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

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

by

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CHAPTER I

INTRODUCTION

PURPOSE. There is a common concern in the adult psychiatric out-patient clinics regarding the number of patients who remain in treatment only a short time. This is true at the West Side Veterans Administration Hospital, Mental Hygiene Clinic Service, Chicago, Illinois. There is also considerable speculation as to the reasons for the situation. To attempt to isolate some of the possible causes is the purpose of this study.

METHOD. In contrast to the patient who is seen for a brief time our clinic has a large number of patients who do continue in treatment. We believe that a comparison of these two extreme groups may indicate differences or similarities that will be revealing. Material from case records was set onto schedules. Specific definition of precise meaning of items used for schedules will be made as comparisons are discussed in the body of the study.

SCOPE. The decision as to what constitutes short term treatment was determined arbitrarily. Group A consists of fifty case records where there were five or less treatment interviews,

chosen by random sampling from a total of 250 cases. Group B consists of fifty case records where there were fifteen or more treatment interviews, which includes one-half of all the available records in that category.

SOURCE. Information was obtained from case records in the clinic.

LIMITATIONS. The study was restricted to cases closed from January through December, 1952. Further limitation is made in that the cases must have been assigned to psychotherapy. The study is concerned with only the treatment type of interview. The treatment interview is defined as an interview with the veteran by a professional person after the veteran has been formally assigned to therapist at a group conference.

FUNCTION OF THE CLINIC. According to VA Circular #169 (7-15-46),

> The primary function of a Mental Hygiene Clinic is to treat the veteran suffering from a service connected neuropsychiatric illness not requiring hospitalization.[1]

Our clinic treats veterans who have a service connected neuropsychiatric disability, those attending school under Public Law 16, as well as those veterans where their neuropsychiatric disability is aggravating their service connected condition.

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1 Veterans Administration "Circular 169" July 16, 1946

The staff is involved in these services in various ways and may conclude service by closing the case at the intake level. A patient may be referred to Neurology, one of the out-patient clinics, or to another VA office. Perhaps evaluation is done for fee basis treatment. A request may be received for a trial visit evaluation from a veteran's hospital. Hospitalization may be arranged for a veteran. The veteran may at any time decline to complete the intake process.

CLINIC ADMINISTRATION AND STAFF. The staff of the Mental Hygiene Clinic is under a Medical Director and his assistant, both psychiatrists. There are staff and resident psychiatrists; psychology chief, staff psychologists, and trainees; psychiatric social work chief, staff, and students; a psychiatric nurse, plus the clerical personnel.

The clinic operates on the team basis with representatives from each of the three above listed professions participating in regular meetings for purpose of diagnosis and assignment of cases, as well as to provide assistance in treatment planning. The responsibility for diagnosis and assignment rests with the group moderator, a staff psychiatrist. On each team a social worker and psychologist is assigned to present the intake material for his profession. Each therapist presents his own case in the treatment evaluation conference.

INTAKE PROCESS. When the veteran arrives at the clinic he is seen by a clerical worker who obtains face sheet information for the record. His first professional contact usually is with the psychiatric social worker, who obtains a social history; evaluates insofar as possible what the veteran wants from the clinic; orients the veteran to psychotherapy and clinic procedures; helps the veteran work through his feelings around the acceptance or rejection of clinic services; and directs him to another appropriate agency, if that seems to be indicated. The veteran is also given an appointment with the psychiatrist if he is continuing. This interview is for evaluation, diagnosis, and determination of any organic illness that may be related to present disturbance. Subsequently the veteran is seen by the clinical psychologist and psychometric tests are administered. All of the intake material is presented in the group meeting and a disposition is made. If he is assigned to psychotherapy the therapist notifies the veteran by letter of his first appointment. The treatment interviews are held routinely once a week but other arrangements may be made by therapist and veteran.

HYPOTHESIS. Certainly there are many reasons and probably not simply a reason in any instance that veterans do not remain in treatment. There is a question of adequate motivation. There is consideration of what attention is given ambivalent feelings regarding treatment. There is the possibility that the

patient finds that he cannot quite face the demands on himself that are necessitated in treatment. It may be that a reality stress situation that initially moved him to the clinic has become more comfortable. These are not the types of answers we can hope to find in the present study.

As stated above, this study was conducted as a comparison of two extreme groups and emphasis will be placed on differences and similarities in the groups. Areas of comparison were selected on the basis of possible significance which they might have on the veteran's ability to accept psychotherapy. We will look at some of the external factors that help to place the veteran in his environment at the time he is seen at the clinic; how he arrived there; what service he requested; whether he has had previous psychiatric care. We will check into some of the elements of his early family life. We will evaluate military experience. We will use some of the clinical thinking regarding the veteran, asobtained from the record of team meetings. We are testing the variable of assignment in terms of profession. We are comparing termination data, educational background, and practical considerations of distance veteran lived from clinic and season of year he began treatment.

METHOD OF PRESENTATION. The study will be presented in the following manner:

1. In Chapter II the length of time the veterans were in

treatment and record of previous clinic contact will be determined.

2. Some background factors, including early parental ties, education, military history, care since discharge, will be considered and compared in Chapter III.

3. A comparison will be made in Chapter IV of some of the current identifying and social information of the study group.

4. In Chapters V and VI analysis will be focussed on how veteran arrived at the clinic, what he initially requested, his early clinic experience, staff thinking, and termination data.

5. In the last chapter the findings and conclusions of the study will be summarized.

CHAPTER II

VETERANS' CONTACT IN THE CLINIC

INTRODUCTION. This chapter deals with the number of interviews for each veteran during the period that he was in therapy and the amount of contact the veteran has had earlier in the clinic.

DEFINITION OF STUDY GROUP. As defined in the introduction, Group A will be composed of fifty veterans who had five or less treatment interviews, where the case was closed from January through December, 1952. Group A is a random sample of a total of two hundred and fifty case records, obtained by using every fifth case. Group B is an equal number of veterans who had fifteen or more treatment interviews during the same period of time. Group B represents one-half of the total available cases in that category. Intake process interviews were not counted in either group, in accord with the agency's use of the term, treatment interview. Interviews were counted from the last reopening date at the clinic.

NUMBER OF TREATMENT INTERVIEWS. The total number of treatment interviews for Group A was fifty-five. The average

number for the group was one treatment interview. The following table shows that almost one-half of Group A, twenty-three veterans, or forty-six percent, were not seen in any treatment interviews. Almost one-third of the group were seen just once. These facts indicate the large number of veterans who, for one reason or another, do not follow through with psychotherapy in the Mental Hygiene Clinic. The matter of eligibility could be a partial explanation. If the veteran's eligibility is established he is free to request and not utilize the clinic service.

The total number of treatment interviews for Group B was 2317. The average number of interviews in this group is forty-six. The highest number of interviews was two hundred and thirty-one. One veteran was seen in one hundred and four treatment interviews and thirty-three group therapy meetings. The majority of veterans, or forty-four percent, were seen an average number of twenty times. It seems then that the majority of veterans who are in treatment are not seen on any long term basis. This is in accord with the clinic function.

TABLE I

NUMBER OF TREATMENT INTERVIEWS

Group A		Group B	
No Interview	23	15 to 25	22
1	15	26 to 40	12
2	2	41 to 75	7
3	5	76 and Over	8
4	4	Other	1
5	1		
TOTAL	50	TOTAL	50

Comparison of the number of interviews in the study group is made only to show clearly the range in these veterans' use of psychotherapy at the Mental Hygiene Clinic in terms of time and to bring out the reason for the clinic's concern regarding the situation.

EARLIER CONTACT WITH THE CLINIC. A case is ordinarily considered to be reopened at the Mental Hygiene Clinic when it has been closed by the staff for over ninety days and the veteran returns to request service. The regular intake process is necessary unless special permission is obtained by the therapist from the group moderator. The length or kind of earlier contact

is not included in the study.

In the study groups the records showed that sixteen veterans, or thirty-two percent of Group A had been known to the clinic earlier. Twelve veterans, or twenty-four percent, had been known once before and four veterans, or eight percent, had been known twice before. In Group B, twenty-one veterans, or forty-two percent had been reopened at least once; sixteen veterans, or thirty-two percent had been known twice; and one veteran, or two percent, had been known to the clinic on three previous occasions.

The majority of veterans in both groups were new to the Mental Hygiene Clinic. There was a slightly higher number of reopened cases among the veterans that remained in treatment but the difference is not pronounced.

SUMMARY. The object of this chapter has been to point up the use of the Mental Hygiene Clinic by these veterans in terms of time. The range in length of time in treatment is considerable. There does not seem to be a significant divergence in the number of veterans who had been known to the clinic earlier.

CHAPTER III

COMPARISON OF BACKGROUND FACTORS IN THE STUDY GROUP

INTRODUCTION. The analysis in this chapter is concerned with some of the veteran's previous life experience; parental ties in early childhood; education; service branch; term, and combat history; and medical and psychiatric record since discharge.

PARENTAL TIES IN CHILDHOOD. The data on parental ties in childhood is restricted only to the actual physical presence of the parent of the veteran in his home to at least the age of twelve years. No attempt was made to evaluate the value of the relationship. In those situations where both parents were out of the home no distinction was made as to type of substitute parent. The home was considered intact if both parents were in the home until the veteran was twelve years of age; the remaining classifications were made on the basis of whether one or both parents was absent during that period.

The following table indicates that the groups were very similar in this area.

TABLE II

PARENTAL SITUATION IN WHICH

VETERAN WAS REARED

Parents	Group A	Group B
Both parents in home	31	30
Mother out of home	2	1
Father out of home	6	7
Both parents out of home	5	5
Unknown	6	7
TOTAL	50	50

The majority of patients in both groups, thirty-one veterans, or sixty-two percent in Group A, and thirty veterans, or sixty percent in Group B, had intact homes. The other subdivisions were consistently equally distributed. It would appear that for these veterans the fact of parental presence in the home made no difference in the veteran's ability to accept psychotherapy.

EDUCATION. Education was divided into four main classifications: elementary, high school, professional and trade training. These classifications were broken down further on the basis of partial completion and combination within the classifications.

TABLE III

EDUCATION

Amount of Education	Group A	Group B
4th through 8th grade	12	2
8th grade plus trade school	2	1
1 through 2 years high school	4	6
1 through 2 years high school plus trade school	1	2
3 through 4 years high school	12	19
3 through 4 years high school plus trade school	6	5
1 - 2 years college	0	4
3 - 4 years college	4	1
3 - 4 years college plus additional training	0	1
Unknown	9	9
TOTAL	50	50

The table discloses that in Group A twelve veterans, or twenty-four percent, had only elementary education while in Group B only two veterans, or four percent, had just elementary education. We see that thirty veterans, or sixty percent, of Group B had at least three years of high school while twenty-two veterans, or forty-four percent of Group A had like training. At the high level of education the groups tended to balance quite evenly.

There were six veterans, or twelve percent, of Group B and four veterans, or eight percent, of Group A who had college training. Trade training occurred in eighteen percent of the cases in Group A and in sixteen percent of the cases in Group B. It is interesting that there were more veterans with trade training than with college education in both groups.

MILITARY SERVICE DATA. Service information regarding military experience was considered on the basis of branch of service, length of time in service, and whether or not the veteran had combat experience.

BRANCH OF SERVICE. In Group A thirty-one veterans, or sixty-two percent, had been in the army; fifteen veterans, or thirty percent, had been in the navy; and four veterans, or eight percent, had served in the marine corps. In Group B forty veterans, or eighty percent, had been in the army; nine veterans, or eighteen percent, had been in the navy; and one veteran, or two percent, had been in the coast guard.

The majority of veterans in both groups had been in the army branch of military service. There was wider distribution among the four branches of service in Group A but there does not appear to be significance in the difference found.

COMBAT EXPERIENCE. We are dealing only with the fact of combat experience. The amount was not our concern in this study, nor did we attempt to evaluate the kind of combat

experience.

TABLE IV

COMBAT EXPERIENCE IN MILITARY SERVICE

Combat Experience	Group A	Group B
Combat	25	19
No Combat	12	25
Unknown	13	6
TOTAL	50	50

Although Group A had a higher percentage of combatants, fifty percent as against thirty-eight percent in Group B, the difference does not seem to be conclusive, at least from this comparatively small sample. One might speculate as to the importance of combat as a cause for breakdown in military service when one-half of the veterans in treatment had no combat experience.

LENGTH OF MILITARY SERVICE. The amount of time in military service was classified in terms of months, ranging from under six months to sixty-six months and over. Seven divisions of time were made within this limitation.

TABLE V

LENGTH OF TIME IN MILITARY SERVICE

Months of Military Service	Group A	Group B
0 - 6	3	1
7 - 17	4	15
18 - 29	11	18
30 - 40	14	11
41 - 53	14	4
54 - 65	2	0
66 or over	2	0
Unknown	0	1
TOTAL	50	50

Comparison of the two groups discloses that twenty-eight veterans, or fifty-six percent, of Group A had from thirty to fifty-three months of military service and thirty-three veterans, or sixty-six percent of Group B had from seven to twenty-nine months of military service. It seems that in the study group the veterans that remained in treatment spent less time in military service.

MEDICAL AND PSYCHIATRIC CARE SINCE DISCHARGE. Consideration of this material includes both hospital and out-patients, VA and non VA care.

TABLE VI

MEDICAL AND PSYCHIATRIC CARE SINCE DISCHARGE

Care	Group A	Group B
Psychiatric		
Out-Patient Only	7	4
Hospitalization Only	5	13
Both	7	7
Medical		
Out-Patient Only	7	2
Hospitalization Only	0	3
Both Care	8	6
Neither Care	15	15
No Record	1	0
TOTAL	50	50

A similar number in both groups, fifteen veterans, or thirty percent, had neither medical nor psychiatric care since discharge from military service, prior to initiation of treatment at Mental Hygiene Clinic. This would imply that they had made at least a fair adjustment. Over half of the veterans in both groups, thirty-one veterans, or sixty-two percent in Group A and twenty-nine veterans, or fifty-eight percent in Group B, had psychiatric care since discharge. One might expect this

similarity in that all members of the study had a service-connected neuropsychiatric disability.

A slightly larger percentage had psychiatric care during the interim among the group who left the treatment situation. It appears that a larger proportion of veterans who were hospitalized for psychiatric care only, twenty-six percent as against ten percent, did not remain in therapy while more veterans with only psychiatric out-patient care, fourteen percent as against eight percent, stayed in treatment. Thirty of the veterans, or sixty percent, seen only briefly, as compared with twenty veterans, or forty percent, who remained in psychotherapy had had hospital care, either medical or psychiatric. Also, more of the veterans who remained in therapy, fifty-two percent as against thirty-four percent, had previous out-patient care. There does not seem to be strong enough differences in these findings to validate conclusive statements regarding the influence of earlier medical or psychiatric care upon the veteran's ability to accept psychotherapy.

SUMMARY. This chapter has been concerned with the comparison of some of the life experiences of the veterans to find out whether, on the basis of material used, there were outstanding differences or similarities that might have a bearing on the veteran's use of the clinic services.

1. There was no difference between Groups A and B in the following areas; parental situation which the veteran was reared and branch of military service.
2. There was a slight difference between Groups A and B in the areas of combat experience and medical and psychiatric care since discharge.
3. There was a considerable difference between Groups A and B in the areas of education and length of time in military service.

CHAPTER IV

COMPARISON OF CURRENT IDENTIFYING AND SOCIAL INFORMATION ABOUT THE VETERANS

INTRODUCTION. In this chapter we will present and compare current identifying information regarding the two groups of veterans. Age, marital status, number of dependent children, living arrangements, occupational classification, and travelling distance from the clinic will be considered. Information in all of these classifications is current with last reopening date of application, insofar as possible.

AGE. The age of the veterans is divided into four sub-groups; twenty to thirty years; thirty-one to forty years; forty-one to fifty years; and fifty-one years and over.

TABLE VII

AGE

Age at Initiation of Treatment	Group A	Group B
20 - 30 years	19	24
31 - 40 years	24	19
41 - 50 years	3	5
51 years and over	4	2
TOTAL	50	50

The majority of veterans who remained in treatment were from twenty to thirty years of age and the majority of veterans who terminated prior to the sixth treatment interview were thirty-one to forty years of age. Generally it appears that the veterans who remain in treatment are a slightly younger group.

MARITAL STATUS. Marital status of the veterans was divided into the following classifications which are self-explanatory: single, married, divorced, separated, and widower.

TABLE VIII

MARITAL STATUS

Marital Status	Group A	Group B
Single	21	19
Married	23	25
Divorced	2	2
Separated	3	3
Widowed	1	1
TOTAL	50	50

There was a slightly higher number of married veterans in the group that remained in treatment but the majority of the total study group was married. Oddly enough, the groups were exactly alike in divorce rate, separation and death of partner. Over one-third of the veterans in both groups were single. There is no appreciable difference in the marital status of the study group.

DEPENDENTS. In regard to family responsibility, children living in the home were the only persons considered as dependents, for our purposes.

TABLE IX

DEPENDENT CHILDREN IN VETERAN'S HOME

Number of Dependent Children	Group A	Group B
No Children	30	27
One Child	7	9
Two Children	8	8
Three Children	3	4
Four or More Children	2	2
TOTAL	50	50

There appears to be no significant difference in the number of dependent children in the home of veterans who did or did not remain in treatment. The majority of veterans in both groups had no children. This is to be expected because over a third of both groups were single. Of those who had children the majority had one or two children.

LIVING ARRANGEMENTS. Living arrangements of veterans were classified on the basis of the veteran living with his spouse, parents, relatives, or in independent accommodations.

TABLE X

LIVING ARRANGEMENTS OF VETERANS IN THE STUDY GROUP

Living With	Group A	Group B
Spouse	23	25
Parents	12	13
Relatives	3	1
Alone	12	11
TOTAL	50	50

It seems that the two groups are very similar in regard to living arrangements. One would assume that the majority would be living with spouse since we learned earlier that the majority of both groups are married. One wonders whether a question might be raised regarding dependency in both groups when it is found that of the one-third that is single and ranging in age from twenty to forty years, approximately one-half of each group continues to live with parents.

EMPLOYMENT. Classifications used in this category are based on and taken from the "Dictionary of Occupational Titles", Volume 2, Second Edition, Occupational Classifications, published in Washington, D.C., 1949.

TABLE XI

EMPLOYMENT CLASSIFICATION

Employment Classification	Group A	Group B
Professional	2	1
Technical	5	3
Managerial	0	0
Clerical	7	9
Sales	0	3
Services	1	5
Mechanical	9	8
Manual	21	13
Student	2	5
No Record	3	3
TOTAL	50	50

The main distinction between the two groups in the area of employment seems to be that Group A had more manual laborers than Group B -- twenty-six percent as against forty-two percent. However, the highest number in any kind of employment for both groups was in manual labor. The next most common types of employment for both groups were clerical and mechanical. It is interesting that the only type of employment this sample did not include was the managerial kind of work. It is apparent that the

group who remained in therapy were fairly well dispersed through the occupational gamut.

TRAVELLING DISTANCE. Throughout the year 1952 the Mental Hygiene Clinic was located in its former quarters, 744 West Adams Street in Chicago, Illinois. In considering travelling distance involved for the veteran it was computed by the distance from his home to the agency. It is true that a number of veterans might be coming to the clinic from their place of employment rather than their homes.

TABLE XII

TRAVELLING DISTANCE FROM VETERAN'S HOME TO THE MENTAL HYGIENE CLINIC

Travelling Distance	Group A	Group B
Under 3 Miles	10	2
3 to 5 Miles	6	9
5 to 8 Miles	11	12
8 to 10 Miles	11	14
10 to 15 Miles	6	8
15 Miles and More	6	5
TOTAL	50	50

The majority of veterans in both groups, twenty-two veterans, or forty-four percent in Group A, twenty-six veterans, or fifty-two percent in Group B, had to travel from six to ten miles from their home to the clinic. Actually, more of those veterans who remained in treatment travelled farther. It is interesting that twenty percent of those veterans who terminated therapy prior to the sixth interview lived less than three miles from the clinic. The clinic was then located on the periphery of the "loop" section of the city. It might be that the persons living in that area tended generally to be a transient group.

SUMMARY. Analysis in the foregoing identifying and social information indicates that the two groups of veterans are much alike in these areas.

1. There was a slight difference in age in that the group that remained in treatment tended to be younger.
2. Although there was a slightly higher number of married veterans in the group that remained in treatment, the majority of both groups were married.
3. There was no significant difference in the number of dependent children in the homes of the veterans. The majority of both groups had no children and of those who did, the range was similar.

4. The groups were very similar in regard to living arrangements in that the majority of both groups lived with spouse. The remaining veterans in both groups were similar in that approximately one-fifth of each group lived with parents and another one-fifth lived in independent arrangements.
5. There was some difference in employment classification in that more of the group who terminated were employed in manual labor.
6. The average travelling distance from the veteran's home to the clinic was about the same for both groups although, as a group, those who remained in treatment travelled farther.

CHAPTER V

COMPARISON OF FACTORS IN EARLY CLINIC EXPERIENCE

INTRODUCTION. Information was obtained from the case records regarding the source of referral to the clinic; the nature of the veteran's initial request at the clinic; the season in which treatment was begun; the profession of the therapist; and initial staff thinking in terms of diagnosis and prognosis for the veteran. This material will be discussed in terms of differences or similarities in the study groups.

SOURCE OF REFERRAL. This area has been grouped into six categories: Medical Out-Patient Clinics, VA Hospital, Vocational Rehabilitation Division at the VA, non VA agencies, Self and Others.

In Group A twenty-five veterans, fifty percent of the total group, were self referred to the clinic. Eleven veterans, twenty-two percent, were referred from Medical Out-Patient Clinics. Seven veterans, fourteen percent, had been referred by VA hospitals and there were six veterans, or twelve percent, referred from "other" sources. One veteran was referred by Municipal Court. In one instance the veteran came from the

Pension Unit of the Veteran's Administration and three veterans were referred by private psychiatrists.

In Group B fourteen veterans, twenty-eight percent, were referred from Medical Out-Patient Clinics. Eleven veterans, or twenty-two percent, were referred from VA hospitals. Eighteen veterans, or thirty-six percent, were self referred. Four veterans, or eight percent, were referred from the VA Vocational Rehabilitation section and three veterans fell in the "other" group. One of these veterans was referred from the local Catholic Charities agency, a second veteran was referred by a private psychiatrist, and the third was referred from Special Rehabilitation Services in the VA.

TABLE XIII

SOURCE OF REFERRAL

Source of Referral	Group A	Group B
Medical Out-Patient Clinic	11	14
VA Hospitals	7	11
Vocational Rehabilitation	0	4
Non VA Agency	1	1
Self	25	18
Other	6	2
TOTAL	50	50

It would seem that the highest number of veterans in both groups were self referred to the Mental Hygiene Clinic. However, there were fourteen percent more veterans self referred in the group that did not remain in treatment. The groups were similar too in that the next most frequent sources of referral were the Medical Out-Patient clinics and the VA hospitals. These findings would imply that most of the referrals, apart from the self referrals, came from within the VA organization. The question of what constitutes a self referral would require considerably more intensive study than our present limitations provide but would probably be most helpful in this area.

INITIAL REQUEST OF VETERAN. The nature of the veteran's initial request regarding the service he hoped to receive at the clinic was categorized as follows; medication, psychotherapy, hospitalization, and help with external problems. Veterans usually request one or a combination of these items.

TABLE XIV

NATURE OF VETERAN'S INITIAL REQUEST

Veteran's Initial Request	Group A	Group B
Medication	4	4
Psychotherapy	37	39
Hospitalization	3	2
Help With External Problems	4	7
Medication and Psychotherapy	1	2
Medication and Hospitalization	0	1
Other	1	1
TOTAL	50	50

The table discloses that the great majority of veterans in both groups, seventy-four percent of Group A and seventy-eight percent of Group B, wanted psychotherapy. Perhaps one can assume that most of these veterans are aware that psychotherapy is the primary service offered by the clinic.

It seems logical that no more veterans requested hospitalization in either group because if that were indicated, the case would not have gone to staff for assignment to psychotherapy. In the event that the veteran wants medication and learns it is not often given, he will frequently decline to continue the intake process and thus, he would not be staffed

for assignment to psychotherapy either.

SEASON TREATMENT WAS BEGUN. The beginning months of treatment for the veterans were separated into the season of the year in which the veteran's first treatment interview was scheduled.

In Group A the veterans were scheduled for their first treatment as follows: seventeen veterans, or thirty-four percent, in the Fall months; nine veterans, or twenty-eight percent, in the Spring months; and ten veterans, or twenty percent, in the Summer months. There was really little difference among the group except that the Fall and Spring seasons tended to be more popular to a slight degree.

In Group B the veterans were scheduled for their first treatment interview as follows; thirteen veterans, or twenty-six percent, in the Fall; ten veterans, or twenty percent, in the Winter months; sixteen veterans, or thirty-two percent, in the Spring months; and eleven veterans, or twenty-two percent, in the Summer months. Group B followed the pattern of Group A in that more began treatment in the Fall and Spring months.

There appears to be no significant difference in the two groups regarding the season of the year during which treatment was initiated.

NIGHT CLINIC. Some veterans request night clinic appointments, usually because day hours would interfere unduly

with employment. There are facilities available at the Mental Hygiene Clinic for a limited number of night clinic patients. The study group was checked regarding this factor and it was found that those patients in both groups who requested night clinic appointments were given such time.

PROFESSION OF THERAPIST. As stated in the introduction, therapy at the clinic is conducted by the psychiatrist, clinical psychologist, and psychiatric social worker. Occasionally a patient will be seen by members of two professions at different intervals for various reasons.

TABLE XV

PROFESSION TO WHICH VETERAN WAS ASSIGNED AT INITIATION OF TREATMENT

Profession of Therapist	Group A	Group B
Psychiatry	12	17
Psychology	15	15
Social Work	23	10
Psychiatry and Psychology	0	4
Psychiatry and Social Work	0	4
Psychology and Social Work	0	0
TOTAL	50	50

The table discloses a real difference in this area. In the group that remained in treatment, psychotherapy was handled most frequently by psychiatrists; secondly, by the clinical psychologists; and least frequently by the psychiatric social workers. In the group that left treatment almost one-half of the total had been assigned to the social service department. We know that almost one-half of the patients in this group did not keep any treatment appointments. Question might be raised here as to the kind of patients assigned to and seen by social service in therapy.

DIAGNOSIS. The diagnosis for the veterans was taken only from the initial staffing record of the group meeting. The classifications used are; psychotic reaction, psychoneurotic reaction, and character disorders. Naturally the staff diagnosis is more specific than these large classifications but enumeration of each of these was not practical for our purposes.

Definitions of these classifications were taken from the "Nomenclature on Mental Disorders" prepared by the committee on Nomenclature and Statistics of the American Psychiatric Association, published in 1952.

> Grouped as Psychoneurotic Disorders are those disturbances in which "anxiety" is a chief characteristic, directly felt and expressed, or automatically controlled by such defense as depression, conversion, disassociation, displacement, phobia formation, or repetitive thoughts and acts. A psychoneurotic action may be defined as one in which the personality in its struggle for adjustment

to internal and external stresses, utilizes the mechanism listed above to handle the anxiety created. A specified example may be seen in an episode of acute anxiety occurring in an homosexual.

Psychotic disorders are 1) affective disorders, characterized by severe mood disturbance, with associated alterations in thought and behavior, in consonance with the affect; 2) schizophrenic reactions, characterized by fundamental disturbances in reality relationships and concept formations, with associated affective, behavioral, and intellectual disturbances, marked by a tendency to retreat from reality, by regressive trends, by bizarre behavior, by disturbance in stream of thought, and by formation of delusions and hallucinations; 3) paranoid reactions, characterized by persistent delusions and other evidence of the projective mechanisms. A psychotic reaction may be defined as one in which the personality in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism and withdrawal from reality, and/or formation of delusions and/or hallucinations.

Grouped as Personality Disorders are those 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. A behavioral reaction (personality disorder) may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes primarily a pattern of action or behavior. [1]

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1 "Mental Disorders", Nomenclature of Mental Disorders, prepared by Committee on Nomenclature and Statistics, American Psychiatric Association, 1952.

TABLE XVI

INITIAL STAFF DIAGNOSIS

Diagnosis	Group A	Group B
Psychoneurotic Reaction	35	28
Psychotic Reaction	13	17
Character Disorder	2	5
TOTAL	50	50

The majority of veterans in both groups carried a diagnosis of psychoneurotic reaction although there was a higher percentage in the group that terminated therapy. It is interesting that one-third of the group that continued threatment had a diagnosis of psychotic reaction.

PROGNOSIS. The prognosis was taken, as was the diagnosis, from the initial staffing record.

TABLE XVII

INITIAL STAFF PROGNOSIS

Prognosis	Group A	Group B
Good	1	1
Fair	4	7
Guarded	11	3
Poor	9	16
Deferred	0	10
Not Given	25	13
TOTAL	50	50

There were more veterans that remained in treatment that received a poor prognosis. The prognosis most frequently given in the group that terminated therapy was guarded. It is interesting that only one veteran in each of the two groups received a prognosis of good. The prognosis was not given in so many cases that it is not felt that conclusions can be drawn in comparing the groups in this area.

SUMMARY.

1. The two groups were similar in that the highest number of veterans were self referred to the Mental Hygiene Clinic; the majority of the veterans requested psychotherapy as initial service;

more veterans tended to begin treatment in the Fall and Spring seasons of the year; and in that the majority of the veterans carried a diagnosis of psycho neurotic reaction.

2. There was considerable difference in the area of profession assigned to veterans. Almost one-half of the veterans who did not continue psychotherapy were assigned to the social service section and more veterans who remained in psychotherapy were assigned to psychiatrists.
3. There were more veterans with a poor prognosis in the group that remained in therapy but because almost one-half of the cases in the group that terminated gave no information about the prognosis, no difference can be validly shown.

CHAPTER VI

COMPARISON OF TERMINATION DATA ON VETERANS IN THE STUDY GROUP

INTRODUCTION. It would seem that some termination data is appropriate for comparison. In this chapter we will consider by whom and for what reason treatment was terminated, and staff statement regarding veteran's condition at closure.

HOW TREATMENT WAS TERMINATED. Treatment is considered terminated by the veteran when he expresses this decision verbally as well as when he indicates his decision by failing his appointments. The following table includes the other possible ways these cases were closed.

TABLE XVIII

BY WHOM TREATMENT WAS TERMINATED

By Whom Treatment Was Terminated	Group A	Group B
Veteran	45	31
Therapist	1	2
Mutual Agreement	2	10
Hospitalized	1	4
Declared Ineligible	0	1
Other	1	2
TOTAL	50	50

Comparison of the groups discloses that treatment was terminated in the majority of cases in both groups by the veteran and in almost all of the cases where treatment was discontinued prior to the sixth interview. It would seem that quite a good representation of cases, one-fifth of the group that remained, were terminated by mutual agreement. Although four times as many veterans were hospitalized in Group B, it is to be remembered that it is possible that veterans in Group A may have arranged hospitalization through other means.

In the sub-group "Other" one case in Group A was closed because domicilliary care was made available to the veteran. In Group B one case was closed because the veteran moved out of the

city and one veteran left therapy because the group therapy sessions were discontinued.

PSYCHIATRIC CONDITION AT TERMINATION. Statement regarding the condition of the veteran at termination of treatment was taken from the record of the closing staff meeting.

TABLE XIX

PSYCHIATRIC CONDITION AT TERMINATION OF TREATMENT

Veteran's Condition	Group A	Group B
Improved	1	24
No Change	12	5
Worse	2	4
No Statement	35	17
TOTAL	50	50

Almost one-half of the group that remained in treatment were considered to be in an improved condition at termination of treatment. Only one veteran in the group that terminated prior to the sixth interview was considered to be improved. Because there was no information available regarding so many of the veterans who discontinued therapy it is not felt that there is basis for comparison.

REASONS FOR TERMINATION. The reasons for termination

were divided into the following classifications: veteran declined further treatment; maximum benefit and improved; veteran left the city; veteran hospitalized; and others. It would be helpful in clarifying the reason that the veteran declined treatment to be able to discuss it with him but as has been shown, the veterans often indicate that they decline further treatment by failing appointments. In Group A in the sub-group "other" one veteran was accepted for domicilliary care and one veteran was considered not amenable to treatment. In the similar sub-group for Group B one veteran was declared ineligible and one veteran terminated because the group sessions were discontinued.

TABLE XX

REASONS FOR TERMINATION

Reason	Group A	Group B
Veteran Declined Treatment	44	27
Maximum Benefit	0	13
Veteran Left City	2	4
Veteran Hospitalized	2	4
Other	2	2
TOTAL	50	50

The primary reason for closure of the cases in both groups was that the veteran declined treatment. However, almost all of the veterans who terminated prior to the sixth interview declined -- eighty-eight percent as against fifty-four percent. There is a complete divergence where "improvement" was involved.

SUMMARY.

1. Because of lack of adequate information no statement can be made regarding psychiatric condition of the veterans at closure.
2. The groups were similar in that the reason for termination was primarily that the veteran declined treatment and the fact that termination in the majority of cases was done by the veteran.

CHAPTER VII

SUMMARY AND CONCLUSIONS

SIGNIFICANT DIFFERENCES. The purpose of this study has been to attempt to ascertain some of the possible reasons why veterans do not remain in treatment at our clinic. Analysis and comparison of data taken from clinic case records of veterans who did and did not continue in treatment discloses significant differences in the following areas:

1. The amount of education and subsequent type of employment varied to the extent that it seems that those veterans in the study group with more education and who are out of the completely unskilled or manual labor classification in employment were better able to enter into treatment. We saw that education at the extremely high level balanced quite evenly but sixteen percent more of the veterans who remained in treatment had completed at least three years of high school and that twenty-four percent of those veterans who terminated prior to the sixth interview had only

elementary education. The highest number of veterans in both groups were employed as manual laborers but there were sixteen percent fewer veterans in this category that continued in treatment.

2. It would seem that those veterans among the study group who remained in treatment may have been more seriously ill. Although the majority of veterans in both groups, thirty-five veterans or seventy percent of Group A and twenty-eight veterans, or fifty-six percent of Group B, carried a diagnosis of psychoneurotic reaction, one-third of the group who remained had a diagnosis of psychosis. This appears to be further borne out by the fact that four times as many of the veterans who remained were later hospitalized. It is acknowledged that possibly these veterans who did not continue treatment could have been hospitalized through other means.

3. On the basis of military history it appears that those veterans who remained in treatment had had more difficulty in making an adjustment. Exactly one-half of the veterans who terminated treatment and only thirty-eight percent of those who

remained were combatants. Those veterans who remained in treatment spent less time in military service. Fifty-six percent of Group A had thirty to fifty-three months of military service and fifty-six percent of Group B had seven to twenty-nine months of service. This data implies that in general those who left treatment were better able to cope with stress situations.

4. There is a real difference in the profession of the therapist among these veterans. The therapist assigned to twenty-two veterans, or forty-four percent of Group A, was a psychiatric social worker. It is to be remembered here that forty-six percent of the veterans in this group were not seen in any treatment interviews. The therapist in Group B was a psychiatrist in thirty percent of the cases and a social worker in twenty percent of the cases.

5. There is considerable range in the length of time those veterans were in therapy and it appears that generally treatment at the clinic is fairly short term. As stated above, almost one-half of Group A, twenty-three veterans, or forty-six percent, were not seen in any treatment interviews and the average

number of treatment interviews for the group, which is a random sample of two hundred and fifty cases, was one treatment interview. In Group B the average number of interviews was forty-six and almost one-half of the group, twenty-two veterans, or forty-four percent, were seen an average of twenty times.

INCONCLUSIVE DATA. It is felt that there is no basis for comparison in the schedule items regarding the veteran's initial prognosis and his psychiatric condition at termination because of insufficient information in the case records. However, in regard to the latter item, it is interesting to note that half of the group that remained in treatment were considered to be in an improved condition.

SUGGESTIBLE DIFFERENCES. There were slight and suggestible differences between Groups A and B in the following areas:

1. Although the majority of these veterans had served in the army, forty veterans, or eighty percent of Group A, and thirty-one veterans, or sixty-two percent of Group B, there was wider distribution in branch of military service among the veterans who followed through on psychotherapy.

2. The veterans who continued past five treatment interviews tended to be a slightly younger group. The majority of Group A were in the twenty to thirty age bracket while more of those who terminated were from thirty to forty years old. It is to be remembered that veterans were beginning to return from Korea in an increasing number during this period of time.
3. According to the case records the primary source of referral for the total group was the veteran himself. However, there were fourteen percent more self referrals in the group that did not remain in therapy. It was found that, apart from the self referrals, the majority of these veterans had been referred from VA Medical Out-Patient Clinics and hospitals. It is believed that what constitutes a self referral is not sufficiently clear to warrant any conclusive statement regarding this area. For Example, a veteran may be considered a self referral in that no physician, agency or hospital advised him to come to the clinic but he may be under severe pressure from a person in his immediate family.

4. The majority of these veterans, forty-four percent of Group A and fifty-four percent of Group B, travelled six to ten miles to the clinic from their home but for the most part those who remained in treatment travelled farther. It is noteworthy that twenty percent of those who terminated lived less than three miles from the clinic. In relation to this practical aspect of distance was season of year for initiation of treatment. It was found that Spring and Fall tended to be slightly more popular but not appreciably more so than Winter and Summer. This material suggests that neither weather nor distance was a factor in the veteran's use of the clinic services.

5. The majority of veterans in the total study group, sixty-eight percent of Group A and fifty-eight percent of Group B, were new to the Mental Hygiene Clinic at this time. Although there was a slightly higher number of reopened cases among the veterans that remained in treatment, the difference is not pronounced. The groups are fairly similar too in that the majority of veterans had had some type of psychiatric care since discharge from military service. It is interesting that sixteen percent more of the group that remained in treatment had

been hospitalized for psychiatric care only.

6. The veteran was responsible for termination of treatment in the majority of cases in both groups. However, there was a marked difference in that twenty-eight percent more of the veterans who terminated treatment prior to the sixth interview simply decided to discontinue.

COMMON CHARACTERISTICS. The following data appears to indicate common characteristics in both groups:

1. Veterans who come to the Mental Hygiene Clinic for the most part initially request psychotherapy. This was the request made by thirty-seven veterans, or seventy-four percent of Group A, and thirty-nine veterans, or seventy-eight percent of Group B.
2. The majority of these veterans had both parents in the home until the veteran was at least twelve years of age. This was the situation for thirty-one veterans, or sixty-two percent of Group A, and thirty veterans, or sixty percent of Group B. The veterans had an equal distribution too in the sub-groups where one or both parents were out of the home.
3. The marital status, living arrangements, and number of dependent children living in the home of the veterans in the study group were quite similar.

Approximately one-half of these veterans were married and living with spouse -- twenty-three veterans, or forty-six percent of Group A and twenty-five veterans, or fifty percent of Group B. Just three veterans in Group A and two veterans in Group B had no children. The majority of the veterans in both groups had either one or two children living in the home.

The great majority of the veterans were single -- twenty-one veterans, or forty-two percent of Group A and nineteen veterans, or thirty-eight percent of Group B. Approximately one-half of these veterans lived with parents and the other half lived in independent arrangements.

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SCHEDULE

I. IDENTIFYING DATA

A. Case #_____

B. Address:_____

C. Age: (1)Under 20___; (2)20-30___; (3)30-40___ (4)40-50___; (5) 50 and over____.

D. Marital Status: (1)Single___; (2)Married___; (3)Divorced___; (4)Separated___; (5)Widowed___.

E. Number of Dependents_____.

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

(3) 1 2 3 4; (4) Other Training_____.
College

G. Occupational Classification_____.

H. Living with: (1)Spouse___; (2)Parents___; (3)Relatives___; (4)Independent Arrangements_____.

I. Family Situation in which veteran was reared: (1) Intact__;

(2) Mother out___; (3)Father out___; (4) Both out___.

II. MILITARY DATA

A. Branch of Service: (1)Army___; (2)Navy_ __; (3)Marine__; (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. VA Hospital_____
C. Vocational Rehabilitation____
D. Self____
E. Other____

IV. MEDICAL RECORD SINCE DISCHARGE

A. Hospitalized; (1)Yes___; (2)no___
B. Out-Patient Care: (1)yes___; (2)no____
C. Psychiatric Care: (1)yes___; (2)no____
D. Medical Care: (1)yes____; (2)no____

V. MENTAL HYGIENE CLINIC SERVICE

A. Initial Diagnosis: (1)Psychoneurotic Reaction____; (2) Psychotic Reaction____; (3) Character Disorder____.

B. Initial Prognosis: (1) Good___; (2) Fair___; (3) Guarded___; (4) Poor____; (5) No Information____.

C. Nature of Veteran's Initial Request: (1) Medication____; (2) Psychotherapy____; (3) Hospitalization____; (4) Help with external problems____.

D. Patient's Expressed Choice: (1) Day Clinic___; (2) Night____; (3) No Choice____; (4)Request Granted____.

E. Beginning month of treatment_____.

F. Profession of Therapist: (1) Psychiatry_____; (2) Psychology____; (3) Social Work_____.

G. Length of Time in Therapy_____

H. Termination of Treatment by: (1) Veteran____; (2) Therapist___; (3) Mutual Agreement____; (4) Hospitalized____; (5) Other ____.

I. Reason for Termination_____.

J. Psychiatric Condition of Veteran at Termination: (1) Improved___; (2) Same____; (3) Worse____; (4) No Statement____.

K. New Case_____; Old Case: (1) First Reopening_____; (2) Second Reopening_____; (3) Third Reopening_____; (4) Over Three_____.