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## A Study of one Hundred and Seventy New Applicants at the Veterans Administration Mental Hygiene Clinic from January 1, 1950 Through March 31, 1950

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A STUDY OF ONE HUNDRED AND SEVENTY NEW APPLICANTS AT THE  
VETERANS ADMINISTRATION MENTAL HYGIENE CLINIC  
FROM JANUARY 1, 1950 THROUGH MARCH 31, 1950

by  
Martha Gloria Sellers

A Thesis Submitted to the Faculty of the Graduate School  
of Loyola University in Partial Fulfillment of  
the Requirements for the Degree of  
Master of Social Work

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## INTRODUCTION

The Mental Hygiene Clinic of the Chicago Regional Office, Veterans Administration, offers out-patient psychiatric services to veterans who are discharged from military service with neuropsychiatric disabilities and is designed to treat those who do not require hospitalization. The present study is focused on the intake process in the clinic and has, as its purpose, the analysis of the 170 new applications made at the clinic from January 1, 1950 through March 31, 1950.

This number represents thirty-four less applications than the total of two hundred that were coded as new applications on the daily intake records for the period. These thirty-four were initially included in the study, but were dropped because fifteen of the applicants had moved and their records were no longer in the Regional Office. Fourteen had been seen previously in the clinic and therefore did not fit into the classification of new cases; three requests were for services that did not fall within the function of the clinic and were coded as brief contact cases, and two applications were for trial visit services, and therefore did not fall within the scope of this study.

"Trial visit" referred primarily to the status of those veterans from a Veterans Administration Neuropsychiatric Hospital

who were at home or in their communities temporarily in order to test their capacity to adjust outside of the hospital. Although these applications were new to the clinic, the veterans nevertheless had received previous psychiatric treatment, and, therefore, did not meet the requirements of the study.

The decision to use only new cases resulted from the fact that approximately one-half of the applications made during the period of the study belonged in this classification. This raised the question of why these veterans were seeking help for the first time almost five years after the cessation of war.

The data on the study group were secured through the use of schedules.<sup>1</sup> These schedules were designed to obtain: (1) a composite picture of the veterans, (2) the reasons why the veterans were applying for service at this particular time, (3) the intake activities on the individual cases in the study group, and (4) the status of the cases at the time of this research.

A description of the intake process in the clinic is given and a brief discussion of the organizational structure of the Veterans Administration are included in the study in order to show the relative position of the Mental Hygiene Clinic to the total Veterans Administration program.

The resource material used in the study included the case records and various publications of the Veterans Administration Central Office in Washington, D. C., the Chicago Regional Office, the Government Printing Office, Washington, D. C., and unpublished memoranda and circulars written by officials of the Administration. Because there was little printed material on the activities of the Chicago Regional Office Mental Hygiene Clinic, it was necessary to rely upon verbal information from the staff members, especially the chief psychiatric social worker.



## CHAPTER I

### THE MENTAL HYGIENE CLINIC OF THE VETERANS ADMINISTRATION OF CHICAGO, ILLINOIS

A description of the program of the Veterans Administration, with emphasis upon the social service activities including the Mental Hygiene Clinics, is presented in this chapter as a background for the study of applications. Special consideration is given to the clinic attached to the regional office in Chicago and its intake procedure, since this clinic is the setting for the present study.

The Veterans Administration, at the time of this study, was an independent agency of the United States Government. It administered all benefits, provided by Federal Laws, for veterans and dependents of deceased veterans who served in the Armed Forces in any war or during peacetime. Benefits included compensation, pension, vocational rehabilitation and education, as well as guaranty of loans for purchase or construction of homes, farms and business properties. They also included allowances for unemployed veterans; National Service and United States Government Life Insurance, death benefits, adjusted compensation, emergency

and certain other officers' retirement pay; physical examination, hospital and out-patient treatment or domiciliary care. The agency also administered the insurance section of the Soldiers' and Sailors' Civil Relief Act for persons in active military service.<sup>1</sup>

An Administrator of Veterans Affairs, appointed by, and responsible to, the President of the United States, is the chief officer of the administration. His duties are to administer all laws governing the agency and to formulate policies and plans. He is assisted by the Chief Medical Director, the Chairman of the Board of Appeals, the Solicitor, responsible for legal services, and other Assistant Administrators responsible for such services as claims, insurance, and vocational rehabilitation and education.<sup>2</sup>

The Veterans Administration Organizational Units included, in 1950, the Central Office, located in Washington, D. C., which was the headquarters of the Administrator of Veterans Affairs and his Assistant Administrators, and the Field Stations, which included District Offices, Regional Offices,

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<sup>1</sup> United States Government Organizational Manual, 1949-1950, "Veterans Administration", Government Printing Office, Washington, D. C., page 521, July, 1949.

<sup>2</sup> Ibid.

Hospitals, Centers (a combination of two or more Field Units), Domiciliary Centers and Veterans Administration Offices, located throughout the United States. These Field Station installations were established to provide services on a local level, and to facilitate the granting of benefits and services to veterans and their families. Each Field Station, excluding the Veterans Administration offices, was supervised by a local administrator who represented, and was responsible directly to, the Administrator of Veterans Affairs for the proper functioning of the program within his jurisdiction.<sup>3</sup> The Veterans Administration Offices operated under the jurisdiction of the Regional Offices and were established for the purpose of giving extensive services for the Regional Office to which it was assigned. A manager-in-charge was assigned to each Veterans Administration Office,<sup>4</sup> and was responsible to the parent Regional Office.

The social service activities were carried on in hospitals, centers, domiciliary centers, regional offices and Veterans Administration offices equipped to give such services. The latter two provided essentially the out-patient activities of the social service program. Social Service was a division of

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<sup>3</sup> "Veterans Administration", U. S. Government Organizational Manual, July 1949, pages 521-531.

<sup>4</sup> Ibid, page 532

the Department of Medicine and Surgery, which was headed by the Chief Medical Director in the Central Office. Its program embraced social case-work, with emphasis on the identification and treatment of the social and emotional factors in a veteran's illness or disability and his use of treatment resources. It further assisted veterans in dealing with problems that complicated entrance upon a medical care regime (hospital or out-patient); problems that retarded or prolonged out-patient care or adjustment while on trial visit or on leaving hospital or domiciliary care and problems that affected vocational rehabilitation.<sup>5</sup>

#### The Chicago Mental Hygiene Clinic

The Mental Hygiene Clinic, as of 1950, represented one division of the social service program in the Chicago Regional Office. The other division was known as Medical and General Social Service. The total social service program was headed by a chief social worker, who had the responsibility of defining the functions of both the Medical and General Social Service sections and the Mental Hygiene Clinic, including the social service program in the Veterans Administration Offices under the jurisdiction of the Regional Office.

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<sup>5</sup> Handbook of Information Concerning Servicemen and Veterans, A.R.C. 207, Sections 1060-1068, The American Red Cross, Washington, D.C., July 1949 and March 1950.

General Social Service operated separately from the Mental Hygiene Clinic and had its own intake department. It provided services on a general level, including help with medical, financial, housing and family problems, and gave consideration to the various requests directed to the department in the agency.

The purpose of the Mental Hygiene Clinic was the treatment of veterans who had a service-connected psychiatric disability, or who were attending school under Public Law 16, and to evaluate and treat patients who were at home or in the community on "trial visits". In addition, the clinic referred patients to the psychiatric examination and hospitalization section for hospitalization in psychiatric units. Treatment facilities were also extended to relatives of veterans if such treatment was necessary for total rehabilitation. This program was designed to alleviate minor psychiatric disorders, to prevent the development of more serious illnesses, and, consequently, to reduce the number of veterans requiring hospitalization. Besides these direct services to veterans, the clinic operated as an integral part of the training and teaching program of the Administration.<sup>6</sup>

The term "trial visit" referred primarily to the veterans discharged from psychiatric hospitals on "trial visit" so

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<sup>6</sup> Veterans Administration, Mental Hygiene Clinics, Circular 169, Washington, D. C., July 1946.

that their capacity to adjust outside a hospital could be determined. These cases were generally carried by social workers in General Social service, but individual cases were referred to the Mental Hygiene Clinic for psychiatric consultation or treatment when the need arose.

The professional staff of the clinic, at the time of this study, consisted of a chief psychiatrist, an assistant chief psychiatrist, eleven full-time psychiatrists, fourteen psychiatrists in residence and one neurologist. In addition, there were seven full-time psychologists, seventeen psychologists in training, a chief psychiatric social worker, fifteen full-time psychiatric social workers, of which two were regular intake workers, and seven social workers in training. A consulting neurosurgeon was in the clinic one day a week, and he, with a full-time speech consultant and a nurse completed the professional staff. In addition, there were twenty clerks and stenographers, a receptionist, three attendants, and two encephalograph technicians.

The chief psychiatrist had the responsibility of directing the Mental Hygiene Clinic, in accordance with the directions

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7 Chief, Social Service Section Branch #7, Social Service for Patients Discharged on Trial Visit from Veterans Administration Hospitals, July 25, 1947.

from the Chief Medical Director's Office. He was under the immediate supervision of the Chief Medical Officer in the Regional Office. The chief psychiatric social worker had the responsibility of supervising the social service activities in the clinic. He was under the immediate supervision of the chief psychiatrist and the general supervision of the chief social worker in the Regional Office. The detailed qualifications and duties of the professional staff were listed in the Veterans Administration Circular 169, July 15, 1946.<sup>9</sup>

The veteran, upon making application for out-patient treatment in the Mental Hygiene Clinic, was, at the time of this study, required to complete a Veterans Administration Form 10-2827 "Application for Out-Patient Treatment." This application was processed in the Eligibility Unit of the Medical Out-Patient Department to determine eligibility for the type of service requested. If the veteran was found to be eligible he could be then referred to the Mental Hygiene Clinic for treatment. Sometimes, however, in the cases of self-referrals, or referrals from non-Veterans Administration affiliated referral sources, the veterans would come directly to the clinic without having followed this procedure. In such instances, it was the responsibility

of the Clinic receptionist to direct them to the Eligibility Unit of the Medical Out-Patient Department to complete the Form 10-2827.

Prior to February 1950 it was routine procedure in the Medical Out-Patient Department to give the veteran a physical examination at the time of application when he presented complaints largely of a physical nature, even though he might have had a service-connected psychiatric disability. However, after this date, the Chief Medical Director recommended that this procedure be discontinued for veterans with service-connected psy-  
<sup>10</sup>  
 chiatric disabilities and the chief psychiatrist officially ac-  
<sup>11</sup>  
 tivated the new directive . According to this, applications of all service-connected veterans were routinely referred to the Mental Hygiene Clinic for disposition as to the necessity of a physical examination.

When applications were accepted in Mental Hygiene Clinic the veteran was first seen by the intake receptionist, who obtained identifying information and compiled the Regional Office

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10 Office of the Chief Medical Director, Discontinu-  
 ance of the Screening of Service-Connected Veterans and Non-  
 Service Connected Veterans, Official Memorandum, February 2, 1950.

11 Chief Psychiatrist, Chicago Mental Hygiene Clinic, Procedure for Handling Service-Connected Veterans in the Mental Hygiene Clinic, Intra-Office Memorandum, February 2, 1950.



Social Service Card, which was used to set up all subsequent records in the clinic. The intake receptionist also cleared each application with the intake clerk to determine whether or not the veteran had been previously seen in the clinic. If so, he was given an appointment with the social worker concerned. If he was a new applicant, he was assigned for regular intake processing. The intake receptionist did not take the responsibility for making emergency decisions, but if any questions arose, immediately notified the psychiatric social worker or the chief psychiatric social worker.

After the intake receptionist had gathered all the identifying information, she explained to the veteran that he would next be seen by a psychiatric social worker. This appointment was usually made for the same day that the veteran applied, unless he was not seen by the intake receptionist until the latter part of the day. However, even in these instances, an effort was made to have the social worker see the veteran for a few minutes, during which time he and social worker could decide upon a future appointment. The initial interview with the intake

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12 Appendix III

13 Chicago Veterans Administration Mental Hygiene Clinic, Intake Procedure in Mental Hygiene Clinic, unpublished memorandum.

social worker included an attempt: (1) to ascertain why the veteran applied, (2) to secure a social history, (3) to arrive at tentative diagnostic impressions, (4) to give interpretation of the clinic, and (5) to prepare the veteran for therapy.

The policy of the clinic was to accept every patient with a service-connected disability of a psychiatric nature. However, since eligibility for treatment did not always imply suitability for treatment, an attempt was made, during the intake interviews, to evaluate the veteran's suitability for, and willingness to accept treatment. If the social worker recognized that treatment was needed to prevent the development of a more serious emotional disturbance, and if the veteran was not willing to accept the clinic's service, the worker took an active role in encouraging him to do so, at the same time recognizing with him the fact that this was a voluntary clinic.<sup>14</sup>

In respect to those veterans whose complaints were largely of a physical nature, the social worker could refer them, at this point, to the Medical Out-Patient Department if the following conditions existed: (1) if the veteran had not received a physical examination within a year, and (2) upon

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14 Phillip Reichline and Samuel Futterman, Veterans Administration Mental Hygiene Clinic, Los Angeles, "Intake Techniques in a Mental Hygiene Clinic", Journal of Social Case Work, February 1948.

authorization of the chief intake psychiatrist, if the veteran had received such an examination within a year, but felt he could not accept clinic services until assured he did not have a physical disability.

If the veteran decided to accept the services indicated, the social worker, either independently or in consultation with the psychiatrist, determined the urgency of the case. If hospitalization, or any other emergency existed, an immediate appointment was made with a psychiatrist. If no emergency existed, the appointment was made within a week. The intervening time was needed so that the social worker could prepare a written summary of her interview with the veteran, and could carry on any activity indicated during the interview, such as referrals to outside agencies and contacts with members of the family.

The veteran was next seen by the intake psychiatrist who completed the psychiatric evaluation, and determined the disposition of the case. This might mean further treatment, such as hospitalization or out-patient care, or it might mean that the case was closed.

If the psychiatrist recognized the need for immediate hospitalization, he encouraged the veteran to accept this voluntarily. If the veteran refused, the family was contacted and asked to assume responsibility for commitment. If the family

also refused, and if the psychiatrist was certain that hospitalization was necessary, he compiled a memorandum addressed to the Chief Attorney in the Regional Office and formally reported his recommendations. This memorandum contained a delineation of the pertinent clinical facts on the case, the diagnosis and a closing statement, such as "in my opinion this veteran is mentally ill and is dangerous to himself and others and should be committed to and confined in an appropriate mental hospital."<sup>15</sup>

All cases recommended for therapy were discussed in the Intake Conference. During this discussion, diagnostic impressions were formulated and joint decisions were made as to whether or not further diagnostic study was indicated, and, if so, what type of study. It was also decided, at this time, whether or not the veteran should be assigned directly for treatment, either in psychiatry, psychology or social service. Decisions relative to the closing of cases or referral to other agencies were also made at this time. The Intake Conference team was headed by a psychiatrist who served as moderator for the group, and included the psychiatric social worker, a psychiatrist and a psychologist. Sometimes they were attended by other members of the professional

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<sup>15</sup> Chief Psychiatrist, Chicago Regional Office Mental Hygiene Clinic, Office Memorandum, "Committment of Mentally Ill to Hospital", October 26, 1946.

personnel. The psychiatrist served as chairman for the team.

When, on the basis of this conference, further diagnostic study was recommended, the chairman, with the help of special clerical staff, became responsible for seeing that recommendations were carried out and for scheduling the cases for After Study Conference. In this conference the same procedure was followed. The cases on which study was completed were assigned for treatment and those which were incomplete, because the veterans failed to respond either by not giving necessary information or by not keeping appointments, were closed. In those which remained open, therapy was carried on by psychiatrists, psychologists and psychiatric social workers. In assigning the cases, the patients' illnesses, and the skill and experience of the therapist, were taken into consideration.

Cases were usually referred to a psychologist if they involved conditions such as "readjustment of habits; personality problems within the normal range; educational disabilities, including speech impairment and similar difficulties requiring education; or relatively minor psychoneurotic conditions without im-<sup>16</sup>portant somatic components." The psychiatric social workers were usually assigned cases which primarily involved help in the

solving of difficulties relating to family, work or social relationships. Some psychiatric social workers assisted in therapy when, in the opinion of the psychiatrist, they had the necessary skill. In such instances the social worker had access to psychiatric consultation. Veterans who presented major neuropsychiatric disorders were assigned directly to psychiatrists.<sup>17</sup>

This chapter presented a brief description of the total administrative organization of the Veterans Administration. Special consideration was also given to the Chicago Regional Office Mental Hygiene Clinic which served as the setting for the study. Chapter II begins a consideration of the study group itself.

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<sup>17</sup> Veterans Administration, "Circular 169", July 16, 1946.

## CHAPTER II

### THE STUDY GROUP

This chapter covers an analysis of the personal and social data of the veterans in the study group, their reasons for making application at the clinic and their pre-clinic medical or psychiatric records. Social and personal data included such factors as race, sex, residence, age at time of entry into military service, military records, marital status and living conditions, educational attainment, and occupation and employment records. As stated in Chapter I, these data were secured from the veterans during the Intake interviews. The clinic recognized the importance of considering such factors in evaluating the veteran's ability to relate to the clinic and his suitability for treatment. The knowledge also enabled the clinic team to arrive at valid diagnoses.

In considering the data with respect to the race, sex, residence and age at entry into service of the 170 veterans, the following facts were uncovered: 145 were white and 25 were Negroes; 169 were men and one was a woman (a former Wave); 135 resided in Chicago and thirty-five resided in suburban areas.

The distribution according to age at the time of entry into the service is shown graphically in Figure 1.

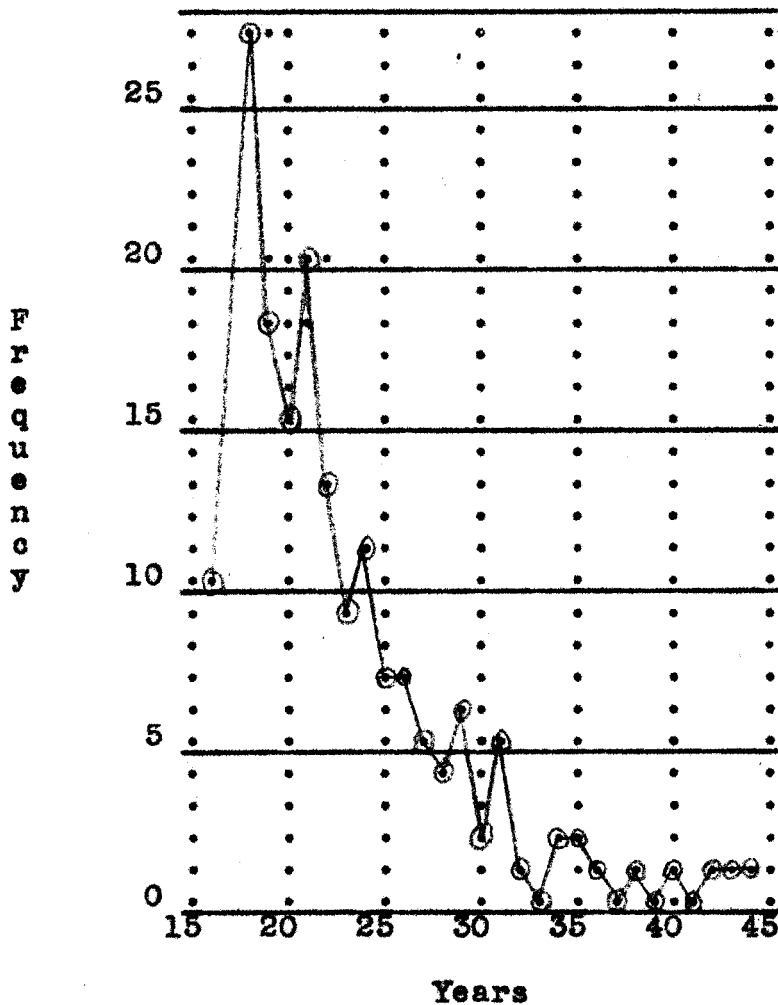


FIGURE 1.

DISTRIBUTION ACCORDING TO AGE  
AT TIME OF ENTRY INTO SERVICE



As shown in Figure 1., page 16, the distribution according to age at the time of entry into service ranged from seventeen through forty-four years. A little more than three-fourths of the veterans were under twenty-six years of age, with the larger concentration between seventeen and twenty-one years. The eighteen-year olds composed the largest single group. Eight veterans entered service after they were thirty-five years old. There seems to be nothing especially significant in this distribution except, perhaps, that the majority were under twenty-one at the time they entered military service. The group was, therefore, composed of men at the younger age level.

The military records were analysed with respect to the method of entry into the service, the branches of service and types of military duty, the length of time spent in service and the length of time out of service. One hundred and four veterans were drafted and fifty-nine enlisted. Twenty-six of the fifty-nine who enlisted were between 17 and 24 years of age, and twenty-two of the twenty-six were either 17 or 18 years old. The method of entry of seven veterans was not given.

Table I, page 18, shows the distribution according to the branches of service and the military duty. As it shows, 115 served in the army, twenty-seven in the navy, twelve in the marines and six in the coast guards. One hundred and three saw

overseas duty, and 76 participated in combat. The fact that almost half of the total number saw combat duty might have accounted for the substantially large number of veterans in the study group suffering with brain damages.

TABLE I

DISTRIBUTION ACCORDING TO THE BRANCH OF SERVICE  
AND TYPES OF MILITARY DUTY

Branch of Service	Total	Duty				
		U. S. only	Over- seas	In Combat	Not in Combat	Not Given
Total	171*	57	103	76	84	11
Army	115	37	78*	63	52	6
Navy	27	12	15	7	20	4
Marines	12	2	10	6*	6	0
Coast Guard.	6	6	0	0	6	0
Not Given	1	0	0	0	0	1

\* One veteran served two enlistments; one in the army and one in the marines

Figure 2. graphically shows the distribution of the 170 veterans according to the length of service.

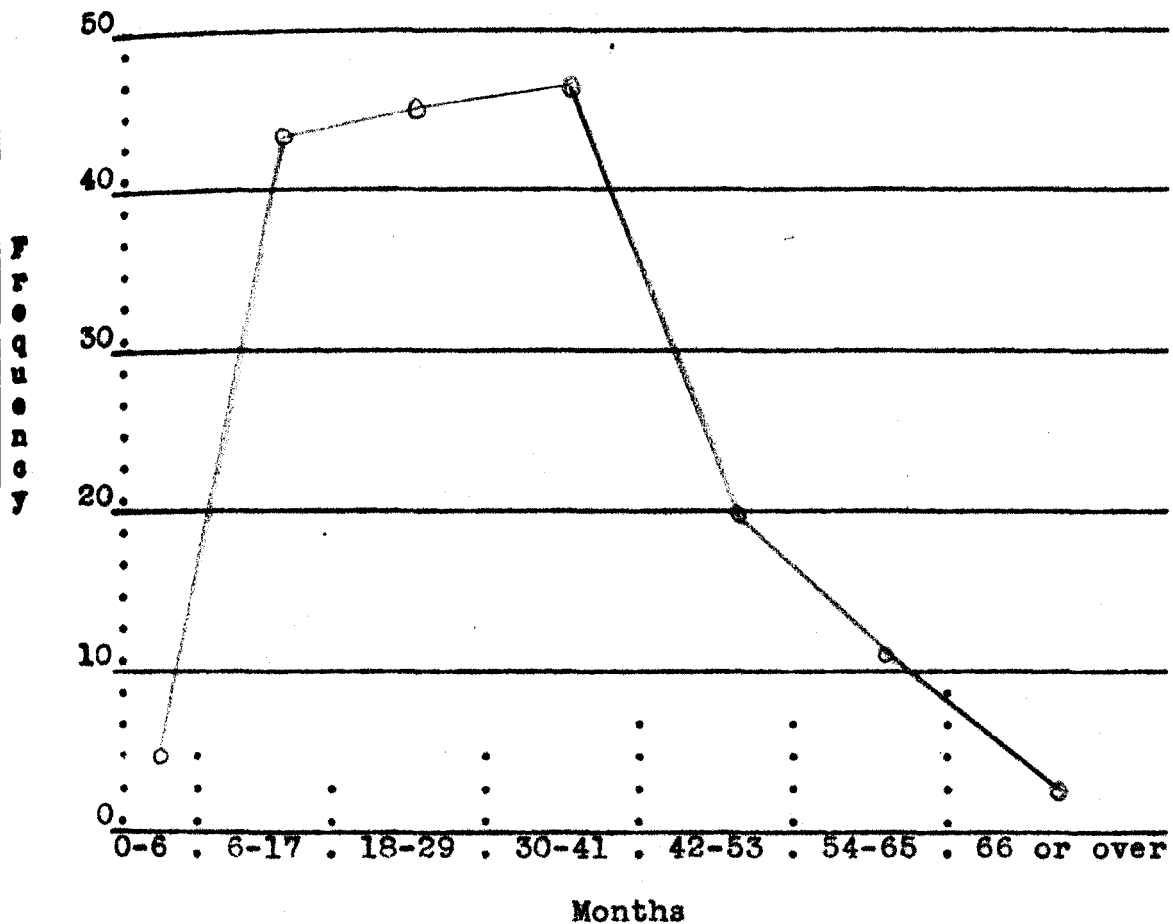


FIGURE 2.

#### DISTRIBUTION ACCORDING TO LENGTH OF SERVICE

As shown in Figure 2., the length of service ranged from six months to sixty-six months. The average length was approximately thirty months, with 43 veterans spending from six

months through seventeen months and 89 from eighteen through forty-one months. Only five veterans were in service less than six months and two for more than sixty-five months. The study showed virtually no relationship between the length of service and the severity of the illnesses manifested by the veterans.

Some consideration was given to the length of time the veterans had been out of service prior to becoming known to the Mental Hygiene Clinic. Figure 3. shows this distribution.

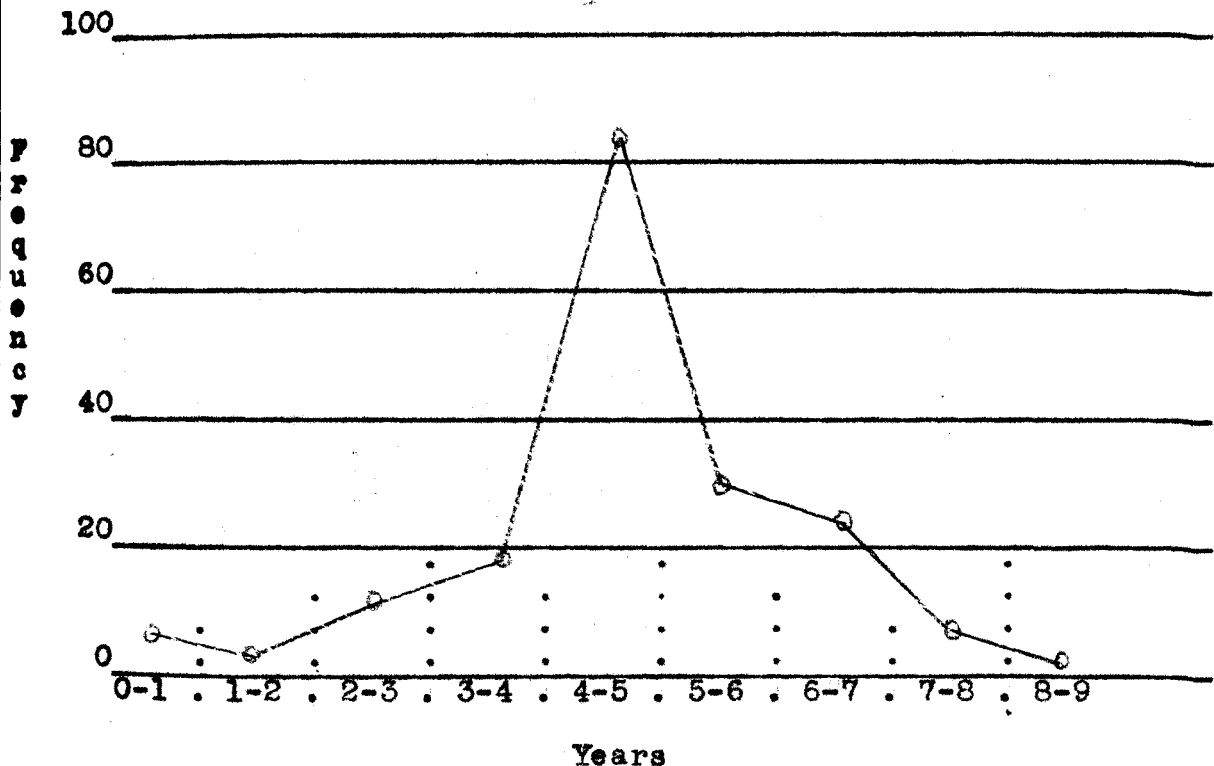


FIGURE 3.  
TIME INTERVAL BETWEEN DISCHARGE FROM MILITARY SERVICE  
AND INTAKE

As shown in Figure 3., the length of time out of service ranged from less than one year to nine years. One hundred and thirty veterans had been out of service from three to six years, with 84 of this number having been out from four to five years. Only one veteran had been out less than one year and one veteran for over eight years. These facts would indicate that these veterans had experienced relapses of their illnesses after approximately five years out of service but, as was shown in the study, many of them had received medical or psychiatric care during the interim period.

The distribution according to the marital status of the 170 veterans is shown in Table II.

TABLE II

THE MARITAL STATUS OF THE ONE HUNDRED AND SEVENTY  
APPLICANTS AND THEIR LIVING ARRANGEMENTS

Marital Status	Total	Spouse	Alone	Parents	Relatives	Not Given
Total	170	72	35	30	13	20
Married	88	70	2	0	3	13
Single	59	0	21	28	6	6
Separated	11	2	2	3	4	0
Divorced	11	0	10	1	0	0
Not Given	1	0	0	0	0	1

An analysis of the marital status and living arrangements as shown in Table II, page 21, indicated that 110 out of 170 veterans had, at sometime, been married. Of the eighty-eight veterans who were still married, seventy were living with their spouses. No indication was given as to the whereabouts of the spouses of the three veterans who were living with relatives. The two married veterans who were living alone were doing so while in Chicago attending school. Eleven veterans were separated and eleven were divorced. In the cases of two veterans who were separated, but who were actually living with their wives, one reported that he and his wife were having marital difficulties and were, therefore, maintaining separate quarters in the same household. The other was living with his common law wife, although separated from his legal wife.

It is further significant that seven of the eleven separated veterans, and six of the eleven divorced veterans, gave, as the basis for their illnesses, difficulties in marital and interpersonal relationships. Although the veterans who were separated or divorced represented a comparatively smaller percentage in relation to the married veterans, the majority of the married veterans also manifested marital difficulties or family dissensions. It is common in intake interviews to make specific reference to the living arrangements of the applicants only when

this is in some way connected with the applicants complaints or symptoms. This may have accounted for the comparatively high number of cases which are recorded as "not given."

Table III shows the distribution of the applicants according to pre-induction education and Government sponsored education.

TABLE III

DISTRIBUTION ACCORDING TO PRE-INDUCTION EDUCATION  
AND GOVERNMENT SPONSORED EDUCATION

Government Sponsored Education	Pre-induction Education						Not Given
	Total	Less than 6 years	6 Yrs. to H.S.	H.S. Educ.	College Educ.		
Total	170	5	26	89	32		19
P. L. 16	35	2	4	20	7		2
P. L. 346	31	0	6	11	12		2
None	89	3	14	53	10		9
Not Given	15	0	2	4	3		6

As shown in Table III, 89 veterans had one or more years of high school before entrance into service. Thirty-two veterans had some college education and 31 had received less than high school education, with five of this group completing less than six years of education. The educational attainment of 19

veterans was not given. Of those veterans who had received a college education, 59 percent were taking advantage of Government sponsored educational benefits under Public Laws 16 or 346, while only 55 percent of those who had received a high school education had done likewise. Of those who had less than a high school education, 37 percent were enrolled under Public Law 346.

An analysis was made of employment status in relation to economic adjustment after discharge. Table IV shows the distribution according to employment status of the 170 veterans.

TABLE IV

## DISTRIBUTION ACCORDING TO EMPLOYMENT STATUS

Employment Status	Number	Percent
Total	170	100
Unemployed	83	48.8
Employed	79	46.5
Unemployable	2	1.2
Not Given	6	3.5



As shown in Table IV, page 24, two veterans were unemployable and 83 were unemployed, 79 were employed, and the employment status of six was not given. Of the two veterans who were unemployable, one was totally incapacitated because of a brain tumor which he developed soon after his discharge from World War I. The other veteran sustained a head injury in combat duty in World War II which resulted in paralysis of his entire left side. Both of these veterans were receiving 100 percent disability pensions.

Of the 83 unemployed veterans, 46 percent gave ill health as the reason for their unemployment. Twenty-two reported inability to obtain or hold a job because of interpersonal difficulties, and five percent reported unavailability of employment. In these instances, the veterans were depending upon their disability pensions for their livelihood and, therefore, were not able to make adequate economic adjustments. Twenty-four percent of the unemployed veterans were in school and, for this reason, were not engaged in remunerative employment. Three percent were recently unemployed and this sudden and unanticipated change in their situations resulted in the reoccurrence of their symptoms and directly precipitated their request for help.

Of the 79 employed veterans, ten were working irregularly or on a part time basis. The irregularity of employment,

in most instances, resulted from the fact that the veterans had exhibited lack of responsibility toward their jobs.

The various occupations of the employed veterans were classified according to the Dictionary of Occupational Titles,<sup>1</sup> and the distribution is shown in Table V.

TABLE V  
DISTRIBUTION OF OCCUPATIONS  
OF THE SEVENTY-NINE EMPLOYED VETERANS

Major Occupational Groups	Number	Percent
Total	79	100
Professional, Technical and Managerial	14	17.6
Clerical and Sales	26	33
Service	6	7.5
Agriculture, Marine and Forestry	1	1.3
Mechanical	19	24.1
Manual	13	16.5

As shown in Table V, 33 percent of the veterans were employed in the clerical and sales fields. The majority of these had two or more years of high school education and three had only

<sup>1</sup> Dictionary of Occupational Titles, Part IV, Revised Edition, War Man Power Commission, Division of Occupational Analysis, Washington, D. C., 1944.

eight grade education. Eight veterans had received some college training and five of the eight had completed four years of college. The professional, technical and managerial fields were well represented, with the concentration in the technical and managerial fields. There was one college professor and one high school teacher. Generally, it can be concluded that each major group was sufficiently represented to indicate that the veterans of varied occupational levels were using the facilities of the clinic.

The reasons for the applications were considered in terms of the actual complaints and the symptomology that was manifested, as well as the problems and requests presented. These complaints fell into the following classifications: Somatic, Emotional, "Nervousness", Social, Seizures and associated disorders, Pre-psychotic, Psychotic, and Combination of symptoms.

For purposes of this study, the following interpretations of each classification were used:

- (1) Somatic complaints covered those cases in which the complaints were chiefly or entirely physical;
- (2) Emotional included mild disturbances in the emotional area;
- (3) "Nervousness" covered any disturbance affecting the nervous system or in which the veteran specifically referred to "nervousness";

- (4) Social complaints covered any verbalized difficulties in interpersonal relationships;
- (5) Seizures and associated disorders covered those disturbances which involved seizure attacks;
- (6) Pre-psychotic states were considered to exist when the veterans were manifesting minor psychotic symptoms;
- (7) Psychotic states were considered to exist when the veterans were largely or completely disorientated as to time, place or person;
- (8) Combination of symptoms included those cases in which two or more classifications of symptoms were revealed.

Table VI shows the distribution of complaints and symptomatology according to these classifications.

TABLE VI

## SYMPTOMATOLOGY OF COMPLAINTS AT INTAKE

Symptomatology or Complaint	Number	Percent
Total	170	100
Somatic	36	21.2
Seizures	27	15.8
Emotional	25	14.7
Pre-psychotic	16	9.4
Nervousness	9	5.4
Psychotic	8	4.7
Social	6	3.5
Combinations	43	25.3

It is significant to note, as shown in Table VI, page 28, that varied complaints and symptomatology, covering almost the entire psychosomatic field, were manifested by the veterans.

Thirty-six veterans regarded their illnesses as being organic rather than functional. Twenty-seven reported seizures due to epilepsy or brain damages which they related to military experiences. Thirty-four reported emotional difficulties or "nervousness" and these verbalized the idea that their troubles were a direct outgrowth of, or were directly connected with, an organic illness. Some of these showed partial insight into the psychogenic character of their illnesses, but were unable to face their situations realistically. This was evident in their tendency to avoid discussing the emotional aspects of their illnesses.

These thirty-four, combined, in terms of the area of disturbances, with the pre-psychotics or psychotics, shows that fifty-eight or 34.1 percent presented problems that were psychogenic in character, as against the sixty-three or 37 percent in which the major difficulty was either somatic, or embraced somatic manifestations, such as seizures. The largest single group presented a combination of symptoms. Many of these veterans were not clear as to the probable basis for their disorders; they simply recognized, or verbalized, the fact that something

was wrong and indicated a desire to understand it and to accept treatment. Many of the self-referrals were in this group. It is interesting that only 3.5 percent presented complaints that were primarily social.

In considering the problems presented, it is of note that marital and family difficulties were evidenced by fifty-three of the veterans. Thirty-three reported inability to adjust to their employment, twenty-seven were concerned about the effects of their illnesses on other people and twenty-four were having problems in school. The difficulties presented by the remaining thirty-three included inability to settle down, sexual difficulties, financial pressures and difficulties in interpersonal relationships. Although difficulties in interpersonal relationships existed among many of the veterans, there were six who actually recognized this problem as being predominate in their illnesses. Eight of the above thirty-three stated that they had no problems.

Since the majority of the veterans had been out of service from three to six years, the question was raised as to whether or not they had received pre-clinic medical or psychiatric treatment. The findings are shown in Table VII, page 31.

As shown in this table, 107 veterans had received either pre-clinic medical or psychiatric out-patient treatment

TABLE VII  
DISTRIBUTION ACCORDING TO PRE-CLINIC MEDICAL RECORD

Medical Record	Number	Percent
Total	171*	100
None	53	31
Medical Out-Patient	37	21.6
Psychiatric Hospital	29*	17
Medical Hospital	23*	13.4
Psychiatric Out-Patient	19	11.1
Not Given	10	5.9

\* One veteran had a pre-clinic record of hospitalization for medical and psychiatric care.

or hospitalization. For sixty percent of these the out-patient treatment or hospitalization was medical and for forty-eight percent it was psychiatric. Therefore, although the 170 veterans had not been previously seen in the Mental Hygiene Clinic, approximately fifty-two percent of the 160 for whom the information was available had received pre-clinic treatment.

One hundred and twenty-two veterans requested psychiatric or medical treatment. Twenty-seven had other specific requests, such as help in securing work, pension increases, job transfers, housing, vocational advisement and help in establish-

ing additional service-connected disabilities. Only twenty-two veterans actually stated that they came to the clinic because they were sent by the Veterans Administration or other agencies.

This chapter presented an analysis of the personal and social data of the veterans included in the study group and their reasons for making application to the clinic. Such factors as race, sex, residence, age at the time of entry into service, as well as length of service, marital status and living conditions, educational attainment and employment status and complaints, symptomatology and problems presented were discussed.

In general it was shown that marital and family difficulties, employment and financial problems, sexual difficulties, concern about illnesses and difficulties in interpersonal relationships were among the major difficulties that these veterans faced. In many cases there was a definite relationship between the veteran's illness and the problems that he presented when he came to the clinic. The data also showed that approximately one-half of the veterans had received pre-clinic medical or psychiatric care.



### CHAPTER III

#### INTAKE ACTIVITY ON THE ONE HUNDRED AND SEVENTY APPLICATIONS

This chapter deals with the intake activity on the total study group and is discussed under four headings: (1) Activity at the time of the intake interviews, (2) Activity in the intake conference, (3) Activity in the after study conference, and (4) the status of the cases at the time of this study. The first three headings coincided with the manner in which the cases were handled in the intake process. The fourth heading was added in an effort to ascertain the number of cases that were still active in the clinic at the time of this study.

Activity at the time of the intake interviews was considered in terms of the sources of referrals, the Rating Board diagnoses and the action taken on the cases at this point. 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 referral sources were divided into two major groups, departments or installations associated with the Veterans Administration, and other agencies and individuals. Table VIII.

shows the distribution of the applications according to these sources.

TABLE VIII

## DISTRIBUTION OF REFERRALS ACCORDING TO SOURCE

Veterans Administration Departments or Installations		.	Other Agencies and Individuals	
Total	117	.	Total	53
Medical Out-Patient	55	.	Self	31
Vocational Rehabilitation	26	.	Private Physicians	8
Hines Hospital	10	..	Relatives	6
Mental Hygiene Clinic	9	.	American Red Cross	3
Pension Examining Board	8	.	Other	5
Sub-Regional Office	4	.		
Other	5	.		

Table VIII shows that 117 out of the 170 veterans were referred to the Mental Hygiene Clinic from departments or installations associated with the Veterans Administration. Almost fifty percent of this number came from the Medical Out-Patient Department and the remaining were scattered among the six other sources, with the largest single group coming from Hines Hospital. The referrals shown as having originated in the Mental Hygiene Clinic included a group of veterans who were suffering

from convulsion disorders or related physical symptoms due to epilepsy or brain damages. In these cases the Mental Hygiene Clinic initiated the request that they come to the clinic for examination. These veterans were receiving anti-convulsion medication by mail and were required by the Veterans Administration to have periodic diagnostic examinations.

Only four referrals came directly from Veterans Administration Offices. These were cases in which the Office in question was not equipped to give the particular service that was needed. Referrals under the heading "other" included three referrals from General Social Service, one from Adjudication and one referral from a Veterans Administration employee in Personnel.

The largest number of referrals from other agencies and individuals was the thirty-one veterans who made personal applications. Approximately seventy percent of these thirty-one described their difficulties as being of a psychiatric nature. The second largest referral group came from private physicians. The majority of these were initiated when the physicians recognized the existence of a psychiatric disturbance accompanying the physical or organic complaint. Referrals under the heading "other" included two referrals from other social agencies; one from Veterans Rehabilitation Center, one from an employer and one from the American Legion.

**TABLE IX**  
**DISTRIBUTION ACCORDING TO THE**  
**BROAD DISORDER GROUPS**

Broad Disorder Groups	Number	Percent
Total	170	100
Psychoneurotic disorders	66	39
Psychiatric conditions with demonstrable etiology or associated structural changes in brain, or both	46	27
Psychosis without known organic etiology	32	19
Physical disorders	14	8
Transient personality reactions to acute or special stress	8	5
Disorders of intelligence	2	1
Character and behavior disorders	1	0.5
No disease	1*	0.5
Alcoholic and drug addiction	0	0
Psychosis unclassified	0	0
*still pending		

Every veteran who has a service-connected psychiatric disability is given a classification by a Rating Board. This classification is based on his personality make-up, his experiences and his adjustment and reactions to military service. The Rating Board diagnoses of the study group were classified according to the Broad Disorder Groups recognized by the Veterans Administration.<sup>1</sup> Table IX, page 36, shows the distribution of the Rating Board diagnoses according to this classification.

As shown in Table IX, page 36, the majority of the veterans were diagnosed as having psychoneurotic disorders. Many in this group presented anxiety and somatization reactions, each of which apparently resulted from the inability to adjust to immediate environmental circumstances. The majority of these were having difficulty managing economically and socially. The second largest group were composed of those suffering from brain damages. Many of these related their illnesses to some head injury incurred either in service or in combat. The thirty-two veterans classified as psychosis without known organic etiology included the schizophrenics. This shows that 144 out of the 170 belonged in these three classifications. The remaining twenty-six

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1. Office of the Chief Medical Director, "Nomenclature of Psychiatric Disorders and Reactions", Veterans Administration Technical Bulletin, TB 10 A-78, October 1947, page 2.

were scattered through six classifications, including the one that was diagnosed as "no disease" because his claim for a service-connected disability disorder was still pending.

It was significant that nineteen of the 170 veterans received their disability rating after discharge. Practically all of these had experienced long periods of military service, with combat duty, and found it difficult to re-adjust adequately in civilian life. The majority of them manifested considerable anxiety about their physical condition or "nervousness". It was difficult for them to understand why they could live through combat experience without becoming ill and, afterwards, were unable to resume a normal role in civilian life. It was further hard for some of them to accept their disorders as having an emotional component.

It was the procedure in the clinic to present all intake cases in the Intake Conference, which was held approximately one week after the intake interviews, with the psychiatric social worker and the psychiatrist. However, in certain instances it was necessary to take action at the time of the intake interviews. Such actions usually consisted of making dispositions or offering special services when required.

Fifteen of the cases in the study group were disposed of at the time of the intake interviews either by immediate

hospitalization or by the fact that they declined treatment. Twelve veterans were immediately hospitalized because they were experiencing pre-psychotic or psychotic episodes and, therefore, were not in condition to benefit from out-patient treatment. Eleven of the twelve voluntarily entered the hospital. The other veteran was completely out of contact with reality and consent for his commitment was given by his wife. Three veterans declined treatment, one because he was only interested in obtaining a confirmative statement from the psychiatrist that he was not psychoneurotic, the other because he could not accept the fact that he needed psychiatric treatment, and the third because he preferred to continue psychiatric treatment with a private psychiatrist.

Hospitalization was recommended for two other veterans (not included in the above fifteen) but was refused by them. The intake psychiatrist did not impose compulsory hospitalization in these cases because the veterans were not dangerous to themselves or others. Instead, he recommended, as second choice, out-patient psychiatric treatment. One of these veterans responded to, and was still in, treatment in the clinic at the time of this study. The other veteran decided to enter the hospital a few days later.

In respect to the study group, special services were

offered in two instances. In one of these arrangements were made for emergency shelter and financial assistance for a veteran who was extremely upset emotionally and was entirely without funds. He recently had come to Chicago to attend school, had encountered difficulties in becoming established, and was referred to the clinic from Hines Hospital where he had requested hospitalization because he had no place to stay. This veteran was scheduled for a future appointment with an intake psychiatrist but, in the meantime, telephoned to say that he had secured employment and did not feel the need for further services from the clinic. The case was closed, therefore, before Intake Conference. The second instance in which special services were offered was one in which a veteran was immediately hospitalized. Arrangements were made with an outside agency for financial assistance for his wife and children.

Sixteen cases were disposed of before Intake Conference, and 154 were presented in Intake Conferences. Each of these cases was discussed individually for the purpose of arriving at diagnostic impressions, deciding upon treatment or assignment to therapy, or for reassignment for further diagnostic study.

In arriving at diagnostic impressions in the Intake Conference, the broad psychiatric disorder classifications were avoided whenever possible, and the specific types of psychiatric



conditions or reactions were used. This procedure was followed,<sup>2</sup> in accordance with instructions from the Chief Medical Director, and because the emphasis in the clinic was not upon classification, but upon the diagnostic evaluation of the psychodynamics involved. This evaluation could, in turn, be used in evaluating the veteran's capacity for treatment, and in formulating treatment procedures and goals. For example, where a psychoneurotic disorder was recognized, the broad term "psychoneurotic disorder" usually was not recorded, but the specific manifestation, such as "anxiety reaction", "conversion reaction", "somatization reaction", was recorded. In instances where more than one psychiatric disorder was observed, or where a psychiatric and physical disorder co-existed, both disorders were recorded separately.

In addition to this over-all picture, the Chief Medical Director also recommended that certain specific reactions be recorded when they were known or recognized. These included the manner in which the reaction was manifested and its severity, the external precipitating stresses and the pre-morbid personality and pre-dispositions of the patient.

In connection with the present study an arbitrary classification was adopted for grouping the diagnostic

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<sup>2</sup> Hawley, "Nomenclature of Psychiatric Disorders and Reactions", October 1947.

impressions recorded in the 154 cases on which intake conferences were held. This classification allowed for four groups:

- (1) Simple, where only one psychiatric disorder was manifested;
- (2) Combination Psychiatric, where two or more distinct and separate psychiatric disorders co-existed;
- (3) Combination Psychiatric and Physical, where a psychiatric and an unrelated physical disorder co-existed; and
- (4) Deferred, where diagnostic impressions were deferred pending further study.

Disorders grouped under the classification Simple were further sorted according to the broad disorder groups represented.

Table X, page 43, shows the distribution of the 154 applications according to these classifications.

As Table X shows, diagnostic impressions on eighty-seven cases, or more than 55 percent of the study group were deferred. In these cases, the members of the team thought that further examinations and evaluations were indicated before substantial impressions could be derived. Of the remaining sixty-seven cases, there were forty-eight manifesting only one disorder. This means that only nineteen cases which presented any appreciable complications were actually classified at the Intake Conference, and all but one of the veterans having demonstrable etiology or associated structural changes in the brain, or both, were deferred for further study. Of the forty-eight cases

**TABLE X**  
**DIAGNOSTIC IMPRESSIONS MADE BY THE**  
**INTAKE CONFERENCE**

Classifications	Number	Percent
Total	154	100
Referred	87	56.5
Simple	48	31.1
Combination, psychiatric	15	9.8
Combination, psychiatric and physical	4	2.6

Simple Sub-classification	Number	Percent
Total	48	100
Psychoneurotic	29	60.5
Psychosis without known etiology	15	31.3
Character or behavior disorders	3	6.2
Psychiatric conditions with demonstrable etiology or associated structural change in the brain, or both	1	2

classified as Simple, twenty-nine were psychoneurotic, fifteen were without known etiology and only four were designated in terms of specific disorders or etiology.

The dispositions made in Intake Conference on the 154 cases are shown in Table XI.

TABLE XI  
DISPOSITIONS MADE IN INTAKE CONFERENCE

Dispositions	Number	Percent
Total	154	100
For further study	87	56.5
Psychiatrist for therapy	33	21.6
Psychologist for therapy	12	7.8
Psychiatric social worker for therapy	11	7.2
Combination therapy	3	1.9
Closed	5	3.2
Social worker under psychiatrist's supervision	1	.6
Informative letter to veteran	1	.6
Psychiatrist on fee basis	1	.6

As Table XI shows, eighty-seven veterans were referred for further diagnostic study; fifty-seven were referred for therapy, more than half, or thirty-four, being assigned to a psychiatrist, and the other half divided almost equally between

psychologists and social workers. Of the three veterans referred to combination therapy, one was assigned to a psychiatrist for "adjunct"<sup>3</sup> therapy and to a social worker in General Social Service for help in connection with his service-connected disability which was of a physical nature. This veteran had been referred to Mental Hygiene Clinic by General Social Service when he manifested psychiatric symptoms unrelated to his physical disability.

Another veteran was assigned to a psychiatrist for supervision and medication and to group therapy. He was manifesting considerable guilt and hostility toward his epileptic condition and it was thought that contact with a group of persons who were manifesting similar problems would help to modify his own feelings and reactions. The third veteran to receive combination therapy was suffering with epileptic seizures and was referred to a neurologist for medication and observation and to a psychiatric social worker for supportive therapy.

One veteran was assigned to a psychiatric social worker who was to be under close supervision of a psychiatrist. Another was assigned to a psychiatrist in his home town on a fee basis because he lived a considerable distance from the Regional

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<sup>3</sup> The term "adjunct" refers to additional services or treatment given to the veteran to aid in treating his primary disability, which was not being treated in the Mental Hygiene Clinic.

Office. The psychiatrist's fee was to be paid by the Veterans Administration. One veteran who had requested only medication at intake was advised that this was unavailable in the clinic except in combination with psychotherapy. He was left to make his own decision about continuing and nothing more was heard from him.

Five cases were closed in Intake Conference. Four of these were considered to be not feasible for treatment. Of the four, one was a veteran of World War I, age fifty-seven, who had been referred from the Medical Out-Patient Department because of his service-connected disability. He was only interested in having his cut finger surgically dressed and agreed, at the suggestion of the intake social worker, to accept whatever the clinic recommended. The Intake Conference team thought this veteran could not derive benefit from psychotherapy because of his age and the nature of his illness and recommended closing the case. Two of the four veterans were not accepted in the Mental Hygiene Clinic because their histories indicated they were only interested in using the clinic to obtain pension increases. The fourth was experiencing financial difficulties and was referred to an outside agency for assistance. The fifth veteran was referred to the Veterans Rehabilitation Center because his psychiatric disability was not service-connected.

The eighty-seven veterans who were assigned for further diagnostic study were given one or more of the following examinations: a psychological, neurological, electroencephalograph test, physical or other laboratory tests. Additional information relative to their histories was secured from claim folders, from other agencies, surgical consultations, speech consultations and from the psychiatric social worker assigned to the case during the course of the intake study. Twenty of the eighty-seven veterans required only one type of examination and fourteen of these were psychologicals. The remaining sixty-seven required a combination of two or more of the possible examinations or tests. It was interesting to note that, for forty of the veterans, the three basic examinations, namely: psychological, neurological, and electroencephalograph test, were recommended. Thirteen were assigned to psychiatric social workers for supportive therapy and interpretations of the tests, and six were assigned to supervisory medication during the course of the intake study. One veteran was recommended for speech consultation and another, neurosurgical consultation.

Study was completed on sixty-four cases. These were then discussed in After Study Conference, where diagnostic impressions and dispositions were made. The diagnostic impressions were grouped according to the classifications listed in Table X,

page 43. Forty-six were classified as Simple, nine as Combination Psychiatric, seven as Combination Psychiatric and Physical and the diagnostic impressions of two were deferred.

The simple disorders were further classified according to the broad disorder groups. Thirty veterans had disorders which were associated with demonstrable etiology or associated structural change in the brain, or both. Nine disorders were classified as psychoneurotic and the seven remaining disorders were grouped as psychoses of unknown etiology. Six of these were classified as schizophrenic disorders and one as migraine headache. Table XII shows the distribution of the eighty-seven cases according to dispositions made in After Study Conference.

TABLE XII

## DISPOSITIONS OF THE CASES ASSIGNED TO STUDY

Dispositions	Number	Percent
Total	87	100
Psychiatrist for therapy	29	33.3
Study incompleted	23	26.5
Combination therapy	16	18.4
Psychologist for therapy	2	2.3
Psychiatric social worker for therapy	9	10.3
Neurologist for medication	2	2.3
Hospitalized	2	2.3
Other dispositions	4	4.6



As shown in Table XII, page 48, forty-two, or almost half, of the eighty-seven cases were assigned for therapy; almost two-thirds of these were assigned to psychiatrist and the remaining one-third was divided between psychologists, social workers, and neurologists. Sixteen, or about twenty percent of the group were assigned to combination therapy. Three of these were classified as schizophrenics and the remaining thirteen had disorders associated with brain damages.

Six of the thirteen were assigned to a neurologist for medication and to psychiatric social workers for supportive therapy. The other seven were assigned to the following combination of services: two to psychiatrists and speech therapy, one to a psychiatrist and to the Medical Out-Patient Department, two to a neurologist and to group therapy, one to a psychiatrist and to group therapy, and one to a neurologist and to a psychiatric social worker. Two veterans were assigned to hospitals because they had severe brain damages and hospitalization was required for further studies. In twenty-three cases the studies were not completed, nineteen because the veterans failed to keep appointments, three because the veterans were hospitalized and one because the veteran moved from the city.

Some consideration was given to the status of the cases at the time of this research since the number of cases still

active might be indicative of the veterans' ability to adjust to the clinic, or of his suitability for treatment. Table XIII shows the distribution according to status of the 170 cases.

TABLE XIII

## STATUS OF THE TOTAL CASES AT THE TIME OF RESEARCH

Status	Number	Percent
Total	170	100
Closed at Intake	15	8.8
Closed between Intake and Intake Conference	1	.6
Closed in Intake Conference	5	2.9
Closed during study	23	13.6
Closed after study	37	21.7
Closed after treatment	36	21.2
Open	53	31.2
Open Cases	Number	Percent
Total	53	100
Psychiatrist for therapy	25	47.2
Combination therapy	17	32.1
Psychologist for therapy	5	9.4
Psychiatric Social Workers for therapy	5	9.4
Neurologist for Medication	1	1.9

As shown in Table XIII, page 50, fifty-three cases, or 31.2 percent of the total number, were still open at the time of the study, and 117 had been closed. Sixty, or approximately 52 percent of these closings occurred during or after study and about 30 percent of them occurred after treatment. The remaining twenty-one, or approximately 17 percent, were closed either at Intake or in connection with the intake process. Of the fifty-three open cases, and in therapy approximately one-half were with a psychiatrist, the remaining were distributed among psychologists, psychiatric social workers and neurologists, either singly or in combination.

This chapter dealt with the intake activity on the total study group and followed the cases from the initial intake to final dispositions. The analysis of the records showed that dispositions were made in respect to sixteen cases before Intake Conference, sixty-seven at the time of Intake Conference, and sixty-four at the time of After Study Conference. Twenty-three veterans that were assigned for further diagnostic studies did not complete their studies. Of the 118 cases on which assignment to therapist were made, sixty-two were assigned to psychiatrists, twenty-one to psychiatric social workers, nineteen to combination therapy, fourteen to psychologists, one to the neurologist for medication only and one to a psychiatrist on a

fee basis. Fifty-three cases were still active in the clinic at the time of this study.

## CHAPTER IV

### SELECTED CASES

The following cases are presented as examples of the types of cases that comprised the study group, and to illustrate intake activity on individual cases. As was brought out in previous chapters, dispositions were made on new intake cases either in Intake Conference or After Study Conference, except in emergency situations where decisions were made at the time of the initial interview. In the first and second cases summarized here dispositions were made in After Study Conference because further diagnostic studies were recommended by the clinic team before final decisions could be given. In the third case disposition was made in the Intake Conference. The fourth case is presented as illustrative of an incomplete intake study resulting from lack of cooperation on the part of the veteran. In general, the problems and circumstances in these cases are typical of other cases in the study group.

The first case is one in which the veteran was requesting psychiatric treatment on his own initiative and was able to accept and follow through with the clinics recommendation:

Mr. B. was a self-referral and wanted help because he was "dissatisfied with his own inner feelings." He also suffered with periodic headaches, temperature elevation and extreme fatigue, which was a source of disturbance in all his activities and was interfering with his success in business. At the time of intake he was twenty-four years old, was married and living with his wife, and his marital relationship, according to himself, was "very satisfactory."

Mr. B. was first interviewed by an intake worker who obtained a social history. This history indicated that the framework for his personality difficulties began with an unsatisfactory relationship with his mother, whom he described as being a "highly selfish, neurotic, insincere, hostile and demanding person who never gave him any love or attention." His father died when he was three years old, leaving the mother and him financially secure, but, because the father died before making a will, the mother made changes in the securities, which consequently cheated Mr. B. out of his one-third share in the estate. As a child Mr. B. was placed in a series of military and private schools, during which times the mother visited him very infrequently. Mr. B. liked school and, in spite of spasmodic attendances, was able to complete high school.

Mr. B. cited an incident in which his mother instigated his referral to a psychiatrist, but, when the psychiatrist requested regular interviews with her, she discontinued the relationship, calling the psychiatrist a "quack." Mr. B. stated that he still had very hostile feelings toward his mother which he found it hard to overcome.

Mr. B. enlisted at the age of eighteen years, soon after his graduation from high school, and completed one year and five months in service, all in the United States. After his basic training he was assigned to Aviation Cadet School where he had a "nervous breakdown" under the pressure of school training and required hospitalization. He remained

in the hospital until his discharge from service. Upon discharge on May 30, 1944 he was given a ten percent disability rating for psychoneurosis which later was reduced to zero percent by the Rating Board.

After his discharge Mr. B. secured several jobs as an insurance salesman. He managed to do well in this business by making many substantial gains on a few sales. However, after about six months on one job he would become very irritable and fatigued, thus necessitating his having to either change jobs or stop work and rest for a while. He estimated that he was able to work on the average of only six or seven months out of each year.

Mr. B. had availed himself of medical examinations many times, but when these showed no basis for organic difficulties he decided that he had a psychiatric problem on which he required help.

In the Intake Conference it was recommended that B. be given complete physical and psychological examinations before a final diagnostic impression or disposition. The physical examination was essentially negative. Excerpts from the findings of the psychological examination show how these examinations aided in a better understanding of Mr. B.'s condition, and how psychological findings were usually recorded in the clinic:

Mr. B. is a very sick man who apparently has been able to stave off an acute emotional crisis by abrupt withdrawal from business activities for periods of months. He has fantastic aspirations which are far in excess of his ability. Achievement and success are his only supports in the absence of any ability to give or receive sympathetic emotional support. As long as he is upwardly mobile he has enough

esteem to guard against overwhelming feelings of hostility toward himself and those who seem to make demands upon him. Blocking of his success pattern is so threatening that all defenses are activated and one sees hypochondriacal preoccupation, diffuse felt anxiety, a number of compulsive tension reducing activities (chain smoking - easy fatigability) and on the favorable side his seeking psychiatric assistance.

Recommendations for treatment by the After Study Conference included referral to a neuropsychiatrist for immediate and prolonged psychotherapy. A favorable factor in Mr. B.'s chances for recovery was seen in his wife, who was a very understanding, talented and cooperative person. Mr. B. was still in treatment at the time of this study.

The second case represents a veteran whose illness had not been adequately evaluated prior to his being seen in the Mental Hygiene Clinic:

Mr. R., age twenty-seven, was referred from Medical Out-Patient Department. He had complained of dizziness, periodic loss of consciousness lasting from two to fifteen minutes, and headaches which occurred almost continuously and became worse during periods of excitement or worry. He was drafted into the Army in October, 1942 at the age of eighteen years, soon after his graduation from high school. He served for two years and two months, and experienced combat duty for approximately one year.

In discussing Mr. R.'s military experiences with him, the social worker learned that his first attack of loss of consciousness occurred spontaneously in 1944 while he was overseas. This attack was followed by several more which precipitated his hospitalization. Mr. R.



responded satisfactorily to hospital care and was discharged to return to duty after a few weeks of confinement. Although Mr. R. was aware of the fact that he had been in an accident while on maneuvers in 1943 when a tank in which he was driving fell into a tank trap, he nevertheless did not associate this experience with his attacks. He thought that they were due to "nerves" and "tension" associated with combat experiences and to "poor rations." The accident was not reported at the time it occurred because the servicemen involved feared disciplinary measure. It, therefore, was not known at the time of Mr. R.'s hospitalization since there were no further attacks during his remaining period of military service. Mr. R. was discharged on points in December, 1945. A few months after his discharge he filed a claim and was given a service-connected disability rating of ten percent for psychoneurosis, conversion reaction, chronic, moderate, with minimal degree of incapacity.

For about a year and a half Mr. R. suffered only occasional minor headaches, but after that time he began to experience a re-occurrence of his previous symptoms which became progressively worse and resulted in social maladjustment. His illness was also causing poor performance at work and this eventually cost him his job, which he had held satisfactorily since his discharge. After this Mr. R. attempted to qualify for other work but could not pass the necessary tests. It was at this point that he requested help from the Veterans Administration. At the time of the Intake interview Mr. R. manifested severe anxiety about his illness and verbalized a willingness to submit to any examinations recommended.

In the Intake Conference it was thought that the physical factors presented by Mr. R. indicated the need for a thorough organic evaluation and he was given an electroencephalograph test, as well as psychological and neurological examinations.

The electroencephalograph test was abnormal, which meant that Mr. R. was suffering from brain damage. This was consistent with the psychological findings, as follows: "the psychological studies are classically those of a brain-injured person. He has failed a learning situation due to difficulties in attention and concentration. This man is organically damaged more severely than the nature of his complaints would indicate."

The After Study Conference gave the diagnostic impression of Encephalopathy, manifested by Encephalosynapse and marked intellectual and emotional change of encephalopathy (no basis for psychoneurosis conversion hysteria), and recommended assignment to a psychiatrist for therapy, including medication. Mr. R. was still in treatment at the time of this study.

The third case represents a veteran who had received his psychiatric disability after discharge from service and was finding it difficult to accept his disorder as having a psychiatric component.

Mr. M. was referred to the clinic from the Medical Out-Patient Department when he requested treatment for a stomach condition which he thought was a manifestation of an ulcer condition. The Intake interview brought out the following: Mr. M. was born May 26, 1920. He left high school after completing two years, in order to go into the carpenter trade with his father. He stated that, prior to his induction into the service, he liked his work and was doing well both financially and socially.

Mr. M. was drafted into the Navy at the age of twenty-one years. He spent six years in the service and about one-half of this time was spent

overseas. His job was Storekeeper, Second Class, which he found "relaxing and safe." He adjusted well in service but began experiencing symptoms of nervousness, paleness and shakiness during terminal leave prior to discharge from service. He had, however, sufficiently overcome these feelings at the time of his discharge and was given a discharge on points May 31, 1947.

After discharge Mr. M. had difficulty in settling down. He was unable to return to his previous work as a skilled carpenter and subsequently developed what he considered the ulcer condition which, in turn, caused him to curtail his social activities. He was, at the time of the interview, living alone in a rooming house. He thought that he could not consider marriage because of his physical condition.

At his own request, Mr. M. had been hospitalized at Hines Hospital about a year after discharge from service. A physical examination revealed no evidence of an ulcer condition and, upon release, Mr. M. was given a ten percent disability rating for psychoneurosis, anxiety type. He then visited several doctors, and all but one of these told him he did not have ulcers. The doctor who agreed that there was a possibility of his having an ulcer condition recommended further examinations and treatment, but Mr. M. discontinued treatment after several visits because he thought the doctor was not helping him.

In the Intake interview, Mr. M. told the worker that he only wanted treatment for ulcers and did not feel the need for psychiatric examinations. The worker agreed with him that he might have ulcers, but pointed out that, since numerous examinations had not shown ulcers, he should consider the possibility of his symptoms having multiple origins, that is, physical and emotional. In this approach the worker did not take away all of Mr. M.'s defenses. He was able to accept her explanation and agreed to see the psychiatrist for further examination.

Mr. M. was seen by a psychiatrist and his case was presented in Intake Conference. The team agreed upon a diagnostic impression of psychoneurosis, anxiety reaction, chronic mild, and recommended psychiatric treatment. When Mr. M. was told that psychiatric treatment would be helpful and that he was being assigned to a psychiatrist for psychotherapy, he declined.

The fourth case is that of a veteran whose primary interest was in having his disability status increased so that he could receive a pension.

Mr. S., age twenty-eight, was referred to the clinic from the Pension Examining Board, where he had gone for his periodic examination in connection with his service-connected psychiatric disability. During this examination he had complained of irritability and "nervousness" which interfered with his economic adjustment and his ability to get along with people. Because of these complaints he was referred to the clinic for a complete diagnostic study.

Mr. S. gave the following information in the initial interviews. He was born January 21, 1921, in Chicago, Illinois. He only completed the eighth grade in school, but had been able to secure what he considered to be a good job as a machinist in a factory. Mr. S. said that he liked his job because he was making a good salary which enabled him to provide adequately for his wife. He was dissatisfied upon being inducted into the Navy.

In the Navy, Mr. S. attained the rank of Seaman, Second Class. He served for thirteen months and had overseas duty. Mr. S. found it difficult to adjust to Navy life and, as a result, developed many complaints and symptoms,

including headaches, backache, nervousness and irritability, which could not be substantiated by medical examinations. Therefore, he was accused, by the military authorities of malingering. He was eventually discharged as a psychoneurotic, anxiety type, with a zero percent disability rating for which he received no monetary compensation.

Since discharge, Mr. S. complained that he had been unable to secure the type of employment he desired and, therefore, he changed jobs frequently. He could not enjoy the company of other people and had withdrawn from adequate social contacts. He stated that, in the five and one-half years out of the service, he had not been able to "get back on his feet." He had availed himself of numerous physical examinations without being helped. Mr. S. specifically thought that his condition was due to his Navy experience and he contended that he should be adequately compensated. He told the intake worker that he agreed to come to the clinic only because he thought it would help him get his disability rating increased.

When the function of the clinic, and the type of services offered, were explained to Mr. S., his first comment was that he was not going to have any psychiatrist "talking to him." However, before the interview was completed he agreed to keep the appointment with the neuropsychiatrist, which he did.

Mr. S.'s case was later discussed in the Intake Conference, where a tentative diagnostic impression of conversion reaction in a schizoid personality was given pending further study. Recommended study included psychological and neurological examinations and a review of the claims folder. Mr. S. did not keep his appointment for study, nor did he respond to

follow-up letters sent to him by the psychiatric social worker. His case was closed in the After Study Conference.

These four cases are summarized to illustrate some of the problems presented by the veterans in the study group and to show intake activity. Consideration of this activity on each case indicated that efforts were made to understand and coordinate all the factors involved in the veterans' total situations before making dispositions. Such emphasis aided the clinic team in formulating proper treatment recommendations and in the giving of adequate services to the veterans.

## SUMMARY AND CONCLUSIONS

This study was focused on the intake process in the Chicago Mental Hygiene Clinic of the Veterans Administration and had as its purpose an analysis of all the new applications made at the clinic from January 1, 1950 through March 31, 1951. There were 200 applications coded as new applications during this period. Of this number thirty-four were excluded from study because fifteen of the applicants had been seen previously in the clinic, three involved services that did not come within the scope of the clinic, and two were for "trial visit" services. The decision to use only new applications resulted from the fact that approximately one-half of the applications made during the period of the study belonged in this classification. This raised the question as to why these veterans were seeking help for the first time almost five years after the cessation of hostilities.

The Mental Hygiene Clinic offers out-patient psychiatric services to veterans who are discharged from military service with psychiatric difficulties and is designed to treat those who do not require hospitalization. The clinic operates under the direct supervision of a Chief Psychiatrist and the general supervision of the Chief Medical Director.

Chapter I dealt with a brief resume of the total program of the Veterans Administration, with emphasis upon the social service activities which included the Mental Hygiene Clinic. A description of the Chicago Mental Hygiene Clinic and its intake procedure was given as a background for the study. As was shown in the study the clinic was staffed with psychiatrists, psychologists, social workers and special consultants who functioned as a team, coordinating their activities and skills for the purpose of providing adequate services to the veterans.

The study was conducted to obtain: (1) a composite picture of the veterans, (2) their reasons for applying for service at this particular time, (3) the intake activities on the individual cases in the study group, and (4) the status of the cases at the time of this research.

Tables and graphs were presented in Chapter II in order to point out significant observations and facts pertaining to the study group, such as, personal and social data, reasons for making applications and pre-clinic medical and psychiatric records. It was significant to note that the major problems of the veterans included marital and family difficulties. Further, it was observed that approximately one-half of the veterans had received pre-clinic medical or psychiatric care. The complaints of the veterans were varied, covering almost the entire psychosomatic



field. Approximately one-third of the veterans regarded their problems as being primarily psychogenic in character and about the same number regarded their illnesses as being organic. The remainder of the group thought their illnesses had both a psychogenic and organic origin.

The intake activity on the total study group was presented descriptively in Chapter III and augmented by the use of tables. This activity was considered under three headings: (1) Activity at the Time of the Intake Interviews, (2) Activity in the Intake Conference, and (3) Activity in the After Study Conference. The significant factor in regard to the total intake process was the individual attention that was given to each case. The study showed that emphasis in the clinic was placed upon formulation of diagnostic impressions or the making of dispositions only after complete evaluation of all factors involved in each individual case. Dispositions were made on only a few cases prior to the Intake Conference and these involved two types of situations, those in which hospitalization was necessary and those in which the veterans declined treatment. Dispositions were made on sixty-seven cases at the time of Intake Conference and sixty-four at the time of After Study Conference. Study was incomplete on twenty-three cases. Of the 118 cases that were assigned to therapy, fifty-three were still active at the time of

this research.

The selected cases presented examples of the types of cases common to the total group and of the intake activity on specific cases.

APPENDIX I  
SCHEDULE

IDENTIFYING DATA

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Birthplace \_\_\_\_\_ Religion \_\_\_\_\_ Race \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Sep. \_\_\_\_\_ Div. \_\_\_\_\_ Wid. \_\_\_\_\_ C.L. \_\_\_\_\_  
Education: 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 Adv. Training \_\_\_\_\_  
Elem. High Coll.  
Unemployed \_\_\_\_\_ Unemployable \_\_\_\_\_ Employed \_\_\_\_\_  
Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Type \_\_\_\_\_  
Living With: Parents \_\_\_\_\_ Relatives \_\_\_\_\_ Spouse \_\_\_\_\_ Alone \_\_\_\_\_  
V.R.E.: Yes \_\_\_\_\_ No \_\_\_\_\_ 746 \_\_\_\_\_ 16 \_\_\_\_\_ Course \_\_\_\_\_

MILITARY DATA

Inducted \_\_\_\_\_ Age \_\_\_\_\_ Enlisted \_\_\_\_\_ Drafted \_\_\_\_\_  
Branch \_\_\_\_\_ Duty: U.S. \_\_\_\_\_ O.S. \_\_\_\_\_ Combat \_\_\_\_\_ Not in Com. \_\_\_\_\_  
Discharged \_\_\_\_\_ Length of Service \_\_\_\_\_ Mos. Rank \_\_\_\_\_

Rating Board Diagnosis

N.P. \_\_\_\_\_

Medical \_\_\_\_\_ Comp. \_\_\_\_\_

Medical \_\_\_\_\_ Comp. \_\_\_\_\_

ILLNESS

Intake Date \_\_\_\_\_ Date Interviewed by Soc. Wkr. \_\_\_\_\_  
Age at Intake \_\_\_\_\_ Date interviewed by Psy. \_\_\_\_\_

Referral: Source \_\_\_\_\_  
Purpose \_\_\_\_\_

Vets stated reason for coming in \_\_\_\_\_

Precipitating factor by Vet: Military \_\_\_\_\_

Recent \_\_\_\_\_

Symptoms Noted by Vet: Before Ser. \_\_\_\_\_ Dur.Ser \_\_\_\_\_ Aft.Ser. \_\_\_\_\_

## Adjustment since discharge

Economic: Adequate \_\_\_\_\_ Inadequate \_\_\_\_\_ Questionable \_\_\_\_\_  
Social: Adequate \_\_\_\_\_ Inadequate \_\_\_\_\_ Questionable \_\_\_\_\_

## Medical Record since Discharge

Hospitalization: Yes \_\_\_\_\_ No \_\_\_\_\_ Out-Patient: Yes \_\_\_\_\_ No \_\_\_\_\_  
Psychiatric: Yes \_\_\_\_\_ No \_\_\_\_\_ Medical: Yes \_\_\_\_\_ No \_\_\_\_\_

## CLINIC STUDY

Diagnosis \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Organic Involvement: Yes \_\_\_\_\_ No \_\_\_\_\_

Prognosis for Treatment \_\_\_\_\_

Disposition \_\_\_\_\_  
\_\_\_\_\_

Status at time of study: Open \_\_\_\_\_ Closed \_\_\_\_\_ Date Closed \_\_\_\_\_

## APPENDIX II

CIRCULAR NO. 169  
JULY 16, 1946

### EXTRACT FROM CIRCULAR 169

#### MENTAL HYGIENE CLINICS OF THE VETERANS ADMINISTRATION

1. Introduction. Mental Hygiene Clinics, in addition to those already authorized, will be established in regional offices which the Deputy Administrator having jurisdiction determines that such clinics are necessary and can be properly staffed within the approved personnel ceiling. They will be a part of the medical service of such regional offices, responsible to the Chief Medical Officer, as are the other medical units. When a Deputy Administrator finds that the establishment of a Mental Hygiene Clinic is clearly essential, but that personnel limitations preclude such action, he will submit full facts in justification of the plan to Central Office for consideration, including an increase in the personnel ceiling.
2. Purpose and Responsibility. The need for treatment of the large number of veterans discharged from service with mental and nervous illnesses is evident. Experience in civilian practice before the war and in the armed services during the war indicates that the majority of these cases can be treated effectively in a clinic without hospitalization. The Mental Hygiene Clinics 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.
3. Functions of the Mental Hygiene Clinic. a. Primarily, treat the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization. The veteran may present himself for treatment or be referred by

another component of the VA, a public or private agency, or an organization in the community. Emphasis will be placed on the utilization of group therapy. Individual treatment will be provided as necessary, and as facilities and time are available.

b. Treat patients on "trial visit".

c. Refer patients to the Neuropsychiatric Examinations and Hospitalization Section for hospitalization in Convalescent Sections (formerly known as Neurosis Centers) or in other neuropsychiatric units.

d. Serve as an integral part of the general training and teaching program.

4. Relations with the Neuropsychiatric Examinations and Hospitalization Section. Although the Neuropsychiatric Examinations and Hospitalization Section and the Mental Hygiene Clinic of a regional office Medical Division have separate and distinct functions, and the chief of these reports individually to the chief medical officer, there will be a close liaison between the two to insure active professional relations and mutual availability of records. The Neuropsychiatric Examinations and Hospitalization Section is expected to be a major source of referrals to the Mental Hygiene Clinic.

5. Organization. a. The personnel will consist of a full-time staff of chief neuropsychiatrist, chief clinical psychologist, case supervisor, and a variable number of neuropsychiatrists (both full and part-time), clinical psychologist, two case workers and two clerical assistants for each group of fifty patients. This case load is predicted on the emphasis to be placed on group therapy as indicated in paragraph 3b.

b. A Mental Hygiene Clinic will function only when a neuropsychiatrist is present on duty status.

6. Qualifications of Neuropsychiatrists.

a. Neuropsychiatrists. (See Doctor of Medicine, DMS, P-640, change 19, VA Manual M5-3 "Qualification Standards and Rating Schedules.")

- (1) Must meet basic qualifications for appointment as doctor in the department of medicine and surgery.
  - (2) Should be a veteran, if possible.
  - (3) Diplomate of the American Board of Psychiatry and Neurology, or ready to take the examination.
  - (4) Experience must include intensive treatment of the psychoneuroses and allied conditions and a working knowledge of modern techniques, such as practiced in Mental Hygiene Clinics, institutions and in branches of the armed services.
- b. Chief Neuropsychiatrist. The chief neuropsychiatrist, in addition, should have demonstrated administrative ability to integrate the services of neuropsychiatrist, clinical psychologist, social worker, and clerical assistants. (See Doctor of Medicine, DM&S, P-640, Change 19, VA Manual M5-3).

7. Duties of Neuropsychiatrists.

a. Chief Neuropsychiatrist.

- (1) Directs the Mental Hygiene Clinic and is responsible to the chief medical officer for its functioning.
- (2) Supervises all personnel of the Mental Hygiene Clinic determines the treatment needs of individual patients and allocates intake, diagnostic and therapeutic responsibilities to neuropsychiatrists, clinical psychologists and social workers.
- (3) Develops the skill of the professional staff by instruction and guidance.
- (4) Effects a liaison and working relationship with other units of the Medical Division, other divisions of the regional office and community agencies.
- (5) Maintains a system of records and case histories.
- (6) Maintains records of activities pertaining to the Mental Hygiene Clinic; renders a monthly report to the chief medical officer to be forwarded through

the branch chief of neuropsychiatry to the assistant medical director for neuropsychiatry.

(7) Plans and conducts staff conferences.

(8) Directs or stimulates research projects.

(9) Takes necessary action to obtain and maintain contracts with appropriate civilian Mental Hygiene Clinics; surveys for approval contracts submitted by such offices.

(10) Responsible with other neuropsychiatrists for treatment of patients.

(11) Responsible for interviewing, evaluating and making recommendations for appointment of applicants to the position of neuropsychiatrist in the Mental Hygiene Clinic.

b. Neuropsychiatrists

(1) Engage in therapy.

(2) Designation of one neuropsychiatrist as assistant chief neuropsychiatrist who will aid the chief neuropsychiatrist in carrying out his functions and act as chief neuropsychiatrist in his absence.

B. Qualifications for Psychological Personnel.

a. Chief Clinical Psychologist, Grade P-4 or P-5

(1) Education. Applicants must have completed all requirements for a doctor's degree in psychology.

(2) Experience. Applicants for P-4 must have a minimum of three years and for P-5 a minimum of four years of progressively responsible experience in the following:

(a) application of a variety of psychological principles and techniques under the supervision of, or in consultation with, a qualified psychiatrist attached to a clinic, a branch of the armed forces, or any other organization whose functions include aid to maladjusted individuals; or



- (b) teaching in the field of clinical psychology, which must have been associated with work in a psychological clinic of a training institution or college or university of recognized standing. To be qualifying, this experience must indicate that the applicant has the ability to examine maladjusted individuals for diagnostic or therapeutic purposes as a means to their adjustment.

b. Clinical Psychologist, Grade P-3

(1) Education. Applicants must have successfully completed at an accredited college or university all requirements for a doctor's degree in psychology, or courses covering subject matter taught in the following fields:

- (a) Abnormal psychology, clinical psychology, mental hygiene, or personality adjustment (Two courses.)
- (b) Clinical techniques such as individual testing, interviewing, or the case-study method. (Two courses.)
- (c) Differential psychology, tests and measurements (educational, vocational, psychological, personality, attitude), or statistics. (Two courses.)
- (d) Human biology, neurology, or physiological psychology (One course.)
- (e) General, experimental, child, adolescent, social, animal, or systematic psychology or additional courses from among those listed in the foregoing paragraphs. (Three courses.)

(2) Experience. Applicants must have a minimum of two years of experience similar to that required of the chief clinical psychologist.

9. Duties of Psychological Personnel.

a. Chief Clinical Psychologist under the direction of the Chief Neuropsychiatrist:

- (1) Supervises the psychological examination activities of the clinic.

- (2) Maintains the administrative statistics of the psychological unit.
- (3) Directs the clinical teaching of trainees and psychological interns who may be assigned to the Mental Hygiene Clinic.
- (4) Directs and stimulates the research program of the psychological unit.
- (5) Participates in research activities of the Mental Hygiene Clinic.
- (6) Conducts psychometric tests and measurements appropriate to a variety of mental and nervous conditions and situations, including tests of intellectual ability, projective tests, examinations of attitudes and aptitudes, group and individual situational tests, and diagnostic psychodramatic procedures.
- (7) Interprets and reports the above findings in relation to medical, psychiatric, social, and educational data, and in relation to the patients' problems of personality adjustment.
- (8) Carries out individual or group therapy under direction of the responsible neuropsychiatrist who will first review the case to determine if the problem can be competently handled by a clinical psychologist. The Chief neuropsychiatrist will delegate such therapeutic duties only when he believes the individual clinical psychologist to be fully competent to handle the case. Periodically the individual clinical psychologist will consult with the neuropsychiatrist on the progress of the therapy and additional treatment. The patient may be referred to a clinical psychologist for individual or group treatment if the case involves conditions such as: readjustment of habits; personality problems within the normal range; educational disabilities, including speech impairment, and similar difficulties requiring re-education; or relatively minor psychoneurotic conditions without important somatic components.
- (9) Participates in clinic staff conferences.

(10) Participates in interpretation of psychological mechanisms and their measurement.

b. Clinical Psychologists. Assists in work described in subparagraphs (5) and (11) under the direction of the chief psychologist.

10. Qualifications for Social Work Personnel

a. Case Supervisor P-3

- (1) Education. Completion of at least one year of training at an accredited school of social work, this training having included supervised field work and courses in psychiatric or medical information.
- (2) Experience. At least three years of social case work experience in a health or welfare agency of acceptable standards.
- (3) Substitution. A second year of school work training may be substituted for the one year of required social case work experience.

b. In the selection of candidates, it is desirable to give preference to candidates who have had the full two years of graduate school of social work preparation and experience in a Mental Hygiene Clinic treating adults.

11. Duties of Social Work Personnel.

a. The case supervisor, under the immediate direction of the chief neuropsychiatrist of the clinic, and the general direction of the chief social worker of the station:

- (1) Supervises the social study and social treatment activities of the clinic, with responsibility for adequate social service to patients, and for developing increased skill of the workers in the clinic.
- (2) Instructs and supervises school of social work students assigned to the Mental Hygiene Clinic for their field work in neuropsychiatric social work.
- (3) Directs and stimulates the research program of the social service unit.

- (4) Brings to the total diagnostic study of the patient an analysis of the factors of the patient's history and current circumstances having significant bearing on the cause, development, and nature of the patient's illness; identifies the adverse and favorable factors requiring clinical consideration from the viewpoint of diagnosis and treatment, including available community resources.
  - (5) She participates in the therapeutic activities of the clinic under the immediate direction of the neuropsychiatrist treating the patient. This participation will include:
    - (a) Enabling the patient to recognize and develop the capacities within his own personality, and to use the resources and services available to him in the VA, home and community for the solution of difficulties in family, work, and social relationships having bearing on his illness and recovery.
    - (b) Assisting the patient's family and others, either directly or through referral to other agencies, in solving problems which arise out of the patient's illness in order to maintain their cooperation in administering treatment plans.
    - (c) Assisting in therapy when, in the opinion of the chief neuropsychiatrist, the individual case worker has the necessary experience, training and personality to deal with the problems of the particular patient. In such instances the case worker will receive sustained supervision from the neuropsychiatrist in charge of the patient.
  - (6) Participates in clinic staff conferences.
  - (7) May participate in the research work of the clinic.
  - (8) Interprets the social aspects of mental hygiene to community social agencies concerned with the problems of veterans with nervous and mental conditions.
- b. Duties of social worker under the direction of the case supervisor. Assists in the work described in subparagraphs (4) and (8).

12. Routing and Intake Procedure. a. When a decision has been made to refer a patient with a nervous or mental illness to the Mental Hygiene Clinic, or when a patient presents himself and states he has such illness, whether or not he asks for treatment, he will be referred to the Mental Hygiene Clinic immediately. There he will first be interviewed by a social worker of the Mental Hygiene Clinic where, under the direction of the case supervisor, a statement will be prepared to assist the neuropsychiatrist in determining the patient's suitability for treatment. There also the social worker will, if necessary, orient and prepare him for treatment. On the same day, the patient will be interviewed by a neuropsychiatrist of the Mental Hygiene Clinic to insure that patients with certain mental and nervous conditions such as severe anxiety and depression will be put under care at the earliest time possible. Suitability for treatment will also be determined at this time or at a succeeding visit, if necessary.
- b. During the interviews, a determination will be made as to the patient's eligibility for neuropsychiatric treatment. If no such determination has as yet been made, the chief medical officer of the regional office will name one or more of the neuropsychiatrists of the Mental Hygiene Clinic to determine evidence of eligibility under the provisions of Section II, VA Circular 26, 1946.
- c. After the patient has been found eligible and suitable for care, the social service unit of the Mental Hygiene Clinic will arrange for the patient's treatment at the Mental Hygiene Clinic, at a contract clinic or through other available resources. If the patient is found to be ineligible for treatment under VA regulations, the social service unit will use available community resources to have him treated.
13. References. a. Medical Director's letter, September 17, 1945: "Organization and Development of Out-Patient Mental Hygiene Clinics," to All Stations Having Out-Patient Mental Hygiene Clinics.
- b. Section I, VA Circular 70, 1946.
- c. Medical Director's letter, March 6, 1946: "Internal Organization of Regional Office Medical Service with

Reference to Mental Hygiene Clinic," to Director of Medical Service.

d. Section II, VA Circular 26, 1946. (Circular 229: III 1946.

(10 CB)

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. C-NO.	
3. ADDRESS			
4. NAME AND ADDRESS OF NEAREST RELATIVE			
6. RACE	7. WAR <input type="checkbox"/> WW I <input type="checkbox"/> WW II	8. SERVICE-CONNECTED DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	5. RELATIONSHIP 9. DISABILITY RATING %
10. DIAGNOSIS			
11. REFERRAL <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> ADJUDICATION <input type="checkbox"/> CHIEF ATTORNEY <input type="checkbox"/> VOCATIONAL REHABILITATION <input type="checkbox"/> OTHER VA REGIONAL OFFICE (Specify) <input type="checkbox"/> VA HOSPITAL (Specify) <input type="checkbox"/> CONTACT <input type="checkbox"/> OTHER <input type="checkbox"/> SELF <input type="checkbox"/> COMMUNITY AGENCY (Specify)			
12. DATE REFERRED	13. DATE REPORT DUE	14. DATE REOPENED	15. DATE CLOSED
16. NATURE OF REQUEST			
17. SERVICE <input type="checkbox"/> REFERRED TO OUTSIDE AGENCY (Specify)			
18. CONTACT <input type="checkbox"/> IMMEDIATE <input type="checkbox"/> CONTINUED <input type="checkbox"/> TREATMENT IN MENTAL HYGIENE <input type="checkbox"/> VETERAN <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYER <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> COMMUNITY AGENCY <input type="checkbox"/> OTHER			
20. REPORTS		19. SOCIAL SERVICE EXCHANGE <input type="checkbox"/> IDENTIFIED <input type="checkbox"/> UNIDENTIFIED	
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**

## BIBLIOGRAPHY

Aceham, Nathan, "Psychiatric Disorders in Servicemen and Veterans," American Journal of Orthopsychiatry, 1945.

American Red Cross, Handbook of Information Concerning Servicemen and Veterans, A.R.C. 207, Sections 1060-1068, The American Red Cross, Washington, D. C., July, 1949 and March, 1950.

Chief Neuropsychiatrist, Chicago Regional Office Mental Hygiene Clinic, "Committment of Mentally Ill to Hospital", Office Memorandum, October 26, 1946.

Chief Neuropsychiatrist, Chicago Regional Office Mental Hygiene Clinic, "Procedure for Handling Service-Connected Veterans in the Mental Hygiene Clinic", Unpublished Intra-Office Memorandum, February 2, 1950.

Chicago Veterans Administration Mental Hygiene Clinic, "Intake Procedure in The Mental Hygiene Clinic", Unpublished Intra-Office Memorandum.

Circular #169, "Mental Hygiene Clinics", Veterans Administration, Washington 25, D.C., July 15, 1946.

Dictionary of Occupational Titles, Volume II, Second Edition, "Occupational Classifications", Washington, D. C., 1949.

Directive, Branch Office #7, "Social Services for Patients Discharged on Trial Visit from Veterans Administration Hospitals", Chicago, Illinois, July 25, 1947.

Fildman, Fred B. and Regus, Edward, "A Follow-Up Study of Army Enlisted Psychoneurotic Discharges", Journal of Nervous and Mental Disorders, Volume 106, July-December, 1947.

Fineson, Jacob and Lindeman, Erich, "A Discussion of the Psychiatric Aspects of Rehabilitation," Diseases of the Nervous System, Volume 6, May, 1946.



Office of the Chief Medical Director, "Discontinuance of the Screening of Service-Connected and Non Service-Connected Veterans", Official Memorandum, Washington, D. C., February 2, 1950.

Office of the Chief Medical Director, "Organization and Development of Out-Patient Mental Hygiene Clinics", Washington, D. C., September 19, 1945. .

Pratt, D. "Persistence of Symptoms in the Psychoneurotic Ex-Serviceman", Journal of Nervous and Mental Diseases, Volume 103, 1945.

Reichline, Philip and Futterman, Samuel, Veterans Administration Mental Hygiene Clinic, Los Angeles, California, "Intake Techniques in a Mental Hygiene Clinic", Journal of Social Case Work, February, 1948.

Skinner, John, Veterans Administration Mental Hospital, Los Angeles, California, "Defining Treatment Aims for Initial Interviews", Journal of Psychiatric Social Work, Spring, 1948.

Stipe, Jack H., "Social Services in Veterans Administration", Journal of Social Case Work, Volume 29, February, 1948.

Technical Bulletin TB 10 A-78, Veterans Administration, "Nomenclature of Psychiatric Disorders and Reactions", Washington, D. C., October, 1947.

United States Government Organizational Manual, 1949-1950, "Veterans Administration", Government Printing Office, Washington, D. C., July, 1949.

Unpublished Memorandum, Chicago Veterans Administration Mental Hygiene Clinic, "Intake Procedure in Mental Hygiene Clinic".