"AN EXPLORATORY STUDY OF SOME OF THE FACTORS CHARACTERIZING INTENSIVE CASEWORK IN THE BATTLE CREEK, MICHIGAN VETERANS ADMINISTRATION HOSPITAL"

by

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TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
LIST OF TABLES	iv
CHAPTER	
I. PROBLEM AND CONTEXT	1
II. ASSUMPTIONS AND METHODOLOGY	16
III. PRESENTATION AND ANALYSIS OF DATA....	34
IV. CONCLUSIONS AND RECOMMENDATIONS	50
APPENDIX	56
BIBLIOGRAPHY	67

LIST OF TABLES

Table		Page
1.	Frequency of Direct Interviews With Patients.....	35
2.	Frequency of Interviews With Relatives of Patients.....	36
3.	Source of Referral for Social Service...	39
4.	Techniques Used in Working With Patient.	43
5.	Number of Months Patient was in Hospital Before Interview by Caseworker.....	45
6.	Marital Status of Patients.....	46
7.	Age of Patients.....	47
8.	Medical Diagnosis of Patients.....	47

CHAPTER I

PROBLEM AND CONTEXT

This was an exploratory study of some of the factors characterizing the practice of casework in the Battle Creek Veterans Administration Hospital. The hospital is a 2,056 bed neuropsychiatric treatment center located in the now deactivated Fort Custer, approximately six miles west of Battle Creek, Michigan. The Social Service staff is composed of twelve professionally trained social workers and five secretaries, as well as a varying number of graduate social work students from Michigan State University, University of Michigan and Smith College. Emphasis is placed on the team approach of psychiatrist, psychologist, and social worker, although the respective functions are not rigidly defined. A working relationship exists between the aforementioned departments as well as between the other departments such as nursing, occupational therapy, and educational therapy.

Although it cannot be said that the research here represented is typical of social science research in general, it does rest upon many of the assumptions which are common to the broad area of social science.

Without going into detail, the most obvious of these assumptions are: that behavior is knowable and purposeful, that although no exact measurements are possible in the social sciences statistical measurement is meaningful, and that the solutions to problems based essentially in the realm of behavior will be found both in empirical observation and rationalistic generalization.[1] Another assumption which is often overlooked but is an implicit component of social science is that pertaining to development. It is sometimes felt that the whole of social science research is useless due to the inadequacies of its findings and the nature of its inquiry. Hans Reichenbach states that "The philosopher speaks an unscientific language because he attempts to answer questions at a time when the means to scientific answer are not yet at hand."[2] At present much of social science inquiry is philosophical. However, it may be that the means are not yet at hand.

This study was not concerned with the broad issues facing the whole of social science, but rather with some of the problems confronting social work. Social work, as a profession, is wrestling with many

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[1] Hans Reichenbach, The Rise of Scientific Philosophy (Berkeley: University of California Press, 1951).

[2] Ibid., p. 25.

problems of definition, not only of function but also of knowledge which it holds uniquely. Within this context there are also several assumptions upon which this study rests. One of these is that social work represents a professional area of practice based upon a body of knowledge that is transmittible. Social work is in the early stages of development but it has now reached a point where definition and varied research focuses may be attempted. A factor which plays a primary role in defining the theoretical context for this study is that social work has been historically and is at present, essentially an area of clinical practice. Social work has not concerned itself with the evolving of new, basic knowledge, but has rather been occupied with the effecting of change. The specific focus has been on attaining goals in terms of techniques which have been clinically tried and in some cases evaluated. The particular type of transmittible knowledge which social work possesses rests in methodology or conversion of knowledge which has been eclectically borrowed from many areas and converted into practice.[1] Although social work is advancing toward more exact knowledge as a whole, it is not progressing evenly in terms of specialties within the profession. Social

[1] David G. French, An Approach to Measuring Results in Social Work (New York: Columbia University Press, 1952).

casework has tended to develop much faster than many of its generically related siblings. In addition to this, social casework has had a longer history and has consequently reached a point where the rate of development is increasing.

This study was theoretically situated in the area of social casework and was directed toward an identification of the methods used in social casework. It was concerned with the way in which an eclectic fund of knowledge was converted into practice. It was not concerned with an evaluation of the practice, but rather with the identification of the method. However, as indicated in the title, this was an attempt to identify only one aspect of casework, that which is here called intensive. Intensive casework was a term found in use at the hospital by the caseworkers and which was found in use at sixteen other major Veterans Administration hospitals by the social service staff.[1] This study was an attempt to identify on a practice level some of the characteristics of intensive casework and to determine whether or not intensive casework was a homogeneous grouping of factors.

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[1] See Appendix A.

REASON FOR STUDY

There were essentially five reasons for this study being conducted. The first of these was found when an examination of the literature was made in an attempt to find meaning for the term "intensive casework". No literature was found which lent itself directly to an explanation of the term. However, the implicit assumption in the use of the term intensive is that it refers to something closely aligning itself to psychotherapy. Many articles have been written attempting to differentiate psychotherapy and casework. One common characteristic of the articles is the ambiguity which surrounds the definitions of the terms. Kaplan stated that "There is general agreement that social casework is a less intensive and a more supportive treatment than intensive psychoanalytic therapy."[1] There is a certain degree of ease associated with definitions in extremes. However, the definition in extremes tends to avoid the basic issue of essential difference between social casework and psychotherapy, if such a difference exists. Marmor stated that:

We must face the fact that there is a significant

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[1]Alex H. Kaplan, "Psychiatric Syndromes and the Practice of Social Work", Social Casework, March, 1956, p. 108.

> area of overlapping in the techniques of casework and brief psychotherapy, an area in which more or less identical approaches are utilized by caseworkers in social agencies and by short-term psychotherapists in mental health clinics. At the casework end of the scale, however, there is an area in which environmental manipulation is utilized to an extent that is beyond the scope and capacity of the average psychiatrist; while at the psychiatrist's end of the scale there is a group of patients with whom deep uncovering techniques are utilized to an extent that is beyond the scope of the average caseworker.[1]

In much the same vein Coleman explains that for terminological and administrative clarity:

> I see no value in calling casework anything but casework, even though it is a genuine psychotherapeutic endeavor, since casework has potentially a broader and more elastic field of usefulness than psychotherapy practiced by psychiatrist. In other words, casework is a form of psychotherapy with special orientation, differential aims, and a particular methodology; in effect, it is an application of psychotherapeutic prinicples in a setting and in a manner which is uniquely its own.[2]

Another article related to this area came as a result of an analysis of forty-three cases at the Mental Hygiene Clinic, Veterans Administration, Seattle, Washington. In this study a section was devoted to factors in supportive treatment (seemingly supportive treatment aligned itself with total casework treatment) in which

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[1] Judd Marmor, "Indications for Psychiatric Therapy or Social Casework", Social Casework, February, 1955, p. 61.

[2] Jules V. Coleman, "Psychotherapy and Casework", (Presented at a Symposium on Psychotherapy and Casework, sponsored by the Boston Psychoanalytic Society, Boston, February 19-20, 1949).

they felt that:

> Here the term 'supportive therapy' by and large is used in juxtaposition to 'insight therapy' or 'interpretative therapy'. As a rule, we use the words 'supportive treatment' or 'supportive therapy' in the sense of focusing attention on the clients' present reality problems and minimizing efforts to give the patient insight into the unconscious courses of behavior. [1]

The theme which evidenced itself consistently in the articles which were reviewed was that casework was not clearly defined but seemed to be similar to psychotherapy. The only article which attempted to relate some general statements to specifics was that of Coleman in which professional training was cited as a differential factor.[2]

A statement which seems appropriate at this point (in relation to professional training as a differential factor) is "When ignorance is universal, the degree of inexpertness is secondary."[3] One of the outstanding problems confronting the specific answering of a question such as "Is this psychotherapy being done by a caseworker?" is the lack of definitions of the term psychotherapy. As evidenced in the articles cited,

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[1] Fritz Schmidl, "A Study of Techniques Used in Supportive Treatment", Social Casework, December, 1951.

[2] Coleman, op. cit.

[3] Herbert Sanderson, Basic Concepts in Vocational Guidance (New York: McGraw Hill Book Company, 1954), p. 41.

definitions were being attempted in a comparative manner when both factors were variable; this presents a philosophically difficult task. In order to adequately relate casework to another framework, it is necessary to be able to specifically and empirically define what is meant by the term.

The second major reason for this study was that the workers in the agency gave the impression that they were able to communicate with each other when using the term "intensive casework". Statements such as, "I feel that this patient would profit from intensive casework," were used when the workers were discussing cases, and statements such as, "This patient will receive intensive casework",were found in the records. Many of the workers felt that intensive casework was an individually defined concept. However, the degree of communication achieved served to refute this. The thinking which was stimulated by this was that perhaps there was a good deal more inconsistency on the verbal level when discussing intensive casework than there was on the practice level. This would be somewhat contradictory to the findings of a survey of some major principles of casework in which it was felt that inconsistency may be found on the theoretical level but this was not reflected in practice.[1]

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[1]Callman Rauley, "A Sampling of Expert Opinion on Some Principles of Casework", Social Casework, April, 1954.

The third factor which prompted this study was that the term "intensive casework" was being used differentially by the workers for particular cases. It was felt that intensive casework was applicable to certain types of patients or situations and that it was not appropriate for others. This was also evidenced in other Veterans Administration hospitals by the indicating of factors such as: (1) willingness to participate by client, (2) age of patient, (3) length of hospitalization, (4) patient's past adjustment, (5) worker's interest in the case or feeling toward patient, (6) the patient's capacity to relate to the worker.[1] All of these factors tended to substantiate the presence of a differential use of the term "intensive casework". It would seem necessary to be able to adequately describe a term which was being used differentially in practice in order to evaluate it as well as to refine the practice.

The fourth factor which underscored this study is the pressing need for research in treatment. "The very fundamentals of therapeutic interpersonal relationships remain with scientific validation."[2] In this article four questions were posed for basic research:

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[1] See Appendix B.

[2] Kurt Freudenthal, "Need for Research in the Area of Treatment Relationship", Social Casework, October, 1955, p. 369.

(1) Who can benefit from relationship therapy? (2) When has maximum benefit from relationship therapy been achieved? (3) In cases of improvement or regression, is relationship therapy causal? (4) Does the approach represent differentiated therapeutic areas which justify referral? In the Social Work Yearbook reference was made to the need for continuing study and evaluation of the function and scope of social work.[1] In the same volume Fletcher listed as one of four objectives of social work, research to improve and enlarge the techniques of diagnosis and treatment as they are used in social work practice.[2] The most profound need of social work research (as well as all social science research) is the development of concepts. "Our greatest need is a frame of reference and a system of concepts which will generate testable hypothesis and will encourage precise observation and analyses."[3] The need for basic research in social work is promoted in numerous articles and lectures so much that it has become a cliche in social work to indicate the need for research. Although this was continually emphasized,

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[1]Clyde E. Murray, "Social Work as a Profession", Social Work Yearbook 1954, ed. by Russell A. Kurtz, (New York: AASW).

[2]Social Work Yearbook Staff, "Research in Social Work", Social Work Yearbook 1954, ed. by Russell A. Kurtz, (New York: AASW).

[3]Morton B. Ring, Jr.,"Some Comments on Concepts", Social Forces, October, 1955.

few such pieces of research have evolved. This leads to the fifth reason for this study.

There has been in social work research the vestige of a historical past, namely, an emphasis on results. Social work research has tended to grasp at this same emphasis as evidenced by the dearth of studies examining practice and the emphasis on follow-up or evaluation.[1] The value of studies such as these is not to be underrated. However, this type of study should be considered as only one aspect of a total research program. One of the major objections to the follow-up study is the inability of the research design to control variables which may be more causal than the assumed case-work process. This is a problem which is inherent in social science research; however, other disciplines such as psychology have attempted to cope with it by identifying as precisely as possible the object under study. It is difficult to control the variables in social case-work for there have been few attempts to identify the components of this practice on an empirical level. As a result, we know a good deal about people and problems receiving social casework and something of what happens afterward, but very little of what happens in between.[2]

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[1]For example see: Dorothy Levy, "A Follow-up Study of Unmarried Mothers", Social Casework, January, 1955.

[2]For example see: Margaret Blenker, J. Mc V. Hunt, Leonard S. Kogan, "A Study of Interrelated Factors in the Initial Interview with New Clients", Research Programs and Projects in Social Work, FSAA, 1953.

The material which related itself directly to a definition of social casework defined goals rather than process. Gordon Hamilton, one of the foremost interpreters of social casework,noted the process as ". . . the release of resources in the immediate environment and capacities in the individual."[1] This partial definition seemed to be representative of most definitions. It placed an emphasis on removing blocks to the individual whether these blocks were within the individual himself or more broadly defined in terms of his immediate environment.

> The process of social casework and its usefulness rests upon a conviction of accepting people as they are, respecting their rights to live their own lives according to their best lights, and a willingness to work with them on their plans rather than to make their plans for them. The worker's effectiveness lies in what he does in helping people and how he does it. He does not take over their difficulties nor their own share of responsibility, rather he helps them to face their difficulties and to carry what is their part of the load. Casework is a skillful way of working with people in trouble. It is not the only way. It is one way that has proven its value by helping people to develop their own capacities for usefulness and satisfying living.[2]

As one moves from the more broad conceptual material portrayed above to the more specific, the

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[1]Gordon Hamilton, Theory and Practice of Social Casework (New York: Columbia University Press, 1951).

[2]Arthur E. Fink, The Field of Social Work New York: Henry Holt & Company, 1952), p. 63.

definitions are still philosophical. "The casework relationship is the dynamic interaction of feelings and attitudes between the caseworker and the client with the purpose of helping the client achieve a better adjustment between himself and his environment."[1]

It was on this philosophical level that a schism developed in social work. One approach to social work became known as the functional[2] and the other as the organismic. The theoretical foundations for these areas have evolved from the theories of Otto Rank and Sigmund Freud, respectively. It has been felt by several persons that the primary separation of these two approaches is in theory, although a recent publication contests this thinking,[3] and that a comparison of practice would not exhibit the schism. This again emphasizes the need for an examination of the casework process.

There seemed, then, to be a lack of consistency in definition of social casework as well as a degree of defensiveness on the part of the profession in the

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[1]Felix P. Biestek, "An Analysis of the Casework Relationship", Social Casework, February, 1954.

[2]Herbert H. Aptekar, Basic Concepts in Social Casework, (Chapel Hill: University of North Carolina Press, 1941).

[3]Herbert H. Aptekar, The Dynamics of Casework and Counseling, (New York: Houghton Mifflin Company, 1955).

psychotherapy-casework controversy. This lack of consistency was represented theoretically and has not been evaluated empirically; that is, there is a lack of studies examining practice. Although this study did not attempt to examine the total area of casework, it did examine a particular aspect of it. While intensive casework may be defined theoretically (this author did not find this to be true), it has not been examined empirically.

The purposes of the study fell into two categories. The first was that it was felt that communication could be improved both within and outside the profession. The foremost research need in social science as well as in social work is the need for construction of concepts. It was hoped that this study would provide at least a partial movement toward construction of a concept of intensive casework. There was recognition that the construction of a total concept of intensive casework would not be feasible at this time, due to factors of time and development of research technique; however, partial solidification was attempted. If concepts could be developed which are meaningful on the practice level as well as on the theoretical level, the task of communication between workers as well as the enormous

job of interpretation to other disciplines and the public would be made much easier. It was felt that research technique as well as subject matter could be explored in an attempt to provide a research base from which improvements and refinements could be made. In accordance with this, the study hopefully will focus attention upon an examination of social work process on the empirical level.

CHAPTER II

ASSUMPTIONS AND METHODOLOGY

Hypothesis

In order to systematize an approach to this study and to provide a framework in which to examine the practice of intensive casework, the following hypothesis was formulated: the factors which characterize active casework also characterize intensive casework but distribute themselves bi-modally. It was felt that a series of factors would manifest themselves in both intensive and active casework but that in each of these cases some of the factors would be more pronounced in one than in the other.

For purposes of this study the terms "intensive case" and"active case" were determined by the workers. An intensive case was one which the individual worker indicated as being intensive. All other cases in which the worker had performed some activity but did not feel that it constituted intensive casework were labeled active.

The hypothesis stated above was used for several reasons, the most fundamental being that some control was needed to differentiate intensive casework. It

would not have been meaningful to extract factors from cases in which intensive casework only was believed to have been practiced for there would have been nothing to make these factors different from those found in active casework. By using a framework such as the one implied in the hypothesis a control group was incorporated in the design.

Another basic reason for the use of the hypothesis was that the literature and the discussions which were held with the workers gave reason to believe that there were no distinct factors in either intensive or active casework. A generic base was found to exist in the philosophical definitions of casework and also in the material found in the psychotherapy-casework controversy.

Assumptions

Three assumptions provided the base for this study. The first of these was that casework is an analyzable process with distinguishable characteristics. In attempting an exploratory study of factors characterizing intensive casework, it would be necessary to assume that such factors were accessible. There is a good deal of controversy regarding the measurement of dynamic, intangible, conceptual material with the tools we now have available. It has been stated that casework

is an art based upon a science and that perhaps the art may never be meaningfully measured. In terms of these limitations, the title of this study points out that this is a study of some of the factors characterizing intensive casework and makes no claim to measuring or identifying all of them. The assumption as stated above, however, is located more appropriately in the philosophical base of social science research and represents a goal rather than a specific entity, namely, that behavior is measureable and knowable. Our inability to measure behavior at any particular point in time rests in the lack of adequate tools rather than the inaccessibility of the product.

The second assumption of this study was that the separation of cases by individual workers (into intensive and active) provided two groups which were distinguishable. Although the completion of this study will serve toward validating this assumption, the literature supported the view that the two groups were somewhat different. This assumption was borderline between a hypothesis and an assumption, for the reason stated previously. However, it was necessary in that the study was directed primarily at an identification of factors characterizing one of the groups. This assumption also became necessary due to the absence of

any tangible separation of cases in terms of administrative procedures or policies.

The third assumption defined the source of the data: case records contain data which identify factors characterizing intensive and active cases. It was recognized from the beginning of the study that all of the factors could not be identified. Nevertheless, case records represent at least partial recording of casework process. In this sense it would be conceivable that characteristic factors would be evidenced in the records. There are many limitations to the use of case records for social work research. In many studies it has been necessary to define the recording to be done by workers as part of the study design; however, this methodological tool could easily provide a sample which was not representative.

Plan of Study

In its simplest form this study consisted of a selection of intensive and active cases as defined by the individual workers, construction of a schedule for gathering recurring factors in these cases, application of this schedule to the case by three observers (author and two workers in the agency) and a classification of the factors as they were found. The same schedule was applied to both active and intensive cases in order to

obtain a basis for comparison of the two groups; that is, the schedule served as the standardizing instrument.

As indicated in the assumptions stated, the data for the study were gathered from case records in the agency. The cases were selected on the basis of requests to the individual workers for cases which they felt were intensive and those which they felt were active. Many requests were made by the workers for clarification of what the author meant by intensive, feeling that perhaps the terms was one which they alone used. In each of these cases the explanation given was that the study was concerned with what they felt intensive casework was rather than what the author felt it was. The only other stipulation was that the cases which were submitted be closed; that is, either the patient had left the hospital or it was felt that no further casework services were needed. Aside from these two qualifications no other information was given, although a great deal of pressure was exerted on the author to do this.

Numerically, thirty-six cases composed the group which was examined. This group was divided into eighteen active and eighteen intensive cases. The number of cases used was dictated by the number of intensive cases which could be obtained. The cases

were obtained from the workers and were available only on the basis of workers' recall. Eighteen intensive cases constitued the group which they submitted and this was used as the sample. There was no such limitation on active cases since the supply was unlimited.

The reason for using this method in selecting the cases was that the study was concerned with an examination of a relatively undefined concept which was being developed by the workers on a practice level. No administrative or formal method had been utilized which allowed for classification; consequently, no method other than this would have allowed for a non-skewed group.

This method of selection, however, introduced several limitations to the study. Since this group was not in any way selected from a population of intensive cases and there was no way of knowing precisely what the total population of intensive cases was, it was impossible to speculate as to how representative this group was of the total population. This limited the degree of generalization which could be made on the basis of the conclusions of the study. Closely related to this factor was that of memory as being the basis upon which the workers selected the cases. In other words, they

had no method for submitting the cases other than the submission of ones which had been recalled by them. The flaws involved in perception may have skewed the group toward cases in which the workers had derived a certain degree of satisfaction rather than ones in which they practiced intensive casework. Another limitation in the use of this group is that there was no attempt made to determine how representative this group was of groups in other agencies. Although data have been collected indicating the differential use of the term intensive casework, it is conceivable that this may be an agency centered rather than generic term.

Although these are severe limitations, they do not negate the findings of the study. As suggested in the introduction one of the fundamental purposes of the study was to provide a basis for further research. In this sense the study offers a basis for comparison in other agencies and with different groups of cases.

In order to systematically extract information from the case material, a schedule was constructed.[1] The basis for construction of the schedule came from three sources: a survey of Veterans Administration Neuropsychiatric Hospitals, written submissions and

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[1]See Appendix C.

interviews with the agency workers, and a review of the records.

A letter asking an open end question, "What are some of the factors which the workers feel characterize the practice of intensive casework," was sent to thirty-one Veterans Administration Neuropsychiatric Hospitals.[1] Several responses reflected factors resulting from staff meetings held to discuss the question and arrive at a group definition. In other cases the answers reflected the opinion of the Chief of Social Service. The factors which applied to the intensive casework method rather than factors noted in differential use of the method appeared to be: (1) continuing interviews, (2) scheduled interviews, (3) focus on emotional and personality aspects of the total problem, (4) formulation of goals, (5) collaboration with other disciplines, (6) frequency of interviews.[2]

The second source of information consisted of interviews with staff personnel and written statements from the staff.[3] The standard question in the letter to the hospitals was used to obtain responses from the staff. The characteristics suggested by this group were: (1) focus on personality, (2) planned contacts,

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[1]See Appendix D.

[2]See Appendix E.

[3]See Appendix F.

(3) structured purpose, (4) considerable emotional investment by worker.

The third source of information was found in a review of the records which had been submitted by the workers. The factors which seemed to be consistently evident in the records were much the same as those found in the survey and discussions with staff personnel. Another source of material used in developing the schedule was the literature. Although no specific mention was made of the degree of emotional investment by patient and worker in intensive casework, this was implied throughout.[1] In response to this, a question was included on the schedule which indirectly reflected this factor.

In summary, the factors which seemed to characterize intensive casework were: (1) continuing interviews, (2) structured interviews, (3) focus on personality, (4) more emotional involvement by worker and patient, (5) formulation of goals, (6) interdisciplinary coordination. Many of these factors could not be directly observed on the basis of material contained in records. However, when interpreted in a

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[1]Intensive casework is being interpreted as similar to casework as this was interpreted in the articles discussing psychotherapy and casework.

configurational manner the factors found pointed toward several of the unobserable factors mentioned. In order to avoid confusion in the analyses, the factors noted are defined in the following material.

Definition of terms and source of material.

Age - The age to the nearest whole year at the time of admittance to the hospital.

Medical Diagnosis - The final diagnosis given a patient by the staff doctor. Patients are always given an admitting diagnosis which may or may not be the one which is finally reached by the staff doctors after study. Final diagnosis is usually determined through cooperative efforts of the Psychology Department, Social Service, and the medical staff.

Marital Status - Status at the time of admittance.

Referral - Defined to include any way in which the social worker became involved in the case. It was divided into six specific parts:

(1) Formal staff meetings. All cases in which a staff meeting had been called by one of the team to diagnose the problems and evolve treatment planning or to evaluate progress and alter treatment planning for a particular patient. The cases included were those in

which reference was made to a direct referral to Social Service Staff at the meeting.

(2) Request from patient. Self Referrals.

(3) Doctor. Those cases in which a formal staff meeting had not been held but the staff doctor had made an informal request for Social Service.

(4) Other Social Service Staff. Designated those cases in which a referral for social service was made by a previous worker upon transfer of the case to a new worker as well as those in which service was suggested by another worker on the staff.

(5) Worker. Cases in which the worker defined the need for service and instigated action.

(6) Other hospital personnel. Included all the referrals from hospital personnel not included in other categories. Examples: clothing clerk, special service worker, routine administrative referral upon admission.

Frequency of contacts per six month period - Contacts, for purposes of the study, referred to face to face contacts with the patient. An attempt was made to obtain the number of contacts; however,

this was not possible. The contacts were stated in the records as being on a weekly, daily, or less frequent basis, rather than actual chronological interview by interview recording.

Scheduled or non-scheduled. The terms are self explanatory. Statements were contained in the records referring to the absence or presence of scheduled interviews. A case was considered non-scheduled if such a statement was not in the record.

Primary focus of direct contacts with patient. The term primary was used to indicate the overall focus rather than focus at any specific time. Two categories were used for this question.

(1) Environmental. Cases in which the focus of the contact was primarily on the externals of the patient's adjustment. Examples: finances, arranging for visit with relatives, obtaining clothing.

(2) Personality. Cases in which the focus of the contact was primarily on the internal problems of the patient's adjustment. Examples: anxiety feelings, delusions or hallucinations, sexual problem.

There was no way of determining an exact point at which a particular case became one or the other; however,

the problems which the worker focused on provided a basis for overall differentiation. A similar classification was utilized in a study conducted by Ripple and Alexander[1] in which they defined the categories in terms of the problem as presented.

> The problems fall into two categories: (1) those in which the problem for solution involves external, that is, environmental maladjustments or deficiencies and, concomitantly, the problem solving process contains at least some element acting upon that environment; and (2) that in which environmental circumstances per se have minor, if any, place in defining the question for solution and, consequently, the problem solving process to be set in operation does not involve acting upon that environment.

Since this classification was largely subjective, a board was used to make a judgement. This technique is explained later.

Termination of direct contact. This classification was divided into two categories: (1) planned, (2) unplanned. Planned termination included those cases in which termination was discussed with the patient and plans were made for referrals to other agencies, follow-up reports, or some other activity. Unplanned termination included those cases in which contact ended abruptly as in the case of a patient being discharged or leaving the

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[1] Lillian Ripple and Ernestina Alexander, "Motivation, Capacity, and Opportunity as Related to the Use of Casework Service: Nature of Client's Problem", Social Service Review, March, [illegible], p. 40.

hospital without notice.

The final factor was concerned with the technique used in working with the patient. The classification of techniques was borrowed from Hollis.[1] The four techniques which she listed were: (1) modifying the environment, (2) psychological support, (3) clarification, (4) insight. Her description of the terms was found to be impractical for the purposes of this study. However, they did provide a basis for further refinement. The terms as finally used were defined as follows:[2]

(1) Environmental Manipulation.

Altering with the patient his environmental situation. Providing concrete services for the patient. Examples of this technique would be: taking the patient to employment office, arranging transportation for patient's return to his home, finding a job for the patient.

(2) Clarification.

Examining and evaluating with the patient the major problems surrounding the social, physical, or emotional illness and his attitudes toward

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[1] Florence Hollis, "The Techniques of Casework", Social Casework, June, 1949.

[2] Although the terms used to classify techniques were derived from Hollis, much of the interpretation was derived from an unpublished report received by Battle Creek Social Service from Veterans Administration Central Office.

them to determine what goals are to be set and what action taken. Interpretation of hospital function and restrictions. Examples: intake interviewing, explaining administratively determined alternatives for leaving the hospital.

(3) Support.

Selective use of acceptance, interest, and encouragement to utilize and reinforce ego strengths in order to promote the patient's confidence in his ability to handle his situation and to function better. Allowing or encouraging the expression of charged feelings around a pressing, immediate need. Encouraging expression of charged feelings through a planned, channeled process on the part of the worker related to his awareness of patient's situation, his underlying longstanding needs, and the meaning of the experience to him.

(4) Insight.

Helping the patient to see his feelings and attitudes on a conscious or preconscious level and to see his own responsibility for functioning in relation to his social problem; descriptive addition of separate episodes in an orderly arrangement so that the patient can see the

same themes in his reactions; helping patient understand the nature of his emotion in the present situation, the situation that stimulates it, the inappropriateness of it to a situational demand and the undesirable mechanisms by which the patient attempts to handle his feelings; helping the patient to utilize self-knowledge in order to avoid stress situations for him. Example: patient finds that present feelings and thinking regarding doctor are similar to his feelings and thinking about his father.

The definitions did not provide a system which allowed a cataloguing of specific activities as evidenced in the records. It was used to provide a framework of interpretation for the purposes of the study. In addition, it was recognized that these categories are related and could be manifested at one time or another in a particular record. The basis for classification was the overall technique used, or more specifically, the technique used for the problem to be solved.[1]

Gathering of Data

The schedule was used in two ways. All of the questions were answered by the author. Two of the questions,

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[1]Ripple and Alexander, op. cit.

focus of direct contacts with patient and technique used, were derived subjectively. In these two questions, two staff workers were used to provide responses. Each of the two workers has had more than five years experience in social work and holds a Master of Social Work degree. At the time of the study one was a supervisor and the other a ward worker. They were selected primarily on the basis of interest in the study, understanding of the problem, and experience in intensive casework. The two workers were given a definition of the techniques and what was meant by focus of interviews.

Limitations

There were several limitations to the schedule used in the study. The most prominent was that no measure of feeling tones was obtained. This is an area which has eluded measurement in all research of interpersonal contacts. The usual method used to cope with this problem was utilized in this study, namely, the indirect measurement. An assumption was made that the presence of contacts focused on personality, use of insight or supportive techniques would indicate a more involved relationship than the absence of these factors. In essence, this constituted the indirect measurement of feeling tones.

Another limitation of the schedule was that no measurement of inter-professional, inter-agency, or correspondence contacts was obtained. There were many indications that these factors may have provided a basis for distinction between intensive and active casework. This points up another limitation. The case records did not display systematic or consistent methods of recording. It would have been easier to obtain data (particularly questions of frequency and structure of interviews) if the contacts had been noted individually and chronologically. For purposes of this study, however, enough information was obtained to come to conclusions regarding the questions mentioned above.

CHAPTER III

PRESENTATION AND ANALYSIS OF DATA

In the preceding chapter six factors were listed as characterizing intensive casework: (1) continuing interviews, (2) structured interviews, (3) focus on personality, (4) formulation of goals, (5) interdisciplinary coordination, (6) emotional involvement by worker and patient. The data gathered from the case records indicated directly or indirectly the presence or absence of these factors in the records.

The first factor, continuing interviews, could be interpreted in two ways: (1) by amount of time elapsed during treatment, or (2) number of interviews with the patient. In many cases it was difficult to ascertain the total time span due to summary recording. However, in most of the records it was possible to find statements indicating frequency of contact; consequently, this factor was utilized.

All of the active cases were found to have direct, face to face interviews with the patient once a month or less. Two of the active cases had direct interviews with the patient once a month. In sixteen of the active cases

direct interviews with the patient were held less than six times per six month period of time. All of the intensive cases had direct interviews with the patient from one to five times per week with nine, or half of them, falling in the once per week classification. The active cases, then, were characterized by direct interviews with the patient less than once a week and the intensive cases by interviews one to five times per week. The coefficient of contingency when cases were compared in this manner was -1 indicating a significant difference.

TABLE I

FREQUENCY OF DIRECT INTERVIEWS WITH PATIENTS

Number of Contacts Per Week	Active Cases	Intensive Cases[a]
5	0	2
4	0	0
3	0	1
2	0	5
1	0	9
Less than 1	18[b]	0
Total	18	17

[a]One case did not clearly indicate the frequency of interviews.

[b]Two of these cases were seen once per month, twelve were seen less than once per month.

It was felt that the frequency of direct interviews with the patient did not provide a complete picture, for in some cases the problem may have been evaluated with the

patient's family. In order to control this an attempt was made to obtain the frequency of interviews with relatives.

Two-thirds, or twelve, of the active cases showed no interview with the relatives. Over two-thirds, or thirteen, of the intensive cases had interviews from one to twelve times per six month period. It is interesting that no active cases had interviews with relatives more than three times per six month period, while the intensive cases indicated four such instances. However, no significant differences were found between active and intensive cases in terms of frequency of interviews with relatives.[1]

TABLE 2

FREQUENCY OF INTERVIEWS WITH RELATIVES OF PATIENTS

Number of Contacts Per Six Month Period	Active Cases	Intensive Cases
0	12	5
1-3	6	9
4-6	0	2
7-9	0	1
10-12	0	1
Total	18	18

The second factor, structured interviews, was interpreted as the presence or absence of scheduled or

[1]Coefficient of contingency of +.81 was found when the cases were compared on the basis of presence or absence of interviews. When the cases were compared in terms of less than 3 or more than 3 contacts, Q = 1.

non-scheduled interviews. The recording usually stated whether the interviews were held on a scheduled basis; if no statement was made to this effect it was assumed that the interviews were not scheduled. A significant difference was found when the cases were compared in this manner.[1] In two-thirds of the intensive cases interviews were held with the patient on a scheduled basis. In all but one of the active cases interviews were held on a non-scheduled basis.

Type of Interview	Active Cases	Intensive Cases
Scheduled	1	12
Non-Scheduled	17	6
Total	18	18

These findings support those found in a measurement of the frequency of contacts. A higher number of non-scheduled interviews would be anticipated where fewer contacts had been made.

The third factor, formulation of goals, could not be measured directly. If the psycho-social diagnosis had been used in practice over a long period of time this could have been utilized to measure formulation of goals. However, the psycho-social diagnosis is only beginning to be used at this agency and consequently was not found consistently in the cases. Two factors were used to

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[1]Coefficient of contingency -.94.

indicate indirectly the formulation of goals: (1) source of referral, and (2) planning or lack of planning in termination of direct contacts with the patient. In the active cases five-sixths or fifteen of the cases were referred from "other" sources. This means that those cases were referred from non-professional staff and in many instances were administrative referrals in which the case was not discussed with other hospital personnel. No intensive cases were found in the "other" category. Seven, or almost half of the intensive cases were referred at a formal staff meeting. In all but four intensive cases there was some communication with professional hospital staff when the case was referred. In four of the cases the referral came from the patient. A significant difference was found when the cases were compared on the basis of referral from non-professional or professional (including self-referrals).[1] The source of the referral then would indicate that the intensive cases were more often discussed with professional hospital personnel when referred. [2]

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[1]Coefficient of contingency - 1.

[2]See Table 3 on p. 39.

TABLE 3

SOURCE OF REFERRAL FOR SOCIAL SERVICE

Source of Referral	Active Cases	Intensive Cases
Formal staff	1	7
Self	0	4
Social Service	0	3
Worker	0	3
Doctor	2	1
Other*.....	15	0
Total	18	18

*Includes administrative referrals and referrals from departments other than Social Service, Medical, or Psychology.

No significant differences were found when termination planning was considered.[1] Thirteen of the intensive and ten of the active cases were found to have planned termination of direct contact with the patient.

Type of Termination	Active Cases	Intensive Cases
Planned	10	13
Not planned	8	5
Total	18	18

These findings may be in part due to the way this category was defined. The presence or absence of planned termination was based on the presence or absence of social planning with the patient. One of the responsibilities of the Social Service department is to effect social

[1]Coefficient of contingency +.35.

planning; consequently, most cases in which the patient leaves the hospital the Social Service department would record social planning and the case would therefore be classified as planned termination. The difference may be found in the preparation of the patient for leaving rather than in actual leaving. In relation to evaluating formulation of goals, however, this is interesting. It is indicative of conscious social work practice with a difference between intensive and active perhaps found more in the type of problem and the methods used to evolve goals. In both active and intensive cases goals are formulated in working with the patient; however, there is some indication that other professional hospital personnel are utilized in formulating the goals in the intensive case.

Focus of direct contacts with patient was indicated by attempting to judge whether the focus was environmental or personality. In both intensive and active cases the focus was on personality. The findings indicated no significant differences.[1]

Focus	Active Cases	Intensive Cases
Personality	17	16
Environmental	1	2
Total	18	18

[1]Coefficient of contingency +.36.

Since this factor was dependent largely upon a subjective evaluation, a board of three was utilized to give a judgment. The final determination was made by selecting the category which was chosen by two of the three judges. Total agreement was found in twenty-one of the thirty-six cases judged, with more agreement in the intensive cases than the active cases.[1]

Judgments	Active Cases	Intensive Cases
Total agreement	6	15
Disagreement	12	3
	18	18

It is difficult to evaluate the factor being measured in terms of the lack of consistency found in the judgments. The findings indicate that the categories of personality and environment may not have been sharply enough defined in order to reach total agreement; however, it may also indicate that in subjective evaluation perception is a highly important variable to be controlled. The answers to these questions may be found in other attempts to utilize the board judgment in evaluating the two categories. It was felt, however, that the results obtained were indicative of some consistency and were consequently useful.

The findings are interesting in their implications.

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[1]The disagreement came largely from the same individual on the board.

They tend to support the belief that social casework is a working with people around realistic problems on a tangible level. Even though a problem may be defined in a tangible manner, such as arranging for a pass, the help which is given is primarily concerned with the individual in relation to the tangible service being rendered. As in the case of goals no differentiation can be made in terms of focus on personality.

The fifth factor, interdisciplinary coordination, was not directly indicated due to limitations in the recording. A good deal of communication is known to take place between members of the professional departments; however, due to the frequency and informality of the contacts they are seldom recorded. The only source of information which would be indicative of the degree of coordination is found in the source of referral.[1] As indicated previously the intensive cases were characterized by more referrals from the hospital's professional staff. This would provide some basis for feeling that the other disciplines would be more apt to define their respective roles in the intensive cases than the active. In addition, seven intensive cases were referred from formal staff meetings which would require a discussion of what discipline would take part in

[1]See Table 3, p. 39.

particular activities. In this sense there is some evidence to support a higher degree of coordination in the intensive cases.

The final factor to be considered is the amount of emotional involvement by caseworker and patient. The technique used in the case was judged in an attempt to get some indication of the degree of emotional involvement. Four categories were used to classify the cases: insight, support, clarification, and environmental manipulation. All but one of the intensive cases were placed in the insight or support categories. Five of the active cases were placed in the insight or support categories. Thirteen of the active and one of the intensive cases were placed in the clarification or environmental manipulation categories.

TABLE 4

TECHNIQUES USED IN WORKING WITH PATIENT

Technique	Active Cases	Intensive Cases
Insight	1	6
Support	4	11
Clarification	6	0
Environmental manipulation	7	1
Total	18	18

The significant difference is that the intensive cases more often used insight and support while the active cases

more often used clarification and manipulation as techniques.[1] Although most of the active cases were classified as clarification or environmental manipulation five of the active cases were found in the support and insight categories. Only one of the active cases was classified as insight, however. If we can assume that these categories can be placed on a continuum of increasing involvement between the worker and patient,[2] the findings would point toward intensive casework having a higher degree of involvement.

As in the case of focus, this factor was largely a subjective evaluation and was similarly judged. Total agreement was found in thirteen of the cases while twenty-three of the cases were agreed upon by two of the members of the board. These findings, as well as those in the discussion of focus, would lead one to wonder if the categories are meaningful. As in the previous case, however, this method was utilized to reduce subjectivity of interpretation without attempting to validate the concepts used. The variation which was found in the active cases could be due to this factor. If, however, the findings are interpreted in the extremes and in relation to the findings regarding

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[1] Coefficient of contingency -.96.

[2] insight, support, clarification, environmental manipulation

structure, frequency of contact and source of referral, the statement above referring to the higher degree of emotional involvement would seem to be justified.

Some material was gathered which did not lend itself directly to the casework process but rather to characteristics of the patient. There was no significant difference found between intensive and active cases when time interval before first contact with the patient was considered.[1] In eleven of the intensive and fifteen of the active cases interviews with the patient were held within one month from time of admittance to the hospital. In four of the intensive and three of the active cases interviews were held after the patient had been in the hospital six months.

TABLE 5

NUMBER OF MONTHS PATIENT WAS IN HOSPITAL BEFORE INTERVIEW BY CASEWORKER

Months	Active Cases	Intensive Cases
Less than 1*	15	11
1 - 3	0	1
4 - 6	0	2
Over 6	3	4
Total	18	18

*Included estimates of time interval as indicated by date of dictation on intake history.

[1] A coefficient of contingency of +.52 was found when the time interval is divided into less than 1 month or more than 1 month.

No difference was found when marital status of the intensive and active cases was compared.

TABLE 6

MARITAL STATUS OF PATIENTS

Marital Status	Active Cases	Intensive Cases
Married	7	8
Single	8	7
Divorced	2	3
Separated	1	0
Total	18	18

Eight of the active cases and one of the intensive cases were found in the age group over forty.[1] It appears that the patients which are involved in intensive casework are a somewhat younger group than the patients involved in active casework.[2] It may be that the younger patient is more able to utilize techniques such as insight and support; however, the sample which is here represented is not large enough to draw such an inference.

The medical diagnosis of the patients in the sample group did not provide any basis for distinction between intensive and active cases. If a larger sample had been utilized some distinctions might have become

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[1] See Table 7 on p. 47.

[2] Coefficient of contingency -.86 when compared on basis of under forty or over forty years of age.

evident. It was interesting to find that when cases were divided into schizophrenic and other categories, the intensive cases had more schizophrenic diagnosis than the active. The difference,however, was not significant.[1]

TABLE 7

AGE OF PATIENTS

Age	Active Cases	Intensive Cases
16-20	0	3
21-25	3	3
26-30	3	3
31-35	2	6
36-40	2	2
41-45	4	0
46-50	0	0
51-55	1	1
56-60	1	0
61-65	2	0
Total	18	18

TABLE 8

MEDICAL DIAGNOSIS OF PATIENTS

Diagnosis	Active Cases	Intensive Cases
Schizophrenic		
Simple	1	0
Hebophrenic	0	1
Paranoid	5	7
Catatonic	0	2
Unqualified	4	5
Brain Damage	4	1
Anxiety Reaction ...	0	1
Manic-Depressive ...	1	1
Sexual Deviate	1	0
Alcoholic Psychosis.	1	0
Character Disorder..	1	0
Total	18	18

[1]Coefficient of contingency -.60.

Summary

If a chart were drawn showing the major differences between intensive and active cases it would appear as follows:

Factor	Active Cases	Intensive Cases
Contacts with patient	Less than 1 per week	1-5 per week
Referral	Non-proffesional personnel	Proffession-al personnel
Scheduled Non - scheduled	Non-scheduled	Scheduled
Technique	Clarification Environmental manipulation	Insight Support

The factors which were listed at the beginning of this chapter were in large part substantiated, with exception of focus on personality. The hypothesis which was utilized for the study implied that factors would be evidenced which were common to both intensive and active casework, but that they would distribute themselves bi-modally. Specifically, this would mean that if each of the factors noted in the study were arranged on a scale of increasing intensity a frequency distribution would evolve which would be bi-modal in form. This

would also imply that intensive and active casework are not separate and unique entities. The hypothesis was in part borne out. In measuring the individual factors it was found that each factor was found in both active and intensive cases but some factors were found more frequently in one type of case than in the other. This could be related to the research design not being precise enough in the definition of the categories, or it may be indicative of a scale of relative intensity.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In the cases which were used as a sample, intensive casework is characterized by more frequent, usually one to five per week, scheduled interviews. The source of referral is usually professional hospital personnel or the patient himself. Insight and support tend to be the techniques used in working with the patient.

Active casework, as seen in the sample, is characterized by less frequent, usually less than one per month, interviews. The interviews are more often held on a non-scheduled basis and the referral usually comes from non-professional hospital personnel. The techniques used in working with the patient are usually clarification or environmental manipulation. Intensive and active casework did not provide mutually exclusive categories in terms of the factors which were considered in the study.

One significant point was brought out in the study. It is evident that intensive casework is not merely an increase in activity. It would seem to be only an increase in activity when factors such as

frequency of interviews are considered. However, as the technique used is examined a shifting is found. If support and insight may be equated with more emotional involvement, a higher level of emotional involvement is found in the intensive cases. It would be interesting to know if the nature of the presenting problem changes in the same manner. In other words, it seems that in the intensive cases a different technique is used to cope with the problems presented. This would involve a differential diagnosis. Some of the factors which were felt to characterize this differential diagnosis were summarized in Chapter I.[1] Among them were: (1) willingness of client to participate, (2) worker's interest in the case or feeling toward the patient, (3) length of hospitalization, (4) patient's capacity to relate to the worker. It is notable that no mention is made of the problems involved, but rather an emphasis is placed on the patient's characteristics. This would lead one to wonder if the shift in technique is a function of the problem or of the caseworker's interest and need.

Although not conclusive, some evidence was found to support a generic view of casework. Two factors,

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[1]Chapter I, p. 9.

planning of termination of contacts with the patient and focus of interviews (personality and environmental), were found to be insignificant in distinguishing between intensive and active casework. Since termination planning is a function of the Social Service department in this hospital, the absence of this factor would reflect on the quality of the casework. With reference to focus on personality it is recognized that tangible problems which are presented to caseworkers are dynamically related to the individual and would consequently involve working with the individual and his need in relation to the tangible problem. If a service, such as arranging for transportation, were presented to the patient, with no involvement of the patient, the quality of the casework service would be highly questionable. These two factors, in all probability, represent a small part of the total generic area of casework. It is in this area that studies of evaluation might be conducted.

Two goals for this study were indicated in the first chapter: (1) to work toward construction of a concept of intensive casework, and (2) to provide a basis for further research of the casework process. The first goal has been attained. Intensive casework has been examined on an empirical level and some factors have evolved which characterize intensive casework.

The limitations of this study, in part, provide for the attainment of the second goal in that three fundamental questions were raised.

The first of these is related to the characteristics of the patients and workers who become involved in intensive casework. Since this level of casework is seemingly used in a differential manner, it would be valuable to know more about the basis for the decisions. This study has, in part, defined the cases which can be used for research of these characteristics.

On the other side of the problem and in relation to the other parts, an evaluation of this level of casework is needed. As shown in the study, an investment of time and energy is required for the practice of intensive casework which is greater than that found in active casework. It seems feasible to wonder if this investment is warranted in terms of the results obtained.

The final question raised is an old one. How does intensive casework differ from therapy in other disciplines? The factors which were found to characterize intensive casework align themselves closely with many of the factors which are discussed in the literature as characterizing therapy in other professions. Perhaps there is no difference. It may be, however, that the concepts which are being used for purposes of comparison

are fluid enough to prevent comparison. This factor was mentioned in relation to the discussion of techniques and particularly with reference to the board judgment. It may be that what social work calls "insight" is quite different from what is called insight by other professions, and the same may be true for the other techniques mentioned.

Recommendations

The recommendations which evolve from a study of this type are usually related to the need for further research, and this study is no exception. The need for further research falls into two major categories.

The first is the need for refinement of the study. The classifications which were used could be further broken down and more specifically defined. There is a reasonable amount of evidence to make one doubt the utility of using the case records in this agency as the source for data for a study of this type. Perhaps the recording should be defined for research purposes; however, the dangers of bias and skewing are well known when this procedure is utilized.

The most prominent research need is for further investigation of the techniques mentioned in this study. It is not believed that these techniques should provide for a casework classification system. It would seem

more appropriate to define levels of casework, using particular techniques, than to have the technique define the level of casework.

The second need is for this study and approach to be applied in different settings and with different groups of cases to get some indication of reliability. Until this is done, few generalizations may be drawn from the study. This is directly related to one of the outstanding problems in social work, namely, the difficulty and confusion found in attempts to provide a basis for effective recording. Until such time as concepts can be used which will be meaningful and relatively conclusive, social work recording will continue to be an unorganized description of events. Concepts which reduce the need for bulk descriptive recording would be helpful.

Intensive casework may be used as a term to describe a level of casework possessing characteristics which tend to differentiate it substantially from generic casework. The findings of this study need further evaluation but lend support to intensive casework as a meaningful concept.

APPENDIX

APPENDIX A

This was a survey of thirty-one Veterans Administration neuropsychiatric hospitals. The hospitals constitued the total population of Veterans Hospitals devoted to neuropsychiatric disorders. A letter was sent (see Appendix D) to the Chief of Social Service of each hospital asking for the staff's cooperation in answering two questions:

(1) Do the individual workers make an informal, non-administrative separation of some cases into those in which they engage in intensive casework and those in which they are actively working but no on an intensive basis; and (2) what are some of the factors which the workers feel characterize the practice of intensive casework?

Twenty-three responses were received from the hospitals. Two of the responses were incomplete, that is, they did not answer the questions, leaving twenty-one meaningful reports. The response to question one broke down as follows:

Used the differentiation 16

Did not use the differentiation 5

The responses to question two are noted in appendices B and E.

APPENDIX B

Factors Considered in Selection of Cases for Intensive Casework as Reported by Social Workers in VAH Neuropsychiatric Hospitals

Factor Noted	Frequency of Notation*
Willingness of patient to participate	4
Age	2
Length of hospitalization	3
Past adjustment	3
Worker's interest in patient	1
Patient's capacity to relate	6

*Frequency of factor being listed in response from hospitals.

Source: See Appendix A.

APPENDIX C

SCHEDULE FOR THE STUDY OF FACTORS CHARACTERIZING INTENSIVE CASEWORK

Code No.____

1. MEDICAL DIAGNOSIS_____

2. AGE____MARITAL STATUS: single___divorced____
widowed____separated___

3. AT THE TIME OF CONTACT PATIENT HAD BEEN IN HOSPITAL:
_____years_____months_____days

4. REFERRAL CAME FROM: formal staff meeting_____request from patient_____social service staff____doctor____ other hospital personnel_____

5. AVERAGE FREQUENCY OF CONTACTS PER SIX MONTH PERIOD:
Direct with patient_____
Direct with relatives_____

6. PRIMARY FOCUS OF DIRECT CONTACTS WITH PATIENT WAS:

ENVIRONMENTAL_____
(finances, arranging weekend pass, etc.)

PERSONALITY_____
(anxiety feelings, delusions, sexual problem)

7. INTERVIEWS WERE ON: Scheduled basis___non-scheduled___

8. TERMINATION OF DIRECT CONTACT WITH PATIENT WAS:
Planned with patient_____
Unplanned_____(patient leaving hospital abruptly, not returning for interview, etc.)

9. PRIMARY METHOD USED DURING CONTACTS ON CASE:

Insight_____

Support_____

Clarification_____

Environmental Manipulation_____

APPENDIX D

February 14, 1956

To: Chief of Social Service
Veterans Administration Hospital

Subject: Study of Factors Characterizing Intensive Casework

I am a second year graduate Social Work student attending Michigan State University and doing my field work at the Battle Creek Veterans Administration Hospital. As partial fulfillment of the requirements for a Master of Social Work degree I am conducting a study of the factors characterizing intensive casework.

I would appreciate you and your staff's cooperation in answering two questions which I plan on incorporating in the thesis:

(1) Do the individual workers make an informal non-administrative separation of some cases into those in which they engage in intensive casework and those in which they are actively working but not on an intensive basis?

(2) What are some of the factors which the workers feel characterize the practice of intensive casework?

Intensive casework at this hospital seems to be thought of in terms of more frequent contacts between patient and worker, scheduled interviews, focus on personality adjustment, etc.

In that this project is to be completed early in March, I would appreciate your response before March 7, 1956. Your cooperation will be highly appreciated and any additional comments you wish to make will be welcomed. Thank you.

Sincerely,

APPENDIX E

FACTORS CHARACTERIZING INTENSIVE CASEWORK AS REPORTED BY SOCIAL WORKERS IN VAH NEUROPSYCHIATRIC HOSPITALS

Factor Noted	Frequency of Notation*
Interviews continuing overtime	6
Scheduled interviews	9
Content of interviews focused on personality	11
Formulation of goals	9
Staffing of cases	3
Collaboration with other disciplines	5
Frequency of interviews	3

*Frequency of factor being listed in response from the hospitals.
Source: See Appendix A.

APPENDIX F

INTERPRETATIONS OF INTENSIVE CASEWORK BY THREE BATTLE CREEK VETERANS ADMINISTRATION HOSPITAL SOCIAL SERVICE CASEWORKERS

A

This method of casework, first of all, presupposes a knowledge of human dynamics, personality structure and complete diagnosis of the person and/or problems being treated. Intensive casework has as its main focus a change in personality and/or attitude (the inner man) so as to enable him to react with his environment in a more satisfying manner.

A complete diagnosis is particularly important since it is impossible to treat and/or change a personality unless one knows what to treat. Through a knowledge of human dynamics the object relationship and the diagnosis can be established. The techniques used in this form of treatment involve use of transference in the relationship, use of ego strength, modifying inappropriate ego defenses, strengthening appropriate defenses, limited interpretation of unconscious material, handling external dangers which generate anxiety and weaken the ego, and re-education.

Some examples of the foregoing statements may be helpful, particularly with regard to limited interpretation. This calls for a thorough understanding of the ego.

Certainly dynamic interpretation as used in "insight" or "deep psychotherapy" would be inappropriate with a person with a crumbling, weak ego structure. Conversely, a person deeply concerned with his ordinarily unconscious strivings does not need to have them reemphasized--a kind of wading through the id. In intensive casework I often find it appropriate to strengthen appropriate ego defenses. I am reminded of a schizophrenic who experienced a psychotic break almost immediately after marriage. Study revealed that the break was definitely related to the marriage and the patient's inability to tolerate a marital relationship. When he developed the rationalization that he would not get married again until he had purchased and elaborately furnished their own home, owned an expensive automobile, and had a high paying job, I supported this rationalization. I knew first, another marriage would precipitate another break and I knew too that there was little likelihood that he would acquire all the wealth prerequisite to another marriage.

Sometimes it is necessary to modify existing attitudes and patterns of behavior. This is done simply by minutely examining existing attitudes and reviewing frustrations because of attempted ways of handling one's problems. Many times honest persuasion to try another method is sufficiently gratifying after trial to induce

different approaches to a hitherto very vexing problem.

I am often impressed with the frequent incident of simple request for information. Clarification of these requests clearly points to a body of mis-information harbored by the patient. It is not improbably that one will encounter transference in this area. The mis-information has often been imparted by a well meaning parent or parent surrogate. Re-education in these instances of necessity and definition brings into play the transference phenomenon.

In intensive casework the idea of contact, both with regards to incident and duration comes up. This is probably purely academic. I have found that a great deal can transpire to change an attitude or pattern of behavior in a relatively short time or even in one contact. One cannot measure the intensity of feeling or the amount of movement solely with the yardstick of time. I must say, however, that a planned approach to inherent problems and planned contact is vital to the relationship, the medium through which intensive casework goals are realized.

B

Intensive casework is that form of direct social work with clients where there is some form of conscious focus and structural purpose in offering this therapeutic service.

This process is carried on through a series of regular scheduled interviews held by the caseworker where the primary focus is emotional and personality adjustment. Intensive casework takes place in a dynamic caseworker-client relationship with both having considerable emotional investment which is controlled and used by the worker.

Psychological support, understanding, clarification, etc., are used in dealing with the client's problems. The client is guided to participate to his fullest capacity in helping to understand and modify his behavior.

C

In a broad concept casework is the giving of practical service to an individual in relationship to the existing social or emotional problem for which he is asking help. These problems, to a varying degree, are psychosocial. Some individuals are capable of recognizing feeling, or sensing themselves as an integral part of the existing problem.

With time, motivation, and professional assistance, these persons may achieve solution or resolution of the existing difficulty. In a professional social work relationship these individuals are candidates for intensive casework treatment.

Other individuals, and perhaps the vast majority, are able to accept and utilize social work services only to a limited degree. They may have the inability to see themselves as a part of the problem, and a considerable need to externalize the existing difficulty. Because of emotional or physical damage an individual may be unable to use an intensive approach to the difficulty. Motivation may be lacking, time insufficient or other factors may enter to indicate that only limited goals or a manipulation of the environment are practical. In this broad sense these cases can be construed as active social work cases.

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