McGill University

Referrals of Patients From Medical Service to Psychiatric Service

The role of the medical social worker in helping patients at The Royal Victoria Hospital to accept and use a referral to the psychiatric service when their original request was for treatment of their physical complaints

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PREFACE

The subject of this study arose out of the need for information concerning the role of the medical social worker in helping patients to receive the maximum benefit from the specialized services of a modern hospital.

The writer is deeply indebted to all those who assisted in any way with this study, but particularly to those mentioned below:

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CHAPTER I

Introduction

Great progress has been made by medical science today toward the successful treatment of many diseases so that they no longer present the same threat to man's existence. Along with this, increasing attention is being directed toward those patients who return again and again to the clinic or the private doctor with complaints for which no organic basis can be found. It is generally agreed that this group now comprises about one-third of all patients coming to the medical clinic of a general hospital, and about one in every thirteen patients admitted to the medical wards.

It is now widely recognized by the medical profession that there are both physical and emotional components in the disease process and that the existence of one may produce the other. There is abundant evidence today that medical physicians and psychiatrists are working more and more closely together with the common goal of treating the patient as a whole person. Psychiatrists are now seen on the staffs of general hospitals and psychiatric treatment is included as part of the general hospital service.

What does all this mean for the individual patient who comes to the medical clinic expecting a specific medication for the pain in his heart, or the patient who "knows" that the pain in the left side of his abdomen means he will have to have an operation? How does he feel when, instead of being given a bottle of pills or being referred to surgery,

he is asked to see a psychiatrist? We know from experience that presenting the patient with a slip of paper for a psychiatric consultation as one would direct him to the X-ray department, is no guarantee that the patient will ever go to see the psychiatrist. For many patients a transfer to the psychiatric service seems to have a particular meaning which makes this transfer far more difficult than a transfer to almost any other service.

It is for this reason that the medical social worker has a very real service to perform with this group of patients. It seems important at this time when so many of these patients are seen in general medical clinics, and the caseworker's services are so urgently required, that a study be made of the medical social worker's role with them, to ascertain how she may best function as a member of the medical team and co-operate with others outside the hospital to help the patient make the best possible use of the treatment offered toward his optimum recovery.

Each patient has his individual reaction to being told that he needs the help of a psychiatrist. If we consider patients in terms of the resistance they show to a referral to the psychiatric service, it appears that most of them fall into one of the three following groups. Firstly, there is the patient who does not recognize the emotional component in physical illness. He has no insight into his condition and cannot accept the relationship between his physical symptoms and his emotional disturbance. To this patient a referral to the psychiatrist causes him to doubt the doctor's ability, or else it makes him feel that the doctor is denying the reality of his illness. Secondly, there is the patient who has recognized this relationship, but the very fact that

he has some insight into the emotional factors responsible for his physical symptoms, fills him with anxiety and with fear that he cannot control his own reactions. He may be afraid that this will eventually lead to mental illness and the referral to psychiatry may only serve to verify his fears. Thirdly, there is the patient who has accepted both the relationship between physical reactions and emotional stress and the fact that the psychiatrist can help him, but he is concerned about the stigma that has long been connected with psychiatric treatment. He himself would like to try it, but he thinks of psychiatry as treatment only for the mentally ill and therefore not for him. An important factor in any case where emotional reactions are expressed physically, whether the patient is conscious of the process or not, is that physical illness is socially acceptable, while emotional illness is not.

In order to assist the patient toward accepting psychiatric help, the medical social worker must begin where the patient is. At the outset it is important that the patient feel the worker's acceptance of him as a person and her recognition of the reality of his illness. If the patient lacks insight into his condition, the worker's interpretation will consist of helping the patient gradually to link his physical symptoms with upsetting experiences and emotional reactions he has had so he will come to understand the relationship between them. As he gains understanding of his own feelings and their physical expression, the worker will begin to interpret psychiatric treatment and the way in which a psychiatrist may be able to help him. At this point she will try to relieve this form of treatment of the stigma long connected with it and she will help the patient to handle his feelings in regard to accepting

psychiatric care. The patient may need a great deal of support and reassurance in order to help him maintain treatment, and casework help may be needed for some time after the patient has accepted the psychiatric referral.

It must be remembered that the medical social worker is at all times a member of the medical team. Leading medical schools have more and more accepted the thesis that the physician should be trained in the psychological and social handling of his patients, and co-operation along these lines with the social worker in the hospital in a teamwork relationship has already been tried and proved successful.[1.]

A comparatively recent study on the functioning of psychiatric clinics in New York city by the New York city committee on mental hygiene[2.] has served to point out the need for careful preparation of the patient, who came originally with physical symptoms but who was later referred to the psychiatric service. The need for medical social work help in this referral has also been shown by both doctors and social workers alike. Social workers from community agencies have long since demonstrated the value of their careful preparation of the patient for psychiatric treatment and also of preparing a social history for the psychiatric clinic, by the success of their referral process.

In Montreal, psychiatric services are readily available in a number of the general hospitals and psychiatrists are frequently members of

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1. Jurgen Ruesch, "What are the Known Facts About Psychosomatic Medicine at the Present Time?", Journal of Social Casework, (October, 1947), pp.291-294.

2. The Functioning of Psychiatric Clinics in New York City, New York City Committee on Mental Hygiene of the State Charities Aid Association, (New York, 1949).

the hospital staff. At the Royal Victoria Hospital, where this study was made, there is a psychiatric clinic to which patients may be referred for treatment and psychiatric internes also rotate on the medical service as part of the medical team. With such facilities available, and in the light of experience elsewhere, it seems timely here at the Royal Victoria Hospital to study the role of the social worker with patients who request medical treatment and who at a later time are referred to the psychiatric service.

At the time of this study, there was a medical social worker on the medical service at the Royal Victoria Hospital who received referrals from both the medical clinic and the medical wards. Patients were referred to her by the medical doctor only as he saw the need for it. Sometimes further treatment plans were formulated on the basis of her evaluation and in this way, a referral to the psychiatric service might be made. It is hoped, as a result of this study, to be able to make some evaluation of this referral process and the role of the medical social worker in connection with the particular group of patients studied here.

In order to study the social worker's role with these patients, it will be necessary to study each case in some detail. It will be important to consider the symptoms the patient presents, his history and his present social situation, as well as influences of other people, both family and friends, upon him. The understanding thus gained will enable the social worker to decide how she can use this information to help the patient. The writer will want to consider other factors which influence the patient's acceptance or rejection of psychiatric care, and also the social worker's role in relation to them. The basis of selection of

these patients for both social service care and psychiatric care, and the source of each referral, must also be considered and evaluated in terms of the patients in this group and their acceptance of psychiatric treatment and eventual improvement. The aim of the social worker and the way in which she functions as a member of the medical team will be studied from a social service point of view in relation to that of the physician on the medical service and that of the psychiatrist. Finally the writer would like to consider and attempt to evaluate the ways in which the social worker has helped these patients accept and maintain psychiatric care. It is recognized that this will not be a simple question of success or failure. It is felt that in each case the worker's role will have to be evaluated individually, and the outcome of her work will have to be considered in relation to her aim in that particular case.

The cases used for this study were all carried by the social service department at the Royal Victoria Hospital at some time during the three and a half years between January 1, 1947, and June 30, 1950. They were all adults who presented physical symptoms and who were referred during this period to the Allan Memorial Institute as indoor patients, or to the psychiatric clinic at the Royal Victoria Hospital, or to the psychiatric resident on the medical service at the Royal Victoria Hospital. They were all patients who required some help in order to accept or make use of psychiatric treatment. Some returned for treatment and some did not.

The intake of the social service department during the specified period of time was reviewed and those cases which appeared to have a psychiatric diagnosis were selected for this study. This yielded 54

cases which were scanned and 19 rejected on the basis of insufficient material for study purposes, or absence of a referral for psychiatric help. The remaining 35 were then studied more carefully and only 18 were considered to fulfil the above criteria. These 18 have been used in this study.

Case material was derived primarily from the case records of the social service department and from the medical indoor and outdoor records. This material was supplemented in most cases by information gained through personal interviews with the social worker who carried the case and in some cases also with the psychiatrist who treated the patient.

A document schedule was used for abstracting the data, a sample of which may be found in the appendix. The amount of material available differed in each case, and some questions remained unanswered for individual cases. Each question was answered by a majority of the cases, however, and the case material showed great variety.

Theoretical material for this study was derived from the medical and social work literature in psychosomatic medicine, and from other published works and reports of studies which had a bearing on the problem. The theoretical material will be presented in chapter II.

The sample group will be analysed according to improvement shown as indicated by the evaluation of the psychiatrist who treated the patient. In the first group are five patients who showed marked improvement following a period of psychiatric treatment. This group will be presented in chapter III. The second group, presented in chapter IV, consists of eight patients who showed some improvement following psych-

iatric treatment and in the third group, presented in chapter V, are the remaining five patients who showed no obvious improvement and who rejected psychiatric help. Grouping on the basis of improvement was finally decided upon since so many factors contributed to this improvement that it was not considered advisable to group them according to any one factor. These factors will still be considered and the caseworker's role will be studied in each group in relation to the improvement shown.

It is intended to review the main findings of this study in chapter VI and, on the basis of these findings, it is hoped to be able to indicate areas for further study and to make certain recommendations in regard to the medical social worker's role with patients referred from the medical to the psychiatric services, when the patient's original request was for medical care.

CHAPTER II

A Psychosomatic Orientation

> "Just as you ought not to attempt to cure eyes without head, or head without body, so you should not treat body without soul". - Socrates.

Psychosomatic medicine as such is not new. It is well known that when human beings do not feel as well as usual and are troubled they seek a father person for care and comfort. Thus it is to be expected that the general practitioner and the general medical clinic of a hospital will receive many patients who have vague physical symptoms and are burdened emotionally. Long before the term "psychosomatic" came into use, family physicians were considering emotional influences in the diagnosis and treatment of illness. With increasing specialization in the field of medicine, however, and the development of complex techniques for examining the patient, there has been an increasing emphasis on the disease process, without considering the patient himself and the effect that his emotions and social environment play in his illness. In fact, with this greater scientific knowledge, the tendency has been to treat the disease and not the patient.

With the influence which psychiatry has had on medical practice and the growing realization on the part of patient and physician alike that something was missing in this technical approach to diagnosis and treatment there has been an effort to bridge this gap between mind and body. The biologically oriented psychology of Freud has made this

possible[1]. and following his discoveries, interest in psychosomatic medicine has increased rapidly.

At the same time, the results of research in physiology have served to emphasize the relationship between emotions and bodily functions. Nolan Lewis[2]. says in regard to this, that -

> The affective or emotional equipment of the patient not infrequently dominates the physiologic functions, and is probably always part of the general process which may and usually does function beneath the level of awareness. There is quite a body of physiological evidence to show that parts of the vegetative nervous system respond whenever the body is attacked, or threatened with attack regardless of whether the disturbing elements are animals, human beings, disease processes, or mental conflicts.

Pointing out that the cortex has no direct control, Walter Cannon[3]. stressed the futility of trying to argue a patient out of his emotional reactions. "The factors in the whole situation which are the source of strong feeling must be discussed and either explained away or eliminated".

With this background, modern psychosomatic medicine "represents a serious attempt to include psychological factors in the practice of medicine and to accomplish such in a scientific way, in order that they may become an integral part of a therapeutic discipline".[4].

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1. Edward Weiss and Spurgeon English, Psychosomatic Medicine, (Philadelphia, 1943).

2. Nolan Lewis, "Psychosomatic Medicine", University of Pennsylvania Bicentennial Conference, (Philadelphia, 1941), pp.15-26.

3. Walter Cannon, "The Mechanism of Emotional Disturbance of Bodily Functions". New England Journal of Medicine, 198, 1928, pp.877-884.

4. Lewis, op.cit., pp.15-26.

Deutsch[1] describes psychosomatic medicine as "the systematized knowledge of how to study bodily processes which are fused and amalgamated with emotional processes of the past and the present".

"This newer concept", Lewis says, "which considers the organism as a whole, has opened a very wide field for psychiatry and has emphasized the influence of 'physical diseases' upon mental processes, as well as the effect of mental deviations upon certain 'organic processes' of the body".[2]

Concerning the latter which is the subject of this thesis, Felix Deutsch[3] says,

> there is an inter-relation between bodily functions and emotions which represents the need for a somatic expression of an individual's feelings which he cannot express or does not want to express in another way. An organ neurosis is the pathological, psychosomatic expression of this inter-relationship. It is the necessary expression of a neurotic conflict in terms of an organic disorder which has an inevitably specific character.

In such a neurotic conflict anxiety, which is not directly expressed, may be channelled in various ways and through various systems in the body. We are familiar with this inter-relationship in every day life. We know that under emotional and mental stress people have reactions such as headaches, abdominal pains, loss of appetite, palpitations, and other physical symptoms. We know that "bodily changes may be brought about by mental stimuli, by emotion, just as effectively as by bacteria and toxins and

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1. Felix Deutsch, "The Use of the Psychosomatic Concept in Medicine" Bulletin of the Johns Hopkins Hospital, Vol. LXXX No.1, (January, 1947), pp.71-85.

2. Lewis, op.cit., pp.15-26.

3. Felix Deutsch, "Social Service and Psychosomatic Medicine" A.A.M.S.W. reprint, (Chicago, 1940), p.8.

that physiological changes accompanying emotion may disturb any organ in the body".[1.]

The question arises as to why one person reacts with a headache while another loses his appetite. Dr.Saul[2.] has found the following emotional conflicts to be frequently associated with the following medical conditions. This does not mean that they are necessarily the cause or the only cause.

In cases of stomach or bowel disturbances, which includes ulcers and also constipation, he has frequently found a thwarted craving for the kind of love that means support, indulgence, and being fed. In cases of asthma he has often found a thwarted love which means the closeness and protectiveness of the mother, and in these cases the threat of separation from the mother or mother person usually brings on an attack. In cases of high blood pressure or other cardiac conditions, anger and hostility frequently seem to be the chief impulses involved. The patient is caught in an emotional conflict which he is not able to solve.

In a more recent article,[3.] Saul states that "it is well established that regression is a basic motivation for many psychosomatic symptoms as well as for all neurotic symptoms" and that "most psychosomatic symptoms are forms of neurotic symptoms and are best understood and

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1. Flanders Dunbar, Psychosomatic Diagnosis, (New York: Hoeber Inc., 1943), p.9.

2. Leon Saul, "The Place of Psychosomatic Knowledge in Casework", The Family, 22, (November, 1941), pp.219-227.

3. Leon Saul, "Physiologic Symptoms and Emotional Development", The Psychoanalytic Quarterly, XIX, (April, 1950), p.158.

treated as such". Again Saul[1] says that "psychosomatic symptoms represent deeper regressions or earlier failures to progress and hence are more infantile than psychologic symptoms, but this need not mean the whole personality is more infantile".

"All phases of early libidinal needs are represented in varying degrees in the adult personality", Saul continues.[2] He points out, however, that Freud's libido theory neglected other physiologic systems and he shows that there are biologic attachments to the mother other than oral which are important psychologically and have meaning for psychosomatic symptoms. In the respiratory system, for example, the fetal respiration through the skin and the later relationship to the mother through the cry are important in the later formation of symptoms. "The psychobiology of these relationships", he stresses, "is essential to the understanding of symptoms expressed in diseases of the skin, respiratory, muscular and other systems".[3]

It seems, then, that there is some reason for the choice of the symptom. In discussing this, Saul says that

> the punishment (symptom) fits the source of the motive. A person whose hostility is revenge for oral frustration develops oral symptoms. The main interplay of emotion..... takes place over this pathway. The central pathway may be an organ system or may be on a higher or more sublimated level. Each person has or tends to have

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1. W.T. Lhamon and Leon Saul, "A Note on Psychosomatic Correlations", Psychosomatic Medicine, XII, (March-April, 1950), p.113.

2. Ibid, p.114.

3. Saul, op. cit., p.159.

a particular pathway or combination of pathways for satisfying his needs, over which major emotional interplay is expressed .[1.]

Flanders Dunbar has carried this further and has developed the personality profile as a predisposing factor in illness. She has correlated the personality profile with the illness history and has found this to indicate that "very few accidents or illnesses are solely results of environmental impact and even hereditary predisposition appears not to be the major pathogenic agent".[2.] Dr.Dunbar considers some illness syndromes which are not yet generally recognized such as "accident proneness" and "the cold habit".

In an article in which he attempts to present the physician's point of view regarding the patient, Margolis[3.] considers illness in terms of adjustment. He points out that the concept of homeostasis is not limited to purely physical phenomena. "The individual adapts his physiologic resources, not only to the physical universe about him, but to the shifting requirements of the interpersonal and social relationships in his environment".[4.] He speaks not only of "organ equilibrium" but also of "family equilibrium" and the balance the patient strives to maintain.

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1. Leon Saul, "The Punishment Fits the Source", The Psychoanalytic Quarterly, XIX, (April, 1950), p.168.

2. Flanders Dunbar, Emotions and Bodily Changes, (New York: Columbia University Press, 1947), p.xxxvii.

3. H.M. Margolis, "The Biodynamic Point of View in Medicine", The Journal of Social Casework, (January, 1949), pp.3-9.

4. Ibid, p.4.

Margolis considers the decisive element in illness to be "the loss of capacity of the organism to regain its normal physiologic equilibrium when the latter is seriously disturbed." "Disease can be precipitated only by failure of adjustment in many decisive segments of the entire area of living". Given this concept of disease, Margolis continues, treatment then becomes an attempt to "reinforce nature's own attempt to restore physiologic balance and since balance is dependent upon many factors, physical, psychological and sociological, the therapeutic program must be channeled through all these paths."[1.]

With a growing emphasis in medicine today on the meaning of illness in terms of the "whole person" and his adjustment in all areas of living the role of the social worker has become more and more important. The social worker as well as the physician must consider the broad range of factors contributing to the patient's illness, but her particular area of concern is, of course, the patient's adjustment in his social milieu and interpersonal relations.

When illness is viewed from this point of view, we find many cases in which there are similar social or emotional aspects while the disease syndrome is quite different. This is understandable since we know that anxiety may be expressed in various ways in different individuals, and through different body systems. As caseworkers we also know that we have to start where the patient is. If the patient comes to the clinic concerned about physical symptoms primarily, then the

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1. Ibid, p.6.

worker will approach this case by first of all recognizing the patient's illness and what this means to him.

De la Fontaine[1] has pointed out the importance of sensing that disease is an indicator of "trouble" and that medical facilities are not enough. This is necessary in all illness, but it is particularly important in those cases where the physical findings are not sufficient justification for the symptoms. These are the cases with which we are particularly concerned here.

Among other things, De la Fontaine considers the role of the social worker who is influenced by the psychosomatic approach in medicine, to be first of all, that of obtaining a meaningful history in terms of the patient's adjustment in other areas of life. She must then "consider the disease as one symptom of socio-emotional conflict". Finally, she must also assume the responsibility of helping the doctor to see the patient as a whole person.[2] The doctor and the social worker can then pool their knowledge of the patient for purposes of diagnosis and can work along together in the treatment process while both bring information from their professional points of view to bear on the total problem.

Yugend and Falsey[3] point out that the social worker's knowledge should also enable her to recognize those patients who are emotionally

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1. Elise de la Fontaine, "Some Implications of Psychosomatic Medicine for Casework", The Family, Vol. XXVII, (June, 1946), pp.127-134.

2. Ibid, pp.127-134.

3. Lee Yugend and Edward Falsey, "Consultation Between the Psychiatrist and the Medical Social Worker", The Family, (December, 1943), pp.307-312.

ill and require the help and skill of a psychiatrist. It would then be her responsibility to bring this to the attention of the medical doctor and to consider such a referral jointly with him.

In many of these cases, however, particularly where the somatic expression of the conflict is of long standing, the neurosis may be too deep and acting out too real for psychoanalysis, and the patient will not follow through treatment. De la Fontaine suggests that in such cases, casework treatment may be the only acceptable help. Also,"where organic findings are present..... they may enhance the resistance of the patient toward admission of psychological factors".[1.] She feels that the hope for them lies in internists who are psychosomatically oriented. These patients, however, recognize their problems, and there is a place here for the social worker, working with the doctor. "By reducing external and/or more conscious reactions of the patient to external problems, the worker can ease indirectly the more fundamental problem and this gives a chance for the physical symptoms to be reduced".[2.]

In those cases where the referral to psychiatry is decided upon, the social worker has a further responsibility to prepare the patient for psychiatric help just as she does for any other kind of treatment within the medical setting. We know that many patients who come with physical complaints, would consider a referral to psychiatry out of the question. Or they might feel that this was one way in which the doctor or the social worker too, had chosen to dispose of them. They might go

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1. De la Fontaine, op.cit., pp.127-134.

2. Ibid, pp.127-134.

for a first appointment not realizing the nature of the referral, and then they may not be able to accept further treatment. Thus we find patients who discontinue psychiatric treatment after the first appointment or else they "shop around" for other doctors and other methods of treatment.

How, then, can the social worker help the patient accept psychiatric treatment? Catherine Chapman discusses this in her article on "Some Casework Techniques Necessary in Referring Clients to Psychiatric Clinics".[1] She points out that first and foremost, the relationship between the client's anxiety and his specific request has to be clear before he can profit by psychiatric help with this anxiety. For the patient with psychosomatic symptoms this means that he has to understand the meaning of his physical symptoms in terms of his emotional conflict before he can accept a referral by the medical doctor to the psychiatrist. Miss Chapman thinks that the referral should be made at the point where the client can verbalize this anxiety.

Secondly, the client has to feel emotional acceptance from the worker before he is able to move on to a psychiatrist. This reassures the patient that he is not simply being disposed of, but that there is someone who accepts him and his problem, and that this person is recommending what she and the doctor consider to be the best kind of treatment for him.

Prejudices and fear in regard to psychiatric treatment and mental

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1. Catherine Chapman, "Some Casework Techniques Necessary in Referring Clients to Psychiatric Clinics", Journal of Psychiatric Social Work, (September, 1950), pp.11-17.

illness must also be handled by the social worker. Miss Chapman makes the third point that feeling regarding previous unfortunate contacts must be cleared away. She points out that the first contact of the lay person with a psychiatrist is frightening, and that the worker needs to be alert to all the client's fears. She feels that supplementary support is frequently needed in the early stages of treatment because of the client's fears of being thought crazy or of being committed to a mental hospital.

Finally, she emphasizes that the client should understand that the material given the caseworker will be shared with the psychiatrist. It is important that the client should not feel that the caseworker has betrayed him, but that she and the psychiatrist are both working together to help him.

In the hospital setting, as previously stated, the medical doctor, the medical social worker and the psychiatrist are working together as a team to help the patient. Professional information about the patient is shared between them in the same way as between doctor and social worker, and the patient should understand this.

Yugend and Falsey have described consultation between the psychiatrist and the medical social worker at the Long Island College Hospital in Brooklyn, New York.[1.] They feel that "the caseworker in the medical setting has a special need for this kind of help because patients who have sought the help of a medical agency frequently present a marked

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1. Lee and Falsey, op.cit. pp.307-312.

degree of emotional involvement.[1]

They have considered referrals of patients by the medical social worker to psychiatry to fall into three groups. The first group of patients, when behaviour was suggestive of emotional illness, were referred to psychiatry in order to establish the presence or absence of a psychosis. In the second group, patients were referred for the purpose of evaluating the extent of emotional involvement that might be responsible for the manifestation or the degree of physical symptoms. In these cases the psychiatrist frequently continued to act as a consultant in the casework process. In the third group, the referral by the caseworker to the psychiatrist resulted in the psychiatrist's assumption of the major responsibility for treatment.

None of these cases, however, were referred to the social worker because they were emotionally disturbed, but because of a need for help in relation to some phase of medical care. Nor is there any evidence of the medical doctor participating in the referral or continuing as an active member of the team with the psychiatrist and the social worker.

A study[2] of the functioning of psychiatric clinics in New York City in 1949, revealed the need for better preparation of those patients who were referred from medical sources for psychiatric help, and the importance of the medical doctor's participation in this.

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1. Ibid, p.311.

2. The Functioning of Psychiatric Clinics in New York City, New York City Committee on Mental Hygiene of the State Charities Aid Association, (105 E 22 St., New York, 1949).

This was a study of the psychiatric clinic which is operated by the general hospital. A large proportion of the patients referred to the psychiatric clinic came for relief of physical symptoms, and only a small percentage of these patients improved. It was found that this externalizing of their problem prevented effective treatment. Over half of the patients were referred from medical services within the hospital. Most of these were diagnosed originally as suffering from some organic illness, and they had undergone various degrees of treatment. Those who had had more than 15 contacts under medical care seldom benefited from psychotherapy.

There seemed to be a tendency on the part of the referring clinics to regard the psychiatric clinic as a "disposal mechanism", and in only a few cases was there evidence that there had been clear planning and occasional co-operation in therapy between the medical and the psychiatric clinic. This type of "disposal to psychiatry" after the emphasis had been entirely on the medical factors served only to fortify the patient's resistance and his feeling of rejection.

On the other hand, in certain patients where the problem was understood, it was frequently found that the patient not only believed his problem to have a physical basis but that he also used it as a "crutch" or a "weapon". It was felt from this study that to be prepared adequately for psychotherapy, the patient must realize the nature of his own problem and the nature of the help the psychiatric clinic can offer. The relation of this kind of preparation to effective therapy was clearly shown. If this is understood by those concerned with the patient he need not be referred to psychiatry until he is able to see what this means.

It was found also, that an interview with the psychiatric social worker during the first five visits apparently acted as a deterrent to dropping out on the part of the patient. The worker was able to tackle the problem in a way that the patient could understand and appreciate. A family consultation was also significantly related to the duration of the patient's clinic contact.

Social data on cases from medical sources were all but absent, and the sample included no case in which the medical social service of the hospital had been enlisted at any point.

This study illustrates the importance of the patient's preparation for a psychiatric referral and the preparation of the clinic to which he is sent, for effective therapy.

It will be of interest now to examine the way in which psychiatric evaluations are made at the Western Reserve University Hospital in Cleveland, Ohio, and to note the medical social worker's role in this program.[1.]

> Patients from any clinic within the hospital can be referred to the psychiatric clinic for evaluation. The referring physician is expected to discuss with the patient the reason for referral and in the clinics where there is a medical social worker, the patients are seen routinely by her for evaluation of their understanding of the referral and attitude toward it. Screening of referrals for allocation of cases is done by a senior staff psychiatrist from material provided by the social worker, from the patient's chart and from interview material, and by the psychiatric interne from the patient's medical chart. Usually after the patient has been seen once or twice in the psychiatric clinic the case is discussed in an intake conference attended by a senior staff psychiatrist, the interne and the social worker who have seen the patient, for the formulation of

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1. Eleanor C. Cockerill and John M. Flumerfelt, "One Method of Psychiatric Consultation to the Case Worker in a General Hospital", Bulletin of the American Association of Medical Social Workers, (December, 1949), p.72.

> treatment plans. Only a relatively small number of referred patients can be taken on for long-time study. Many are referred to the referring clinic after having been seen a few times with recommendations as to care. Some are assigned to the social worker.

Here we have an illustration of how the medical social worker can function as part of the referral process for purposes of evaluating the patient's understanding of the referral and her attitude toward it. It illustrates, also, the way in which helpful material from medical, psychiatric and social work sources is shared for the purpose of formulating and carrying out treatment plans.

The following three chapters will deal with the three groups of patients as described in the introduction to this study. These will include, the patientswho showed marked improvement, those who showed some improvement and those who showed no obvious improvement and rejected psychiatric help. The role of the medical social worker will be discussed in each of these three chapters.

CHAPTER III

Patients Who Were Able to Make Use of Psychiatric Treatment and Showed Marked Improvement

This chapter deals with that group of five patients who showed marked improvement following a period of psychiatric treatment. The material will be analysed in relation to the improvement of the patients, and consideration will be given to all factors which seem to have contributed to it. The caseworker's role will be evaluated in terms of the nature of the referral made to her, of what she learns about the patient and his particular problem and history, and in terms of the eventual outcome.

Two cases were referred to the social service department a short while before being referred to psychiatry, one case the same day, and the other two cases within a short time after being referred to psychiatry. Three cases were referred by outside agencies, one by the doctor in the medical clinic and the fifth by the psychiatrist who saw the patient on the ward.

All cases were actually referred to the psychiatric service by the doctor on the medical service, but two of these were referred on the recommendation of an outside agency and a third in conjunction with the medical social worker in the clinic.

This group of five patients consists of five women ranging in age from 28 to 45 years of age. Two of these are married, one widowed, and two single. The occupations represented are housewife, domestic, nurse-

maid, and finisher in a garment factory.

The first case to be presented is that of a patient who had a long history of both physical symptoms and mental upset. The patient presented a number and a variety of complaints that are frequently found in a general medical clinic and which, without knowledge of the patient's background, and with physical examinations being negative, might easily have been considered quite insignificant. In relation to the patient's history, however, it may be seen how long standing such symptoms can be and what they may really mean to the patient.

> Mrs. A. is a married woman of 35, with three children. She complained of fainting attacks, dizziness, headaches, poor appetite, shortness of breath, various pains, fatigue and restlessness. She had a vaginal discharge and she was frigid.
>
> She apparently had suicidal desires which she restrained. She showed paranoid symptoms, for example, that her husband was plotting against her, and she had many fears, nervousness and anxiety.
>
> Mrs. A. had a long history of poor physical health, fainting attacks, and frequent emotional upsets. In 1934, seven months after her first child was born, she noted the onset of the fainting spells. Yet in the summer of 1947, when she had no financial worries, and things were going well, she was free of these attacks.
>
> Mrs. A. was born in England in 1913 and came to Canada with her parents in 1922. She and her brothers and sisters were brought up partly by their maternal grandmother and then by their maternal aunt while their mother worked in a factory. Mrs. A. left school at 11 and herself began work in a factory at 14. Here she met her husband and in 1933, six years later, she was forced by pregnancy into an unwelcome marriage.
>
> Her husband's work record was very irregular and in September, 1933, they were on unemployment relief. They lived for about a year with Mrs. A's parents and there was considerable friction between her husband and her family during this time.
>
> Mrs. A. has always had financial difficulties, partially due to her husband's low earnings. At the time of referral they were unable to meet their expenses. Mr. and Mrs. A. have both language and religious differences and few interests apart from a weekly show.

The patient attributed much of her trouble to financial worries but she did not relate her fainting attacks to her present ill health. She disliked describing her feelings because she felt she sounded "crazy". She said she was nervous and upset, everything bothered her, and she did not feel strong. She wished she were a man and bitterly resented her present life.

Mrs. A. was already known to a family agency and it was the worker there who was responsible for her referral to the medical clinic at the Royal Victoria Hospital and three weeks later to the social service department for a report and interpretation of the findings. Since the case was being carried by the family agency worker it was the medical social worker's plan to continue as a liaison between the family agency and the doctor for interpretation and to play a supportive role with the patient at the clinic whenever necessary.

Mrs. A. knew that she was referred to a psychiatrist and that he was there to help her and would be understanding, but the worker did not feel she realized the depth to which he would expect her to go into her emotional problems. She was fearful of the clinic at first and needed a great deal of reassurance, one minute feeling that it was silly and the next feeling anxious.

There are several family influences to be considered in regard to the patient's attitude toward her condition. She had a sister who was mentally defective and an uncle who died in an asylum. These two things must have contributed to her fear that she was going "crazy". It should be noted also that Mrs. A. said her mother had similar fainting spells and a certain amount of identification must be suspected here.

Mrs. A. was upset by psychiatric treatment and many times felt very ambivalent about continuing. After the fourth psychiatric interview her husband came to the clinic concerned and fearful about the treatment she was receiving. He felt the clinic was making the patient "crazy", saying she was worried and showed increased nervousness. He complained that the clinic was a torture chamber. The medical social worker interviewed Mr. A. at this time and following her interpretation to him, Mrs. A. telephoned the worker to say that she wanted to continue psychotherapy.

Approximately one month later Mrs. A. again felt that she could not return to the clinic because everyone was against her. Following this there were no psychiatric appointments made for three months. It was later learned from the patient that coming out with so much material in the psychiatric interviews had been very upsetting to her and she had stopped for this reason. Then she believed that the psychiatrist had helped her since she needed someone understanding with whom to talk over her troubles and she returned wanting to resume treatment.

After this appointment another month went by and Mrs. A. began to feel worse, fearing a nervous breakdown and that she should perhaps be committed. An appointment was made which she did not keep. She returned a month later, without an appointment, in the hope that the psychiatrist would see her. This was arranged by the medical social worker and two more interviews followed. She was much better after this and it was left to her to come in at a later date if she wanted to.

Two months later she called for an appointment but did not keep it, and finally she returned in another four months, extremely anxious and wanted to be reassured. She was seen for a month in the clinic and then admitted to the Allan Memorial Institute for a period of two months as an in-patient. She was discharged from the Allan Memorial Institute in an improved condition. Her paranoid delusions had completely disappeared and her anxiety minimized considerably. Mrs. A. had gained weight and it had been possible to remove her frigidity.

This case illustrated several interesting points. Mrs. A. had a variety of symptoms which were, for the most part, vague and general. But there were two symptoms of long standing, the fainting attacks and the frigidity, and there was also the actual diagnosis of pelvic inflammatory disease. The fainting attacks seemed to be the chief complaint and the main problem for Mrs. A. In this case also there were decided mental symptoms which the patient herself could express fairly well.

The case illustrates a long history of both physical symptoms and mental upset, with the onset of fainting attacks soon after her first child was born. It should be noted that Mrs. A's mother also had similar fainting attacks. The family history of a mentally defective sister and an uncle who died in an asylum must be considered of significance in the patient's own attitude toward mental illness and psychiatric treatment. It is important to notice, too, that Mrs. A. relates her condition to her environmental situation and that at one time when it was improved and she was free of worry, her health was also improved.

There seems to be a lack of security in Mrs. A's personal life, both in love and in material things. It is noted that she says she was brought up by an aunt and grandmother and not by her mother. Then she was forced into an unwelcome marriage and since then she has lived a life of almost continual financial worry.

The case shows an extreme dissatisfaction on the part of the patient with her present life situation and an attitude of fear and ambivalence toward the clinic and psychiatric treatment. Mrs. A. felt that she sounded "crazy" and was "unworthy".

The case is a good illustration of co-operation between the medical social worker and a worker from an outside agency and the importance of their co-operative roles, in helping the patient both with a referral to and continuing with psychiatric treatment.

The social worker at the family agency was already close to the family and was responsible for initiating the referral to the Royal Victoria Hospital and for helping the patient to go for a psychiatric appointment. At the same time, the medical social worker saw both the patient and her husband in order to discuss psychiatry, and she helped the patient with various clinic procedures. The medical worker felt that it was her acceptance of the patient and acceptance of Mrs. A's feelings of being "bad" and "unworthy" that enabled her to keep coming back to the clinic. Throughout the case the medical worker was always there to reassure and to help Mrs. A. obtain psychiatric appointments when she needed them most.

The medical worker did not feel, however, that she had fulfilled her role sufficiently well in terms of getting at the basis of Mrs. A's

feelings about psychiatric help. Some of her ambivalence about treatment was directly related to her illness, for example, her feeling that people were against her, and to the anxiety produced by the uncovering of so much material that was difficult for her to accept. Some of her fear must also have been related to the meaning psychiatry had for her in view of her family history. These are areas where the medical social worker might have been more helpful.

The medical social worker realized, however, what an important influence the patient's husband could be in regard to her acceptance of psychiatry and this case illustrates careful and worthwhile work with a family member and the effect of this upon the patient.

Finally, the case illustrates a close teamwork relationship with the psychiatrist in the sharing of information about the patient for co-operative planning and treatment. This was exhibited by the psychiatrist's readiness to interview the patient one time without an appointment when the medical social worker felt that it was important.

In the next case although the symptoms are still many and varied they are more specific. This case presents a contrast to the first case in that the patient has diagnosed her own illness. Here there is a greater degree of somatisation and it will take a little longer for such a patient to accept the need for help of a psychiatric nature. In such cases there seems to be need for a caseworker at the beginning of treatment to help insure earlier and better results.

Mrs. B. is a married woman of 32 who has no children. For two months, she complained of pain in the joints and back and pain in the abdomen after bowel movements. She complained of waterbrash and diarrhoea with gradual loss of appetite, dysuria and dyspareunia.

She ran a low fever and complained that she had had right-sided headaches for several years.

Mrs. B. had the fixed idea that she had undulant fever. She said she had always been nervous and that this nervousness was accompanied by epigastric distress. She showed symptoms of anxiety, depression and definite homesickness.

In September, 1948, she began to feel weak and tired and developed vague pains in her back. Her nervous symptoms were those of anxiety with dreams of bombing during the war and fear lest someone would kill her. She had numerous somatic complaints which continually changed, but the anxiety remained. Previous to this, during the war, she had had somewhat similar symptoms and in 1944 she had contracted vaginitis while in Berlin. A year after her marriage in 1944 she began to notice dyspareunia.

Mrs. B. was born in 1917 in the Ukraine, where her father was well-to-do. At the age of two her family was compelled to leave their Russian dominated town and go to Wilna, Poland, because of the revolution. At 16, Mrs. B. had to leave school because of financial difficulty. She went on the stage and was quite successful. She had a theatrical contract in Warsaw, but when the Germans took Poland, she returned to Wilna and stayed until 1944, when she went to Latvia to avoid the Russians, whom she hated. From Latvia, she went back with the German armies as an entertainer. When the Americans came in, the troupe was picked up and continued to work, entertaining United States troops. Finally, she became alarmed at the proximity of the Russians and applied to come to Canada.

Mrs. B. first began to have sexual relations at the age of 19. She lived with an actor for eight years and then she was attracted for some time to a pianist whom she described as ugly. She left both of these men and finally married her husband in 1944, whom she met in the theatre in Latvia.

They worked together as entertainers during the war in Germany and then came to Canada in July, 1948. Mrs. B. had wanted to go to South America and had started to study Spanish, but her husband insisted they go to Canada. They were placed on a farm where her husband contracted undulant fever and had to be hospitalized in Montreal. Mrs. B. had been unable to work since December, 1948, and finally came to Montreal in February for medical attention.

Although tests were negative, Mrs. B. was positive she had undulant fever and that the doctors were just not aware of it. She was interested only in her own illness and seemed to be gaining considerable satisfaction from it. She did not think she would ever be well enough to return to domestic work, which she said she had never had to do in Europe. From the psychiatrist's report, she appeared to have no insight into her condition.

Once she was hospitalized, she became concerned chiefly with her dyspareunia, which she related only to her vaginitis, and she felt that all her difficulties hinged on this. She dreaded going back to live with her husband because of it.

The case was referred to the medical social worker by the Department of Labour, since the patient was still under contract, for a report of her medical condition. The medical worker did not see Mrs. B. before her referral to psychiatry, but once referred, it was her purpose to help her with living arrangements in the city so that she might receive treatment at the Allan Memorial Institute.

Mrs. B. was admitted to hospital and given a complete physical examination, which revealed no organic basis for her complaints, and she was reassured by the medical physician that she did not have undulant fever as her husband had. He also told her that her dyspareunia was mental, which convinced her that she was not being treated in the right way. The psychiatrist saw the patient several times on the ward and attempted to explain her symptoms on an emotional and mental basis, but she could not accept this. She was in a difficult position, however, since she was still under contract and knew that if there was nothing wrong with her she was faced with returning to work she disliked. Treatment meant that she was ill, and she finally agreed to day care at the Allan Memorial Institute if arrangements could be made for this. She did not seem to have any real understanding of psychiatry.

In this case the social worker simply reinforced the interpretation of emotional illness given by the psychiatrist. She did spend some time, however, interpreting this to the patient's husband. He was anxious to talk to someone at the hospital, believing that his wife had undulant fever and that the doctors were fooled by it. He was convinced that the medical system in Europe was better. The medical social worker helped him to express his feelings and she felt this interview was of real value to him.

Mrs. B. began psychiatric treatment feeling sure she was not being treated in the right way, but resigned to it because she had to accept help of some sort. She maintained treatment until discharge three months later, however, and made a good response to somnolent insulin therapy and to psychotherapy. She was symptom free at the time of discharge and had gained ten pounds.

In this case the symptoms the patient had were vague and changeful. Nervous symptoms were definitely present as well. Patient had a history of these symptoms for several months, beginning about two months after their arrival in Canada, and previous to this she had had similar

symptoms during the war. The symptoms seemed to bear a relationship to her life situation and her illness separated her from unpleasant reality. It is interesting to note as well that the most recent of her symptoms were those of undulant fever, the disease her husband had. Identifying with his symptoms brought her medical attention too.

The case shows an upsetting life for a patient who was uprooted from her home and familiar surroundings, and had to move elsewhere due to foreign occupation of her country. Life was uncertain and she seemed always to be running away. Her premarital relationships indicate uncertainty and insecurity in her emotional life and her career was one of change and uncertainty.

This case also shows a patient who was entirely concerned with her physical ailments and had even given herself a definite diagnosis. For this reason it would take a longer time to help the patient to see the relationship between her symptoms and emotions, which at the time she did not recognize, so that she might eventually accept her need for psychiatric treatment. It must have been threatening to the patient, therefore, when the medical doctor told her that she did not have undulant fever and that her dyspareunia was mental.

This case was not referred to the medical social worker by the doctor to help with the referral to psychiatry and the patient had been seen by the psychiatrist before the medical social worker's first interview. Co-operative work with the doctor at the beginning might have contributed considerably to the patient's understanding of her condition and the psychiatrist's interpretation might then have been better received. Although the patient did receive psychiatric treatment, accept-

ing it because it was the only alternative was not the best guarantee of successful results. Treatment might have been accepted more quickly and might have been more effective from the beginning if the patient had been better prepared for it.

The medical social worker's role with the husband is important in this case. His influence had been reinforcing the patient's concern about her physical ailments and her lack of faith in the doctors. The worker's interpretation and time spent with him was very valuable at this point.

The medical social worker's role with the psychiatrist was definitely that of teamwork. Both had the same goal in mind and with consultation, both worked in their own sphere to achieve it. The case was later transferred to the psychiatric social worker at the Allan Memorial Institute.

The third case is that of a patient who had actually had a disabling illness as well as a history of increasing physical and nervous complaints. This patient's recovery was being prevented by treating her only on a physical basis. The real problem which became evident upon studying her personal history had been completely overlooked. The medical social worker's role in this case is an illustration of a brief but very important service.

> The patient was Mrs. C. a widow, 28 years old, who had two children. She presented symptoms of chronic fatigue, shooting pains in the side and head, insomnia, palpitations, tingling sensations in the extremities and occasional nausea. She was recently recovering from pleurisy and whooping cough. She had lost weight and complained of pains in the chest, side, and arm and noted that her toes turned blue.

She seemed preoccupied with her physical symptoms, but said she had had nightmares during the period of chest pains, about her mother and father, both of whom were dead. Recently she had a fear of going "crazy".

Mrs. C. had a history of a "nervous ailment" which developed shortly after her husband died and for which she was taking pills. This became more intense and she developed physical symptoms after the death of her father.

Mrs. C. was born in Montreal and went to school until she was 12. She had no money for high school and so worked for a while at housework and then at Woolworth's. In 1945, her husband died in the services and in 1946 her mother died of a cardiac condition. Mrs. C. nursed her mother and was present at her death. Her father had tuberculosis since 1945 and finally died of a heart ailment in 1948, with Mrs. C. in attendance. She had one married brother with whom she was quite close. She received a government pension, but her income was very limited and she applied to D.V.A. for help with a coal debt.

Through further contact with the Department of Veterans Affairs social worker, it was found that the patient was taking expensive medication for her condition and she was referred to the Royal Victoria Hospital for medical and psychiatric evaluation and also to the social service department there for help with this referral.

Mrs. C. stated that she felt her complaints were due to "nerves" and said she had had a great number of worries during the past few years. She mentioned specifically her financial worries and the fear of her family contracting tuberculosis. She was afraid that the pain in her chest and the tingling sensation and blue color of her toes was caused by her heart. She told the psychiatrist that she was not really ill until after her father's death. She had then consulted a doctor who had told her that her condition was due to her "nerves" and since then she has attended this doctor and has been taking numerous medicines.

It was the medical social worker's plan in this case to help Mrs. C. to the psychiatrist and give her a feeling of security in the clinic setting. The medical physician gave the patient a thorough examination and reassured her that there was no physical illness present. The Department of Veterans Affairs social worker had already prepared Mrs. C. for the possibility of a psychiatric consultation and she had agreed to this if it was necessary. She was ready, therefore, when the doctor recommended psychiatry. The medical social worker had arranged for her to have an appointment the same day so there would be no uncertain waiting period.

Mrs. C. seemed quite satisfied and relieved that nothing had been found and readily accepted her first psychiatric appointment. After this appointment, she cried and told the medical social worker how very relieved she felt at the result of the reassurance she had been given in the clinic.

Mrs. C. had two subsequent psychiatric interviews. She kept her appointments well and on her last visit she told the psychiatrist she had been feeling much better ever since her first interview with him. She said she was now able to work hard about her house, had plenty of energy and was sleeping better. Her various bodily symptoms had disappeared by this interview. The patient had very quickly made a constructive readjustment.

Like the other two cases, this case again illustrates vague physical symptoms, accompanied by nervous symptoms, such as an ill-defined "nervous ailment" and nightmares. The illness history of the patient is clearly related to emotional trauma in her life and the symptoms she fears most are cardiac symptoms which she identifies with those of her father who died of a heart ailment and possibly those of her mother, who also died of a heart ailment.

It is interesting to note that the patient was already attending a doctor and taking expensive medication. This case illustrates a dramatic loss of love for the patient, who suffered first the loss of her husband and shortly afterwards the loss of her mother, only to be followed a year later by the death of her father. The resulting insecurity can hardly be estimated but must certainly be taken into account by the social worker in dealing with the patient.

Again we see illustrated the fear on the part of the patient that she is going "crazy", and her own feeling that her complaints are due to "nerves". This is another example of good co-operation with an outside agency where the medical worker fulfills the important function of liaison. This contributed to the patient's sense of security by

giving her the feeling of teamwork between social workers and between the social workers and the doctor.

The effectiveness of some previous preparation for a referral to psychiatry is also illustrated here. It is clear that the Department of Veterans Affairs worker's preparation in this regard made it much easier for the patient to accept the doctor's referral when it came and to accept as reassurance his explanation that there was no physical illness present.

The medical worker's role in this case is an illustration of a brief, but important service. By steering the patient through clinic and by arranging a psychiatric appointment for the same day as she was referred from medical clinic so there would be no uncertain waiting period, the worker gave the patient the feeling of security in the clinic setting which is so important to such an insecure person. Although she might eventually have been able to go through the clinic and have seen the psychiatrist herself, the worker's protective and supportive role gave the patient the strength to move ahead and make constructive use of psychiatric treatment in her daily life.

The following case is one in which the medical doctors for some time had recognized other factors besides the physical symptoms, and finally referred the case to the medical social service, not for any help with the psychiatric referral but for social readjustment. The social worker's evaluation of the case and the sharing of information between doctor and social worker made possible a definite referral to psychiatry and one which was timed to meet the patient's need. The medical social worker's role in this case is an excellent example of in-

terpretation and encouragement which recognized the stage at which the patient was and did not push her beyond her capacity for accepting treatment of a psychiatric nature.

Miss D. was a 39 year old single woman. She complained of shortness of breath for four months, vomiting on the week-ends when she was not working and dizziness for twenty-five years, and sacral pain (for two years) when walking. She said she had a noise in her ear which settled on the top of her head and she complained of "travelling pains", headaches and nausea with her periods, nasal discharge and excessive perspiration.

She was very apprehensive, unable to concentrate, had disturbing dreams, nervousness, and constant noise in her ears. The psychiatrist suspected auditory hallucinations.

Miss D. had had a history of dermatitis since 1942 when she was seen and treated for this at the clinic. She was worried at that time about the possibilities of a serious disease. The doctor's impression was that of anxiety state. Miss D. was reassured about the dermatitis and she was seen again for the same reason in 1943, and again in 1948. The patient also gave a history of a nervous breakdown with sudden weakness, vomiting and terrible headaches.

Miss D. was born in Russia. Her mother died when she was four years old and she was brought to Canada at the age of six by her father who had come to Canada when the patient was an infant. When her mother died, the children were kept apart in different families until their father brought them to Canada. Miss D's father remarried in Canada and his wife died shortly after.

Miss D. went through second grade at school and at 10 years of age she began to work at sewing. She had a brother whom she considered "just like a boy friend". He was clever, had a good education, and was now an accountant. He married a person Miss D. disliked, however, and without her consent. Miss D. lives now with her father and supports him, since he is apparently considered chronically ill with asthma and the results of a street car accident 20 years ago. She stated to the psychiatrist that she had not talked to her father for 25 years "since he once hurt her head and she was not guilty". It was not clear what she meant by this.

Miss D. belonged to the Ladies International Garment Worker's Union and felt that the Union was always on the employees side against her. The Union reported that she was a good worker, but wanted to make money by doing a great deal of overtime work. This was against Union regulations. They reported also that after the first week on a job, Miss D. began to fight with the other workers.

Miss D. insisted that she was not "crazy". She related all her problems to external factors and did not feel she was the problem. She felt that the Union made her sick and that everyone in the business world was against her. She believed that work made her strong and that when she did not work she became sick. The medical worker's plan when the case was first referred was to contact the patient's Union and to help her find another job and to keep in touch with her to see how she was getting along.

The medical doctor reassured Miss D. that she had nc disease of the chest. She was told to go back to work and if she had further trouble with her "nerves" to return and he would refer her to psychiatry. Miss D. did return in four weeks time but complaining of a cough. She complained also of nervousness and irritablity in getting along with fellow workers. She was referred to psychiatry but no appointment was made for her at that time.

The medical worker found that Miss D. would discuss any of her problems, providing it did not involve her family or her "secrets". She kept everything very external and the worker felt her capacity for insight from psychiatry at that time was very poor.

To the patient, going to psychiatry meant that she was crazy, and it was, therefore, very threatening to her. She had been rejected by her family and had been accused of being "crazy" at work. The Union felt that she was a mental case. There is little wonder then, that Miss D. was on the defensive about her mental condition.

Although she resisted seeing a psychiatrist, Miss D. did want to see a doctor and partially accepted it on that basis. The worker could get an appointment for her more quickly with a psychiatrist than with another doctor at that time and capitalized on this. The medical doctor had already recommended psychiatry and the worker took a definite stand with the patient about the kind of help the hospital could offer her. She told her the psychiatrist could help her if she would let him. The worker spent a long interview with Miss D. at this time, interpreting psychiatry. In view of the patient's feeling about psychiatry the interpretation dealt mainly with the problem of stigma connected in the patient's mind with this kind of treatment. Following this interview, the worker made the referral to the psychiatrist and the worker felt definitely that it was due to this interview that Miss D. was able to go.

Miss D. kept her first appointment with the psychiatrist, June 25, 1949. This was on a trial basis as far as the patient was concerned, but she did return for continued treatment. By February, 1950, Miss D. was able to express herself freely about family problems and her fear of the future. In April, Miss D. had no physical complaints, stating that all she needed was a "new head". In

> May, there was further marked improvement both in her feelings and her socialization and there were no somatic complaints. Treatment was eventually discontinued due to the patient's improvement.

In this case again, we see a variety of vague physical symptoms and definite mental symptoms, with the history of a nervous breakdown, accompanied by physical discomfort. The patient's present illness was related to her work situation and her relationships at work were very unhappy. Some of the symptoms were of particularly long standing, for example, the dizziness and vomiting, which she claimed to have had for twenty-five years. It is of interest that she had come to the clinic before at which time the doctor's impression was "anxiety state" and that the reassurance given then had not been very effective, since patient kept returning and her symptoms remained.

Here again is a case which illustrates insecurity in the patient's life. Miss D. lived with her mother until she was four, and then when her mother died, she was separated from her brothers and sisters and lived with relatives until she came to Canada at six years of age, to a father she did not know and a country that was strange. Later in her life, when her brother was married, she felt as though she had lost him as well. The relationship with her father had been difficult for a long time and Miss D. did not have any close relationship with anyone.

The outstanding features in Miss D's attitude toward her illness were the fear of "going crazy" and the feeling that everyone was against her. The fear was so real, especially with the accusations of her fellow-workers, that she could only externalize her problem and could not recognize her part in it at all.

The case was referred by the doctor not for any help with a referral to psychiatry, but for social readjustment. The medical doctor in this case, too, reassured the patient that there was no physical illness, but told her he would refer her to psychiatry for her nerves if she wished. The patient's answer to this was to return to clinic again a month later with a cough, keeping her condition on a physical basis, although there were nervous symptoms as well. This time she was referred to psychiatry, but no appointment was made.

The worker saw the patient and made an evaluation of the case at the beginning when she realized her capacity for insight from psychiatry was very poor. Following this, she had brief contacts with the patient and then there was a month when she did not see her at all. But the relationship was sufficient to enable the patient, when she finally returned and was unable to see the doctor, to see the worker. The worker took advantage of this opportunity and also of the clinic procedures to pick up the doctor's recommendation and to take the stand that psychiatry was the most readily available and the best kind of treatment for the patient. Understanding Miss D's fear of psychiatry, the worker spent a long time in very worthwhile interpretation to the patient and, without pushing her, encouraged her to accept a psychiatric appointment on a trial basis. Although the patient did not return to see the social worker, the worker was already successful in helping her to accept and continue with psychiatric treatment and the patient improved as a result of it.

The case was not considered a truly co-operative case by the worker, but there was sufficient sharing of information between doctor

and worker, and worker and psychiatrist at the beginning so that each was aware of the plans of the other.

The last case in this group is one which was referred to the medical social worker not by the medical doctor but by the psychiatrist. It was referred early enough so that the worker could play an effective role in helping the patient to maintain treatment.

The patient was Miss E., a 45 year old single woman. She complained of abdominal pain, accompanied by nausea and vomiting, one month prior to admission. She had depressive symptoms and was a conscientious individual with conflict about her job.

Miss E. admitted that for many years her digestion had been upset and she had had vague dyspepsia caused by any tensional state existent in her life. The present symptoms, too, were found to be related to both physical and emotional stress in her work situation at the time.

Miss E. was born in Scotland in 1902. Both parents died when she was a child, her mother from childbirth. The patient was brought up in an orphanage. During the first war she suffered the loss of her fiance, and she seemed to have sublimated her maternal feelings by turning to nursemaid work.

In 1928, Miss E. came to Canada and had since been employed as a domestic and nursemaid, as well as working six and a half years in a munition factory. She had always earned a moderate wage and had been able to accumulate some savings.

Miss E. lived in a five-room flat with her sister and brother-in-law and paid $20.00 a month to this household. She had another sister in Scotland. She had few friends, none of whom seemed to be acknowledged by her sister. This sister was apparently a dominating woman who criticized everything Miss E. did and resented her outside contacts.

Miss E. had been working at a T.B. hospital and seemed to have a sub-conscious fear of having developed T.B. She felt that part of her trouble was of nervous origin and was related to her work. She considered her supervisor a tyrant and worried considerably about her relationship with this woman. Miss E. volunteered that she thought her sister, too, had some bearing on her emotional life and on her present medical situation.

Psychiatric consultation was requested while the patient was in hospital, by the doctor on the medical ward but there was no evidence of any preparation of the patient for this. The psychiatrist helped her to see and admit that part of her trouble was of nervous origin and seemed to be related to her work. Miss E. said that she had told things to this doctor that no-one else had ever known.

The case was referred to social service by the psychiatrist two days after he had seen the patient, for help in rehabilitation, because he felt Miss E's complaints to be of psychogenic origin with their basis in an unhappy job adjustment. It was the social worker's plan then to help Miss E. with her job adjustment and to carry on casework on a supportive basis. When the worker first saw Miss E. the psychiatrist's interpretation and something in his personality had already helped her to accept it on the basis of her first interview with him. Previous to this, she had had nothing to do with the doctors who had tried to talk to her. She did need help, however, with her feelings of unworthiness, especially in relation to the psychiatrist. Miss E. had been discharged without the psychiatrist's knowledge, so that he had not had time to make a follow-up visit. She was quite nervous about going back to see him again. The worker was able to bridge this gap when Miss E. came to see her after a clinic visit. The worker gave her the necessary ego strength to go, by first calling the psychiatrist and arranging for her to see him, and secondly, by going over to the Allan Memorial Institute with her and waiting with her outside his office. The worker felt that Miss E. would not have gone otherwise. After this, the patient was able to continue treatment herself.

The worker continued casework support after this and helped Miss E. both with employment and with planning for her to go to a convalescent home, for the summer. She came back feeling well, with new friends and added self-confidence.

The worker also helped Miss E. to express herself and some of her hostility. She helped her gain some insight into the value of sharing her thoughts and feelings with others. Miss E. said she found it helpful to be able to come in and talk over her problems with the worker. She described it as the "best medicine" she could get.

Miss E. was eventually sufficiently improved to carry on without psychiatric help and casework was discontinued when she was happily established in another position, where she lived in and not at her sister's.

This patient's symptoms were again vague, but they were primarily digestive symptoms. There was also the mental symptom of depression.

The symptoms were quite directly related to the environmental stress of unhappy situations both at work and at home.

This patient suffered considerable loss of love through the death of her parents, and later in her life, her fiance. It would be important for the worker to take these things into consideration in terms of the patient's sense of security.

Miss E. was able to relate her trouble to her work situation and to her relationship with her supervisor and her sister. She was able to say that she felt part of her trouble was of nervous origin.

A large part of her acceptance of psychiatry was the result of an understanding and kind psychiatrist. To have someone take such an interest was a new experience for this patient and while she accepted it, she did need help with her own feelings about it, so that she could make use of it. The case shows the value of the worker's sustaining relationship here and the way in which she was able to bridge the gap between the interview on the ward and the one at the psychiatrist's office. It shows also the importance of the help she gave the patient in being able to express herself and her feelings of unworthiness and to gain strength through sharing these worries with others.

In addition to this, the worker followed through with concrete help in realistic planning with the patient to improve her environmental situation. She also continued her support and interest in the patient throughout the period of psychiatric treatment and until she was happily adjusted and able to carry on alone.

This case shows a close working relationship between the psychiatrist and the worker. To begin with, the psychiatrist referred the

case to social service for help with rehabilitation. Then the worker was responsible for getting the patient back to the psychiatrist again. There were several consultations for the purpose of clarifying their separate roles and for sharing of information. The worker consulted with the medical doctor as well, preparing him for a clinic visit at one point and interpreting what she and the psychiatrist were trying to do. Together the worker and psychiatrist clarified their ultimate goal as being to widen the patient's basis for security so that she would not have to resort to illness as an escape from responsibility or reality.

In this group of five patients who showed marked improvement none were referred by the medical doctor to the medical social worker specifically for help with the psychiatric referral and there seems to have been limited teamwork in this area. The doctor made the referral to social service in only one of the five cases. In others, however, he co-operated by interpreting emotional illness to the patient when the worker called this to his attention. From the various reactions when the patients were told there was no physical illness, it would seem that, where there has been no previous preparation for the emotional basis for illness, there is a tendency on the part of the patient to interpret this information as a denial of illness. For this reason it would seem that teamwork between the medical doctor and the medical social worker is of the utmost importance to insure the patient's understanding of illness that may be mental or emotional in origin, and to give the patient the necessary interpretation and support around the referral to psychiatry.

There was more evidence of teamwork between the medical social worker and the psychiatrist. In the cases of Miss E. and Mrs. A. there

was close liaison between worker and psychiatrist both in initial planning and in treatment of the patient. There was co-operation also in the case of Mrs. C., although this was a very brief case, and a little co-operation in the case of Mrs.B. Here, there was the common goal of helping her to accept treatment at the Allan Memorial Institute. Although the worker made arrangements for Miss D. to see the psychiatrist, this was not really a co-operative case and the worker discontinued casework as soon as the patient had had one appointment with the psychiatrist.

Co-operative work with the psychiatrist for a while after the case is referred would seem to be of value if the patient is to feel a continuity in treatment and is to be able to handle the anxiety which is frequently felt around the initial psychiatric interviews. If necessary, in cases where the patient will be under psychiatric treatment for some time, the patient may later be transferred to the psychiatric social worker as was done in the case of Mrs. B. The patient and the patient's family can thus be assured of continuous support as long as they need it.

These five cases demonstrate the six following aspects of the medical social worker's role with such patients:

Firstly, her role is supportive and sustaining and may be the means of bridging the gap between the two services of medicine and psychiatry. As we saw in three cases in this group, Mrs. A., Miss E., and Miss D., it can be a determining factor in whether the patient actually makes the transfer or not.

Secondly, and closely related to the support the patient experiences, is the meaning to her of the relationship with the worker. The

very fact that this relationship exists means that someone is taking an interest in the patient as an individual and this may have a great deal to do with the patient's maintaining treatment.

Thirdly, the worker's role is interpretive. With this group she has had to deal in different cases with the patient's attitude about psychiatry and the fear of "going crazy" as well as with the patient's feeling about herself, her emotions, and her preoccupation with physical symptoms.

Fourthly, interpretation extends to the family and it may be seen from two cases in this group how important it was to take some time in careful interpretation to the patient's husband.

Fifthly, the worker has a role to play in giving realistic help with the patient's environment. If the patient is to retain and apply the help she has received through psychiatric treatment, it frequently involves some changes in her environmental situation. The worker must be alert to all that can be done to help the patient make these changes wherever possible.

Sixthly, the worker's role as an effective liaison between the hospital and the community agency has been clearly demonstrated. This effective liaison brought about a better working relationship between the community social worker and the doctors.

Although the patients in this group were not referred to social service specifically for evaluation and interpretation prior to the referral to psychiatry, a social evaluation was available early in these cases, and the social worker became active with the patient soon enough in most instances to give effective support and interpretation. The

question might be raised, therefore, as to whether the help of the medical social worker, demonstrated to be valuable in these five cases, should not be given on a planned basis. Instead of giving this case-work service around a psychiatric referral, only when the case is already known to the medical social worker for some other reason, it might be advisable to refer all these patients to medical social service when these complaints cannot be accounted for on a physical basis. Such cases would then have the benefit of a social evaluation at the beginning and the decision to refer the case to psychiatry could be made jointly on this basis. The medical doctor and the medical social worker could then work together to give the patient adequate preparation and interpretation for it from the beginning of the treatment.

CHAPTER IV

Patients Who Required Considerable Help in Order to Accept Psychiatric Treatment but Then Showed Some Improvement

This chapter deals with that group of eight patients who showed some improvement following psychiatric treatment. The material will be analysed in relation to the amount of improvement shown and consideration given to those factors which seem to have contributed to it as well as to those which seem to have counteracted it. The medical social worker's role will again be evaluated in terms of the nature of the referral made to her, the patient and his particular problem and history, and the eventual outcome.

With the exception of one, all of these patients were referred to social service before they were referred to psychiatry. Four were referred to social service by the doctor in the medical clinic, two by outside agencies and one was already known to social service through her husband, who had previously been referred by a doctor on the surgical service. The exception in the group was referred to social service by the psychiatrist in the medical clinic.

Three cases were referred to psychiatry by the doctor in the medical clinic, three others by the medical doctor in conjunction with the medical social worker, one by the patient's private doctor within the hospital, and the other by the psychiatrist who was following the patient's son in endocrine clinic.

Six of the patients in this group are women, two married, two widowed, and two single. Two of the patients are married men. The

age range of the group is from 27 to 49 years. The occupations represented are those of housewife, dressmaker, housekeeper in a hospital, nurse's aide, typograph operator, and mechanic.

The first case in this group is one in which the patient came to the medical clinic for several years with no evidence of any organic disease before she was referred for a social or a psychiatric evaluation. It is an example of a patient becoming accustomed to clinic attendance and physical symptoms as the chief way of expressing her problems.

> Mrs. F. was a married woman of 47 with no children, whose condition was eventually diagnosed as involutional melancholia and reactive depression. She complained that she felt as though there was something sticking in her throat and causing nausea. She complained of fever and hot flushes, tiredness and sore back. It was felt that some of her symptoms were referrable to the menopause. Somewhat later she complained of black spots moving across her vision when reading.
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> Mrs. F. felt "nervous", very tense, tired and depressed. Evidence of paranoid trends was thought to be understandable in view of her social situation. Some time later, when she returned to clinic, there was a further psychic episode, or nervous reaction, based upon her very unhappy situation.
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> Mrs. F. said she had had no previous episodes such as the one before her admission to the Allan Memorial Institute in 1948. In 1945 when her husband was away in the army, patient complained of pin pricking pains in arms and legs and swelling of the legs. No organic disease was found at this time and it was the doctor's impression that Mrs. F. wanted to be sick and wanted to have a certificate saying that she needed her husband home. In 1947, she returned complaining of amenorrhea, hot flushes, and dizzy spells.
>
> Mrs. F. and her husband were both born in Poland, Mrs. F. coming to Canada in 1927. She had pleasant memories of her childhood. She went to school from seven to ten years of age and then, after the 'flu epidemic, left school to help her parents on the farm.
>
> Mrs. F. was in love with a boy in Poland who courted her for four years and then married another girl whose parents offered him a larger dowry. Mrs. F's present husband married her apparently for the little money she had, placing her savings of $650.00 in his own account, and taking very little interest in her when that was gone. She was married in 1936 and was her husband's second wife. Her

marriage had been an unhappy experience from the beginning. Physical abuse resulted in her husband being jailed under a court order in 1939 but Mrs. F. regretted her action since it took him away from her for a while.

Since the beginning of 1948 the friction had become worse, with Mr. F. sleeping away from home a good deal. Mrs. F. had no children and her husband said she was no good to him. He did not allow her to come near him and they slept with a quilt between them. Although he showed continually that he resented her demands upon him, he continued to have a sense of responsibility toward her, paying the rent and giving her small amounts for food. Mrs. F. still wanted her husband and continually humbled herself to gain his consideration.

Mrs. F. and her husband have had economic difficulties and Mrs. F. had been used to work in a dependent fashion.

Two months prior to her admission to the Allan Memorial Institute, marital relations became increasingly tense. Mrs. F. would spend the nights waiting for her husband's late homecomings. She resorted more and more to religion as a source of comfort and reassurance.

In January, 1950, Mrs. F. told the doctor that her husband had a woman friend and several children. He wanted to be rid of her and to bring them home to live.

She talked of her difficulty at home and her husband's abuse, but she did not relate her physical ailments to her unhappy situation. She did, however, associate her nervousness with her difficulties. On the whole, she was apathetic and disinclined to face her situation.

Later she said she believed her husband had detectives watching her and in January, 1950, she feared her husband would give her dope to get rid of her, or would put her in a "crazy home".

The medical social worker planned to (1) see the patient's husband and discuss the situation with him and, (2) encourage the patient to take up more varied interests outside the home. Later, when the situation became more serious, the worker planned to contact a legal agency in order to evaluate the marital situation and the question of fraud.

In 1945, when Mrs. F. came to the medical clinic, she was told there was no evidence of organic disease. She did not return for a year when again there were no organic findings. The following year she was treated for menopausal symptoms. Following this, when her nervousness and emotional symptoms increased, the medical doctor referred her to social service, since he felt that the social situation should be evaluated before she was seen further in medical

clinic. There was no evidence of the doctor's discussing either a referral to psychiatry, or an emotional basis for illness, with the patient before this.

The first referral to psychiatry was made by the medical social worker in co-operation with the doctor in medical clinic, the worker preparing the patient for this. Mrs. F. kept her first appointment and then accepted continued day care at the Allan Memorial Institute for a month in the summer of 1948. She improved considerably as a result of this, although she had expressed fear of the shock therapy while she was there.

The medical social worker discussed a return to the psychiatric service with Mrs. F. in March, 1949, but at this time she refused to go back, fearing that she would be readmitted to the Allan Memorial Institute. She insisted that she wanted something more specific than psychiatry and said "she would collapse and then they would do something". Although she said she wanted to reconsider the Allan Memorial Institute, she did not return for further attention. It is significant in connection with this that her husband had told her that she was crazy and had threatened to put her in an asylum.

In January, 1950, Mrs. F. again returned to medical clinic. At this time the doctor felt there had been too much of a tendency to consider the case answered by a referral to psychiatry. He felt that the reality factors, the abuse and possible fraud, were very important and that Mrs. F. focussed on these and could not get well until positive steps were taken in this regard. He referred the case again to social service for intensive work, feeling that the patient's health rested with them.

The medical social worker found Mrs. F. very difficult to help, since she displayed a passive submission which only fed her hopelessness.

In February, she returned feeling a little better, but the situation was much the same. In March, the medical social worker referred her to a legal agency for help and for an evaluation of her home situation, but she did not want to go. At that time she received glasses from the clinic. Mrs. F. made one more visit to the clinic a few months later again complaining of being "beaten up" and threatened by her husband. The doctor advised her at this time to continue on the same medication she had been given before.

In this case the patient presented vague, physical symptoms and various mental symptoms as well. The occurrence and intensity of the symptoms clearly seemed to be related to environmental difficulties. There was a short history of physical complaints which seemed to be re-

lated in one way and another to her marital life but the nervous reactions seemed to be of recent occurrence.

Although Mrs. F. was able to associate her nervous symptoms with her environmental difficulties, she was not able to relate her physical symptoms in the same way. She was disinclined to face her situation and do much about it and convinced that she needed some treatment that was more specific than psychiatry.

We have already seen the influence upon the patient of the husband's attitude and it is obvious that it was a factor in this case as well. It was unfortunate that the worker was unable to see him, since his attitude toward the patient was certainly contributing to her illness. Further efforts to contact him might have been made with more success.

It is important in this case that the patient was referred to social service first and that on the basis of her social evaluation, the medical doctor recommended a psychiatric referral. The worker helped the patient to accept this referral and played the part of liaison between the medical and the psychiatric service.

At the time a return visit to psychiatry was recommended, worker again encouraged her to go, but there was no interpretation given at this time. It is felt that more interpretation all the way through the case might have made some difference in the patient's understanding of her condition and ability to use treatment.

When the patient finally returned again to medical clinic the doctor emphasized the social situation which had probably not been given sufficient recognition. Since Mrs. F's mental and emotional difficulties were so directly related to environmental stress it seemed that this

should have been re-evaluated and concrete help given the patient in this area. This was attempted, but it soon became evident to the worker that this was very difficult to carry out in view of the patient's personality. It would seem, however, that both psychiatric help and environmental help were necessary in this case and that no adequate treatment of the patient could afford to neglect either one.

There is evidence here of teamwork between the medical social worker, the medical doctor and the psychiatrist. Teamwork started at the beginning of the case with the doctor's request for a social summary without which he felt he could not effectively continue treatment. The psychiatrist also considered this essential. The working relationship was such that later when the worker saw evidence of the patient's increasing emotional disturbance, she was able to consult with the doctor and psychiatrist and a psychiatric appointment was immediately arranged. Throughout the case there was consultation between all three for purposes of sharing information and planning treatment for the patient.

There was no satisfactory conclusion to the case. The patient showed some improvement, but the reality factors from which she wished to escape still existed. The problem remained primarily one of social readjustment.

The second case is that of a man who had been able to function quite well as long as he could depend upon his wife, but when she eventually became ill, his prop was removed and he himself became ill.

Mr. G. was a married man of 45 with three children. His diagnosis was chronic anxiety state. Mr. G. was hospitalized first for an attack of pneumonia and a year later for observation and treatment

of ulcers. Following this he felt he needed six months rest and requested a referral to a convalescent hospital. He believed himself to have a heart condition and complained of severe chest pains and fainting spells. A year later he had an infected ear and at the same time he was afraid of cancer.

Mr. G's mental state was one of extreme anxiety. He began to worry a great deal after his attack of pneumonia and he believed he was a failure for not being able to support his family. He was depressed and became angry and irritable very easily.

Mr. G. had been well and was a good worker until his attack of pneumonia in 1946. Then he collapsed at work and had not been able to return to steady employment since.

Mr. G's father died when he was four years old and he was sent to a convent, since his mother had to seek employment. At 15 years of age he went to live with his mother. Four months after this his brother died and within a year his mother died, so that Mr. G. was left alone. He went to work on farms before he came to work for a large company in the city. He claimed that he "never knew what mother love was".

At the time that he was convalescing from pneumonia, his wife was sick and had to be hospitalized from time to time, having four operations for chronic otitis media with mastoiditis. Two of the children were placed in convents and the family received financial assistance for some time, since Mr. G. could not work.

Mr. G. himself felt he was very ill and several times was afraid that he was dying. He said that he saw no use in continuing to live. He claimed that all he wanted was to be able to return to work. He felt that his wife and the neighbours thought he was lazy and would like to get rid of him. He was in some conflict as to whether he was to blame for his wife's illness or she for his. Mr.G. told the worker that he knew his trouble "was in the head".

The medical social worker's plan in this case was (1) to help the patient with his work adjustment, (2) to help the patient's wife to understand her husband's illness and (3) to consider the advisability of a psychiatric referral with the medical doctor, and to give supportive help at least until such time as psychiatric treatment was started.

The doctors in the medical clinic reassured Mr. G. that he was not sick and ordered special examinations as a therapeutic measure. They told him there was nothing wrong with him except for his "nerves". Mr. G. could not accept this, however, since he believed that people with "nervous trouble were still able to work". Consequently he claimed that the clinic doctors did not understand his case and he returned to his private doctor who treated him with pills. He con-

tinued to vascillate between his private doctor and the clinic for a long time. He did not like having the clinic doctor ask when he was going to return to work and he was hostile with his wife for sending him to the clinic. He felt something must have been overlooked. The nervous attacks increased, however, and Mr. G. came back to the clinic periodically. The doctors and the medical worker maintained a very permissive attitude toward this behaviour.

The medical social worker gave Mr. G. a great deal of help around the psychiatric referral. The worker explained the relationship of illness and emotional upset and interpreted a psychiatric referral in terms of his need for a special kind of treatment. Mr. G. was fearful that psychiatric treatment consisted only of lying on a couch and talking and that it meant that he was crazy. He said he wished there were "really" something wrong with him so that he could be hospitalized and operated on. The worker tried to give the patient some understanding of the kind of illness he had and told him she knew he would work if he could. She explained that many people had the same trouble he had and were helped. She gave him considerable support during the period of waiting for a psychiatric appointment and assured him that he could always come to see her.

Mrs. G. became quite exasperated with her husband's continual complaints and expressed the feeling to worker that it was his responsibility to support his family. The worker gave her a considerable amount of help with her feelings about her husband and helped her to understand him as he was and be a support in getting him to return to the clinic for psychiatric treatment.

The influence of relatives and friends was important in this case and Mr. G. was particularly sensitive to their attitudes. His sister told him he had heart trouble and a friend, by citing a similar case, implied that it was all in his head. His friends said he was either "lazy or crazy". He was told by another hospital and also by his private doctor that he had a heart condition. This doctor told him he needed five months rest and that he would die if he went back to work. Mr. G. had blind faith in the pills this doctor gave him and was afraid he would become worse if he discontinued them. One day he talked to a man in the clinic who said he had had similar difficulties with doctors and he finally went to the Allan Memorial Institute and was cured. Mr. G. was pulled in all directions and did not know whom to believe. These influences only helped to perpetuate his vascillation between the clinic and his private doctor. His wife, however, was a strong and important influence in helping him to accept the kind of treatment he needed and, later on, an outside doctor and the family agency to whom they were referred for financial assistance, helped to facilitate the actual referral to the Allan Memorial Institute.

Mr. G. did not keep the first psychiatric appointment that was given him and felt very ambivalent about it. He took a summer job at that time, however, and returned to his private doctor whom he attended regularly for a while after this. There was no contact with the hospital for some time until finally Mrs. G. called to say that her husband was worse. It had become so difficult with him at home that arrangements were made for him to go to a convalescent hospital for a while until such time as he could be admitted to the Allan Memorial Institute.

Mr. G. enjoyed his treatment and felt that he had been foolish not to go for treatment earlier. The doctors felt that he still had no insight into his condition, but the medical social worker felt that he had some understanding of the nature of his illness. He told her that he only had the symptoms in his chest when he worried and he knew now it was only his nervous condition. He felt like a new man. He went back to light work in the summer and then to his former job in the fall and was well and uncomplaining. He was still somatizing to some extent; however, it was felt that he would continue to need the support of the hospital and the medical social worker for some time. Psychiatry would continue to be available to him at such time as he might need it again.

In this case it is interesting to notice not only the variety of symptoms the patient presented, but also the tentative diagnosis made by various doctors. The patient had had a long period of unemployment and was quite convinced that he was seriously ill. He had obvious anxiety symptoms and the underlying belief that he was a failure.

Before this period of illness and unemployment he had had no difficulty. His health had been good and his employment record was satisfactory. His personal history, however, clearly shows a lack of love and security without the usual parental relationships.

He finally found a good mother in his wife and he was able to get along quite well until his wife became sick. At the time of her illness and hospitalization, he became sick as well and his illness was directly related to his loss of her support and care. Although the patient did not understand this relationship, he was certainly in some conflict about

it, since he wondered whether he was responsible for her illness or she for his.

Mr. G. himself felt that he was very ill physically. It is important to notice that he did not consider that being emotionally ill was really being ill. He considered what the doctor told him a denial of illness. Later, after he had received considerable help, he was able to tell the worker that he knew his trouble was all in his head.

The worker's role was first of all one of recognition. She accepted the patient as he was, she heard his story and she recognized his illness. Secondly, she gave him support in coming to the clinic and she met his discouragement when the medical doctor told him there was nothing wrong with him. She supported him in making his own decisions and helped him in this way to choose between the clinic and his private doctor, allowing him to make the choice in his own time. Thirdly, the medical worker spent a good deal of time in interpretation in regard to the emotional basis for illness and how psychiatry might help him. It was clearly due to the interpretation and continual support he received that he was eventually able to accept psychiatric treatment at all.

The medical social worker continued her support throughout the patient's treatment period at the Allan Memorial Institute and although he might have continued without this, it no doubt gave him more confidence and helped him to make more constructive use of psychiatric treatment.

In previous cases we have seen the importance of the worker's role with the patient's husband. This case is perhaps the most illustrative of the support and interpretation the medical social worker can give the patient through the marital partner. His or her influence upon

the patient must always be considered and as in this case, it may be necessary for the worker to spend a considerable amount of time with her in order to help her understand the patient and his illness and to enable her to give the patient her support. If it had not been for his wife's confidence in the hospital and her conviction that psychiatric treatment was the only kind of treatment that would help the patient, he would not have continued to come to the clinic.

This case is another example of teamwork with a family agency. This time the medical social worker made the referral to the family agency for financial help and planning due to the unemployment and the illness of both parents. The family worker cooperated with the medical worker to help the patient with his indecision between the clinic and his private doctor. Later, it was through cooperative planning between the medical worker, the family worker and an outside doctor that arrangements were made for the patient to be admitted to the Allan Memorial Institute. There was frequent consultation between the two workers and one conference was held for the purpose of joint planning.

There is evidence, too, of effective teamwork between the medical doctor and the medical social worker in this case. At the beginning, they discussed together their plan of treatment and it was decided jointly to work towards a referral to psychiatry, although it was recognized that the patient was not ready for such a referral yet. In order to evaluate the case as it progressed, there was a sharing of information to the extent that the medical worker recorded in the medical record an account of the patient's feelings after each clinic visit. There was evidence throughout the patient's clinic attendance of consultation

between the medical worker and medical doctor to discuss the patient's progress and to formulate further treatment plans.

Teamwork with the psychiatrist was much less evident while the patient was at the Allan Memorial Institute. More continuity here might have been helpful, but the lack of it at this stage does not appear to have been detrimental.

The case illustrates intensive work on the part of the medical social worker in the role of helping a patient accept and use psychiatric treatment. Movement in the case is slow but nonetheless sure. The patient's symptoms might recur and he might continue to somatize his anxiety and continue to need the support of the hospital for some time, but a family break-up was prevented and an understanding and acceptance of psychiatric treatment achieved that would enable the patient to make use of this service much more readily should he need it in the future.

The third case in this group is that of a patient who had a history of illness and of being "sickly" that dated back to her childhood. The patient had undergone, as well, two surgical operations which had encouraged her to believe that she was an ill person and focus her attention on any physical symptoms.

> Mrs. H. was a 38 year old married woman with no children. Her diagnoses were hypertensive vascular disease, bleeding ulcer, as well as chronic psychoneurosis. In the spring of 1949, she came to the clinic complaining of "attacks" beginning with seeing stars and during which her tongue became numb and there was heavy perspiration. She complained as well of headaches and loss of memory. She complained of vomiting, nausea and anorexia with occasional pain in the epigastrium.
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> The mental symptoms of which Mrs. H. complained were progressive nervousness and loss of memory during the "attacks". These "attacks" were considered by the doctor to have their etiology in anxiety.

Mrs. H. seemed to be a dependent immature individual who became hostile when her dependency needs were not met.

Mrs. H. had a history of headaches for twelve years. In 1945, she underwent a splanchnectomy and sympathectomy for her hypertensive vascular disease and her headaches improved somewhat following these operative procedures. Later, however, they were considered by the doctor to be psychogenic. In 1949, she underwent a gastrectomy for bleeding ulcer. Her present "spells" began to occur after this.

There does not seem to be anything unusual about Mrs. H's early life. She attended public and high school and business college and then worked in an office until she was married.

Mrs. H. met her husband when she was 15 and was impressed with his good looks and respectful manner. After eight years of courtship, they married. Mr. H. earned a steady income and there were no difficulties until Mrs. H. was hospitalized in 1945. Then her husband began having affairs with other women and drank quite heavily. In 1947 he went to live with another woman and Mrs. H. was forced to work in a perfume factory to supplement what he gave her. He had beaten her on several occasions, but this stopped after she took him to court. Mrs. H. tried to be protective of her husband, saying that she considered him mentally ill.

Mrs. H. did not feel now that there was any problem between herself and her husband. Several years ago she gave him the choice between herself and another woman with whom he had been involved and he had returned to her and had been quite content since. Now she said he came home every night and no longer drank.

Mr. H. was a truck driver for a brewery. He had been there eleven years and had good chance of promotion. Their income was adequate and they were building a cottage which Mrs. H. enjoyed very much. Her mother and sister lived near them and helped her daily with her housework since she could not do her own.

Mrs. H. affirmed that her "attacks" were not precipitated by any unpleasantness or trouble. She considered these "attacks" to be the cause of her insecurity. She was not afraid outside, but was fearful of being home alone. She was concerned, she said, because no doctor thus far had been able to give her an answer, but she seemed to accept this form of helplessness with complacency. She wanted the social worker to help her interpret her illness to her husband.

It was the medical social worker's plan to (1) evaluate the social situation and (2) interpret Mrs. H's illness to her husband and prepare the patient for a psychiatric referral.

The medical social worker did evaluate the social situation and saw Mrs. H. in order to interpret emotional illness and the help she might receive from a psychiatrist. Mrs. H. said she was genuinely puzzled now, because she felt she had no problems such as those a few years ago which she thought really had affected her health. But while she did not feel she had any personal problems except those which she considered the result of her physical symptoms, she was willing to have a psychiatric interview which might help in giving an understanding of why these attacks occurred. When the time drew near for her psychiatric appointment, Mrs. H. said she was feeling better and needed some encouragement from the social worker in order to keep her appointment.

All her life, Mrs. H. was subject to the influence of a mother who kept telling her she was a sick child and easily susceptible to any infections. Her mother was at this time very concerned about Mrs. H's illness. On the other hand, her husband was not very sympathetic and did not believe that she was as sick as she appeared to be. Later he showed a little more understanding and expressed the hope that her "spells" could be cured.

Mrs. H. did keep her first appointment with the psychiatrist and continued to see him for a short time in the medical outdoor. He recommended superficial psychotherapy for this patient. Unfortunately there was a change of psychiatrists at this time and the treatment had to be discontinued temporarily.

Again we see illustrated a variety of vague symptoms and in this case there is emphasis on the patient's so-called "attacks". There are also the accompanying symptoms of progressive nervousness and a loss of memory during the "attacks".

Mrs. H. had a history of illness that dated back to being a sickly child, but began as far as patient herself remembered with headaches which troubled her for twelve years. There were also the two diagnoses of hypertension and bleeding ulcer, both of which were treated surgically.

The patient is described as being a dependent, immature person, and her illness seems to have been a part of this pattern throughout her life, bringing with it, and being fostered by, the concern and protection of her mother. Her headaches began about three years after her marriage and it may be significant that Mrs. H. was first hospitalized

at about the same time that her husband began to have affairs with other women.

Mrs. H. herself admitted that her personal problems had an effect upon her health at that time, but did not believe that this relationship existed at the present time. She claimed now that there was no problem with her husband and that her "attacks" were not precipitated by any unpleasantness or trouble. She was convinced that it was as a result of these attacks that she felt insecure. Here again we see a denial of an emotional basis for illness, probably due to the misunderstanding that her symptoms could not be real if they had an emotional origin.

In this case, too, it is clear that the patient's husband had an important influence upon the patient's attitude toward her illness and toward psychiatric treatment. As long as he did not believe that she was ill, her energy was directed toward proving this rather than making use of available treatment in order to recover. It was hard for her to accept the doctors' findings that there were no physical bases for her symptoms since this seemed, too, to be denial of illness. At this point her husband could have been a very strong influence in helping the patient accept psychiatric treatment. Although the worker made several attempts to see her husband, he broke his appointment each time.

The medical social worker's role with the patient, however, was successful as long as it lasted. The worker saw Mrs. H. on every occasion that she came to the clinic, recognizing her illness as real. Mrs. H. responded to this supportive casework relationship. Emotional bases for illness were discussed with her and careful interpretation was given

about the kind of help a psychiatrist could give her. It was due to this interpretation and the worker's continuous support that the patient finally made and kept her psychiatric appointment.

Teamwork with both the medical doctor and the psychiatrist is well illustrated. At the beginning, when the doctor could not account for the patient's symptoms on a physical basis, he asked for a social evaluation in order to gain a better understanding of the case before referring the patient to psychiatry. When a referral to psychiatry was recommended by both the medical doctor and the social worker, a conference was held with the psychiatrist where there was joint planning for the patient's treatment. The plan was for the medical social worker to continue casework support with psychiatric interviews at intervals.

The case was carried according to this plan for a short time and then it was necessary to make a transfer, not only to another psychiatrist, but to another social worker as well. The transitional period when the medical social worker's role is so important, was successfully completed, however, and the case gave promise of some improvement.

The fourth case in the group is that of a man who had a five year history of illness and who had been to a number of other doctors. He was dissatisfied with the negative results and considered their investigations to be inadequate.

> Mr. I. was a married man of 30, with two children. His final diagnosis was that of anxiety state. He came to the medical clinic complaining of pain in the epigastrium, associated pain in the back of the legs, the knee and ankle joints and burning pain in the chest. He complained also of insomnia and later noted the occasional yellow tinge to his skin.
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> Five years prior to this, Mr. I. had suffered from general debility, weakness and insomnia, which was believed to have been brought

on by over-work. Treatment for this was varied. The following year Mr. I. was able to carry on work again, but digestive difficulties resulted in epigastric pain which had increased over this five-year period. At about the time these symptoms began in 1943, he was rejected for military service due to a hernia.

Mr. I. was born in the country, the second in a family of eight children. The family moved to the city when he was ten. At thirteen he left school in grade VII and began working as a newsboy. Following this he did clerical work for five years and since 1936 he was a typograph operator, earning a good average wage. Little was known about the early influences in his life except that his father was alcoholic.

In 1943, Mr. I. married, and at the present time he and his family were living in a four-room flat in a poor neighbourhood in the city. Mrs. I. was attending the arthritis clinic.

Mr. I. felt he was under considerable strain in his work, since there were always time limits on assignments which had to be met. There he encountered personal difficulties as well, both with men under his responsibility and over whom he had no authority, and with his foreman. He was dissatisfied with his social status and his job, wanting something with more prestige and money.

Mr. I. felt his health was first impaired after working steadily day and night for four years. He visited several physicians privately, but was never satisfied because he felt investigating procedures were not adequate. He felt better now than he did at the beginning of his illness in 1943, but came to the clinic for preventive as well as curative measures.

Later when he was talking with the medical social worker, Mr. I. spoke of being unable to express his hostility easily and said he knew he "kept everything inside until it was too late".

It was the medical social worker's plan in this case to follow the patient during his clinic visits, giving him reassurance and an opportunity to discuss his problems and feelings on a conscious level with a view to helping him better accept himself as a person.

The medical doctor gave the patient considerable reassurance. Weekly discussions with him were arranged in conjunction with the medical social worker's report, with the aim of removing Mr. I's symptoms by means of reassurance and readjustment of his way of life. He was given one long interview in which the doctor gave him a complete explanation of the various tests and examinations done. He was reassured that there were no organic lesions. The emotional basis of his complaints was explained in simple terms and the doctor felt that he gained a good understanding of this. In later interviews, Mr. I's employment difficulties and his personal relations

were discussed and the doctor attempted to help him with these things. As the doctor gradually interpreted Mr. I's emotional illness to him, the medical social worker handled the patient's reaction to this. The worker felt eventually that he accepted the psychological implications of his illness fairly well. At this point the worker felt that a psychiatric consultation would be helpful. At about this time also, the doctor in the medical clinic left and it was arranged that Mr. I's next interview would be with the psychiatrist.

Mrs. I was very concerned about her husband's illness and wanted him to have a psychiatric appointment. It was the joint decision of the psychiatrist and the medical social worker to have both the patient and his wife referred together to psychiatry since it was felt that Mr. I. needed this additional support and the worker did not think he would go alone. This was possible since his wife was already known to the outpatient department, through the arthritis clinic and was vitally interested in her husband's illness. After this first joint interview which they kept, the psychiatrist continued with Mr. I. alone since he felt that his adjustment was the main problem.

With the help of wife, doctor and medical social worker, the patient accepted continued psychiatric treatment. He was given hourly interviews every two weeks for a total of fifteen hours over a period of seven months. At the end of this time, although he was never symptom free, Mr. I. showed general improvement in his relationship with his wife. Psychiatric treatment was discontinued at the end of this time due to the departure of the psychiatrist and the improvement shown in the patient. Mr. I. understood that he could return to the clinic for further treatment if the need arose.

The case was closed by the medical social worker once it had been successfully transferred to the psychiatrist.

Here again the patient presented vague physical symptoms which he related to stress and strain at work. There did not seem to be any indication of mental symptoms being present. It was noted, however, that Mr. I's relationships with other people were poor, both at work and in his personal life.

Mr. I had a five-year history of illness, the origin of which he also related to overwork. He had been to several other doctors without any successful results.

Mr. I's attitude toward his present life was one of dissatisfaction. He was aware of his personal difficulties with his wife and the strife in his relationships at work. In regard to his illness, he felt that previous investigating procedures had been inadequate and that there was really something physically wrong with him. Later, he showed some awareness of his emotional difficulty, when, with help, he was able to tell the social worker how hard it was for him to express his hostile feelings.

The worker's role in this case was one of support and reassurance, and also one of skilful handling of the patient's feelings, helping him to accept himself as he was and to express himself more easily, thus enabling him to make better use of psychiatric treatment.

Again we see illustrated the important role the marital partner plays in the patient's treatment. Mrs. I. was concerned about her husband's illness and with the help of doctors and social worker, she cooperated in every way she could, even to the extent of seeing the psychiatrist with her husband the first time. Thus the inclusion of the marital partner in the treatment plan for the patient was very important in this case and actually meant the difference between the patient, himself, accepting psychiatry or not.

Teamwork between the medical social worker and the doctor in this case was good. It began when the doctor called the social worker in at the beginning of the case for a social evaluation and for supportive help. Information about the patient and professional opinions were shared and together the doctor and social worker formulated and carried out a treatment plan. There were frequent consultations through-

out this period and the case was discussed at a student medical conference.

There was also consultation with the psychiatrist at the time of the actual referral, but once the patient had accepted continued psychiatric treatment, the psychiatrist carried the case alone.

In this case, a patient who had been "shopping" for a remedy and was dissatisfied with anything that doctors had ever told him, was finally helped to get the treatment he needed and although his symptoms were not entirely removed, the patient improved and did give up going from one doctor to another.

The fifth case in this group is an example of a patient who was at one time considered to be one of the hopeless cases in the clinic and whose symptoms increased under medical treatment. The patient had very strong and deep seated dependency needs and showed a high degree of somatization.

> Mrs. J. was a widow, 49 years old, with two children. Her diagnosis was chronic anxiety neurosis and hysterical depression. She came to the clinic complaining of sharp pain in the left side of the abdomen, dizziness and headaches. She was later hospitalized elsewhere for an emergency appendectomy. Following the operation, however, she still complained of dizziness and weakness and also severe piles. Several months later the complaints were more stressed, but still the same dizzy spells with black spots before the eyes, and sharp pain in the left side of the abdomen.
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> Mrs. J. was anxious and depressed. She complained of forgetfulness. When it was suggested by the doctor that she return to work, she became very resentful and threatened to take her life if the medical social worker did not help her. She also showed considerable hostility toward her daughters.
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> Mrs. J. first came to clinic in 1942 when she complained of pain in her back, loss of weight, fatigue and shortness of breath. Since that time she was treated surgically for pelvic inflammatory disease, and was in and out of hospital several times. Her symptoms persisted however. At one time she thought she had a heart condition like

her daughter. By July, 1945, she was considered a severe neurotic and a social problem. The case was conferenced at that time with the doctor, the medical social worker and the family worker present. Later Mrs. J. attended psychiatric clinic for five months, mainly because she felt rejected by all other clinics. She seemed to gain some insight into her illness. She was hospitalized again for a week the next year, however, and at this time she would not accept psychotherapy. She kept coming to the clinic with various symptoms and complained to the family worker that she was very ill and that no one understood her. She was very upset when finally told in the medical outdoor, in 1947, that there was nothing wrong with her and she should not return. She returned to gynecology clinic, however, and psychiatry was again recommended, but not accepted.

Mrs. J. was born in Poland, and did not have much education due to conditions existing there during the first World War. She was in a concentration camp for two years. In 1928, she came to Canada and worked as a domestic. Her parents were not living when she came to Canada but she had one sister, living in the United States. Mrs. J. worked for a while in a factory when she met and became engaged to a boy who was killed in an accident shortly before they were to be married. Following this she met her husband through a friend and they were married in less than a week.

Mr. J. was a heavy drinker, very abusive to his wife and had even threatened to kill her. Mrs. J. obtained a legal separation in 1944 and her husband was ordered to pay her a weekly allowance, which he failed to do. Later, he had the family evicted and dispossessed of their belongings by some arrangement he made with his wife's landlord, although she had been paying her rent regularly. Mrs. J. tried to work for a while, but was not able to because of poor health. For a long time she lived in fear of her husband returning and harming her and the children.

Mrs. J. was now a widow and was being assisted by a family agency in keeping her home together and bringing up her two girls, who had had a difficult time adjusting to their insecure home environment. Mrs. J. had worked periodically, but the main support of the family was from the family agency. When the family worker visited the home, Mrs. J. was found surrounded by shawls and hot water bottles. When encouraged to work, her complaints only became more acute.

Mrs. J. was apprehensive about her health, focussing many of her problems on her physical condition. She had a pattern of seeing many different doctors, being certain that there was something physically wrong with her. She said that up until the time of her marriage she was in excellent health. Now she feared that she had cancer and that the doctors were keeping this from her. At one time she felt sure she had a heart condition, like her daughter. She was very dependent upon medicines and said she was afraid to go out alone because of her health.

Mrs. J. said she shunned outside contacts because she did not like other people's pity or advice. She felt she was not accepted by other people because she was poor and could not pay her way and also because she did not speak English fluently. The family worker did not feel that Mrs. J. had much insight into the emotional problems affecting her health. Mrs. J. herself denied any problems in the area of emotions of "nerves". Later, however, she did say to the psychiatrist that perhaps she was "thinking too much".

It was the medical social worker's plan to help the patient obtain and use the medical care she needed and it was the family worker's plan to provide supportive contacts with the patient and financial assistance. It was the aim of both workers in conjunction with the psychiatrist, to help the patient get some attention and satisfaction other than through illness and to gain some insight into her present role with her children. It was hoped that she might be encouraged to return to work.

A few years previous to this, Mrs. J. was considered one of the "hopeless" cases in the clinic and was handled as such. Mrs. J. said that every doctor told her he could not help her and she did not like doctors. More recently the doctor in the medical clinic encouraged her in terms of her "will to get better". He also talked with her daughter about her condition but she interpreted this as telling her daughter that she was "crazy" and she lost confidence in the doctor. The doctor, however, was sympathetic to Mrs. J's problem and although there was no physical basis for her distress and he had referred her to psychiatry, he was willing to see her on a supportive basis.

The family worker talked with Mrs. J. about psychiatry, but she resisted the idea of psychiatric help completely and denied any problems with her "nerves". The family worker finally encouraged her to go to psychiatry and arranged an appointment for her. Mrs. J. accepted this at last, but mainly because she wanted medical help of some kind and because the psychiatrist spoke her language. It was some time before Mrs. J. admitted any emotional problems.

Mrs. J. did not have any real understanding of psychiatry and interpreted the insulin therapy at the Allan Memorial Institute as an indication that she was crazy.

She reacted very slowly in psychotherapy. The psychiatrist felt it would take her a long time to realize that there was nothing physically wrong with her, since up to then this had been the only way she could get attention. After two months of therapy, she still insisted that she had some abdominal disease, but stated that it was possibly just her "nerves". In another month she had gained some understanding of her role with her daughters and was less insistent about any somatic disease. She was finally able to accept insulin therapy which she had previously refused completely. By

the fifth month, although the same complaints still existed, she showed some improvement. She was more concerned about her daughters and less about herself and she was less insistent about her somatic complaints.

Mrs. J. complained of a variety of vague symptoms which in this case had persisted in spite of any treatment, and gradually became more stressed. The mental symptoms noted were those of anxiety and depression. She had difficulty making friends and showed hostility toward her own daughters.

Mrs. J. had a long history of illness related significantly to her married life. The case also illustrates the identification of symptoms with those of another member of the family, since for a time, Mrs. J. felt sure she must have a heart condition like that of her daughter. Over this long period of illness, she had a pattern of going from one doctor to another, always dissatisfied with the prescribed treatment.

In this case, the patient had a very insecure background, beginning with her life in Poland during the first World War and two years in a concentration camp, the loss of her parents, and the move to Canada, a strange and new country for her. Then came the loss of her fiance and a quick marriage which brought only unhappiness and abuse and fear for her own safety and that of her children. It does not seem surprising that finally, as a widow, she was a very dependent person, needing support from the family agency and her daughters and using illness as a prop and a means of getting the support and care she needed.

Mrs. J's attitude toward her illness was characterized by this certainty that there was something physically wrong with her. She her-

self related her illness to her married life, saying that she was well before marriage. She did not have much insight into this relationship, however, and denied the existence of any problem in the emotional area. She did have considerable feeling of inadequacy, which she expressed in terms of not being able to pay her way, and not being able to speak English fluently and not feeling accepted by other people.

The case is an excellent illustration of co-operative work with an outside agency where the medical social worker's role was chiefly that of liaison, making it possible for the family worker and the psychiatrist to share information about the patient and work closely together in her treatment. In this case, since the family worker already had a strong relationship with the patient, she gave the necessary support and interpretation for the patient's referral to psychiatry. Without this, Mrs. J. would not have been able to go.

Teamwork with members of the medical staff was also made possible by this liaison provided by the medical social worker. Reports were made through her to the family worker and the psychiatrist and she arranged and attended several conferences. In this manner, with the professional opinions of all three brought to bear upon the problem, treatment plans were formulated and carried out and both workers and psychiatrist were working toward the same goal.

By the end of the period covered in this study, the patient was by no means cured and, judging by her previous pattern and the extent to which her problems were somatized, this would take a long time. She was, however, somewhat improved and acceptance of psychiatric help had at least been achieved.

In the following case the patient received social service help as a result of her husband's illness and psychiatric help as a result of her son's medical condition. Not only did she have to accept a relationship between emotions and physical symptoms, but between her own emotions and someone else's physical symptoms.

Mrs. K. was a 35-year old widow with two children. The diagnosis in her case was hypertensive cardiovascular disease and psychoneurosis with depression. Mrs. K. complained of having numbness and throbbing in the head and hypertension since 1934. Her headaches were aggravated during periods of stress and emotion and she felt tired most of the time. She herself was obese and had a very obese son. Her mental state was characterized by fairly severe attacks of depression.

Mrs. K. was born in Montreal and lived there all her life. She was brought up by a "sister", in the belief that her mother was dead. She was shown little affection, was made to work hard and was not allowed visits from her friends. She was not given any sex education, and, in 1936, she became pregnant by a roomer in her "sister's" house, who was the only person who had shown her any affection. He offered to marry her and it was at the time of her marriage that she discovered that her "sister" was really her aunt. The "sister", whom she regarded with little affection, was her mother, and she herself was an illegitimate child.

Six months after her marriage, John was born and three years later, Eric. When Eric was two, her husband died after a long illness. In 1943, Mrs. K. met and married her second husband and it was the first time in her life that she was really happy. This man had been married before and had had a hard life as she had had. She felt she had been accepted by this man for what she really was. When the medical social worker was first called in on this case in September, 1946, it was for assistance in securing a colostomy cup for Mr. K. who was dying of cancer. With the threat of the death of her second husband, Mrs. K. felt extremely resentful toward a fate which would snatch away the only happiness she had ever had to make up for all the past unhappiness.

It was the medical social worker's plan to carry on supportive casework with the patient in relation to her husband's illness and to help her to gain an understanding of the medical and psychiatric problems in relation to John to enable her to constructively use psychiatric treatment.

In this case, Mrs. K. herself was first referred to psychiatry by the psychiatrist in the endocrine clinic who was treating her son

and felt that she showed obvious signs of anxiety and that the successful treatment of the boy depended upon treatment of the mother. Mrs. K. spoke to the medical social worker about this, saying she did not want to see a psychiatrist. She preferred to have the worker for her psychiatrist and proceeded to tell her everything. As she talked, she began to understand how talking to someone she trusted could help her and she was led to see that she might even be helped further. The worker gave her the support she needed saying that she had shown great courage thus far and that perhaps, with help, would again be able to face the future. The worker told Mrs. K. that by talking to her, she had enabled the worker to better understand her and pointed out that if she would share some of this with John's doctor, as well, he too would be able to understand her better. Mrs. K. found this difficult, and the worker volunteered to talk to the doctor first. Later, after thinking it over, Mrs. K. told the worker to do this. The worker left a note in the medical chart about the patient, but before she spoke to the doctor, Mrs. K. herself had been able to do so and considered this an achievement. The worker supplied the necessary praise at this point. Following this, Mrs. K. accepted a referral to the psychiatric clinic for herself.

From March to July, 1947, Mrs. K. received psychotherapy with some benefit. Treatment was discontinued at the time psychiatrist left since he felt that she did not need further psychiatric help. Further casework was recommended, however. Mrs. K. returned to the medical clinic in January, 1948, for reassurance following the death of her husband. At this time the doctor in the metabolism clinic, in conjunction with the medical social worker, made the second referral to psychiatry and she continued this for some time.

At the time of Mrs. K's second referral to psychiatry, she again needed a considerable amount of support from the worker, and, frequently, telephoned her while awaiting her first interview. She came to talk with the worker after each psychiatric appointment. She thought she would rather talk with the worker since she did not feel the psychiatrist was interested in her. The worker gave her reassurance at this time and helped her with a matter which had come up in the last psychiatric interview. After this, Mrs. K. decided to return for further psychiatric appointments and to try to make the best possible use of them.

In May, 1948, it was felt that Mrs. K's needs were more in the area of family casework and since the medical social worker was leaving the hospital it was thought to be a good time to transfer this case to the family agency, where it was subsequently carried.

In September, 1948, Mrs. K. was admitted to the Allan Memorial Institute for a while and then followed in psychiatric clinic again until February, 1949. During the latter part of 1949, she went to the Allan Memorial Institute for group psychotherapy, but she felt

this helped her very little with her problems. She became increasingly dissatisfied with this type of treatment and discontinued treatment at the end of 1949. It was the psychiatrist's opinion that Mrs. K. had improved somewhat with group therapy, but that further individual therapy was useless. Since she needed continued support, however, further family casework was indicated.

This patient complained of vague disabling symptoms which she clearly said were affected by environmental and emotional factors. The symptoms about which she complained at the clinic were not only her own but also those of her son. There were mental symptoms present, as well, in the form of severe attacks of depression. She gave a history of these symptoms beginning a few years before her marriage.

Mrs. K's life seems to be one of emotional insecurity. She experienced, first, lack of affection and friendship, then the emotional trauma of finding that she was illegitimate and finally the loss of the only real love and happiness she had ever found. She was unhappy and resentful of the way life had treated her.

At first Mrs. K. did not want psychiatric help. She did, however, like talking to the medical social worker and wanted only to continue on this basis. Here is an example of the way in which a relationship with the social worker helped the patient to understand, through experiencing this, the kind of help a psychiatrist could give her. It was a stepping stone, as it were, to her actual acceptance of psychiatric treatment.

It is interesting to notice that, although social service help was continued for the patient, it was initiated at the time of her husband's illness and for help in this area. Then later, psychiatric treatment was first recommended because of the problem the patient was

having with her obese son. One wonders particularly if a psychiatric referral under these circumstances did not contribute to the difficulty of accepting treatment.

The worker's role was one of supportive casework over a long period of time, so that Mrs. K. always felt she had someone to whom to turn. The worker gave interpretation at the time of the psychiatric referral, helping her to work through her feelings about this, and then she helped to sustain her through treatment, talking with her for a short while after each psychiatric interview. When the case seemed no longer to be in the area of medical social work, there was understanding and good co-operative work between the medical social worker and the family worker around the referral so that the family worker could continue the supportive casework where the medical worker left it.

At the point where Mrs. K. returned to the medical clinic for support after her husband's death, there is evidence of teamwork between the doctor in the medical clinic and the medical social worker. Information about the patient was shared at this time, and as the result of consultation, a decision was made jointly to refer her to psychiatry.

There was a longer contact with the psychiatrist and teamwork here is more obvious. At the beginning of psychiatric treatment there was consultation between worker and psychiatrist with regard to treatment plans and the respective roles of each were defined. The worker also helped to reinforce what the psychiatrist was doing and this seemed to consolidate the patient's thinking. The case was evaluated by both social worker and psychiatrist at a later date and plans were made for continued social casework after the psychiatric treatment was concluded.

At the time of the second referral to psychiatry there was again frequent consultation between worker and psychiatrist with sharing of information and the worker's role in relation to the psychiatrist and the patient clearly defined.

While the patient did not show great improvement and would probably continue to be a chronic problem, certainly breakdown was avoided and she did not become worse in spite of the hardships and emotional trauma she experienced. Without the strong relationship the patient had with the medical social worker she might never have accepted psychotherapy and it is not likely that she would have returned the second time to the clinic expressing directly her heed for help. One can visualize instead, her illness becoming more severe with increasing physical symptoms.

The seventh case in this group is that of a patient who had a long history of nervousness and worry and a neurotic behaviour pattern that was well established. She had already been through a serious operation and was strongly focussed on the physical factor in illness.

> Miss L. was a 40-year old single woman, whose diagnosis was Reidel's Struma, a thyroid condition and later, obsessive compulsive neurosis with depression. Miss L. presented symptoms of pain and tenderness over both sterno mastoid muscles and pain behind the right ear as well as fever, loss of weight, perspiration, and pain in the side. At this time a thyroidectomy was done. Miss L. complained of headaches which she had had before coming to hospital, and nervousness for the past five years. Her behaviour indicated strong dependency needs which she was afraid to face.
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> Miss L's history showed a pattern of nervousness, anxiety and fear of criticism and punishment, which was illustrated in two quite different work experiences. She told the doctor also that years ago she had had a pain in her chest which she had thought indicated tuberculosis but after having an examination with negative results, the pain became better.

Miss L. was a member of a large family brought up in a rural locality. She was a teacher for seventeen years and liked this at first. She felt she always had to "keep up a very stern front" and she was proud of the fact that she was a good disciplinarian. She became afraid of the children's criticism, however, and it finally developed to the point where she worried all the time. She became terribly nervous and could never take any time off for relaxation. In her spare moments she would knit constantly. She finally resigned and stayed at home for awhile but she felt guilty about doing this and felt that she must get away from home and have a change. She came to Montreal and found employment on the housekeeping staff of a hospital where she was in charge of the maids. Here the classroom situation was repeated with the girls under her authority and she again worried about her work, feared criticism and could not relax. She occupied her free time by taking a business course.

Miss L. emphasized first the terrible headaches she had had before her operation and how miserable she had felt. The headaches had disappeared following the operation, but the doctor did not think they had been due to the thyroid condition. Miss L. did not think so either but thought, rather, that they had been due to too much concentration on her work and worry about the girls for whom she was responsible. She worried also about her lack of interest in life and thought this must have some connection with her physical condition. She expressed a lifelong desire to be a nun and had rejected proposals of marriage because of this, but at the same time she could not quite bring herself to become a nun and found various reasons for not doing this. She wanted to try everything else first, she said. This indecision gave her a sense of failure and discouragement and she did not see how a doctor or even a psychiatrist could give her an interest in things. She said that she did not enter a convent because of her symptoms, but she knew that her indecision prevented her from getting better. She said she was helpless between the two.

It was the worker's plan to offer the patient two different kinds of help; firstly, casework interviews designed to build up a supportive relationship by which the patient might be helped to return to work and to take steps toward a more satisfactory life adjustment, and, secondly, interviews designed to help the patient make use of other services such as psychiatric help.

Miss L. accepted the fact that the doctor did not think her headaches and miserable feeling were due to her thyroid condition but when the doctor in the clinic suggested that she go to the Allan Memorial Institute for treatment her immediate reaction was, "do you think I am crazy?" She did not keep a later appointment with this doctor because she thought he would just talk to her and that would not do her much good. She wanted instead, to see her

surgeon again regarding the soreness in her incision and a woman doctor regarding the pain in her side. About two months later Miss L. expressed to the medical social worker a continued lack of confidence in the clinic doctors because she said they did not believe her symptoms to be real but caused by her imagination. She saw a different one almost every time she went, but did not think that any of them understood her case. She went privately to two doctors outside the hospital and to a specialist in the hospital. She thought that the specialist, too, considered her condition to be caused by her nerves from what he prescribed, but Miss L. knew that it was real.

In one of her first interviews with Miss L., the medical social worker helped her to understand her worries and fears in connection with her work, especially her fears of criticism and punishment. When Miss L. expressed the feeling that she would sound silly telling the doctor the way she felt, the worker explained that most doctors would consider this a sensible thing to do and told her that many people worried this way and that there were special doctors to understand these things. The worker went on to say that psychiatrists made a study of emotions, fears and worries that kept people from being happy and the patient agreed that this would be the sort of doctor whom she needed. She agreed that she would like to think about seeing such a doctor.

In a later interview, the worker helped Miss L. to understand the doctor's referral to the Allan Memorial Institute, explaining what this hospital was, and recalling their previous discussions about psychiatrists. The worker explained that this did not mean she was crazy. She pointed out the hospital's interest in her receiving help with her nervousness and in her future, and said that her co-operation was very important. When Miss L. questioned whether psychiatry would really help, the worker said that it often helped people to better understand themselves and emphasized again that the patient's attitude was of the utmost importance. Miss L. then said that she understood what the worker meant and that she would like to see a psychiatrist. At this time she related the pain in her side to nervousness and said that perhaps with a physical examination and an X-ray it would go away.

Two months later, Miss L. was expressing her feeling of failure and discouragement as a result of indecision, and her feeling that even a psychiatrist could not give her an interest in things. The worker helped her to meet these feelings and again interpreted the psychiatrist's role, assuring her, when she asked, that she thought it would be worth trying. Miss L. again said she would think more about it.

The following month, there was another interview in which the worker went over many of the same things again and Miss L. assured her that she would decide by the next interview, whether she wanted

to see a psychiatrist or not. Following this, Miss L. began breaking appointments and said she was feeling miserable. When the worker saw her again she had discussed her situation with the specialist and was going to be his private patient, although she seemed a little skeptical of his treatment too. She gained enough insight to see a connection between her symptoms and her emotional state, but she could not bring herself to the point where she could make a psychiatric appointment. The worker felt it was too threatening to her to face her strong unconscious motivations. Her worries and her symptoms brought her attention and support which she was not ready to give up.

Miss L. sought the help and advice of a number of different people before she could finally accept a psychiatric appointment. She saw a general practitioner who had told her there was no medicine he could give her for this great weight she was carrying. She had gone to a priest who was kind, had listened to her and said he would pray for her. Following this, she came back to talk to the social worker. She told the worker about a girl she had known like herself who had had disappointments and had developed rheumatic pains. She had become worse and worse until she did not know her friends and became really "crazy".

Later, Miss L. sought the help of a specialist from the hospital staff, but on a private basis. He was aware of the whole situation and he finally accepted her for treatment on her own terms, hoping that this might be soothing and reassuring and thus relieve some of her anxiety. At this time, Miss L. told the social worker that she was not able to accept a plan for psychiatry, nor did she feel she was able to concentrate on making her outside life more enjoyable at that time. It was agreed to discontinue interviews for the time being but Miss L. was told she could come back to social service later if she wished.

Four months later all treatment to date had failed. The specialist she was attending privately then suggested a referral for psychotherapy and Miss L. finally accepted her first appointment with the psychiatrist. The psychiatrist felt that until then Miss L. had not been ready for this referral since she had had to satisfy herself first that nothing else would help. He felt also that the earlier work of the social worker had been effective in eventually making the referral possible.

Miss L. continued treatment for almost a year, and the following spring the psychiatrist considered her depression improved, but felt that her obsessive compulsive neurosis had remained unchanged. She remained a sick woman in his opinion.

This is a case where there was a specific organic condition and the necessary treatment procedures were carried out. But there were, in

addition, two symptoms, headaches and pain in the side, which particularly concerned the patient and were not thought to be caused by the organic condition. There were mental symptoms, as well, those of nervousness and worry.

We see in this case a long history of this nervousness and worry and of a specific behaviour pattern which by this time had become well established. Due to a lack of information about Miss L's early life we are not able to comment on possible contributing factors, but the fact remains that the established behaviour pattern was of long standing.

Miss L. herself related her symptoms to her work and the worry in connection with it, but at the same time seemed to consider any treatment along these lines a denial of the reality of the symptoms. She considered a referral to psychiatry meant that she was "crazy" and she insisted that none of the doctors she had seen understood her case. Her symptoms seemed to have a particular significance to her. She was aware that they were related to her lack of interest in life, but she did not know how. Her desire to be a nun seemed to express a desire to escape from life, if she could be sure first that life had nothing to offer her, but she could not bring herself to do this and illness provided the only solution for her. It would be very difficult, therefore, for her to give up her symptoms.

As in the case of Mr. G., we see that this patient, when she could not accept the diagnosis of the clinic doctors, went to private doctors in the hope that someone would consider her physically ill and treat her accordingly. This vascillation between doctors and going from

one doctor to another, would appear to be seen quite often in such cases. It is interesting to notice that Miss L. also sought help from the priest, which certainly indicates her recognition of factors other than the physical.

The interpretive work of the medical social worker is well illustrated in this case. We can see, in detail, how the worker helped the patient to a better understanding of her problems and helped her to see how a psychiatrist could assist her with such problems. The worker gave her support and acceptance at the same time, helping her to work through some of her feelings about emotional illness and psychiatric treatment. The worker also offered to help the patient towards a happier adjustment in her every day life through community agencies, but Miss L. was obviously not ready for this yet. It is interesting that in this case it appeared for some time as though the worker had failed. Miss L. could not fully accept psychiatric help until she had herself tried other forms of treatment first. Once convinced that the treatment offered by the specialist was not helping and, in her own good time, Miss L. was finally able to accept the idea of a psychiatric appointment. Without the sustained work of the medical social worker over such a long period of time, however, it is doubtful whether the patient would ever have been able to accept psychiatric treatment.

Miss L. was influenced by a number of people, but she seems to have identified herself with a girl she had known who eventually became "crazy". This must certainly have contributed toward her ambivalent feelings, since she was afraid that being referred for psychiatric treatment meant that she was "crazy".

Teamwork between the medical doctor and the medical social worker appears to have been good. Information about the patient's problem as seen by each person was shared and a plan was made to treat her with a view to referring her to the psychiatrist at the medical clinic. It is possible, however, that there may not have been enough emphasis on the physical aspects for this particular patient. Here was a woman who had already been through a serious operation for a condition that did have an organic basis and being strongly focussed on the physical factors in illness, she, for one reason or another, needed a great deal to convince her that there was not something organic causing her present symptoms.

More extensive examination and further discussion and explanation about the physical aspects might have been beneficial. As it was, the patient finally satisfied herself that physical treatment was not the answer for her.

There was no teamwork between the psychiatrist and the medical social worker in this case, since the patient returned directly to psychiatry.

Through the casework relationship with the medical social worker she was able to readjust sufficiently to return to work and become self-supporting, prior to psychiatric treatment. It is true that this patient remained a "sick woman", but she had gained enough understanding of her condition to accept the kind of treatment she needed and she had made a little improvement.

The last case in this group was not referred to the medical social worker in time for her to help with the original referral to psychiatry

as the others were, but was soon referred by the psychiatrist for help with employment.

Miss M. was a 27-year old single woman whose diagnosis was that of anxiety state. She came to the clinic complaining of fatigue, earaches, dizziness and severe headaches. On a later clinic visit she complained that she found herself short of breath on walking quickly and said that for ten years she noticed that she tired quickly and had trouble with her ankles swelling in the evening. She had had pain in the pre-cardial region for two years and she sometimes had difficulty with her balance and holding objects. She complained of diplopia when very tired. About a year later she complained of low back pain for two months and pain in the left thigh for three weeks.

Miss M. showed paranoid symptoms and nervousness and was immature, anxious and withdrawn. She had few friends, she could not get along with her parents and she showed considerable hostility toward her father. She looked and acted like a 14-year old and she had trouble with stuttering.

All Miss M's complaints had been present for many years. She had pulmonary grippe at the age of 13 and she was never well since then. When she was about 18 she had spells when she was very short of breath, and about two years prior to her clinic visit she started having sharp pain in the pre-cardial region with these spells.

Miss M. was born in Montreal and started school at the age of five. She changed school frequently and then stopped at the age of 13 in grade six, due to pulmonary grippe. Following this she took a business course and worked for a number of years in an office. She then went out west to become a nun but she remained there only four months because she could not get along with the Mother Superior. She then decided to be a baby nurse and started the required course but she again found herself in difficulty because of the authoritative Mother Superior. She also worked for a while as a nurse's aide. Miss M's work history was poor. At the time she came to the clinic she was earning odd money as a baby sitter. Her father was resentful because she was not contributing more to the home. He was a traveller for a kodak company and his office was at home, which necessitated his working at odd hours. Due to crowded conditions at home, Miss M. was forced to sleep in the hallway and when her father was working she was not able to get any rest. Her three sisters did office work.

When discussing her condition, Miss M. said that when she was two and a half an aunt, for the fun of it, gave her too much wine and she had never been the same since. Her uncles used to tease her and she would cry easily. She said she still cried easily. Miss M. felt that her mother was tactless and had no sense of appreciation of her

needs. She kept the home in an untidy state and was often ill. She was not well when Miss M. was born and Miss M. felt this might be the reason she was so weak now. Miss M. said that her father was not much good. She had felt unable to work since August, 1948, but her father insisted that she work. She would have liked to go to the country and to do a light housekeeping job. She felt rejected by her parents and felt that they had been "pushing her around".

Miss M. was referred to the psychiatrist in the medical clinic without very much preparation from the doctor. The referral to the medical social worker was made by the psychiatrist for the purpose of helping Miss M. with employment problems. After a few psychiatric interviews, Miss M. came to the worker for help. She was feeling very ambivalent about returning to the psychiatrist because she seemed to think he reminded her of someone she disliked. At this time the worker interpreted psychiatry and tried to help Miss M. with this transference she was experiencing. By this time, however, Miss M. had found a job and seemed to be reasonably happy for the time being, so the case was closed.

The following spring Miss M. returned to the worker for help and advice and the worker felt that she was really asking for clinic care. The worker helped Miss M. to go through medical clinic in order to pave the way for another psychiatric referral and helped her to realize that the psychiatrist was the person who could help her when she was sick, disturbed and unhappy. The worker gave her a feeling of acceptance and understood her difficulties. She handled the transference Miss M. had had to the previous psychiatrist and helped her to see that she could feel differently about another psychiatrist. Miss M. was anxious for attention and finally accepted the psychiatric referral. Much of her difficulty was due to her relationship with and her hostility toward her father, who did not want her to have psychiatric treatment. The worker talked to him about the patient's difficulties and interpreted psychiatry and he eventually agreed to the treatment plan.

The father's influence in this case was very important, and it was necessary to consider him in any plan for the patient. His relationship to her was pathological, being extremely hostile and preventive. He pretended to co-operate at first and then refused to have Miss M. admitted to the Allan Memorial Institute before a certain length of time. He accepted the fact that she was sick but he seemed to feel he had to live up to what the hospital expected, and the worker felt he had accepted treatment at the Allan Memorial Institute only to please the doctor and herself.

In spite of the difficulty created by her father, Miss M., with the worker's help and encouragement, was able to accept psychiatric treatment and also admission to the Allan Memorial Institute. By the end of the period studied here, Miss M. was having regular interviews with the psychiatrist in the medical clinic and seemed to be

making some progress according to the psychiatrist's evaluation.

In this case we see again certain presenting symptoms which are vague and varied. Nervous symptoms are very noticeable and there are personality traits which seem significant. There is also a long history of this illness, precipitated as it were by an attack of grippe at the age of 13.

Miss M.'s personal history showed a pattern of frequent change as early as her school days. Her parents seem to have been particularly authoritative and even dominating so that she had the feeling she was being "pushed around", and always had difficulty with anyone in an authoritative relationship to her. As the oldest child in the family, she perhaps felt this more than the others.

Miss M. herself easily expressed her feeling about her parents but she seemed to have no insight into her condition or the relationship of her feelings to her physical symptoms.

In this case we see again the influence of a member of the family upon the attitude toward treatment and the necessity for the social worker's interpretation to that member. In this case, the patient's father was a strong influence against her acceptance of psychiatric treatment and we see that the worker's time spent with him in discussing treatment plans for the patient was well worthwhile.

The worker's role when this case was first referred by the psychiatrist was mainly supportive. The worker did attempt to interpret psychiatry, but Miss M. had found herself a job by that time and could see no need to return to psychiatry, so that interpretation was then untimely. A relationship had been established, however, which enabled

Miss M. to return to the worker for help the following year. At this time the worker's role was one of interpretation in regard to a second referral to psychiatry. The worker handled Miss M's feelings about her illness very well and the transference she had had to the previous psychiatrist, and helped her understand that another psychiatrist might be of greater help. At the same time the worker gave her a feeling of acceptance and support which continued along with the psychiatric interviews.

At the time of the first referral there was obviously no teamwork between the doctor and the social worker and very little between the psychiatrist and the social worker, although the psychiatrist had made the referral to social service. The question may be raised as to whether the patient might have been better able to continue treatment if there had been earlier help from the medical social worker and closer co-operation between worker and doctor and psychiatrist.

When the case was re-opened, the worker brought it to the attention of the medical doctor and the referral to psychiatry was made jointly. Following this, there was close co-operation between the worker and the psychiatrist in both the planning and the treatment process and the success of their co-operative work in regard to the patient's acceptance of treatment was soon evident.

Since Miss M. was still in the early stages of treatment it is impossible to comment upon her progress, but she had been helped to gain some understanding of her illness and of the kind of treatment she needed.

In this group of eight patients who showed some improvement, three were referred by the medical doctor to the medical social worker specifically for a social evaluation to aid in formulating a treatment plan. It was on the basis of this evaluation then, that a referral to the psychiatric service was made and timed so that the worker in co-operation with the doctor, could give the patient adequate preparation and interpretation for it. Teamwork between the doctor and the social worker continued throughout the case as long as the patient came to the medical clinic. These are examples, then, of cases that have been referred primarily for the medical social worker's evaluation and help prior to a referral to psychiatry.

A fourth case in this group was referred in the same way with the one difference that the referral was made for help with the patient's environment. Once referred, it resulted in a social evaluation, consultation with the doctor, and a joint referral to psychiatry.

Three other cases in this group were already known to social service for some other reason, or were referred from some other source outside the hospital. In all of these, the teamwork with the medical doctor was good, the referral to psychiatry was a joint one, and the worker had the opportunity to prepare the patient well in advance.

All cases in this group with the exception of one, therefore, were referred to the medical social worker well before their referral to psychiatry and the worker participated in this referral. The exception in the group was referred directly to psychiatry by the medical doctor without a social evaluation. It was referred to social service soon after by the psychiatrist for the purpose of helping the patient with

employment. The worker was not able to help the patient maintain psychiatric treatment at the time, but her relationship with her provided the patient with a link to the hospital so that she was able to come back to her later when she needed help. The worker was then able to interpret psychiatry and enable her to continue treatment.

Six of the cases in the group showed good teamwork between the medical social worker and the psychiatrist. In the other two, teamwork was absent once the case was being carried by the psychiatrist. In view of the difficulty the patients in this group had accepting psychiatry and the consequent difficulty they frequently had maintaining psychiatric treatment, it would seem valuable and, in most cases, necessary to continue the medical social worker's support for some time. As some of these cases demonstrate, the patient may even discontinue psychiatric treatment completely and turn up later in medical clinic. At this point it is important for them to have a good relationship with the medical social worker so that they may return to her or be referred to her, and so that she may enable them to return to the psychiatrist.

In this group of cases, the different aspects of the medical social worker's role, as set forth in the previous chapter, are again demonstrated. With most of the patients in this group, however, the worker's contact extended over a longer period of time due to the patient's need for her continued help. After a longer period of help they showed less improvement than the patients of the previous group. This would seem to be due primarily to a greater degree of somatization on the part of the patient. This is indicated by a long history of illness, five years or more in all cases except one, and by the patient's

own interpretation of his illness and strong denial of problems in the emotional area.

The value of an early referral of patients with vague inorganic complaints to the medical social worker is clearly demonstrated in these cases. It may be seen that it is possible and practical for the medical doctor to make the referral for a social evaluation before the decision is made to refer the patient to psychiatry. Once this decision is made, a referral to the medical social worker may mean the difference between the patient's acceptance or rejection of psychiatric treatment.

CHAPTER V

Patients Whose Emotional Needs Were Well Somatized Over A Long Period of Time and Who Rejected Psychiatric Treatment

This is the chapter that deals with the group of five patients who showed no apparent improvement and completely rejected psychiatric treatment. The material will be analysed in relation to this lack of improvement and all factors which seem to have contributed to their rejection of psychiatric help will be analysed in terms of the referral made to the medical social worker, the patient, his history and his particular problem; and the eventual outcome.

Two of the cases were referred to social service before being referred to psychiatry, two a few days after, and one on the same day. In two cases, the referral was made by the doctor in the medical clinic, in two others, by the psychiatrist in the medical clinic, and, in the fifth case, by a community family agency.

Two patients were referred to the psychiatrist by the doctor in the medical clinic, one by the medical doctor in conjunction with the medical social worker, a fourth by another hospital and the fifth by the medical doctor, when it was already recommended by a family agency.

The group is composed of four women and one man. One woman is a widow and the other patients are single. The age range of the group is from 22-47 years. The occupations represented are those of domestic, waitress, and steamfitter.

The first case in this group is that of a woman who had managed to make some kind of an adjustment to life and had been reasonably well, physically, until the death of her husband some years ago. With this sudden loss of security and status, and the responsibility of looking after herself, and her son thrust upon her, the patient began to feel alone and unwanted and developed physical symptoms which enabled her to receive care from other people.

Mrs. N. was a 47-year old widow with a 12-year old boy. Her diagnoses were cervical polyp, hemorrhoids, dermatitis and retroflexion of the uterus, as well as schizophrenia with reactive and involutional depression. She came to the clinic in September, 1948, with the complaints that something was eating at her heart, that there was a rash all over her body, that there had been a lump on her left leg for six months, and that she suffered from attacks of dizziness. Since her husband's death, eighteen months previous to this, she had reacted to any exertion or emotional upset by becoming excited and then her heart bothered her in some vague way. In May, 1949, she came again with many vague complaints.

Mrs. N. was nervous and excited and became easily flustered when tired. She frequently felt like crying at the end of a hard day and often wanted to get away by herself. At the time of her second clinic visit she did not seem capable of concentrating and she was very depressed. She had difficulties with interpersonal relationships.

Mrs. N's father died when she was nine years old and she does not have any close contact with her mother who is now 73. She is one of seven children, of two families, her mother having remarried when she was fifteen. Mrs. N. lived in a convent from the age of nine to fifteen and reports this as having been enjoyable. She lived with an older sister for three months and attempted nursing in a sanatorium, but gave it up. She had an irregular work history and lost touch with her family. She lived an irregular, nomadic existence until she met and married her husband eighteen years ago. She was fairly happy with this man who claimed at different times to be a doctor, dentist, lawyer, and salesman. He let her do what she wanted and from her description appears to have been a pleasant and passive person, but he drank to excess. She had been unhappy and irritable since his death and although she did not speak of him affectionately, his loss meant a void in her life and caused her to lose her security and social position. Since his death she has become more and more preoccupied with bodily functions and has cut herself off from social contacts.

Mrs. N's present position as waitress, involved standing a good deal, long hours, living in a small basement room and walking about a block to the hospital dining room for meals. She felt her legs were not good enough to walk over and consequently tried to buy food on her limited budget to have in her room. Her young son was in a boarding school and she was responsible for his laundry, which was an additional burden.

The psychiatrist's impression was that Mrs. N. felt alone and unwanted and used her somatic symptoms as a method of being cared for and satisfying her feelings of dependence as well as a means of avoiding the responsibilities which confronted her.

Mrs. N. herself found her living conditions and her work situation very upsetting and depressing. She was upset and preoccupied with her bowels and stomach and was determined that the doctor should cure her. She believed the "poison" from the poison ivy infection the previous summer was in her blood and considered every disease she had came from the "poison in her blood". She associated her physical troubles with her environmental situation. She felt more and more that the future had nothing in store for her and that she was alone and unwanted. She said "if she found a good man like her husband to marry, she would probably be all right". She was very depressed and had little motivation to help herself.

The medical social worker's plan at the time of the referral was to help the patient with her work and living conditions. The worker visited her at work and in her room, discussing her difficulties with her. The medical social worker discussed with the personnel manager the possibility of changing Mrs. N's work, but due to her personality and history it was felt to be impossible.

After several consultations with the doctor in the medical clinic it was decided, jointly, that Mrs. N. should be referred to psychiatry and the doctor, therefore, recommended this. After talking with her several times, however, the medical social worker felt that Mrs. N. was a very emotionally disturbed person who was unable to make constructive use of casework help at that time.

Following this, Mrs. N. was referred to the gynaecological service and was admitted to the ward for an operation. It was the medical social worker at the women's pavillion who saw her through a referral to psychiatry. Mrs. N. at this time was "very vague", preoccupied with her bowels, and anti-social and depressed. She felt that "life was not worth living" and she was very dependent and indecisive. There was no question of her accepting a referral to psychiatry, since the psychiatrist visited her on the ward. There was no evidence that Mrs. N. received much preparation for this.

The medical social worker at the women's pavillion arranged convalescent care for Mrs. N. following her operation and from there

she was admitted to the Allan Memorial Institute. She was very unco-operative at the Allan Memorial Institute and stated that she hated it there. She had become even more preoccupied with bowel function and no laxative or enema, no matter how effective, was ever satisfactory to her. This became an excuse for everything she did not like and did not want to do.

Mrs. N. showed her resistance to treatment in many ways. She went out of doors and off the grounds without permission and refused to tell the nurse when she left the building. She adopted a very independent manner. Due to the development of paranoid ideas, electroshock therapy had to be discontinued. Mrs. N. finally left the hospital without permission and failed to return. Her condition remained unchanged, and she considered the Allan Memorial Institute a place for the "insane".

Mrs. N. came to the clinic with many vague complaints but there was at the same time a specific physical diagnosis for which surgery was indicated. She also showed a number of nervous symptoms and had difficulty with interpersonal relationships. These symptoms she, herself, related to environmental factors and emotional upset.

It is significant that Mrs. N's history of illness went back to the death of her husband and that she considered herself to have been reasonably well the rest of her life.

Mrs. N. appears to have had little family life following her father's death and no very strong relationship with her mother who remarried when Mrs. N. was fifteen. Her life until she married seems to have been an unstable one, and from the information available, may have continued that way to some extent. She lost touch with her family and with the death of her husband she was left alone with the responsibility of a son whom she had placed in a boarding school.

Mrs. N's present situation offered her no security, but only upset and depressed her. She was resentful and reacted by withdrawing more and more and becoming preoccupied with bodily functions. She

related her physical symptoms directly to her unhappy situation but she did not appear to have any real insight into this relationship and had little motivation to improve her situation or to use help toward this end.

The worker's role in this case consisted of an attempt to improve the patient's environmental situation and, through discussion of her problems and interpretation, to bring her to the point where she could make constructive use of psychiatric help. The patient's personality, however, prevented any immediate change in her environment, and, due to her emotional disturbance, she was unable to use casework help.

Although Mrs. N. had not accepted psychiatric help, it was felt she needed this and she was seen on the ward by a psychiatrist and later admitted to the Allan Memorial Institute. She continually resisted treatment at the Allan Memorial Institute until she finally left of her own accord.

There was evidence of good teamwork at the beginning of this case since it was through mutual planning between the doctor and social worker in the medical clinic that the patient was referred to psychiatry. There is no evidence of further teamwork following the actual referral. The case was closed in the medical clinic with the medical social worker there and the worker at the women's pavillion did not follow the patient after her admission to the Allan Memorial Institute. There was no evidence that the case was active with the social service at the Allan Memorial Institute.

In this case the patient's problems were somatized to such an extent, and her symptoms meant so much to her, that for the length of time she was attending medical clinic she was unable to use casework help towards accepting treatment. She had, in addition, a physical condition which required surgery and this hospitalization only served to help her become more focussed upon her physical ills. At this point, with quite unsuccessful preparation, psychiatric treatment was initiated and, although it was continued over a period of time, was ineffectual and never accepted by the patient.

The second case in this group is an example of a patient whose extreme neurotic needs have been somatized over a very long period of time. She had been coming to the clinic, repeatedly, most of her life, seeking physical care and rejecting help with any emotional problem.

Although there was co-operation with agencies outside the hospital in order to help the patient, the case illustrates also the lack of a community resource suitable for the care of such a person.

> Miss O. was a 58-year old single woman. Her case was diagnosed numerous times, one of the more recent diagnoses being hypertension and psychoneurosis and then psychosis with paranoid trends.
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> She came to the clinic over a very long period of time presenting a great variety of ailments and many vague symptoms. Among her many complaints were the following: dyspnea and an ache over her heart, indigestion, feelings of being hot and cold at the same time, fainting feelings, corns, athletes foot, injury to her left knee, carious teeth, multiple calouses, "feelings of weakness and pains in stomach", muscular ache, headaches, urgency of urination and aching in the rectum, hot flushes, cramps, palpitations, and a lump in the epigastrium. She complained also of becoming emotionally upset and then having some of these symptoms. Miss O. was of dull, normal intelligence and showed evidence of psychopathic behaviour.
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> In contrast to the previous case, Miss O. had a long medical history. She was known first to the gynaecology clinic in 1920, when

she had a profuse discharge and laceration of the cervix and a diagnosis of lues. She continued under treatment until 1932 and then, in 1934, her condition was again considered infectious. In 1938, she was admitted for a time as a case of endocrine dystrophy and, in 1939, for metarrhagia. In 1940, patient suffered from puritis. At this time there did not seem to be sufficient basis for her many symptoms and she was felt to be in need of psychiatric help. This referral was consequently made.

Miss O. was known to the medical clinic as well, since 1926, when she came with tonsillitis and then pain in her leg. For the next two or three years she frequently came in to the clinic or called in to say that she was ill, and once that she was going to die. For a few months in 1929, she was admitted to an institution for mentally retarded children since it was discovered she had a mental age of eleven, but this did not last long. From 1929-1949, she continued to make irregular calls and requests for treatment.

In 1940, she was referred to the psychiatric clinic when she was considered to be a "psychopathic type" with poor mental equipment and a long history of poor adaptation. Her prognosis was poor for ever making her own way in life. The following year she was seen again in the psychiatric clinic and her complaints were much the same. She kept returning, however, to see the medical doctor. In 1942, the doctor considered the case a psychiatric one and did not think Miss O. could be helped in the medical clinic. Two months later, the medical doctor warned her that unless she behaved, efforts would be made to send her to the mental hospital. She continued to return to the medical clinic, however, and begged to be readmitted to hospital. In 1946, she was referred again by the medical clinic to the psychiatric clinic and an appointment made, but there was no evidence that she went. In 1947, on one occasion she was given some medicine by the medical doctor, but told that this would not solve her social problems.

Miss O. was born in Scotland, in 1892. Her mother died of cancer six years later, and the following year her father remarried. The family came to Canada in 1904. Miss O's sister reported that, as a child, Miss O. was always willful and bad tempered, crying to have her own way. She went to school until she was fourteen but would or could not learn. One report said that her stepmother was cruel to her and another that she was kind, but tried to control her. Her father indulged her to keep her quiet. Miss O. would never do any housework or schoolwork. Soon after their arrival in Canada, she became so unmanageable that her stepmother said she could no longer have her in the house. Miss O. was 14 at that time and had been on the streets ever since.

When Miss O's sister married she gave her a home and found her a job, but Miss O. would not work and was so quarrelsome and obscene in the house that her sister finally had to ask her to leave. Miss O.

had three illegitimate children from 1913 to 1916, one born in jail while she was serving a six months term. Miss O. lived for a while at a sheltering home and efforts were made to "reclaim her". She was placed as a maid with families who were kind to her, but she would not work, saying the work was too hard. In 1916, she was arrested for vagrancy and sentenced to six months hard labour in the women's jail. She gave birth to another child in 1918. She lived with the father of this child for two years. Twice that year she was jailed for vagrancy.

Miss O. first became known to the social service department at the Royal Victoria Hospital in 1919 when she was referred to the hospital for a blood test. There was always difficulty with her in regard to her keeping a room and finding and keeping a job. She continually complained that she was too sick to work. She lived a hand to mouth existence, sleeping first in one place and then another. She was followed from 1925-1930 and then again from 1937-1948. The medical social workers over this period of time explained that there was nothing the hospital could do for her and kept referring her elsewhere, but Miss O. insisted that she was ill and needed treatment and always returned again to the clinic. The case was carried during this period by a family agency for casework and financial assistance.

In January of 1949, the case was again brought to the attention of the Royal Victoria Hospital social service department by the family agency, who interpreted Miss O's behaviour and asked for a psychiatric consultation in regard to the advisability of commitment. Miss O. was still presenting a pattern of moving from one room to another, becoming upset and gaining sympathy and then becoming critical and demanding. She was still being supported financially, and because of her personality and many inadequacies in handling her affairs, she was given an extra allowance. She frequently requested admission to the convalescent hospital.

Miss O's attitude throughout was that she was physically ill, felt miserable, was too sick to work and needed hospital care. She had paranoid ideas as well. She believed people were not doing what they should for her, including the doctors, and that her landladies were too hard on her. When she came to the clinic in January 1949, she readily accepted an appointment with the psychiatrist in the medical clinic, probably because she wanted attention and care of any sort and not because she understood the meaning of psychiatric treatment. She told the psychiatrist that she was coming to the clinic to get a note to take to "the welfare" so that she might receive convalescent care. When the psychiatrist told her he could not do this for her, she became sullen and left the clinic. The psychiatrist wanted her to go to the psychiatric clinic for evaluation there and Miss O. hotly refused to go.

The medical social worker at this time attempted to explain to Miss O. that convalescent care was not indicated and, therefore, could not be arranged. Miss O. did not accept this at all and was very dissatisfied that no plans were made for her. She became hostile and used extremely abusive language.

In June, 1949, she was referred by the medical doctor to social service for summer convalescent care and this was arranged. In May, 1950, she was again referred back to the psychiatrist by the doctor in the medical clinic. She was much distressed by this and did not go.

Miss O. returned to the medical clinic again in July, 1950, seeking the attention of the social worker and wanting care. The worker arranged for her to see the psychiatrist and, at this time, due to her personality, she was not considered treatable or committable. She was termed a "well of psychopathology" and left to the social service department. The medical social worker considered that planning for this patient should be met by a community agency and since a family agency was already active, the medical worker remained in the case only as liaison between clinic and community. This particular patient required a protective environment, but since there was no such resource for her in the city, it was felt that she would have to continue the way she was.

This case is an extreme example of the number and variety of physical symptoms and ailments that may be found in this type of patient. The symptoms were both vague and specific and there were many small ailments which many people would not consider worthwhile bringing to the doctor's attention. Miss O. became emotionally upset and showed abnormal behaviour which was considered by the psychiatrist to be psychopathic.

Miss O. had a long history of physical ailments and anti-social behaviour dating back to her youth. Her personal history shows an early maladjustment. Her mother died when she was only six and she was never able to get along with her stepmother, who eventually rejected her to the extent of turning her out. Whatever the causative factors may be, it is obvious that her personal problems had their origin in her

early environment and everything from then on served to aggravate the problems, with Miss O. feeling more rejected than ever.

By the time of this study Miss O. had had a very long clinic attendance and had been treated in various ways and for various things, and had been hospitalized several times. All of this seemed to fix in her mind that there was a good deal physically wrong with her. She had been referred to psychiatry several times but had failed to continue with it and always returned again to the medical clinic, with another ailment. Since her problems were considered to be social and emotional, the result was that she was continually being referred to psychiatry and social service and through social service to community agencies, but she herself, kept returning to medical clinic.

Miss O. regarded these referrals to psychiatry as a method of disposing of her and a denial of the fact that she was ill. She had an extreme need to be cared for which had never been satisfied and she believed that no one would look after her.

The medical social worker's role in this case was primarily one of liaison between clinic and community. Shelter and other services were provided by a number of agencies and casework and financial help by the family agency. The medical social worker made an attempt to discuss with Miss O. the nature of her illness and interpret psychiatric help, but she refused to listen. Medical social workers saw her over a long period of time and did make many arrangements for her care, but none of these lasted very long and she invariably returned for further help of this nature.

There was evidence of considerable consultation between doctors

and medical social workers. Both medical doctors and psychiatrist usually considered this case primarily a social problem and it would be referred back to the medical social worker to handle. Although consultation was frequent, partly because the patient kept returning to medical clinic, there was little evidence of continued teamwork, probably because neither the doctors nor the psychiatrist felt they could help her.

This patient was convinced that she was physically ill. She had little insight into her own emotional needs and much less understanding of the relationship between her symptoms and her unhappy situation. Her neurosis was well somatized and her pattern of behaviour and physical symptoms had existed for such a long period of time that there was little hope of change. She became hostile when an attempt was made to discuss any treatment other than physical care as a way of helping her. It was finally decided that due to her personality, she could not be helped by psychiatric treatment.

Similarly, she could not use casework help. In this case, the kind of help that was needed, namely, a protected environment, was not available. Due to lack of resources as well as the patient's well established personality pattern, little could be done at this stage to help her. Miss O. would continue to lead the same kind of life she had always led and continue to take up the time of the social service department and the doctors in the medical clinic at the Royal Victoria Hospital until her illness progressed to the point where she was commitable, or in need of hospitalization.

The third case in this group is that of a patient who had a history of going from doctor to doctor for the previous nine years.

Mr. P. was a 42-year old single man whose diagnosis was psychoneurosis with schizoid tendencies. He showed symptoms of loss of appetite for nine years, epigastric pain "like a ball", loss of weight, loss of energy, weakness and always trouble with constipation. He complained of nervousness and anxiety attacks as well.

Mr. P. has a history of going from one doctor to another. He had been to twelve different doctors since 1940 and had received various kinds of medication. In 1940, he complained of having an "anxiety attack" when he was afraid he was going to die. A year later, he had another such attack when he vomited on the street. He had received electroshock treatment in 1947 at a mental hospital.

Little is known of Mr. P's early history. Since 1940, he had a very unstable employment record. He worked as a pipe fitter in a number of places in Montreal. He had moved around a great deal, living in Newfoundland, Nova Scotia, New Brunswick, Quebec City, and Northern Quebec at different times. He did not work from January, 1948, - April, 1948, but received assistance from a social welfare agency. He was sent to a convalescent home from April to September, 1948, and was then transferred to another convalescent home where he stayed only three weeks because he did not like it. He took work as a plumber in the city instead.

Mr. P. gave a history of excessive masturbation from 1929-1939, and following this excessive sexual relations for two years with a woman living at the same boarding house where he lived from 1940-1942. Since then he had been impotent.

He was boarding in a room until the onset of his illness in February, 1949, but after that he was not able to work and had to give up his room. He stated that he was all alone in Montreal and had to be independent because his brothers and sisters had large families, and other responsibilities.

Mr. P. had a number of explanations for his symptoms. He believed the excessive masturbation might have something to do with his weakness. He related his symptoms to his sexual relations as well, saying that following this he had marked fatigue and felt "very bad and could not eat for three days". Mr. P. had lived with a man at one time who had TB and he believed the man had spit in his mouth when he was asleep. He thought this too might be a reason for his present condition. Mr. P. mentioned also that he had once fallen three stories.

He complained that he had always been rejected by many people. His father had put him out of the house and other people had always treated him in the same way. Mr. P. was influenced also by the fact that one doctor had told him that his "hard nerves were too weak" and he now felt that his nerves were very bad. Another doctor had mentioned that he needed hospitalization and Mr. P. had clung to

this idea and was fighting strongly for it. He felt he was very deserving of medical treatment.

It was the aim of the medical social worker to interpret community resources to this man and to encourage him to work.

The medical doctor assured Mr. P. that there was nothing physically wrong with him, denied him hospitalization, and urged him to go back to work. Mr. P. questioned everything the doctors did and kept thinking they should do more.

Mr. P. readily accepted his first appointment with the psychiatrist on the medical service, liking any medical attention that was offered. He had no understanding of psychiatry, however, and it became clear that he could not use this kind of help. The psychiatrist saw him several times and tried to work gradually toward helping him feel that he would soon be able to work again. It was finally decided that Mr. P. was not a candidate for psychotherapy in view of his total personality. Any contact with medical establishments, even with the psychiatrist, encouraged his idea that he was physically ill, since he could not differentiate between the role of the psychiatrist and that of a medical doctor. He was considered "harmlessly mad" and commitment was not indicated.

The psychiatrist referred Mr. P. to the medical social worker for environmental assistance when he first saw him. The medical worker referred him to a family agency for financial assistance, but when the kind of help Mr. P. wanted was not immediately forthcoming he became very angry and upset. He was very "choosey" and felt he should only take help on his terms. He became quite hostile and sarcastic with the worker and threatened that she would be the cause of his suicide if better help were not obtained for him. Mr. P. was seen several times and an effort was made to interpret community resources. The worker heard his complaints about the doctors as well, but Mr. P. would not listen to any interpretation in this area since no one would say he was physically ill. He refused the help that was offered and finally discontinued clinic attendance.

This patient presented vague pains and complaints which were related to the digestive function and centered in the epigastrium. He complained of nervous symptoms, as well, which he described as "anxiety attacks". He had a ten-year history of these symptoms, definitely related to experiences which were upsetting to him, and a history also of going from one doctor to another with his complaints.

From what is known of the patient's personal history it seems to

have been unstable, Mr. P. having lived and worked in numerous different places and having been unemployed and receiving assistance for a while. His present life was not a happy one. He was alone and financially insecure and forced against his wishes to be independent.

Mr. P's attitude seemed to be that everyone had been very hard on him and that his unfortunate situation and his illness had not been his own fault. He felt, therefore, that he was very deserving of help and medical care, and he interpreted the denial that he was physically ill as further rejection and refusal of help, and became extremely abusive. He seemed to have some guilty feeling about his sexual activities and quite readily related his illness to this, too.

The worker's contact with the patient was of short duration and consisted mainly of interpreting community resources. There is little evidence of any attempt to interpret emotional illness, but there was almost no opportunity to do so since Mr. P. was so focussed on physical illness and so intent on receiving medical care and material assistance. Perhaps the most the worker did was to provide the patient with an opportunity to ventilate his feelings.

There seems to have been a great emphasis from the beginning on Mr. P's ability to work and pressure from everyone to get him to return. Mr. P. obviously resented this strongly. The question might be raised as to whether more could have been done for him if this had not been introduced until a later date when the psychiatrist felt that he might actually be ready to accept it.

There is little evidence of teamwork between the medical doctor and the social worker, but more between the social worker and the psy-

chiatrist. The psychiatrist made the referral to social service and there was consultation throughout with the common aim of helping the patient to go back to work. The medical doctor co-operated in this plan by refusing medical care when Mr. P. returned to him.

The case is an example of a long-standing use of illness which enabled the patient to receive material help and maintain a dependent state. Again the pattern was so well established that at this stage it seemed to be impossible to help him gain any understanding of the emotional factors in his illness or to see how another kind of treatment might help him. Had such help been given to him at the beginning of this illness pattern he might have been treated successfully, but as it was, he would probably continue in his pattern of going from doctor to doctor and seeking care on the basis of illness.

The fourth case in the group is that of a young woman who had been subjected to extreme emotional stress since her childhood and who, previous to her referral to the clinic, had been going through a period of readjustment to a new country and a new way of life and was quite alone.

> Miss Q. was a 29-year old single woman whose diagnosis was anxiety state and hysteria. She came to the clinic presenting complaints of heartburn, pain and feeling of fullness in the epigastrium, a mild temperature, coughs, chills, pain in the chest and back, night perspiration, weight loss, spells of dizziness and frequent fainting, insomnia and a yellow pigmentation on the face. She was anxious, markedly inhibited and showed paranoid trends. She was preoccupied with her present difficulties and apprehensive about discussing details of her past. The psychiatrist concluded, upon reviewing her reaction pattern under stress, that there was evidence of somatic symptom response for four years. She had a history of gastro-intestinal symptoms first in Germany and then in Canada.
>
> Miss Q. was born in the Russian Ukraine in a middle class family. She lived in a large town and attended university for two years,

studying literature and languages and became a teacher. Until the age of ten she lived in constant fear because her father was persecuted for political reasons. Her only satisfaction in life was derived from her success studying and working as a teacher. Her father was an orthodox priest who was killed by the Russians. Her mother was transported to Germany. In 1942, Miss Q. herself was taken to a concentration camp in Germany. In 1945, they were liberated by the U. S. troops and, at this time, she worked as a waitress in an officer's mess and then came to Canada in 1948. Her two older brothers and her fiance were killed in the war.

Miss Q. was employed in a hospital in Montreal since her arrival in Canada, where she stayed on after her year of service because she liked it. At the time of her referral to the clinic she was unable to work and she had been told that she would have to leave the hospital, where she lived in, if she did not work. She had no money and no place to go and was greatly worried. She said she felt humiliated by her inferior social status in Canada and she felt a punitive attitude on the part of her employers.

Miss Q. believed that all her symptoms were caused by "grippe" from which she had suffered several months earlier. She was working as a maid and the person in authority over her did not allow her to remain in bed longer than four days. Later, Miss Q. blamed the head nurse at the hospital for her sickness. She expressed great hostility toward the head nurse and the housekeeper when talking to the medical social worker. Miss Q. denied that she was nervous and she was very suspicious of everything.

The medical social worker's plan was first to meet the patient's physical needs of rest and food and financial support; secondly, to help her relate to the family worker where she received financial support, and, thirdly, to interpret and help her use psychiatric treatment.

Miss Q. was referred directly to the psychiatrist from outside the hospital. The psychiatrist referred her several times, however, to the medical clinic in order to reassure her that there were no physical findings. Miss Q. claimed the medical examination was inadequate and that they would pay more attention to her if she had money. The psychiatrist even recommended admission to the medical ward for rest and care to help convince her that she had no physical ailment and to make her more accessible to psychotherapy. These attempts seemed to be in vain. Miss Q. insisted that she had a physical disease and that she was not "nervous".

The psychiatrist suggested admission to the day ward at the Allan Memorial Institute for diagnosis and treatment. The patient had a great deal of unexpressed hostility at this time and refused to go to the Allan Memorial Institute. She denied that she was nervous. With a great deal of persuasion from both the psychiatrist and the

medical social worker she finally did go for one day and did nothing but sit. She later told the psychiatrist on the medical service that she had refused to go to the Allan Memorial Institute because she was afraid she would become crazy there. This idea was directly related to her hostility toward the supervisor of the hospital where she had worked, who had been sending her verbally in an ironical manner to the Allan Memorial Institute for the past year. This person kept accusing Miss Q. of being "nervous". Miss Q. accepted the psychiatrist on the medical service more as a medical doctor and it was felt that she never really accepted psychiatry, as such, nor did she accept her need for it, but kept insisting that she had a "grippe-cold".

The social worker spent a considerable amount of time in an attempt to interpret emotional illness to Miss Q., and to interpret the way in which the psychiatrist was trying to help her. It was the worker's opinion that the referral to the Allan Memorial Institute had been made too quickly. Miss Q. was very difficult to work with. She said little and talked to the worker in broken sentences. She insisted throughout that it was not her "head", it was a "grippe-cold" and her stomach that bothered her.

Miss Q. continued to see the psychiatrist on the medical clinic a number of times, once having to be recalled by the medical social worker. For a while she seemed to be improved, but then later she was not well and still had many somatic symptoms. The psychiatrist finally considered her not amenable to treatment and it was then that she was admitted to the medical ward for a rest, and in the hope that she would become more accessible to psychiatric treatment. After this hospitalization, however, she did not return to the psychiatrist again. She did not return to see the social worker either, nor did she leave any message. It was discovered later that Miss Q. had returned to live with people of her own nationality and was attending a Polish doctor at another hospital.

This patient had numerous vague somatic symptoms with nervous symptoms as well. Her history showed evidence of somatic symptom response for the past four years and it seemed to be directly related to environmental stress.

Her personal history was one of insecurity and extreme loss of love. She was left, finally, without mother, father, brothers, or fiance, and came to a strange country by herself.

Following this, she had a difficult adjustment to make in Canada

where she felt humiliated by a social status inferior to that to which she had been used. When she did become ill with grippe, she seemed to succumb to a need for care and attention and could not seem to rise again to the demands of her job. She was not allowed to be away from work for more than four days, however, and she has never considered herself well since then. By the time she came to the clinic she was filled with hostility toward the supervisor at the hospital who would not allow her the rest and care she wanted and probably needed, at least from an emotional point of view.

Miss Q. herself explained her symptoms on a purely physical level. She believed that the "grippe-cold" she had had was the cause of all, and she deeply resented any inference that she was nervous. In this case we see the influence that other people may have by teasing or accusing the patient of being crazy. In her mind Miss Q. identified treatment at the Allan Memorial Institute with being crazy and definitely refused to go. Her need for physical care was so strong at that time that she could only understand her symptoms on a physical level.

The social worker's role was threefold. It was felt to be important that Miss Q's physical needs be met first. The worker arranged for Miss Q. to stay at a boarding institution and provided for a special diet for her. She was also referred to the family agency for financial support. These efforts, however, were not very successful. Miss Q. found it very difficult to accept assistance. She did not like the food in the institution and she did not relate well to the family worker.

Secondly, the medical social worker, realizing Miss Q's need for a long-term supportive relationship with someone, tried to help her relate

to the family worker, but, as already stated, this was not successful.

Thirdly, the worker gave Miss Q. a supportive relationship in the medical setting and attempted an interpretation of emotional illness. She saw Miss Q. on almost every clinic visit, giving her reassurance and interpretation and trying to meet her requests at her own level.

Teamwork between the medical social worker and the psychiatrist was very good and there was co-operation with the medical doctor when it was felt medical reassurance was important. There was frequent and continued consultation between psychiatrist and social worker from the beginning of the case and a common goal was established. It was felt by the psychiatrist that the main emphasis in treatment should be on the social worker's support and reassurance and her efforts to remove environmental pressures. At the same time the medical social worker interpreted to the patient the way in which the psychiatrist was trying to help her and then shared with the psychiatrist the patient's feelings and attitudes about this.

Miss Q's deep seated needs proved to be too strong to be met in a short time. She had had somatic symptom response to stress before and this time she seemed to have regressed to the point where she could not give up her symptoms which expressed her need for care and love, no matter how much help was offered. She finally discontinued clinic attendance and sought the emotional satisfaction she needed by returning to people of her own nationality.

The last case in this group is one in which a specific upsetting experience precipitated the physical expression of many of the patient's

problems and served to create several more.

Miss R. was an unmarried mother of 22 years of age, whose diagnosis was anxiety neurosis. She came to the clinic complaining that she had had difficulty breathing for the previous eight months and found her heart beating quickly for no known reason. She had difficulty climbing stairs, and she had a pain in her heart which was relieved by having her mother rub her chest. She complained of a dry cough, frequent dizzy spells and headaches and excessive perspiration.

Miss R. said she worried a great deal and became very nervous when she could not breath, and became "mad for nothing". She had frequent feelings of tension and it seemed to the psychiatrist that she had passive aggressive conflicts with a great deal of hostility toward members of her family.

Miss R. stated that she had always been nervous and used to be troubled with nightmares.

Miss R. was born and brought up in the city. She went to the seventh grade in school and stopped at the age of 13 to work. She has had seven or eight jobs as a waitress and left these for various reasons pertaining to working hours and salary. A year before her clinic visit, she gave birth to a baby boy at a hospital for unmarried mothers. Her pregnancy was the result of a drinking party and the child's father was a boy friend she had known for six months. He gave her no help with the child and she had now no desire to see him again. She had to work to cover the cost of the child's board at the hospital, where he stayed for seven months until she brought him home to her family.

Miss R. had two unmarried sisters and a brother at home. She herself was unemployed at the time of her clinic visit. Her father appeared to be a rather uncommunicative person, but he had grown very fond of the baby and did not want to see him go. Her mother seemed to be protective of the child also, but her sisters felt that the child was a disgrace in the family and this was the centre of much family argument.

Miss R. said she thought her health was affected by getting up to work the second day after the child was born. She thought this was too early and she developed symptoms after she returned home. Now she felt obliged to help her mother and live at home with the child. She was "fed up" and resented being dependent financially. However, the idea of going to work or seeking a new environment was very threatening to her.

It was the plan of the medical social worker to reassure Miss R. that she was well enough to work and to help her to return to work in a happier environment. She planned as well to help her decide

about living arrangements and care for the baby.

The medical doctor saw Miss R. first and then referred the case to the medical social worker to help her return to work in a happier environment. It was the joint decision of the doctor and social worker to refer Miss R. to the psychiatrist. The medical doctor's aim was to reassure the patient about her health and the psychiatrist's plan was to give her some understanding of the relation between physical symptoms and emotions. Miss R., however, had little insight into what the doctors were trying to do.

The medical social worker felt Miss R. had a need for a long-term plan with a caseworker. She felt that her role as a non-judgemental person of Miss R's own generation helped her to cope with the situation at home. The worker had regular interviews with Miss R., helping her to decide what she wanted to do about employment, care of the child and about the home situation. She became more determined to keep the child, but she was ready to take a holiday from him before recommencing to work. With both the medical doctor's and the medical social worker's help, Miss R. felt she had gained a little strength and reassurance about her health.

Miss R. accepted the first appointment with the psychiatrist, but did not return to the clinic to keep the second one. She did not develop any understanding of the relationship between her feelings and her physical symptoms, and did not understand what the medical doctors and the psychiatrist were trying to do. After failing to keep her second appointment with the psychiatrist, she did not return again to the clinic and discontinued interviews with the social worker as well.

Miss R. came to the clinic presenting numerous vague symptoms, most of which centered around her heart. She complained of nervous symptoms as well and a feeling of tension. She said she had always been nervous, but the physical symptoms seemed to be of comparatively recent origin, beginning soon after the birth of her baby.

There are factors in Miss R's personal history which may have contributed to, or have been, the result of insecurity. To begin with, she went to work early and her employment history was unstable. The circumstances around the birth of her illegitimate child indicate that this was an upsetting experience. Following his birth she suffered rejection from

all sides, from her own family and from her boy friend who would not help her but left her alone. She was forced to work in payment for the child's board at the hospital. It was quite a while before her family accepted the child in the home and there were still unhappy family relationships as a result of it.

Miss R. herself related her physical symptoms to the hardship she endured at the time of the child's birth. At the present time she was ambivalent about leaving home since her desire to be independent of her family conflicted with her dependency needs. She was very resentful of her present situation. Her mother's influence was an important factor in this connection as well, since she kept telling Miss R. that she was not well enough to work.

The medical social worker's role in this case was three-fold. She gave the patient support and reassurance in regard to her health and, as a result of the combined efforts of the medical social worker and the medical doctor in this regard, Miss R. did feel that she had gained a little strength. Secondly, the worker endeavoured to help the patient cope with her environment. While the worker's efforts did help to clarify what Miss R. herself really wanted to do, and perhaps started her toward a small measure of independence, this was not what Miss R. wanted primarily from the hospital, and she remained focussed on her physical symptoms. Thirdly, the worker was able to give the patient a relationship with a non-judgemental person and it was the worker's opinion that through this relationship she was able to help her handle her own feelings in such a way that it was easier for her to cope with the situation at home. The worker did not attempt much interpretation of emotional

illness and psychiatry, but concentrated for the period of time she saw Miss R., on her feelings in relation to her environment. It was the psychiatrist's plan to do this following the reassurance given by the medical doctor and the social worker in regard to Miss R's physical health. Perhaps more of this interpretation could have been given to advantage by the medical social worker if Miss R. had been ready to accept it, and in view of the fact that she did not seem ready to accept it, perhaps the psychiatric interview came too early.

Teamwork in this case seems to have been good, both between the medical social worker and the medical doctor, and between the medical social worker and the psychiatrist. The medical doctor referred the case early to the social worker, information about the patient was shared between them and a mutual aim arrived at. There were several consultations both with the medical doctor and the psychiatrist and a joint referral was made to the psychiatric service.

In this case, the patient discontinued all clinic attendance following her first psychiatric interview, not understanding what the doctors were doing, and not feeling satisfied that they were treating her physical symptoms. Although those physical symptoms were not of very long standing due to her present situation the patient needed them very badly and until some change was made toward her individual independence, it would be difficult for her to understand their relationship to her feelings at that time. It is possible that with social service support in the interim, a psychiatric referral at a later date might be more successful.

In this group of five patients who showed no apparent improvement, none were referred specifically for evaluation and help with a possible referral to psychiatry. Two cases resulted in this, but were originally referred by the doctor for environmental help. One other case was already known to the medical social worker since it had been referred by a family agency. After consultation with the medical doctor, and upon the suggestion of the worker, this patient was referred to psychiatry. The other two patients were referred directly to psychiatry by the medical doctor and then to social service by the psychiatrist. In all cases but one, there was evidence of good teamwork between the psychiatrist and the medical social worker and, in all but two, between the medical doctor and the medical social worker.

In the two cases in this group referred directly to psychiatry, there was no preparation given by the medical social worker before the patient actually saw the psychiatrist. In a third, the patient was admitted to the women's pavillion and although the decision to refer the patient to psychiatry was a joint one between the worker and the doctor, there was little preparation for the first psychiatric interview since the patient was interviewed on the ward. The interpretation already given in the clinic had been unsuccessful. In another case, it was impossible to give much interpretation, although the worker tried, since the patient refused to accept it. In the fifth case, it was the plan for the worker to give support and help with the patient's environment and the psychiatrist was to give the interpretation of the relationship between emotions and physical symptoms. It would seem from this illustration that additional interpretation should come from the medical

social worker, with whom the patient already has a relationship, and who may be able as well to help the patient relate to the psychiatrist.

For a number of reasons then none of these patients received an adequate preparation for psychiatric treatment. In four cases, an attempt was at least made by the worker at some time throughout the case to interpret emotional illness and psychiatry. These attempts were quite unsuccessful.

Only in the case of Miss R. could the worker's role be described as supportive. In this case the worker offered the patient the relationship she needed to have with someone, and she attempted to help her with her environmental situation. The worker was partially successful in this, and the patient did gain some reassurance in regard to her health. Real interpretation was lacking, however, and the patient was never able to accept the idea of psychiatric help. In two other cases, liaison work with outside agencies was attempted with unsuccessful results. Environmental help, was also unsuccessful in all cases except that of Miss R. In this group there was no interpretive work done with the family.

Although it is true for this group that timing of the referral to psychiatry and preparation for it by the medical social worker were not always good, the attempts made by the worker and the rest of the medical team would seem to justify better results than were actually obtained. It seems as though there must be some reason for these patients' difficulty in accepting the help and interpretation that was offered.

One notes that the patients' symptoms meant such a great deal to them that it was difficult for them to give them up. In most cases illness justified their need for care and attention, although they were not

necessarily conscious of this. It seems also that there was a greater degree of somatization in the patients of this group than in those of the previous group and that, on the whole, the illness pattern is one of much longer standing. It was obvious that the pattern was so well fixed in some cases that little could be done about it at this stage. The case of Mrs. N. shows clearly that when the transfer was made to the psychiatric service, treatment was either ineffective or it was completely rejected, when the patient had not accepted it first.

It may be concluded, then, that where the illness pattern has existed for a long time and the neurosis is well somatized, the chances of the patient making a successful transfer to the psychiatric service are considerably diminished. A good relationship with the medical social worker and careful teamwork between the medical doctor and social worker are important, but this may have to be continued for a long period of time before the patient is actually able to accept interpretation of his illness on an emotional basis. Yet, without the patient's acceptance of this interpretation, successful treatment is doubtful. Environmental help with these patients is particularly important since the patient himself is very much focussed on his physical needs. Community resources and co-operative help are also necessary in this connection if the patient is to be treated with any lasting success.

CHAPTER VI

Conclusions

This thesis has been a case study of the medical social worker's role with patients who came to the medical clinic at the Royal Victoria Hospital, and who were referred to the psychiatric service when there was found to be insufficient organic basis for their symptoms.

A sample group of eighteen patients was used, and, for study purposes, they were divided into three groups according to the amount of improvement the patient showed as a result of psychiatric treatment. In each group the medical social worker's role was studied in relation to this improvement and in relation to other factors contributing to or detracting from it.

From the medical literature and from experiments in physiology there is a body of scientific knowledge to show that there is a close relationship between emotions and physical reactions. We know that there is a physical expression of feelings that people cannot express directly. It is considered necessary to understand the underlying neurotic conflict in order to successfully treat these psychosomatic symptoms.

It is known that a person's physiological well being depends not only upon his physical environment, but also upon his social and emotional environment and the interrelationship of all three. Thus it is clear that any treatment program must take all three into consideration.

This means that the medical social worker has the responsibility of considering the broad range of factors contributing to the patient's

illness, of which the disease is only one symptom, and then helping the doctor to see the patient as a whole person. It is generally accepted in the social work literature that the social worker's knowledge should enable her to recognize those patients who are emotionally ill and who require the help of a psychiatrist.

The question arises as to how the medical social worker is to fulfill this responsibility since she sees a very small proportion of the patients who attend the medical clinic. As we have seen from the case material in this study, there is no plan for referral of these patients to the medical social worker at the Royal Victoria Hospital. They are referred only as the individual doctor sees the need. In the first group, only one case was referred by the doctor; in the second group, the doctor referred four; and, in the third group, he referred two of those carried by the medical social worker. This represents less than half of the total group. It should be noted, however, that once known to the medical social worker, whether they were referred by the doctor or not, there were ten in the total group who were referred to psychiatry following consultation between the worker and the doctor, and the referral was made jointly.

From the literature, we have an example of a referral process in practice at the Western Reserve University Hospital, Cleveland, Ohio,[1.] where the social worker functions as an integral part of the referral process for purposes of evaluating the social situation and the patient's

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1. Eleanor C. Cockerill and John M. Flumerfelt, "One Method of Psychiatric Consultation to the Case Worker in a General Hospital", Bulletin of the American Association of Medical Social Workers, (December, 1949), p.72.

understanding of the referral and attitude toward it. Other studies, such as the one on the functioning of psychiatric clinics in New York City,[1.] have illustrated the need for such a program in order that the patient coming to the medical clinic of a general hospital may be adequately prepared for the referral, and so that the psychiatric clinic may be adequately prepared for the patient.

Judging also by the various reactions of patients, in this study, who were told that there was no physical illness and who were given no previous interpretation in regard to an emotional basis for illness, we may conclude that there is a tendency on the part of the patient to interpret this information as a denial of illness. Another common reaction of patients who had a little more insight into their condition, was a fear that psychiatry meant that they were mentally ill. For one reason or another this fear may have already been in their mind and the referral to the psychiatrist only confirmed their fears and filled them with anxiety. A third reaction concerned the stigma connected with psychiatric treatment. Patients having this reaction realized how the psychiatrist might help them and usually wanted treatment, but considered it something for the mentally ill and not for them. Some were concerned about what others would say about them, and others felt their problem was unworthy of the psychiatrist's attention.

The help the medical social worker can give in this area, in a teamwork relationship with the medical doctor, is well illustrated in

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1. The Functioning of Psychiatric Clinics in New York City, New York City Committee on Mental Hygiene of the State Charities Aid Association, (105 E 22 St., New York, 1949).

these cases. It has been seen that in some where improvement was shown, the patient would never have accepted the referral to psychiatry, and, in others, he would not have maintained treatment without her help. This clearly indicates the need for the medical social worker's participation in such cases on a planned basis.

The case material in this study illustrates six aspects of the medical social worker's role with these patients. Firstly, the worker's role is supportive and sustaining and may be the means of bridging the gap between the services of medicine and psychiatry. It can be a determining factor in whether the patient actually makes the transfer or not.

Secondly, and closely related, is the meaning to the patient of his relationship with the worker. The very existence of this relationship and the interest the worker takes in the patient can have a great deal to do with the patient's maintenance of treatment.

Thirdly, the worker's role is that of interpretation in regard to emotional illness and the meaning of psychiatric treatment to the patient.

Fourthly, and related to this, is the worker's interpretation to members of the family and it has been clearly shown what an important influence this may be.

Fifthly, the worker has a role to play in giving the patient realistic help with his environment. In several cases it was illustrated that certain changes in the patient's environmental situation helped the patient to retain and apply the help received through psychiatric treatment.

Sixthly, the worker's role as liaison between the hospital and the community has been clearly demonstrated with effective work on the patient's behalf as a result.

In each of the three groups the worker has attempted to carry out most of these things. There is a difference in these groups, however, in terms of the length of time the patient has been ill and the degree to which his neurosis has been somatized. Those in the first group who showed the most improvement, had, on the whole, been ill the shortest length of time and were able to gain some insight into their condition. Those in the second group had been ill for a longer period of time and their problem was more severely somatized. Much more of the worker's time and effort was required in most of these cases before the patient was able to accept psychiatric treatment to begin with, and frequently a great deal more time was required with him so that he was able to maintain treatment. In the last group, the worker and all the medical team were faced with patients whose illness had been a life-long pattern. These patients rejected casework and psychiatric treatment and were almost entirely focussed on their need for material support. Their neurosis had been well somatized for a very long period of time and they presented a much more difficult problem in rehabilitation.

In the early stages it is not possible to tell which patients will be able to use treatment and which ones will not. Some patients, as we have seen, may be able to accept and use treatment very quickly. Others, for whom it is a matter of a life-long adjustment, may resist help for a year or more. Although some of these patients may be very severely somatized, we cannot say that they are not treatable. These people can

be as much of a burden to the community and to their family as the severely physically handicapped person. As with the physically disabled, the longer the condition has existed and the longer the patient has thought of himself as an invalid, the more difficult it is to rehabilitate him. The chances for successful treatment are less hopeful, and it may be necessary for the worker and the doctors to go much more slowly with this person.

Since the results with these patients can never be predicted, we may conclude that it is well worthwhile to do everything possible to help the patient with psychosomatic symptoms to become again a useful member of society and a happier individual.

A P P E N D I X

Documentary Schedule

Documentary Schedule

Name

Age

Sex

Social Service Index

Family constellation

Occupation

Diagnosis

Symptoms

physical

mental

previous occurrences

O.P.D. number
Indoor number

Referral to Social Service Department

date
relative to psychiatry
sources
reason

date seen
date closed
reopened
reason

Referral to psychiatry

date
source
date seen
place (Medical Outpatient Department
(Psychiatric clinic
(Allan Memorial Institute

Brief summary of social situation

Patient's personal history

Patient's own interpretation of his trouble and attitude toward it

Social service aims and plan

Doctor's interpretation of patient's condition, including referral to psychiatry and patient's reaction to this

Documentary Schedule (cont'd)

Social worker's interpretation of emotional illness and preparation for referral to psychiatry and patient's acceptance and reaction to this

Patient's understanding of psychiatry

Attitude of family and friends toward patient, his illness and psychiatry

Other influences upon patient

Acceptance of first appointment with psychiatrist

How well was psychiatric treatment accepted by patient? Indicate lapse of time

acceptance

ambivalence

rejection

Date and reason for discontinuing psychiatric treatment

Date and reason for discontinuing social casework

Summary of the social worker's role throughout the case with patient and family

Summary of social worker's role with members of the medical team

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