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An Analysis of the Length of Time Patients Remain in Treatment at the Mental Hygiene Clinic Service of the West Side Veterans Administration Hospital of Chicago, Illinois

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AN ANALYSIS OF THE LENGTH OF TIME PATIENTS REMAIN IN TREATMENT AT THE MENTAL HYGIENE CLINIC SERVICE OF THE WEST SIDE VETERANS ADMINISTRATION HOSPITAL OF CHICAGO, ILLINOIS

by

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CHAPTER I

INTRODUCTION

The Mental Hygiene Clinic Service of the West Side Veterans Administration Hospital of Chicago, Illinois, affords out-patient psychiatric services to veterans who have been discharged from military duties with service-connected neuropsychiatric disabilities and is structured to treat those whose needs do not require hospitalization.

A recent Pilot Study conducted by staff members of the psychology department of this clinic revealed that a significantly large proportion of veterans who were referred to the clinic for psychotherapy terminate services prior to the sixth interview. In contrast to this group, there is another large group of veterans where fifteen or more treatment interviews have been conducted before termination of services.

Routine admission procedures such as social history, psychiatric evaluation, psychodiagnostic testing, and an admission conference may consume as much as ten to fifteen hours of professional time. In view of this heavy initial investment in all patients, it is important to understand if possible what differentials patients reveal who promptly drop out of treatment from those who go on at least to the point of giving psychotherapy an adequate trial.

Purpose, Focus, and Scope

The intent of the present study is to investigate, compare, and analyse the relationship between the length of stay in the clinic and a number of characteristics of patients determinable from their case records. One purpose it might serve is to delineate more clearly which applicants are not likely to accept treatment. This in turn could be a factor in evaluating admission procedures.

The study is focused on those cases closed between January, 1952, and December, 1952, inclusive, and which were assigned to the Clinic for psychotherapy. In this study, emphasis is placed on the differences and similarities of the two groups.

The total number of cases closed in 1952 was 483. Of these, 373 were seen for five treatment hours or less and 110 were seen for fifteen hours or more. From these two basic groups samples of fifty each were selected at random. Those seen less than six times are henceforth referred to as Group A while those seen fifteen times or more will be designated Group B. The data analysed in the study were obtained from the Mental Hygiene Clinic Service treatment folders and card files with the aid of a schedule.[1] The schedules were designed to obtain a composite picture of the patient and therapy variables within the study groups.

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1 Appendix I.

CHAPTER II

THE MENTAL HYGIENE CLINIC SERVICE OF THE WEST SIDE VETERANS ADMINISTRATION HOSPITAL OF CHICAGO, ILLINOIS

Agency Setting

The Mental Hygiene Clinic Service of the West Side Veterans Administration Hospital of Chicago, Illinois, provided the setting for the present study. A brief description of the program of the Veterans Administration, with emphasis on the Mental Hygiene Clinic Service is presented in this chapter as a background for the study.

Veterans Administration

The Veterans Administration is an independent agency of the United States Government. It administers all benefits, provided by the Federal Government, to veterans and to dependents of deceased veterans who served in the armed forces during war or peace. These benefits include compensations, pensions, vocational rehabilitation and education, guaranty of loans for the purchase or construction of homes or business property. Included also are readjustment allowance for unemployed veterans, National Service and United States Life Insurance, death benefits, adjusted compensation, emergency and officers retirement pay, physical examinations, hospital and out-patient treatment or

domiciliary care.[1]

Organisational Structure

The Veterans Administration consists of two primary units: the Central Office and the Field Stations. At the Central Office in Washington, D. C., the Chief Administrator of Veterans affairs with the aid of his assistants formulates the general policies on program operation. "The staff units of the Central Office include the office of the Deputy Administrator for vocational rehabilitation and education, the Office of the Solicitor, and the Chief Medical Director, and others who are responsible for the administration of special services, construction and supply and real estate, personnel, legislation, insurance, finance, contract and administrative service."[2]

The Field Stations include district offices, regional offices, hospitals, and domiciliary centers which are situated throughout the United States. Specific policies concerning their operation are formulated in the area office on local levels.

The Regional Offices administer benefits and services to veterans and their relatives within a specifically assigned territory. These offices provide to veterans extension services nearest to their homes. "Benefits are administered through some divisions such as adjudication, insurance, vocational

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1 "Veterans Administration," U. S. Government Organisational Manual, Government Printing Office, Washington, D. C., 621-631.

2 Ibid., 621-631.

rehabilitation and education, and the department of medicine and surgery."[3]

The Mental Hygiene Clinic Service

On September 27, 1953, the auspice of the Veterans Administration Mental Hygiene Clinic of Chicago, Illinois, was redesignated as a clinic service rather than a clinic per se. It is now recognized as the Mental Hygiene Clinic Service of the West Side Veterans Administration Hospital and is under the direction of the Department of Medicine and Surgery. The purpose of the Mental Hygiene Clinic Service is designated in the following passage:

> The need for treatment of the large number of veterans discharged from service with mental and nervous illnesses is evident. Experience in civilian practices before the War indicates that the majority of these cases can be treated effectively in a clinic without hospitalization. The Mental Hygiene Clinic will render this treatment on an out-patient status and will be responsible for conducting the entire out-patient neuropsychiatric treatment program in the selected regional offices. This program will serve to alleviate a minor neuropsychiatric illness, prevent the development of a more serious illness and consequently reduce the number of veterans requiring hospitalization.[4]

The fundamental function of the Mental Hygiene Clinic Service is to provide treatment for veterans with service-connected neuropsychiatric disabilities or with certain adjunctive service-connected disabilities. In general, the disability to be judged service-connected must have been incurred in or aggravated while the veteran was on active duty with the armed forces or within a presumptive period after discharge or release to inactive duty. Treatment for

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3 Ibid., 521-523.

4 Veterans Administration Circular Number 169, "Mental Hygiene Clinics," Washington, D. C., July 16, 1946.

neuropsychiatric disabled veterans on an out-patient basis reduces the number of hospitalizations and social and economic incapacities accompanying such disabilities. Other functions of the Mental Hygiene Clinic Service are to treat patients who are on trial visit from a hospital, to refer patients to other neuropsychiatric units, and to serve as an integral part of a general training and teaching program. The term "trial visit" refers to the period in which a hospitalized veteran is released to live with relatives in the community and casework services are offered the veteran to aid him in re-adjusting to the community.

Method of Operation and Procedure

Veterans are referred to the Clinic from a variety of sources. Generally they are referred by the medical out-patient division, by other divisions within the Veterans Administration, by outside agencies and interested persons, or by self-referral. The application for treatment is made in the medical out-patient division where the veteran's record is cleared and where eligibility for treatment is established.

Cases usually are seen initially by a social worker. After the social history is obtained the veteran is interviewed by a psychiatrist. The veteran's first interview with the psychiatrist is considered a part of the intake process. An appointment for psychological study is scheduled if the veteran is considered to be a potential treatment case or is in need of additional diagnostic study. Following this, the case is processed through a formal intake evaluation conference held by a clinical team at which time the type of treatment, the type of discipline, and (if study is indicated) the specific type of

study are discussed. At this point, the case is usually passed on to one of the disciplines for assignment to a therapist.

In addition to the day clinic there is a night clinic and a Fee Basis Group for Treatment. The night clinic operates for the convenience of those veterans who cannot come in for daytime treatment interviews. It operates two evenings a week. The Fee Basis Treatment is for the purpose of serving the veterans who live outside of a sixty-mile radius of Chicago and who are treated for their disabilities by private physicians. The Veterans Administration assumes financial responsibility of this treatment, and pays the physician in charge of the veteran's case.

A part of the overall policy laid down by the Veterans Administration for Mental Hygiene Clinics is the requirement that a goal be set for each patient at the time of his initial examination or soon after. This therapeutic goal varies according to the patient's needs and abilities and is always governed in part by the consideration of time. The clinic team sets this goal with the implied understanding that when it is attained or it becomes clear that it can never be attained, treatment of the patient will be terminated. If no acceptable goal can be set because of the patient's poor motivation or some personality pattern which would inevitably block attainment of a goal, treatment is then considered psychiatrically unfeasible.

The Clinical Team

The Mental Hygiene Clinic Service operates on the clinical team concept. It is a framework in which the members of the team work harmoniously together, each respecting the others' sphere and contribution. The three

disciplines represented, psychiatry, clinical psychology, and psychiatric social work, afford the best opportunity for the examination and evaluation of the patient's total personality. As a part of the initial evaluation of the patient, each of the three disciplines contributes pertinent data and by exchanging viewpoints can be expected to arrive more consistently at a better rounded evaluation than can any one individual.

At the time of this study, the clinic staff included eight psychiatrists, six psychologists, ten social workers, trainees in each of the respective disciplines, and a psychiatric nurse. All of the professional staff of the Mental Hygiene Clinic Service are assigned to clinical teams where they staff or present their treatment cases for discussion, treatment, evaluation, and modification of goals when indicated.

Summary

A description of the organizational structure of the Veterans Administration with emphasis on the Mental Hygiene Clinic Service of the Veterans Administration West Side Hospital has been presented in this chapter. It has provided a background for the present study, which begins in Chapter III.

CHAPTER III

A COMPARISON AND ANALYSIS OF THE PERSONAL, SOCIAL, AND MILITARY DATA OF THE STUDY GROUPS

Thinking of the patient as a total personality and wanting to understand the social as well as the psychic and physical aspects of the patient's participation in psychotherapy, the writer has made the following quantitative analysis of the personal, social, and military data. This analysis involves a comparison of the data secured for the patients who had five or less interviews, Group A, with the data secured for the patients in Group B, who had fifteen or more interviews.

One of the most recent trends in the community's attitudes toward mental health has been its emphasis upon the need to have preventive and adequate psychotherapy for those in need of such help; however, without a comparative analysis, we are unable to know in what kind of social situation our preventive efforts should be concentrated, or what type of patient we can anticipate will wish or be able to have a sustained therapeutic relationship.

The social and personal data gathered included factors such as age, travel distance to clinic, marital status, number of dependents, educational

attainment, occupational classification, living arrangements, family situation in which the veteran was reared, and the medical record of the veteran since his discharge from the armed forces. The military data covers the branch of service to which the veteran was attached as well as the length of service and combat experience.

Age

Of the one hundred patients studied, ninety per cent were between the ages of twenty and forty years, which seems plausible when we consider that it was generally the men between the ages of eighteen and thirty seven who were subject to military service. Nevertheless, this alone would not explain fully the scarcity of patients fifty years and over as the twenty-year old who was a desirable veteran in 1919 would be fifty-four years old in 1952 and eligible for therapy at the Mental Hygiene Clinic for a service-connected mental disability. There were only three patients in Group A who were fifty years or over and one patient in Group B. This suggests very little variation between the two groups and would support the author's speculations that older patients are not in therapy at the Mental Hygiene Clinic because of the following: (1) previous arrest of their illness; (2) hospitalization; (3) domiciliary care; (4) demise; and (5) the veteran's adjustment to a condition which, at the end of World War II was not diagnosed as mental illness, because of the less definitive methods of diagnosis of those times.

One of the most pertinent facts about the age distribution in this study is that there was little variation in the ages of any of the groups. The largest number of patients cluster was around the twenty- to thirty-year range,

with those having five or less interviews constituting 30 per cent of the total number of patients studied, and the patients having fifteen or more interviews constituting 33 per cent.

TABLE I

DISTRIBUTION OF AGE

Age	Group A	Group B	Total
Under 20	2	0	2
20-30	30	33	63
30-40	13	14	27
40-50	2	2	4
50 or Over	3	1	4
Total	50	50	100

Travel Distance to Clinic

Considering the possibility of a relationship between the number of interviews in which a patient participated and the distance he needed to travel from his home to the Mental Hygiene Clinic, where these interviews were held, Table II was drawn up. For the purposes of graphic presentation the cases were grouped according to the distances traveled from house to clinic.

TABLE II

DISTRIBUTION ACCORDING TO TRAVEL DISTANCE TO CLINIC

Distance to Clinic	Group A	Group B	Total
Residing in City			
Less than 1 Mile	0	3	3
1 to 2 Miles	10	8	18
2 to 3 Miles	6	2	8
3 to 4 Miles	4	3	7
4 to 5 Miles	9	8	17
5 to 10 Miles	17	17	34
Total	46	41	87
Residing Out of City			
10 to 20 Miles	2	2	4
20 to 30 Miles	3	1	4
30 to 40 Miles	1	3	4
40 to 50 Miles	0	2	2
50 or over Miles	8	1	9
Total	14	9	23

It is to be noted in Table II that the majority of the patients attending the clinic and living in the city lived within a ten-mile radius of the clinic, which was located in 1952, the year chosen for this study, at 566 West Adams Street, Chicago. Of this number almost one half, or 47 per cent, had five or less interviews, while the remaining 53 per cent of that same number had fifteen or more interviews. These patients who traveled a distance of ten miles and over resided outside the city, in one of the other

areas serviced by this clinic. As these were only 23 per cent of the total one hundred cases used in this study, it does appear that the travel distance is a significant factor affecting the patients' attendance. Unfortunately though, the break-down of this group outside of the city, who must travel ten miles and over to the Mental Hygiene Clinic, does not reveal conclusively that this same distance is the sole determinant of the length of time or number of interviews which they have. Sixty-one per cent of this group (living outside the city) had five or less interviews, while 39 per cent had fifteen or more interviews. Here the author must reflect about this 61 per cent having less than five interviews in light of the facts seen in a subsequent table, XVI, showing that 75 per cent of the patients in the total one hundred cases terminated their own therapy or shared, with the therapist, the making of the decision regarding termination of therapy.

Marital Status

Of the patients studied, 72 per cent at one time had been married or were married at the time of the study. This figure includes, in addition to the married patients, those who were divorced, separated, or widowed. The married patients constitute over 50 per cent of the total study groups. Those married in Group A consist of 57 per cent, while the remaining 43 per cent are in Group B.

Regarding single patients, who total 27 per cent of the entire groups studied, 63 per cent of the single are in Group A, with less than six interviews, and 37 per cent of the single patients were in Group B. Looking more closely at the two groups, it is noticeable that there is small variation

between their distribution and that only 22 per cent of the patients had changed their former status of married patients to that of widowed, separated, or divorced patients.

TABLE III

CLASSIFICATION ACCORDING TO MARITAL STATUS

Marital Status	Group A	Group B	Total
Single	10	17	27
Married	29	22	51
Divorced	3	4	7
Separated	7	5	12
Widowed	1	2	3
Total	50	50	100

Number of Dependents

In light of the fact that 72 per cent of the patients in this study, at one time, had been married, it seems logical for Table IV to show that 61 per cent of them had dependents. Patients with one, two, or three dependents are the largest single group within the study, 54 per cent. Of these, 55 per cent had fewer than six interviews and 45 per cent had fifteen or more interviews. Only seven patients had between four and six dependents and there were no patients with more than six dependents. Approximately 40 per cent of the study groups were without dependents, which would suggest that 12 per cent of the patients who were or who had been married did not have dependents at the time of the study.

TABLE IV

NUMBER OF DEPENDENTS DISTRIBUTED AMONG STUDY GROUPS

Number	Group A	Group B	Total
None	16	23	39
1-3	30	24	54
4-6	4	3	7
Total	50	50	100

Educational Attainment

Thirty-nine per cent of the group studied had some grade-school training or had completed grade school. Four of the patients had less than five years of grade-school education, while the largest single group, 35 per cent, were those who had at least five years of grade school and completion of grade-school work. Thirty-three per cent had attended high school, and 23 per cent had some college training or college training followed by additional vocational or professional training. Of this comparatively high number with college and additional training, 32 per cent had one to five interviews, while the majority, or 68 per cent, had fifteen or more interviews. This leads one to conjecture as to the possibility that patients with higher educational attainments may be more able to either tolerate and/or participate in the therapeutic relationships involving more than five interviews. If primarily those with greater educational attainments seek therapy and are able to stay in therapy longer, it might be desirable to consider the possibility of developing a program to reach the others with the lower intelligence or educational achievement,

unless it is found that these latter can more easily fall into their prior way of life, which alleviates or does not further complicate their neuropsychiatric disability.

TABLE V

DISTRIBUTION OF EDUCATIONAL ATTAINMENT

Number of Years	Group A	Group B	Total
Less than 5 years	3	1	4
5 years to high school	22	13	35
1 to 2 years high school	4	5	9
2 to 4 years high school	12	12	24
1 to 2 years college	5	7	12
2 to 4 years college	4	12	16
Total	50	50	100
Additional Training	19	33	52

Occupational Classification

The various occupations of the veterans were classified according to the Dictionary of Occupational Titles,[1] and the distribution is shown in Table VI.

After considering the preceding Table, V, regarding the patients'

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1 Dictionary of Occupational Titles, Part IV, revised edition, War Man Power Commission, Division of Occupational Analysis, Washington, D. C., 1944.

educational attainments, it is not surprising that 46 per cent of the combined groups, A and B, were distributed in the classifications of professional, technical, managerial, clerical, and sales. Of that percentage, 67.18 per cent were in Group B, which correlates with the 68 per cent shown in Table V as having college and additional training, and who were seen in therapy fifteen or more times.

TABLE VI

DISTRIBUTION OF OCCUPATIONAL CLASSIFICATIONS

Major Occupational Groups	Group A	Group B	Total
Professional, Technical and Managerial	7	13	20
Clerical and Sales	8	18	26
Service	10	7	17
Agriculture	2	3	5
Mechanical	9	3	12
Manual	14	6	20
Total	50	50	100

The percentages in Group B in Table VI seem to diminish as the patients' occupations were lower in the economic scale. Those classified as being engaged in manual work were 12 per cent of the patients in Group B, while those in agricultural and those in mechanical pursuits each had only 6 per cent of the patients who had had fifteen or more interviews.

Living Arrangements

It was found that 53 per cent of the patients studied lived with their spouses, and the remaining 47 per cent lived with parents, relatives, or alone. There was no significant difference noted in the living arrangements of patients in Group A and those patients in Group B.

Family Situation in which Veteran Was Reared

With the present-day concerns about the influence of the home life of a child upon his later adjustment, this writer felt impelled to scrutinize the family situations in which these patients were reared. This was done from five different points of view, namely: (1) family intact, (2) mother out of home, (3) father out of home, (4) both parents out of home, and (5) interfamilial conflict. It was found that the family was intact in 44 per cent of the situations in which patients had been reared and that 57 per cent of those had five or less interviews. The next largest were the 27 per cent who had been reared in situations with interfamilial friction, and it is noted that twice as many in that group had fifteen or more interviews as did the patients with that background who had one to five interviews. There was little variation among the groups where one or both parents were out of the home as 8 per cent were reared with the mother out of the home, 7 per cent with the father out of the home, and 8 per cent had been reared with both parents out of the home.

TABLE VII

DISTRIBUTION ACCORDING TO FAMILY SITUATION IN WHICH PATIENT WAS REARED

Family Situation	Group A	Group B	Total
Family Intact	25	19	44
Mother out of Home	4	4	8
Father out of Home	4	3	7
Neither Parent in Home	5	3	8
Interfamilial Friction	9	18	27
Not Given	3	3	6
Total	50	50	100

Military Data

Inasmuch as patients receiving psychotherapy at the Mental Hygiene Clinic are those whose difficulty is service-connected, it seems important to our considerations to examine the military data which was compiled on these one hundred patients during the course of this study. To do this the author examined the patients' former branch of service, the length of military service, and the record as to whether the patients had combat experience.

Length of Service

Those with eighteen to fifty-three months, or one and one-half to four and one-half years of military service comprised 73 per cent of the one hundred patients studied. Of these 31 per cent had five or less interviews and 69 per cent had fifteen or more interviews. Those patients who had been in military service for seven months to seventeen months made up the next largest

group, equal to 17 per cent of the total of the groups studied. Fifty-nine per cent of these patients had less than six interviews, while 41 per cent of them had fifteen or more interviews. At the top and the bottom of Table VIII, it is shown that a comparatively few of these patients had less than six months or more than fifty-four months of military service.

TABLE VIII

DISTRIBUTION ACCORDING TO LENGTH OF SERVICE

Length of Service	Group A	Group B	Total
0 to 6 months	1	2	3
7 to 17 months	10	7	17
18 to 29 months	11	17	28
30 to 40 months	13	12	25
41 to 53 months	9	11	20
54 to 65 months	1	0	1
66 or over months	5	1	6
Total	50	50	100

Branch of Service and Combat Experience

Most of the patients in the study had served in the army (67 per cent) and there was only a one per cent difference between those who were in Group A and those in Group B. The distribution was exactly even between Group A and Group B with regard to patients who had naval military experience (20 per cent). The exact distribution between the groups was true also for former members of the Coast Guard (4 per cent) and the patients with Marine service. Nine per cent of the total number had only one per cent variation in their percentages

regarding Group A and B. The branch of service reflects the wartime distribution of numbers in the armed services; thus, no one service appeared to contribute more than its expected proportion.

Most of the patients, 61 per cent, had some combat experience, while 39 per cent had no combat experience. Here, too, the distribution was comparatively even between those patients who at the time of the study had five or less interviews and those patients who had had fifteen or more interviews.

TABLE IX

DISTRIBUTION ACCORDING TO BRANCH OF SERVICE AND COMBAT EXPERIENCE

Branch of Service and Combat Experience	Group A	Group B	Total
Branch of Service			
Army	34	33	67
Navy	10	10	20
Marines	4	5	9
Coast Guard	2	2	4
Total	50	50	100
Combat Experience			
In Combat	33	28	61
Not in Combat	17	22	39
Total	50	50	100

Medical Record Since Discharge

Since the majority of the veterans had been out of service over five years, the question was raised as to whether or not they had received pre-clinic

medical or psychiatric treatment. An examination of this aspect revealed that forty six of the study groups had been hospitalized some time since military discharge, twenty-five patients had received out-patient care, thirty-three had received psychiatric treatment, and fifty-six had some post-military medical care. These categories are not exclusive ones, and conceivably some patients received two or more of these services following discharge from service. The important thing seems to be the fact that more than twice as many patients who had been hospitalized participated in one to six treatment interviews than did those who had a record of hospitalization and fifteen or more interviews. There was little variation between Groups A and B for those patients with records of out-patient care. However, the patients with post-military psychiatric care were twice as frequent in Group A as in Group B. As regards the latter, it seems important to reflect again upon the possibility that patients who have attained less education are likewise less able to tolerate or participate in a therapeutic relationship, in spite of their need for psychiatric treatment and thereby terminate prior to the sixth treatment interview.

The patients who had received post-military medical care were almost equally distributed between Group A and Group B.

TABLE X

DISTRIBUTION ACCORDING TO POST-MILITARY MEDICAL RECORD

Medical Record	Group A		Group B		Total	
	Yes	No	Yes	No	Yes	No
Hospitalized	32	18	14	36	46	54
Out Patient Care	10	40	15	35	25	75
Psychiatric Care	22	28	11	39	33	67
Medical Care	29	21	27	23	56	44

Summary

In this chapter the personal, social, and military data secured on the one hundred patients has been discussed, compared, and analyzed. This has included the patients' residence, age, marital status, number of dependents, education, occupational classification, living arrangements, family situation in which patient had been reared, branch of military service, length of military service, combat experience, and medical record since discharge.

The following characteristics were outstanding: (1) The ages of the patients studied most frequently were between twenty and thirty years. This was true of both Groups A and B. (2) The patients served by the Mental Hygiene Clinic and living in the city had ten or less miles to travel to the clinic, and over one-half of this group were seen for fifteen or more interviews. Those patients living outside Chicago and who necessarily traveled more than ten miles to the Clinic were few in number (23 per cent) and of these a majority had less than five interviews. This might indicate that the patients'

emotional resistances to psychotherapy may be re-enforced by the reality factor of long distances to be traveled from home to the clinic. (3) A majority of the patients were married at the time of or prior to the study, and more than one-half of them, or 61 per cent, had dependents. (4) Sixty-one per cent of the patients had received some high school, college, or advanced training; and, within the group with advanced education, 68 per cent had fifteen or more interviews. (5) Almost one-half of the patients, or 46 per cent, were classified as professional, technical, managerial, clerical, or sales persons, which showed a positive correlation between the educational attainment, occupational classification, and participation in long-time therapy. (6) Most of the patients had been reared in homes with the family intact; the most pertinent factor here is that these patients either apparently felt helped in five or less interviews or they were strong enough personalities to terminate therapy before the sixth interview with or without the therapist's agreement. (7) The patients with one and one-half to four and one-half years of military service comprised 73 per cent of those included in the study, and more than twice as many of these patients had fifteen or more interviews than had five or less interviews. (8) Sixty-seven per cent of these patients had been in the army, and the distribution between Groups A and B points to there being practically no difference in the effect of the branch of service on the number of interviews a clinic patient has. (9) This same lack of effect is seen in patients comprising the group with combat experiences, who, although totaling 61 per cent, were almost equally divided between Group A and Group B.

CHAPTER IV

A COMPARISON AND ANALYSIS OF THE MENTAL HYGIENE CLINIC SERVICE DATA

Recognizing that the diagnosis and therapy of the psychiatric clinic is addressed to the individual who has the problem rather than the problem itself, one still needs knowledge of situation or problem to which the person is reacting and the problem which is created within or around the individual as a consequence of this reaction. Directed toward this aim, this chapter covers a comparison and analysis of the clinical data of the veterans in the study groups.

The clinical data gathered included the source of referral, psychiatric classification of patient's complaints, correlation between the nature of patient's initial request and discipline assigned, season of treatment, length of time in therapy, patient's expressed choice of clinic, means of termination, reasons for termination, and psychiatric status of patient at close of treatment.

Source of Referral

Since the sources of referrals and reactions to the referrals are two of the primary factors that are considered in evaluating the veteran's

ability to relate to the clinic and his suitability for treatment, the sources of referral may be viewed in light of the motivational factors possibly involved. Table XI shows the distribution of the applications according to these sources.

TABLE XI

DISTRIBUTION OF REFERRALS ACCORDING TO SOURCE

Source	Group A	Group B	Total
Medical Out-Patient	7	23	30
Veterans Administration Hospital	6	7	13
Vocational Rehabilitation	2	1	3
Non-Veterans Administration Agency	1	1	2
Self	19	16	35
Other	15	2	17
Total	50	50	100

Of these one hundred patients in the study groups, almost fifty per cent were referred to the Mental Hygiene Clinic Service from departments or installations associated with the Veterans Administration. Thirty per cent of this total came referred from the Medical Out-Patient Department. Of this total there were seven in Group A, and twenty-three in Group B. This is peculiarly significant when one recalls that Group B is the one where fifteen or more interviews were held prior to termination of therapy. The second largest single distribution was that of self-referral. This distribution, which includes 35 per cent of the total number of the groups studied, appears most significant

when motivational factors are considered. No significant differences existed between Groups A and B.

Referrals under the heading of "Other" included those initiated by the courts, private physicians, relatives, and other interested individuals who described the veteran's difficulties as being of a psychiatric nature and/or recognized the existence of a psychiatric disturbance accompanying the physical or organic complaint. The number of referrals within this distribution differs significantly in that in Group A there were fifteen, while in Group B there were only two. If lack of motivation is to be considered as one of the psychodynamics of failure in therapy, then it seems that this single distribution is particularly significant because it seems to reflect the possibility that many of the patients in Group A might have been forced into the therapeutic situation by external pressures rather than being personally motivated.

Psychiatric Classification of Patient's Complaints

For the purposes of this study the three broad disorder classifications of psychoneurotic disorders, psychotic disorders, and personality disorders were used. The following are interpretations of each classification:

1. The primary characteristic of psychoneurotic disorders is "anxiety" which may be directly felt and expressed or which may be unconsciously and automatically controlled by utilization of various psychological defense mechanisms such as depression, conversion, dissociation, displacement, phobia formation, or repetitive thoughts and acts. In contrast to those with psychoses, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illusions), and they do not present gross disorganization of the personality.

2. Psychotic disorders are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres. In addition,

> individuals with such disorders fail in their ability to relate themselves effectively to other people or their own work. Grouped under psychotic disorders are: (a) affective disorders, characterized by severe mood disturbances with associated alterations in thought and behavior, in consonance with the affect; (b) schizophrenic reactions, characterized by fundamental disturbances in reality relationships and concept formation, with associated affective, behavioral, and intellectual disturbances, marked by a tendency to retreat from reality, by regressive trends, by bizarre behavior, by disturbances in stream of thought, and by formation of delusions and hallucinations; (c) paranoid reactions, characterized by persistent delusions and other evidence of the projective mechanisms.
>
> 3. Personality disorders are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior. These are the cases in which the personality utilizes primarily a pattern of action or behavior in its adjustment struggle, rather than symptoms in the mental, somatic or emotional spheres.[1]

Naturally, within such broad categories, there might be considerable overlapping of the types of behavior and/or psychic disturbance included in these three groups, but it is practically impossible to set up exclusive groupings. The writer has therefore been guided by the dominant or primary disorder which the patient presented with recognition to the fact that the overlapping reflects the range of problems presented and handled in therapy.

Some of the more enlightening data is included in Table XII, wherein it is noted that 45 per cent of the patients had psychoneurotic disorders, 38 per cent had psychotic disorders, and 17 per cent had personality disorders.

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1 "Mental Disorders," Diagnostic and Statistical Manual, American Psychiatric Association, Mental Hospital Service, Washington, D. C., 1952.

TABLE XII

DISTRIBUTION ACCORDING TO THE BROAD DISORDER GROUPS

Broad Disorder Groups	Group A	Group B	Total
Psychoneurotic Disorders	20	25	45
Psychotic Disorders	24	14	38
Personality Disorders	6	11	17
Total	50	50	100

The above distribution shows that more patients with psychoneurotic disorders remained in therapy for fifteen or more interviews. Many of these patients presented anxiety and somatisation reactions, the majority of which seemed to have resulted from the lack of ability to adjust to immediate environmental pressures or circumstances. Most of these patients were having difficulty managing economically and socially.

More patients with psychotic disorders and personality disorders were seen in treatment less than six times than were patients in the same disorder group who had the longer term therapy (fifteen or more interviews). These figures distributed into the three broad disorder groups seem plausible when one considers that many psychotic persons are either too ill to be living in the community and receiving psychotherapy on an out-patient basis, while others of them are by virtue of their psychosis, unable to face their problem and reach out to the clinic for help with it.

Generally speaking and from the positive point of view, patients suffering from psychotic disorders are thought of as potential hospital cases; but the fact that some can be carried by an out-patient clinic reduces

proportionately the need for hospitalization among some of the neuropsychiatric cases. Considering this, the appreciable number who were able to remain in treatment for fifteen interviews or more (Group B) is worthy of mention. Likewise, recognition must be given to those who stayed in treatment for five or less interviews (Group A), when note is made of the fact that only four terminated treatment because hospitalization was indicated necessary.

It seems plausible to reason that those veterans with personality disorders have probably operated within the framework of their particular disorder for such a period of time that few of them should be expected to come for mental hygiene clinic services either voluntarily or as the result of referral.

When one recalls that 65 per cent of the referrals were made by the Medical Out-Patient Department and by the veterans themselves and that 45 per cent of the disorders presented were psychoneurotic ones, one may speculate that the Medical Department and the veterans are making efforts to recognise the existence of an emotionally based problem at an early date, rather than waiting until the problem has grown too severe for moderate therapeutic goals. This seems to indicate that the Medical Out-Patient Department and the community, the latter being represented by the veterans, are making an appropriate use of the Mental Hygiene Clinic services.

Patient's Initial Request and the Discipline Assigned

To the individual patient and to the referring source, an important criterion for evaluation of the effectiveness of a clinic's services is the positive correlation between the patient's initial request and the discipline

assigned. It is generally accepted that a physician re-sets a broken bone, a theologian redirects spiritual thinking, and that a social worker helps the individual towards a solution to his environmental problems. One wonders then at the figures on Table XIII indicating that social service was assigned to only four of the eleven cases wherein the nature of the request was help with external problems, while psychiatrists were active in five, and psychologists were active in two of the same group. Only four patients, whose initial request was for help with external problems, were seen for fifteen or more interviews; and, again, this poses the question as to whether the other seven might have remained in psychotherapy over a longer period of time if they had felt some relief from external pressures through social work, thus freeing them to work on their internal problems with the helping person, the social worker, or other members of the psychiatric team. The one request for hospitalization was handled by social service,and this assignment seems valid.

It may be noted in Table XIII that Social Service was active in forty seven of the cases, 45 per cent of which initially had requested medication, 45 per cent had requested psychotherapy, 1 per cent requested hospitalization, and 9 per cent had asked for help with external problems. Twenty-nine of the patients were assigned to Psychiatry and of these, 42 per cent requested medication, 42 per cent requested psychotherapy, and 1 per cent requested help with external problems. Twenty-four of the patients studied were assigned to Psychology, when 25 per cent of this group requested medication, 67 per cent requested psychotherapy, and 8 per cent requested help with external problems.

TABLE XIII

CORRELATION BETWEEN PATIENT'S INITIAL REQUEST AND THE DISCIPLINE ASSIGNED

Nature of Request	Social Service		Psychiatry		Psychology		Total	
	A	B	A	B	A	B	A	B
Medication	14	7	4	8	1	5	19	20
Psychotherapy	13	8	7	5	4	12	24	25
Hospitalization	0	1	0	0	0	0	0	0
Help with External Problems	3	1	2	3	2	0	7	4
Total	30	17	13	16	7	17	50	50

One would be likely to question the limited assignment of patients to social service (47 per cent) when these patients are living in the community and it is logically expected that helping the veteran handle situations which arise in daily living would alleviate some of the psychological pressures and complement any other discipline's therapy with the patient. Of the fifty patients seen in fifteen or more interviews, social service was assigned to 34 per cent of that number, psychiatry was assigned to 32 per cent, and psychology was assigned the remaining 34 per cent. It therefore appears that the matter of discipline assignment does not effect the number of interviews which a patient has.

Further observation of the distribution showed that a large number of cases assigned to social service (30 per cent) were those which had less than six interviews prior to termination of treatment. Of this 30 per cent, it seems significant that 14 per cent requested medication when they were first seen in the clinic. Another large group, 13 per cent, implied that they wanted

"treatment of their nerves." A further evaluation of the intake interviews suggests that they also were requesting some type of medication.

In view of this, one wonders whether or not the reason these patients did not remain in treatment was because of their lack of motivation for accepting psychiatric treatment. One may also speculate concerning the possibility that a larger group of these individuals may not have remained in treatment because of the insufficient skills of the social workers to help the patients to work through their initial resistances to treatment.

The author believes that this is an area which indicates a need for further study since there was no attempt made to compare and analyse the differences and similarities of this particular group of cases assigned to social service with other disciplines.

The Season Patient Was Accepted for Treatment

Because of the possible significance of psychologic state in relation to the season of the year, this aspect was studied. It already has been suggested that the reality factor of distance traveled to clinic to some degree affects the number of interviews a patient has at the mental hygiene clinic. Does, then, the weather have a similar effect? Table XIV shows that the largest number of patients, twenty, seen in fifteen or more interviews were accepted for treatment during the summer. Following in size was the group accepted for treatment in the spring, twelve. The patients seen in fifteen or more interviews and accepted in the fall and winter totalled only eighteen in number despite the fact that more than twice that number of patients, forty six, were accepted for therapy in the fall and winter. It is now possible to

determine that travel distance and inclement weather resulted in cases wherein patients had brief therapy (five or less interviews); however, it is noted that the greater the distance and the colder the weather the fewer the number of patients were involved in the fifteen or more interviews.

TABLE XIV

DISTRIBUTION ACCORDING TO SEASON ACCEPTED FOR TREATMENT

Season	Group A	Group B	Total
Spring	15	12	27
Summer	7	20	27
Fall	1	9	10
Winter	27	9	36
Total	50	50	100

Length of Time of Therapy

In an effort to get a closer look at the number of interviews which patients had in Group A, five or less interviews, and in Group B, fifteen or more interviews, an actual count of the interviews was made in each case studied. Within Group A, almost one-third or 32 per cent of the patients had two interviews, one-tenth or 10 per cent had one interview, 30 per cent had three interviews, sixteen had four, and 12 per cent had five interviews.

In Group B, 62 per cent of the patients had fifteen to twenty-five interviews, and the remaining 30 per cent had thirty-five to over one hundred interviews.

TABLE XV

THE LENGTH OF TIME PATIENTS REMAINED IN THERAPY IN TERMS OF NUMBER OF INTERVIEWS

Number of Interviews	Group A	Number of Interviews	Group B
1	5	15-23	31
		25-35	4
2	16	35-45	2
		45-55	3
3	15	55-65	1
		65-75	3
4	8	75-85	1
		85-95	2
5	6	95-100	1
		100 or over	2

Patients Expressed Choice of Clinic

Inquiry into the patient's choice of clinic reflected no significant relation in this study. Every instance in which the patient expressed a specific choice of preference as to day clinic or night clinic was granted. In Group A, fifteen requested night clinic because the patient's employment hours or working conditions would not lend suitably to day-clinic attendance. In Group B, thirteen patients requested night clinic for the same reasons.

Means of Termination

In any attempt to analyze and compare the services of a mental health clinic, it is important to review the end or termination of therapy as well as the beginning or initial request for therapy. Table XVI shows a distribution of the findings according to the means of termination of the one-hundred patients studied.

TABLE XVI

TERMINATION OF THERAPY

Means of Termination	Group A	Group B	Total
Terminated by Patient	35	26	61
Terminated by Therapist	7	4	11
Mutual Agreement	3	11	14
Hospitalized	3	1	4
Declared Ineligible	0	1	1
Other	2	7	9
Total	50	50	100

It is noticeable that the majority of patients, 61 per cent, terminated their own therapy. Only 25 per cent of the study groups had therapy terminated by the therapist and/or by mutual agreement. This large percentage (61 per cent) would appear to underpin the early speculation that many times therapy terminates because of factors which may not be due altogether to patients' reactions around the actual therapeutic experience. In looking at those patients seen in five or less interviews, it is noted that 76 per cent in that group participated in planning termination, whether by mutual agreemen with the therapist or by his decision alone. The same percentage, 76 per cent, were part of the termination plan in the group of patients seen in fifteen or more interviews.

When the status of the patient at the close of treatment is noted, one sees that 41 per cent of the total cases studied were listed as unimproved (no change); 6 per cent were worse; 32 per cent were improved; and the status of 21 per cent was unknown, probably because they terminated before sufficient evidence was obtained to categorize their status. In the group who had no change there was little variation between the number of patients seen in five or less interviews and the number seen in fifteen or more interviews. However, in the group of improved those seen in fifteen or more interviews were overwhelmingly more frequently improved, seven times as often as those patients seen in five or less interviews. Seemingly, the patients seen for more interviews had increased chances of improvement.

TABLE XVII

PSYCHIATRIC STATUS OF PATIENT AT CLOSE OF TREATMENT

Psychiatric Status	Group A	Group B	Total
No change, unimproved	23	18	41
Worse	4	2	6
Improved	4	28	32
Unknown	19	2	21
Total	50	50	100

The further breakdown of the patients' condition at time of termination may be seen in the next Table, XVIII. Here, of the fifteen patients whose intake prognosis was good, four had a terminating prognosis of good. One half of these four were in Group A, and the other two were in Group B. The correlation between intake and terminating prognosis is closer in the groups of guarded and poor with little indication that the number of interviews had any effect upon their correlation.

TABLE XVIII

RELATIONSHIP BETWEEN PROGNOSIS AT INTAKE AND TERMINATING PROGNOSIS

Intake Prognosis			Terminating Prognosis				
			Good	Fair	Guarded	Poor	Not Given
Good	A	9	2	0	1	2	4
	B	6	2	3	0	1	0
Fair	A	8	0	1	1	1	5
	B	6	1	4	0	0	1
Guarded	A	14	1	1	4	3	5
	B	20	1	5	4	6	4
Poor	A	19	1	0	2	11	5
	B	18	5	4	6	3	0
Not Given	A	0					
	B	0					

Reasons for Termination

In considering the patients' reasons for termination the cases studied were classified into four major groups, namely: (1) poor motivation, (2) not feasible for treatment, (3) environmental factors, and (4) maximum benefits attained. The largest single group of patients terminated because of poor motivation. This was true for all patients (fifty three), irrespective of the number of interviews they had. The next highest number of patients terminated because maximum benefits had been attained. These twenty six patients

were divided so that ten of them had participated in five or less interviews, and sixteen patients had participated in fifteen or more interviews.

TABLE XIX

REASONS FOR TERMINATION

Reasons	Cases Studied		
	Group A	Group B	Total
Poor Motivation	34	19	53
Lack of Proper orientation toward Treatment at Outset			
Failure to Accept Emotional Basis or Component of Illness	4	5	9
Forced into Clinic by Outside Pressures Rather Than Personal Interest in Therapy	2		2
Pension Motivations	2		2
Not Ready to Accept Clinic's Therapy	4	1	5
Failed to Keep Appointments or Declined Treatment	22	13	35
Not Feasible for Treatment	5	4	9
Lack of Ability to Tolerate Anxiety or Guilt Feelings Generated by Therapy		2	2
Inadequate Ability to Move into Psychotherapeutic Relationship	5	2	7
Environmental Factors	1	11	12
Moved from Area	1	6	7
Therapist Leaving Clinic and Patient Not Interested in Transfer to Another Therapist		3	3
Lack of Ability to Keep Appointments Due to Employment Ties		2	2
Maximum Benefit Attained	10	16	26
Patient Hospitalized	3	1	4
Therapeutic Goals Achieved	7	14	21
Eligibility for Clinic Service Expired		1	1

The largest single reason for termination may be seen in the subdivision of the classification of poor motivation. These were patients who failed to keep appointments or declined treatment. These thirty-five patients

evoke a question as to whether the patients had adequate orientation about psychotherapy at the outset, as for them not to have known before the second or third interview that they did not want or could not tolerate continued therapy. It is recognized that the real orientation comes from the psychotherapeutic experience itself; however, it is not explained why thirteen of the thirty-five patients who declined or failed to keep appointments did so after the fifteenth interview.

Summary

In the preceding chapter the clinical data compiled on Groups A and B has been compared, discussed, and analyzed. Included in this has been the patients' sources of referrals, the psychiatric classification of the patients' complaints, the nature of the patients' initial request and discipline to which they were assigned, the season of treatment, length of time in therapy, patients' expressed choice of clinic, and means of and reasons for termination.

The following characteristics seem to bear significance: (1) Of the one hundred patients studied almost fifty per cent were referred for mental hygiene clinic services from departments or installations within the Veterans Administration. Of this total thirty-five per cent of the patients were self-referred, and 17 per cent were classified under the heading of "other." The overall picture of this distribution seems to show the lack of motivation and a great amount of emotional resistence a large number of patients had to psychotherapy. (2) More patients with psychoneurotic disorders remained in therapy for fifteen or more interviews. In Group A, more patients with psychotic disorders and personality disorders were seen than were patients of the

same disorder classification in Group B. (3) The appreciable number of patients with psychotic disorders who were able to remain in treatment for fifteen or more interviews (fourteen), as well as those who stayed for five or less interviews (twenty four), is noteworthy, when it is remembered that psychotics are usually thought of as potential hospital cases. (4) The correlation between the patient's initial request and the discipline to which he was assigned showed no indication that the discipline to which a patient is assigned affects the number of interviews that he has. This above correlation reveals data which pose at least two questions which appear to suggest the need for further study indicated: first, whether or not patients dropped out of treatment prior to the sixth interview because they were poorly motivated, and/or because of the insufficient skills of the social worker to help the patients to work through their initial resistances to treatment. (5) Though it is not possible to determine that travel distance and inclement weather resulted in cases wherein patients had brief therapy (five or less interviews), it is notable that the greater the distance and the colder the weather, the fewer the number of patients were involved in fifteen or more interviews. (6) Every request was granted where the patient expressed a specific choice or preference to either the day or the night clinic, and therefore this particular aspect of the study cannot be seen as a contributing factor affecting the length of time patients remained in treatment. (7) In Group A, 76 per cent of the patients participated in planning termination, whether by mutual agreement with the therapist, or by his decision alone. This same percentage, 76 per cent, was also noted in Group B. (8) In considering the status of the

patients at the close of treatment it seems significant that those seen in fifteen or more interviews were by a large proportion more frequently improved (seven times as often) as those patients seen in five or less interviews. This seems to indicate that patients seen for more interviews have increased chances for improvement. (9) Of the fifteen patients whose intake prognosis was good, four had a good terminating prognosis. These patients were evenly divided between Groups A and B. (10) The correlation between intake and terminating prognosis in the groups of guarded and poor gave no indication that the number of interviews had any effect upon their correlation. (11) The largest single reason for termination is seen in the sub-division of the classification of poor motivation. These were patients who failed to keep appointments or declined treatment. This poses a question as to whether these patients had adequate orientation about psychotherapy in the initial contacts with the clinic. It also seems pertinent to question why thirteen of the thirty-five patients who declined or failed to keep appointments did so after the fifteenth interview.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This study was focused on those cases closed between January, 1952, and December, 1952, inclusive, and which were assigned to the Mental Hygiene Clinic Service for psychotherapy. The study groups were composed of Group A, a sample of fifty cases of patients who had been seen for five or less interviews prior to termination of therapy, and Group B, a sample of fifty cases in which the patients had been seen for fifteen or more interviews before the cases were closed.

The purpose of the study was to investigate, compare, and analyze the relationship between the length of stay in the clinic and a number of characteristics of patients determined by their records, so as to gain an understanding, if possible, of what differentiates patients who promptly drop out of treatment from those patients who go on at least to the point of giving psychotherapy an adequate trial.

The Mental Hygiene Clinic offers neuropsychiatric services to veterans who have service-connected disabilities for mental or nervous illnesses and whose needs can be met on an out-patient basis without hospitalization.

In order to determine whether and in what ways the patients in Group A and in Group B differed, it was necessary to consider each patient according

to his current and past personal, social, and military status, so that a clearer conception might be gained as to the kind of person who comes to the Mental Hygiene Clinic for treatment.

The data revealed that the age of the patient was not a significant factor existing between the groups, as patients in both groups were for the most part found to be in their twenties.

The majority of patients attending the clinic and living in the city (77 per cent), resided within a ten-mile radius of the clinic. Sixty-one per cent of those living outside the city had five or less interviews, while 39 per cent of this number had fifteen or more interviews.

Most of the patients in both groups were married, with dependents, and the patients themselves had been reared in homes where the family was intact.

Of the patients remaining in treatment for fifteen or more interviews, there was a striking majority who had some college training and/or training past the college level.

Forty-seven per cent of the combined Groups A and B were distributed in the classification of professional, managerial, clerical, and sales occupations. A little over 68 per cent were in Group B, which significantly correlates positively with the data concerning the educational attainment of the study groups.

Seventy-three per cent of the patients in the total study groups had between one and one-half to four and one-half years of military service, with the patients seen for fifteen or more interviews numbering more than twice as many as those patients who had five or less interviews. There was no significant

difference between the patients in Group A and Group B in regard to their former branch of service and their combat experiences.

Having identified the patients in this study, an observation was made then of the Mental Hygiene Clinic Service data. The findings showed that many of the patients had been referred by the Medical Out-Patient Department, and on these referrals more than three times as many patients remained in therapy for fifteen or more interviews than those who terminated within the first five interviews. Those patients who came to the Clinic classified as "others" in nearly all instances remained in therapy for a comparatively few interviews (five or less).

Once accepted for treatment, the patients whose initial requests were for medication and psychotherapy were most frequently assigned to social service as opposed to being assigned to the other two disciplines on the psychiatric team. Specifically, social service was active in 47 per cent of the one hundred cases studied.

There was little evidence of a positive correlation between Group A and Group B in terms of the prognosis at intake and the prognosis at time of termination. Interestingly enough, more than one-half of the patients in Group A and in Group B terminated their own therapy, whereas the therapist participated in the plan for termination in one-fifth of the cases in Group A and a little over one third of the cases in Group B. In considering the reasons for termination, it has been noted that in Group A and in Group B the majority of the patients fell under the classification of poor motivation.

The significance of the patients' relatively brief treatment and specific factors influencing patients in terms of interviews has been difficult

to identify; nevertheless, the consistent correlation between the numbers of interviews and certain data studied leads the writer to formulate the following tentative conclusions.

For example, in looking at the demonstrated ability of the patients with some college training or more to continue in treatment for fifteen interviews or more seems to indicate that the patient's acceptance and use of treatment increases in direct proportion to his educational attainment. One may wonder what is the implication of this. Is it because veterans of low intelligence are not as motivated to accept the services of the clinic as those of high intelligence, or is it because the treatment of the clinic is more geared to veterans with higher intelligence and adequate motivation for treatment? If the latter is true, then perhaps some thought should be given to readjusting the services of the clinic to meet the needs of the other groups.

It seems significant that a proportionate number of patients came to the clinic referred by the medical out-patient department and by self-referral and remained in treatment for a more lengthy period. It might be presumed that such patients were well motivated and adequately orientated at the time of their initial contact. On the other hand, those patients who came to the clinic as the result of outside pressures, i.e., private physicians, courts, relatives, and other interested persons, in nearly all instances, remained in therapy for a comparatively few interviews (five or less). On the basis of this data, it does seem that adequate orientation and positive motivation are primary, and necessarily factors which play an important part in influencing the patient's length of time in treatment and in determining the successful outcome of the psychotherapy. If this is true, then this writer believes that

there should be a more conscious effort extended during the intake interview in trying to help those veterans who are poorly motivated to either try to move into treatment or to move out of it at that point. This in turn would at the outset delineate more clearly which applicants are likely or not likely to accept treatment as well as prevent waste of time and of money spent staffing those cases which do not respond to treatment letters and drop out of treatment within the relatively brief interview span.

APPENDIX I

SCHEDULE

I. IDENTIFYING DATA

A. Case #_____

B. Address: _____

C. Age: (1) Under 20____; (2) 20-30____; (3) 30-40____; (4) 40-50____; (5) 50 or over ____.

D. Marital Status: (1) Single____; (2) Married____; (3) Divorced____; (4) Separated____; (5) Widowed____; (6) Common Law____.

E. Number of Dependents____.

F. Education: (1) 1 2 3 4 5 6 7 8; (2) 1 2 3 4 (3) 1 2 3 4
Elementary High School College

(4) Other Training_____.

G. Occupational Classification _____.

H. Living with: (1) Spouse____; (2) Parents____; (3) Relatives____; (4) Alone____.

I. Family Situation in Which Veteran Was Reared: (1) Family Intact____; (2) Mother out of Home____; (3) Father out of Home____; (4) Both out of Home____; (5) Other Interfamilial Conflict____.

II. MILITARY DATA

A. Branch of Service: (1) Army____; Navy____; (3) Marines____; (4) Coast Guard____.

B. Length of Service: (1) 0-6____; (2) 7-17____; (3) 18-29____; (4) 30-40____; (5) 41-53____; (6) 54-65____; (7) 66 or over____.

C. Combat Experience: (1) Yes____; (2) No____.

III. SOURCE OF REFERRAL

A. MOP_____
B. Neurology_____
C. VA Hospital_____
D. Adjudication_____
E. Chief Attorney_____
F. Vocational Rehabilitation_____
G. Non V.A. Agency_____
H. Self_____
I. Other_____

IV. MEDICAL RECORD SINCE DISCHARGE

A. Hospitalized - Yes_____ No_____
B. Out Patient Care - Yes_____ No_____
C. Psychiatric Care - Yes_____ No_____
D. Medical Care - Yes_____ No_____

V. MENTAL HYGIENE CLINIC SERVICE

A. Psychiatric Classification of Patient's Complaints: (1) Psychoneurotic Disorders_____; (2) Psychotic Disorders_____; (3) Personality Disorders.

B. Prognosis at Initial Staff: (1) Good_____; (2) Fair; (3) Guarded; (4) Poor.

C. Nature of Patient's Initial Request: (1) Medication_____; Psychotherapy _____; (3) Hospitalization_____; (4) Help with External Problems _____.

D. Patient's Expressed Choice: (1) Day Clinic_____; (2) Night Clinic_____; (3) No Choice_____; (4) Granted - Yes_____, No_____.

E. Beginning month of treatment: _____.

F. Discipline Assigned: (1) Psychiatry_____; (2) Psychology_____; (3) Social Work_____.

G. Sex of Therapist: (1) Male_____; (2) Female.

H. Length of Time in Therapy: (1) Number of interviews_____; (2) Number of Months_____.

I. Termination of Treatment by: (1) Patient_____; (2) Therapist_____; (3) Mutual agreement; (4) Hospitalized; (5) Declared ineligible _____; (6) Other.

J. Reasons for Termination:

K. Psychiatric Status of Patient at Close of Treatment: (1) Unimproved, unchanged; (2) Improved_____; (3) Worse_____; (4) Unknown_____; (5) Prognosis at termination Good_____; Fair_____; Guarded_____; Poor_____.

APPENDIX II

REGIONAL OFFICE SOCIAL SERVICE CARD

1. LAST NAME—FIRST NAME—MIDDLE NAME | 2. C-NO.

3. ADDRESS

4. NAME AND ADDRESS OF NEAREST RELATIVE | 5. RELATIONSHIP

6. RACE | 7. WAR ☐ WW I ☐ WW II | 8. SERVICE-CONNECTED DISABILITY ☐ YES ☐ NO | 9. DISABILITY RATING %

10. DIAGNOSIS

11. REFERRAL
☐ PHYSICIAN ☐ ADJUDICATION ☐ CHIEF ATTORNEY ☐ VOCATIONAL REHABILITATION ☐ CONTACT ☐ OTHER ☐ SELF
☐ OTHER VA REGIONAL OFFICE *(Specify)* ☐ VA HOSPITAL *(Specify)* ☐ COMMUNITY AGENCY *(Specify)*

12. DATE REFERRED | 13. DATE REPORT DUE | 14. DATE REOPENED | 15. DATE CLOSED

16. NATURE OF REQUEST

17. SERVICE
☐ REFERRED TO OUTSIDE AGENCY *(Specify)* ☐ IMMEDIATE ☐ CONTINUED ☐ TREATMENT IN MENTAL HYGIENE

18. CONTACT
☐ VETERAN ☐ FAMILY ☐ EMPLOYER ☐ PHYSICIAN ☐ COMMUNITY AGENCY ☐ OTHER

19. SOCIAL SERVICE EXCHANGE
☐ IDENTIFIED ☐ UNIDENTIFIED

20. REPORTS

21. WORKER | 22. DATE ASSIGNED

VA FORM 10–3903 DEC 1946 Supersedes VA Form 5-3903, Dec 1945, which may NOT be used. 16—52653-2 **REGIONAL OFFICE SOCIAL SERVICE CARD**

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