatment periods.

The diagnosis remained the same during the previous and self-referral for the majority of the group. Schizophrenic reaction was the more frequent diagnosis during the previous referral, and anxiety state during the self-referral.

One veteran had a change in his disability rating from the previous to the self-referral. There is no evidence to support a positive prognosis for the self-referral.

These veterans in this study referred themselves for further help with serious emotional problems. The fact that they had already had similar contact at the clinic previously suggests a positive association with this service.

*Approved 6/27/55
Rose Bernstein*

BIBLIOGRAPHY

Books

- Wecter, Dixon, When Johnny Comes Marching Home, Cambridge, Houghton Mifflin Company, 1944.
- Pratt, George K., M.D., Soldier to Civilian, Mc Graw-Hill Book Company, Inc., New York..1944
- Stipe, Jack H., in the Social Work Yearbook, 1949.
- Rennie, Thomas A. C., "Mental Hygiene", Social Work Yearbook, 1949.
- Grinker, Roy R., M.D., and John P. Spiegel, M.D., Men Under Stress, Blakiston Company, Philadelphia, 1945.
- Woodward, Luther E. and Thomas A. C. Rennie, Jobs And The Man, Charles H. Thomas, publisher, Springfield, Ill., 1945.
- Colby, Kenneth Mark, M. D., A Primer for Psychotherapists, The Ronald Press Company, New York, 1951.

Periodicals

- Barton, Walter E., American Journal of Psychiatry, The American Psychiatric Association, Baltimore, Md., Vol. III, No. 7, January, 1955.

Public Documents

- Veterans Administration Circular 169, Mental Hygiene Clinic, Veterans Administration, July, 1946.

Unpublished Literature

- The Mental Hygiene Clinic and the Role of the Psychiatric Social Worker in the Providence Regional Office of the Veterans Administration, 1946.
- Intake Conference Schedule, Melvyn Johnson, M.D., Chief Psychiatrist, Mental Hygiene Clinic, Providence Veterans Administration Regional Office..

APPENDIX I
DISTRIBUTION OF ESSENTIAL FACTORS ON AN INDIVIDUAL BASIS

Vet.	Age	Marital Status	Service Branch	Length of Service	Com- bat	Per cent Disability	Education	Case Status	Length of Ref. treatment	Self- treatment	Diag- nosis
1	29	Married	Army	6 months	No	10%	8th grade	Closed	4 months		Conversion reaction
2	29	Married	Navy	27 months	Yes	100%	12th "	Closed	20 days		Schizophrenic reaction
3	40	Married	Army	31 months	Yes	10%	10th "	Active	4 months		Anxiety state
4	37	Married	Army	43 months	No	10%	7th "	Active	2 months		Anxiety state
5	36	Married	Navy	40 months	Yes	30%	10th "	Active	4 months		Anxiety reaction
6	37	Single	Army	17 months	No	100%	10th "	Active	5 months		Schizophrenic reaction
7	31	Married	Army	10 months	No	10%	11th "	Closed	1 month		Anxiety state
8	34	Single	Army	45 months	No	70%	2 yrs. law school	Closed	3 months		Schizophrenia
9	30	Married	Army	21 months	Yes	100%	11th grade	Closed	4 months		"
10	29	Married	Army	27 months	Yes	10%	11th "	Active	11 "		Anxiety state
11	30	Married	Army Navy	30 months	Yes	40%	10th "	Closed	9 months		Anxiety state
12	33	Married	Army	26 months	Yes	30%	9th "	Closed	6 months		Conversion reaction
13	23	Married	Army	13 months	No	10%	9th "	Closed	6 months		Conversion reaction
14	35	Married	Army	44 months	Yes	30%	8th "	Active	8 months		Conversion reaction
15	38	Married	C.G.	16 months	No	10%	2 yrs. college	Active	9 months		Schizophrenia
16	30	Married	Navy	31 months	Yes	50%	10th grade	Closed	1 month		Anxiety state

APPENDIX II

SCHEDULE

1. Background Data

Name

Age

Marital status

Diagnosis

Time elapsed since last closing

Date of first application

Date of first closing

Reason for first closing

Status at first closing:

- a. hospitalized
- b. withdrew from treatment
- c. goal completed

Presenting complaint at first application

Presenting complaint at self-referral

2. Military History

Branch of service

Length of service duty

Combat: Yes No

Injuries

Per cent of disability

Final rank attained

Attitude toward military life

3. Treatment in Clinic

Reason for self-referral

APPENDIX II (Cont'd.)

SCHEDULE

3.. Treatment in Clinic (continued)

Reason for termination of treatment during this self-referral

Psychological testing results

Status at this termination:

- a.. hospitalized
- b.. withdrew from treatment
- c.. goal completed
- d. active case at present

4.. Scholastic Record

Extent of education

5.. Community Adjustment (pre-service)

	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Employment			

Social

Recreational

Family

Community Adjustment (post service)

Employment

Social

Recreational

Family

6.. Attitude Towards Treatment

Did veteran have insight?

Was he fearful of stigma?

Attitude towards family and friends?